Kent and Medway NHS
Strategic Health Authority

REPORT INTO THE CARE AND TREATMENT OF

JOHN REGAN

MAY 2005

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The following abbreviations are used in the text of this report:

A&E	Accident and Emergency
CHI	Commission for Health Improvement (Now known as the Healthcare Commission.)
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CMHT	Community Mental Health Team
GP	General Practitioner
OT	Occupational Therapist
PSR	Pre-Sentence Report
PCT	Primary Care Trust
SHO	Senior House Officer
SUI	Serious Untoward Incident
The Trust	East Kent Community NHS Trust

1. INTRODUCTION

1.1 The terms of reference of the inquiry (see attached **Annex 1**) included reviewing all the documentation that was made available in Mr Regan's case (see attached **Annex 2**) and providing a preliminary report to the health authority. The preliminary report was submitted on 5th April 2003.

1.2 Following the submission of this report correspondence took place between the inquiry team and the health authority to clarify the further work that the commissioners required to be undertaken (**Annex 3**). On 16th October 2003 two members of the inquiry team, Linda Bolter and Dr Andrew Johns, travelled to Manchester Prison and interviewed Mr Regan. A record of that meeting, and the resulting correspondence, is annexed. (**Annex 4**)

1.3 On 29th October 2003 and 30th October 2003 the inquiry team then met to hear evidence. The list of witnesses who gave evidence is annexed. (**Annex 5**).

1.4 The report was submitted to the Health Authority on 6 February 2004. The report was then discussed at a meeting on 9 June 2004 where Anthony Harbour and Linda Bolter met with Martin Hawkins and other health authority staff. Following that meeting it was agreed that the report could be presented to the Health Authority Board. On 9 July 2004, however, Anthony Harbour was informed that Dr Garcia was working in the Kent area. Because Dr Garcia was a central figure in the delivery of psychiatric care to Mr Regan, Anthony Harbour decided that evidence should be heard from Dr Garcia. This was arranged and Anthony Harbour, Dr Andrew Johns and Michael Hill met with him on 5 November 2004. East Kent Social Care and Partnerships Trust approached the Health Authority in July and suggested that as the team were going to reconvene, evidence could usefully be provided by Rob Lancaster. Rob Lancaster's evidence was also heard on 5 November 2004.

1.5 This report is therefore an amalgam of the preliminary report and an analysis of the additional material and evidence made available to the inquiry team since April 2003.

2. CHRONOLOGY

22.06.1958	Mr Regan born at Sefton Hospital, Liverpool.
29.11 1999	Mr Regan assigned to the list of Dr Premnath,

	General Practitioner, White Cliffs Medical Centre, Dover.
29.11.1999	Mr Regan attends first consultation with Dr Premnath.
20.12.1999	Mr Regan attends further consultation with Dr Premnath.
22.12.1999	Letter to East Kent Community Alcohol Service from Dr Premnath referring Mr Regan for assessment.
11.01.2000	Mr Regan attends first appointment with Ms Thomasson, alcohol counsellor.
12.01.2000	Letter to Dr Premnath from Ms Thomasson confirming her preliminary assessment of Mr Regan.
25.01.2000	Mr Regan attends second appointment with Ms Thomasson.
25.01.2000	Mr Regan admitted to Ramsay Ward, Buckland Hospital, Dover.
26.01.2000	Plans for Mr Regan's discharge from Ramsay Ward later in the day (Mr Regan took his own discharge at 11.05 hours).
01.02.2000	Mr Regan again seen by Ms Thomasson.
February to November 2000	Ms Thomasson continues to offer appointments to Mr Regan.
02.03.2000	Mr Regan charged by the police that on 06.01.2000 he was in possession of cannabis with intent to supply.
14.11.2000	Mr Regan stands trial at Canterbury Crown Court and is found guilty of possession of cannabis with intent to supply. Sentence deferred for reports; bail granted.
22.11.2000	Mr Regan interviewed by Ms Ashmore, probation officer, for preparation of a pre-sentence report.
05.12.2000	Mr Regan is sentenced at Canterbury Crown Court to a period of 9 months imprisonment for possession

	of cannabis with intent to supply.
27.12.2000	Mr Regan's file at East Kent Community Alcohol Service is officially closed.
20.02.2001	Mr Regan is released from H.M. Prison Canterbury .
02.03.2001	Mr Regan is treated at the A&E Department, William Harvey Hospital, Ashford, Kent, for lacerations to both wrists.
11.04.2001	Mr Regan attends White Cliffs Medical Centre and is seen by Dr Beach, locum to Dr Premnath.
11.04.2001	Letter to CPNs at Coleman House, Dover Mental Health Centre, from Dr Beach.
19.04.2001	Letter to Mr Regan from the secretary to Dr Garcia, locum consultant psychiatrist, Dover Mental Health Centre, confirming plans to visit him at his home address.
23.04.2001	Mr Regan is seen by Dr Garcia at Coleman House, Dover Mental Health Centre.
04.05.2001	Letter to Dr Premnath from Dr Garcia confirming his preliminary assessment of Mr Regan and indicating an initial plan of care.
04.05.2001	Letter to Ms Thomasson from Dr Garcia requesting an assessment of Mr Regan.
08.05.2001	Letter to Mr Regan from the secretary to Dr Garcia confirming a further appointment on 05.06.2001.
11.05.2001	Letter to Mr Regan from Ms Thomasson confirming an appointment on 21.05.2001.
21.05.2001	Mr Regan attends appointment with Ms Thomasson.
24.05.2001	Letter to Dr Garcia from Ms Thomasson recommending that Mr Regan is referred for anxiety management.
05.06.2001	Mr Regan fails to attend appointment with Dr Garcia.
05.07.2001	Letter to Dr Premnath from Dr Garcia discharging Mr

	Regan back to the care of his GP.
July to September 2001	Ms Thomasson continues to offer appointments to Mr Regan.
07.07.2001	Mr Regan attends White Cliffs Medical Centre (this is his last recorded consultation with his GP.).
13.09.2001	Mr Regan's last recorded contact with Ms Thomasson.
13.09.2001	Gilbert McCallum is found dead in a flat in Cherry Tree Avenue, Dover.
14.09.2001	Mr Regan is arrested by police in connection with their investigation into the suspected murder of Mr McCallum.
18.09.2001	Ms Thomasson makes an entry in Mr Regan's notes confirming that her client had been arrested and remanded in prison.
28.09.2001	Mr Regan makes his first appearance at Maidstone Crown Court on a charge of murdering Mr McCallum.
16.10.2001	Dr K White completes chronology of services provided to Mr Regan.
19.10.2001	Meeting of Serious Untoward Incident Group, East Kent Community NHS Trust.
25.10.2001	Letter to Mr Parr, Chief Executive, East Kent Community NHS Trust, from Dr White.
16.11.2001	Meeting of Serious Untoward Incident Group.
17.06.2002	At Maidstone Crown Court Mr Regan pleads guilty to an offence of manslaughter on the grounds of diminished responsibility in relation to the unlawful killing of Mr McCallum.

3. COMPLIANCE WITH STATUTORY OBLIGATIONS

3.1 Statutory obligations, or at least detention and treatment under the Mental Health Act 1983, are not issues in this case. There was evidence that Mr Regan suffered from mental illness, namely anxiety, depression and paranoia. There was, however, no evidence that Mr Regan suffered from mental illness of a nature or degree to warrant his detention under the Mental Health Act. Although Mr Regan was at times severely dependent on alcohol, section 1 of the Mental Health Act 1983 states that no person may be dealt with under the Act 'by reason only of…dependence on alcohol…..'[1]

4. COMPLIANCE WITH THE CPA

4.1 Ms Thomasson, who had most regular contact with Mr Regan, did regard him as CPA eligible when she gave evidence.[2] Mr Mungar did acknowledge that Mr Regan was CPA eligible and identified Dr Garcia as the keyworker.[3] Mr Reading was uncertain as to Mr Regan's CPA eligibility in 2000 and 2001.[4] Dr White was entirely clear – Mr Regan was 'of course' eligible for care at the standard level of CPA[5] and the care co-ordinator would have been Dr Garcia.[6] When Dr Garcia gave evidence he said that although he regarded himself as Mr Regan's care co-ordinator, the best person to act as care co-ordinator was Dawn Thomasson.[7]

4.2 The inquiry team is also clear that Mr Regan was eligible for the CPA. He was 'in contact with the secondary mental health system'[8] and offered a further appointment with psychiatric services. There is evidence of a referral in 2000 to Dr Plummer, consultant psychiatrist to the alcohol service.[9] Dr Plummer did not see Mr Regan because Dr Plummer was apparently off sick. In April 2001 Mr Regan had been referred to the CPN service by his general practitioner. In April 2001 he was assessed by Dr Garcia. He was also in regular contact with the alcohol service, a part of the East Kent Community NHS Trust.

4.3 Mr Lancaster explained that between 1999 and 2001, all patients meeting the Trust Eligibility Criteria, drawn up in 1997, should be accepted for standard CPA (then called "simple"), which involved a brief assessment, including consideration as to suitability for enhanced CPA (then called "complex"). He accepted that alcohol problems alone did not meet acceptance criteria for standard CPA, but that alcohol problems with, for example depression, anxiety, panic attacks, would qualify. These criteria

'were quite strictly intended for people who were suffering from mental illness.'[10]

4.4 Dr Garcia explained that the then Trust eligibility criteria used terms such as 'neurotic' or 'reactive depression' which he regarded as old-fashioned terminology. In his letter to Dr Premnath he advised that he did not think that Mr Regan was suffering from clinical depression, but offered him treatment for his symptoms of anxiety and panic. Whilst regarding the labels of neurotic or reactive depression as not having any applicability to Mr Regan, Dr Garcia nonetheless regarded Mr Regan as eligible for standard CPA. He did not, on the other hand, regard Mr Regan as eligible for enhanced or complex CPA.

4.5 The four main elements to the CPA include: systematic assessment of the patients needs, formation of a care plan to address those needs, appointment of a care co-ordinator and regular review, and where necessary changes, to the care plan.

4.6 Recommendations from Effective Care Co-ordination in Mental Health Services[11] (above) which are also relevant to Mr Regan's care include:

Para 44 A copy of the service user's care plan should be given to his/her GP.

Para 49 If service users have to reside in prison and they are known to have longer term and complex mental health needs, the responsible psychiatric team should maintain contact with the individual and make plans for care on the person's release in collaboration with prison and probation staff as appropriate.

4.7 On 23rd April 2001 a preliminary mental health risk assessment form was completed (although not in full); this did not identify a risk of suicide or self-harm or a risk to others. Dr Garcia agreed that he completed the form. There is no written evidence of a CPA level having been assessed or a CPA plan having been determined. (Effective Care Co-ordination in Mental Health Services[12] states that two levels of the CPA must be introduced: (i) standard and (ii) enhanced.) There is also no evidence that a CPA plan was subject to regular review.

4.8 Dr Garcia's view was that having assessed Mr Regan and completed the risk form, then he was implicitly regarded as "standard CPA", without necessarily ticking a box to make that clear. Dr Garcia also said that for standard CPA, the care plan was generally expressed in his letter to the referring GP. There is no form to show that the "standard CPA" for Mr Regan was reviewed, but Dr Garcia gave evidence that the review process consisted of him offering a follow-up appointment, which he did.

4.8 The divergence between basic CPA requirements, and how the CPA was complied with in Mr Regan's case, can be simply reproduced in tabular form.

CPA level	Nothing recorded, but it was accepted that Mr Regan was eligible at 'Standard level.'
Care co-ordinator	Nothing recorded. Dr Garcia was the care co-ordinator. At that time, there was no reason why consultant psychiatrists should not be care co-ordinators, but 'consultant psychiatrists did not fill in CPA paperwork'.[13]
Care plan	Letter to GP dated 4 May 2001
Regular review	Nothing recorded. Informal liaison with Dawn Thomasson and Dr Garcia. Dr Garcia offering follow up appointment

5. COMPLIANCE WITH LOCAL OPERATIONAL POLICIES

5.1 The Trust document entitled Serious Untoward Incident Policy[14] is dated February 2000 and would, therefore, have been effective at the time Mr Regan committed the index offence. There is guidance in the document on what constitutes a serious untoward incident and on the levels to which such incidents should be reported, together with a procedure for reporting and recording such incidents and an outline of other action to be taken. For both "in hours" and "out of hours" incidents, homicide and attempted homicide involving those under the care of the trust or in current or recent contact with its services, are deemed to be reportable incidents. Appendix 3 of the document contains the form for reporting serious untoward incidents and at Appendix 4 there is guidance on its completion. It would appear that in relation to Mr Regan the provisions of the procedure were applicable and, therefore, the matter should have been formally reported on the designated form and the chief executive should have considered convening a serious untoward incidents team. Whether this was deemed an "in hours" or "out of hours" incident, stages 1 to 3 should have been followed in terms of levels of reporting.

5.2 In the initial stages of their work, the inquiry team was provided with a copy of a document "Chronology of Services Provided to Mr John Regan by the East Kent Community N.H.S. Trust." This document had been

prepared by Dr White, consultant psychiatrist, and was dated 16th October 2001. The information contained in the chronology had been obtained from the notes made by clinicians in the trust in relation to their involvement with Mr Regan. It covered the period from 22nd December 1999 (when Mr Regan's GP referred him for help with his alcohol dependency) to 18th September 2001 (when Ms Thomasson was informed of Mr Regan's arrest on suspicion of murder) and indicated that a number of issues required further consideration; these were:

- Risk assessment by the alcohol service;
- Record keeping;
- Frequency of communication between the alcohol service and Mr Regan's GP;
- Reasons for the delay in Mr Regan's re-assessment by Dr Garcia.

5.3 At the beginning of October 2003 Michael Hill, a member of the inquiry team, had a detailed telephone conversation with Dr White in relation to both the context in which her work on the chronology had been undertaken and the issues she had identified as requiring further consideration. Subsequent to that, Dr White gave evidence to the inquiry.

5.4. When the chronology was prepared by Dr White, she was the chair of the Serious Untoward Incident Panel (SUI) of the East Kent Community N.H.S. Trust; she undertook that role as part of her responsibilities as acting medical director of the trust. She had been requested to prepare the chronology by Mr Parr, the trust's chief executive and the work was undertaken as part of the formal procedure for the management of serious untoward incidents. The purpose of undertaking such a chronology was for an appropriate clinician to identify in a very timely fashion the services provided, who had been involved and whether there were any serious and immediate issues that the trust needed to consider in relation to risk management. In addition, any further matters requiring investigation would be identified. This approach was a development of the trust's procedure of February 2000 regarding the management of serious untoward incidents and had been introduced with the agreement of the chief executive of the East Kent Health Authority in anticipation of new guidance being issued centrally. Despite requests to officials at both regional and health authority level for more precise guidance on how such scoping exercises were to be undertaken and what they should focus upon, this had not been forthcoming. In view of this, the SUI and the trust had developed its own simple methodology which the health authority regarded as helpful.

5.5 The SUI panel met on 19th October 2001. At that meeting Dr White reported that she had produced the chronology relating to Mr Regan. The notes of the meeting confirm that the chronology was to be forwarded to

the trust's chief executive drawing his attention to the lack of formally recorded risk assessment within the alcohol service. On 25th October 2001, Dr White wrote to Mr Parr enclosing the chronology and confirming that it highlighted a number of issues that warranted further investigation. She reported that the SUI Panel had met on 19th October and indicated that she felt that she should draw to his immediate attention the issue of risk assessment within the alcohol service.

5.6 The notes of the next meeting of the SUI Panel held on 16th November 2001 confirmed that the chronology had also been forwarded to the East Kent Health Authority. Also Mr Allpress (who was acting as the trust's chief executive) had written to Mrs Wilson, director of the trust's therapies directorate, regarding risk assessment within the alcohol service. It is recorded that no further action was required by the SUI Panel.

5.7 Other than the actions referred to in paragraph 4.6 above, there was no further contact between senior officials within either the Trust or the Health Authority and Doctor White and her colleagues on the SUI Panel. Dr White was, therefore, unaware as to whether or not specific action had been taken to address those other issues identified by her in the chronology as requiring further consideration. (Record keeping, frequency of communication between the alcohol service and Mr Regan's GP, and the reasons for the delay in Mr Regan's re-assessment by Dr Garcia).

5.8 It should be noted that the scoping exercise undertaken by Dr White focused exclusively on her scrutiny of the notes made by clinicians in the trust in relation to their involvement with Mr Regan. There was no discussion with those clinicians, with their managers or with the client himself. This was entirely consistent with the interim procedure which the trust had developed (see paragraph 4.4 above). That procedure, whilst giving authority for the preparation of scoping exercises and consideration of them by the SUI Panel, did not vest any responsibility in either the author of the report or the SUI Panel for ensuring that appropriate action was taken in relation to specific concerns raised. It would appear, therefore, that in late 2001 the SUI Panel was placed in some difficulty in not having a clear and authoritative place integrated within the trust's clinical governance structures.

5.9 It would seem that, other than the scoping exercise undertaken by Dr White, there has been no other internal investigation or review within the trust in relation to the care and treatment provided to Mr Regan between November 1999 and September 2001. From both the papers provided and the verbal evidence given to the inquiry, it is unclear as to whether other aspects of the procedure for the management of serious untoward incidents were fully complied with. Nor is it clear as to whether or not any

specific and timely action was taken to address those other issues identified by Dr White in the chronology as requiring further consideration.

6. TREATMENT AND CARE

6.1 The inquiry's terms of reference require an evaluation of the appropriateness of Mr Regan's treatment, care and supervision in respect of:

- his actual and assessed health and social support needs;
- his actual and assessed risk of potential harm to himself and others; and
- his previous psychiatric history and treatment including alcohol and drug misuse.

This can best be analysed by looking at the input he received from the individual agencies responsible for his care from 1999 to 2001. Although the input from the alcohol service and the community mental health service has been analysed separately it should be noted that they are both part of the same trust – the East Kent Community NHS Trust.

7. PRIMARY HEALTH CARE

7.1 Following his allocation to the practice at the White Cliffs Medical Centre on 29th November 1999, Mr Regan had fairly regular contact with his GP (or locum). From the beginning of his contact with Dr Premnath and his colleagues, Mr Regan's history of excessive alcohol consumption was noted, as well as the patient's view that he was depressed. Dr Premnath was 'astounded' by the amount Mr Regan admitted to drinking.[15] By December 1999, Doctor Premnath had referred Mr Regan to the Mount Zeehan Unit for assessment. Dr Premnath told the inquiry team that the service he received from Mount Zeehan was very helpful and the providers of service were very co-operative.[16]

7.2 Between January 2000 and July 2001 Mr Regan had intermittent contact with the surgery. In April 2001, following his release from prison in February of that year, he was seen by Dr Beach (locum to Dr Premnath) and was urgently referred for CPN support. In his letter, Dr Beach indicated that Mr Regan suffered from depression, anxiety and paranoia. This would appear to be the only reference in the records relating to paranoia. There was no reference to his alcohol problems in this referral.

Whilst it is noted that Mr Regan's last physical contact with the surgery was on 7th July 2001, there is no indication as to whether indirect contact (such as requests for repeat prescriptions) continued or whether anyone at the practice was in further contact with Mr Regan.

7.3 There is no evidence that Mr Regan received any follow up after July 2001. Dr Beach's referral letter of April 2001 was incomplete in an important respect, that he did not mention his severe alcohol problems. In any event the purpose of the referral was to ensure that Mr Regan was assessed and managed by the catchment area psychiatric team.[17]

8. IN-PATIENT MEDICAL SERVICE

8.1 On Tuesday 25th January 2000, Mr Regan was seen by Ms Thomasson. He had attended to accept her offer to arrange inpatient detoxification from alcohol. She spoke to Dr Kingham Psychiatric SHO and also Dr Ahmed,[18] medical SHO, and it was agreed that 'admission for detox' was necessary and Ms Thomasson arranged it promptly for that day.

8.2 Mr Regan was admitted to Ramsay Ward at the Buckland Hospital at 17.20. This was a general medical ward rather than a specialist drug and alcohol detoxification unit. Ms Thomasson told the inquiry that there were (and this still remains the position) no specialist alcohol detoxification units in the East Kent area.[19] Mr Regan was admitted under the care of Dr Sewell, a consultant in general medicine, and his named nurse was recorded as S R Boyce (possibly Sister Boyce).

8.3 The admission is recorded as having resulted from a request from the CPN. The discharge summary, however, refers to the admission having been via the A&E department, presumably because local procedures required patients to have a preliminary assessment in A&E.

8.4 During his brief in-patient stay Mr Regan was physically examined on admission by Dr Ahmed (17.30 25th January 2000). Dr Ahmed records that there is evidence of chronic liver disease, and makes a diagnosis of alcohol dependence. A range of blood tests plus a chest X-ray were arranged. The medical notes record a ward round by JS (presumably Doctor Sewell) and indicate that Mr Regan was shaking and would go home that day (26th January 2000). There is no reference to a prescribed detoxification regime and no indication as to the opinion of his consultant physician regarding his future physical care needs (if any).

8.5 In terms of nursing care for Mr Regan, a patient assessment sheet was partially completed and a manual handling assessment recorded. Only

three entries are shown in the nursing notes and there is no recorded evidence of the patient's named nurse having met with him. There is also no evidence of a preliminary plan of his nursing care having been prepared. By 11.05 on Wednesday, 26th January 2000, Mr Regan appears to have left the ward without either his discharge paperwork or medication (TTAs). In the nursing notes it is recorded that he had been seen by the doctor and was for discharge that evening.

8.6 Doctor Ahmed completed the general medicine discharge letter indicating that blood tests (including liver function test) and chest X-ray were normal and that nothing untoward was found during his physical examination of Mr Regan. This letter was incorrect, given that physical examination had shown Mr Regan to have an enlarged liver, and he had been observed to be shaking.

8.7 Dr Ahmed adds that the patient was to be seen by the alcohol team on Thursday (presumably 27th January 2000).

8.8 On Friday, 28th January 2000 Ms Thomasson noted[20] that Mr Regan had self-discharged because he felt so paranoid on the ward and that Dr Sewell had advised him that he had serious liver damage and should stop drinking. Dr Sewell's advice is not recorded in the medical notes.

8.9 The records show that Ms Thomasson's expectation of the admission was that Mr Regan would receive an alcohol detoxification regime. All that happened was that a cursory physical examination of Mr Regan's overall physical health was undertaken. There is no record of a mental state examination. Had this occurred, it is probable that Mr Regan's high level of anxiety and paranoia would have been recognized and managed. Given that Mr Regans's mental symptoms were not considered, the inquiry considered that the likelihood of Mr Regan successfully participating in an in-patient detoxification programme was remote.

8.10 Ms Thomasson's notes indicate that she thought that she was assisting in a hospital admission for the purpose of a 'detox.' It is unclear as to whether or not Dr Sewell originally planned to continue to treat Mr Regan on an in-patient basis beyond 26th January 2000; the records would seem to suggest this is not the case, given the references in both medical and nursing notes to his discharge.

8.11 There is no evidence of a discharge summary being made available to the alcohol service, or being requested by the service. It is does not appear that there were any protocols in existence in 2000, which dealt with the management of alcohol withdrawal and any subsequent engagement with follow-up and support services..

9. COMMUNITY MENTAL HEALTH SERVICE

9.1 Following Dr Beach's letter of 11th April 2001, Dr Garcia, locum consultant psychiatrist, and Mr Mungar, CPN, sought to undertake a domiciliary visit to Mr Regan on 23rd April 2001; in the event, he was not at home but he was seen later the same day at Coleman House. It became apparent from the evidence of Mr Mungar that he did not see Mr Regan when he came to Coleman House, Mr Regan was seen alone by Dr Garcia who completed the preliminary mental health risk assessment form.

9.2 Dr Garcia stated that he had sufficient time to conduct his assessment. He wrote "for 12 months - alcoholic for 20 years" which was his shorthand for an alcohol problem lasting at least that time. He also elicited a history of blackouts, suggesting alcohol problems of some severity. Dr Garcia told the inquiry that he "ruled out schizophrenia, bipolar disorder and any mental illness"[21]. By "clinical depression" he meant severe depression that could require hospital admission. He agreed that he accepted the GP account of panic attacks and did not enquire further about these.

9.3 Dr Garcia referred to the risk assessment form then in use for every assessment at a CPA standard level. He checked with Dawn Thomasson that the patient had no convictions for violence. There had been two previous episodes of self-harm, each in response to particular situational pressures, ie one in jail and one following a feeling of abandonment. He did not regard these as equivalent to suicidal attempts. Dr Garcia formed the clinical impression that the patient was not going to self-harm. Dr Garcia did not regard Mr Regan as being at risk of further episodes of suicide of self-harm. Dr Garcia's notes of the examination on 23 April 2001 contain no references to Mr Regan's propensity for self harm.

9.4 Dr Garcia's management plan comprised advising Mr Regan to attend Alcoholics Anonymous (AA), to stop Venlafaxine and to start Seroxat. He chose Seroxat because of its recognised indications for panic disorder with depression, and because it was indicated for a patient vulnerable to alcoholic liver damage. He advised Mr Regan to meet up with Dawn Thomasson and advised the GP to prescribe the above medication. Dr Garcia wrote to Dr Premnath (letter typed 4th May 2001) setting out his assessment and care plan.

9.5 In summary, the inquiry team, having examined the contemporaneous documents and heard evidence, offer no criticism of Dr Garcia's mental health assessment. This elicited the main symptoms, eliminated some

important possible conditions and lead to a practical and appropriate plan of management which was communicated to the GP.

9.6 Dr Garcia then advised Dr Premnath that he would review the patient in about six week's time. An appointment was made for Mr Regan to see Dr Garcia again on 5th June 2001 (see letter to Mr Regan dated 8th May 2001) but he did not attend and so he was discharged back to the care of the GP. (See Dr Garcia's letter to Dr Premnath dated 5th July 2001).

9.7 Dr Garcia accepted that Mr Regan did not attend for follow-up, but he relied on his frequent contacts with Ms. Thomasson to provide an opportunity for her to alert him to any problems.

9.8 Although Mr Mungar was initially involved in Mr Regan's case in relation to the attempted domiciliary visit, CPN input was not considered thereafter. In particular, in relation to the patient's failure to attend the appointments with Dr Garcia scheduled for 5th June 2001 and 23 August 2001. Dr Garcia described his understanding of the practice that was current at the time that if somebody had an alcohol worker, a CPN would not be allocated to a person on the standard level CPA. In any event there were only two CPNs at Coleman House, with one 'off sick on and off.'[22]

9.9 Ms Thomasson suggested that Mr Regan should be referred to an OT for anxiety management.[23] Ms Thomasson told the inquiry that as Mr Regan 'wouldn't do it'[24] the referral probably did not go ahead. She went on to say that 'John wouldn't do any of these things that were recommended. The only thing that John would do is come and see me on an individual basis.'[25] Dr Garcia recalled that he made this referral, but the groups were full at that time and also he considered it would be better if Mr Regan was drinking less before engaging in anxiety management groups.

10. EAST KENT COMMUNITY ALCOHOL SERVICE

10.1 As detailed above (6.1), Dr Premnath had referred Mr Regan to the Mount Zeehan Unit for assessment (letter of 22nd December 1999 refers). The first appointment for Mr Regan to meet with Ms Thomasson was made for 11th January 2000 (see letter to Mr Regan dated 4th January 2000). Ms Thomasson assessed Mr Regan as being a very high risk client. When she gave evidence she elaborated on this: 'he was extremely anxious and tearful and was speaking about the fact that that he wasn't able to go out of the house.[26]

10.2 In her letter dated 12th January 2000, addressed to Dr Premnath, Ms Thomasson indicated that Mr Regan had spoken about taking his life. The letter also indicated that Ms Thomasson proposed to try and re-engage Mr Regan with a further appointment with the view of arranging a psychiatric consultation with Dr Plummer (see ante para 3.2). The Mount Zeehan Patient Information System document[27] indicated that at that time Ms Thomasson was identified as Mr Regan's Key Worker.

10.3 The next occasion when Ms Thomasson saw Mr Regan was on 25th January 2000 when arrangements were made for his admission that day to Ramsay Ward, Buckland Hospital for alcohol detoxification. It is recorded in Ms Thomasson's notes (28th January 2000) that her client had discharged himself from hospital because he felt so paranoid. He was next seen by her on 1st February 2000 and thereafter at fairly regular intervals until late November of that year (on some occasions, Mr Regan appears not to have kept appointments). On 5th December 2000 Mr Regan was sentenced to a period of 9 months imprisonment and, therefore, Ms Thomasson officially closed Mr Regan's file on 27th December 2000.

10.4 Following his release from prison, Mr Regan next met with Ms Thomasson on 21st May 2001. This was in response to the request from Dr Garcia (see letter dated 4th May 2001). In her note of the meeting, Ms Thomasson refers to Mr Regan's involvement with the psychiatric services whilst in prison and to several occasions when he stated that he had seriously considered taking his life. She refers to Mr Mungar as being the client's allocated CPN and confirms an intention to work closely with him at Coleman House. However, there were no separate records completed by Mr Mungar or entries made by him in the Alcohol Service records. Given that he had no contact with Mr Regan, this is not surprising. Following the meeting with Mr Regan, Ms Thomasson wrote to Doctor Garcia (see letter dated 24th May 2001); in this she recommended that he consider referring the client to Ms Chinock, Senior Occupational Therapist, for anxiety management.

10.5 It is recorded that Mr Regan continued to meet with Ms Thomasson between May and 13th September 2001; again, the client did not keep all his appointments. In the papers relating to these meetings there are references to possible appointments to see Dr Garcia. (See, for example, the entry for 11th July 2001, where Ms Thomasson indicates her intention to ask Doctor Garcia to see Mr Regan regarding a possible review of medication). From Ms Thomasson's records, it is evident that the months of July, August and September 2001 were increasingly difficult for Mr Regan, with continued bouts of very heavy drinking, failed attempts at reconciliation with his father, and the threat of eviction from his flat.

10.6 Ms Thomasson's notes dated 13th September 2001 appear to indicate that she saw Mr Regan on 13th September 2001. This conflicts with her report to the crown court in relation to the index offence where she refers to Mr Regan telephoning her.[28] When she gave evidence, and on reflecting on the material before her, she concluded that she had probably only spoken to Mr Regan on the telephone.[29] She records his heavy drinking and the attempt at reconciliation between the client and his father which went "disastrously wrong".[30] Ms Thomasson and Mr Regan agreed to meet again in the immediate future (17th September 2001); however, Mr Regan did not keep the appointment. In her entry for 17th September 2001, Ms Thomasson again refers to an appointment with Dr Garcia and confirms that Mr Regan is aware of the date of 21st September 2001 for this purpose. Ms Thomasson's entry dated 18th September 2001 confirms that her client had been arrested and remanded in prison.

10.7 In January 2000 Ms Thomasson referred to Mr Regan as being a high risk client. There was no risk assessment pro forma available at this time – this has now been rectified and the inquiry was told that a comprehensive risk assessment form is now available.[31] When Mr Regan went to prison for the cannabis offence his case was closed. Ms Thomasson was asked about this and conceded that with hindsight the case closure system could be improved.[32] When Mr Regan was released from prison on 20th February 2001 there was no liaison with the forensic CPN working for the prison medical service[33] and the CMHT. When his case was again referred to the alcohol service it was treated as a new referral rather than an ongoing case. The problem with CMHTs - and the same problem must occur with alcohol service clients – of discharging clients from their caseloads was identified as a significant problem by Mr Reynolds.[34]

10.8 The information about Mr Regan's involvement with firearms, although apparently alarming, did not have any particular relevance to the assessment of risk that he presented.[35] It is apparent that Ms Thomasson did not actually see Mr Regan on 13 September 2001(the date of the offence) - she only had a telephone conversation with him.

11. H.M. PRISON SERVICE

11.1 The prison service records cover two distinct periods. The first period is when Mr Regan served a sentence of imprisonment from 5th December 2000 to 20th February 2001. The second period follows Mr Regans' imprisonment following the homicide. To deal with the second period first, the report prepared in May 2002 by Dr Majid confirms that Mr Regan had no memory of the index offence and suggests that this would be in keeping with periods of dense amnesia known as 'alcohol blackouts'.

Similarly, Dr Wilkins' report prepared in April 2002 refers to Mr Regan having experienced, on many occasions, clear episodes of amnesia, indicating that such memory blackouts are characteristic of chronic alcoholism.

11.2 The continuous medical record maintained by the prison service commenced with Mr Regan's period of imprisonment for possession of cannabis with intent to supply. The notes refer to paranoia and psychotic phenomena and confirm thoughts of, and attempts at, self-harm. In addition to him being seen on a regular basis by medical staff, it appears that Mr Regan was also seen by a forensic CPN. The final entry by a CPN is dated Friday, 16th February 2001; this was prior to his release from prison on Tuesday, 20th February 2001. The entry refers to Mr Regan having apparently arranged to meet with the alcohol counsellor at Coleman House and to the fact that he was also apparently due to see the psychiatrist there for a review of his treatment.

11.3 The inquiry heard from Mr Reynolds who is currently employed by West Kent NHS and Social Care Trust as the team manager for the Community Prison Mental Health In-Reach Service. The function of the service is to provide secondary mental health services for Kent prisons, that is, to promote continuity of care for serving prisoners with mental health problems.

11.4 In 2001 Mr Reynolds was working with mentally disordered offenders, he had a liaison role with the prison and knew the CPN involved in Mr Regan's case Simon Connor. Mr Connor, according to Mr Reynolds, is now in Australia. Mr Reynolds told the inquiry that he would have expected the CPN to identify the names of Mr Regan's alcohol counsellor and psychiatrist, and to have recorded this information in the notes. He would also have expected communication between the CPN and the CMHT informing them of the treatment currently being provided in the prison, and the expectation that the patient will be attending appointments in the very near future.[36]

11.5 In reality this contact did not take place until April 2001 following a referral from Mr Regan's GP. There was no keyworker in the community as his case had been closed. Dr Premnath refers to the absence of any communication between prison service and primary health care.[37]

12 PROBATION SERVICE

12.1 Mr Regan first had contact with Kent Probation Service in relation to the preparation of a pre-sentence report (PSR) in respect of his conviction for

possession of cannabis with intent to supply. The PSR was prepared by a probation officer, Susan Ashmore.[38] Although Ms Ashmore recommended Mr Regan receive a conditional discharge, he in fact received a custodial sentence of nine months imprisonment.

12.2 An assessment of Mr Regan's suitability to be released on license was undertaken by Finola Bates, a probation service officer. On 16th January 2001 she visited 10 High Street Dover (she wrote to 11 High Street to arrange the appointment, but recorded visiting 10 High Street) where it was proposed that Mr Regan would live with his brother, Keith Regan. She noted that she did not consider the accommodation as being suitable for a person on a home detention curfew.[39] Notwithstanding her observation, on 20th February 2001 Mr Regan was granted a home detention curfew and was released from prison. This was to reside at 11 High Street Dover. The curfew expired on 20th April 2001.

13. JOINT WORKING

13.1 The terms of reference of the inquiry require an examination of the process and style of the collaboration within, and between, the agencies involved in the care and treatment of Mr Regan. In 2000 and 2001 there was not always adequate communication between agencies:.

26.01 2000	Mr Regan discharged from Ramsay Ward. No evidence of post-discharge communication with alcohol service.
05.12.2000	Mr Regan imprisoned; no evidence of any communication with the prison medical service regarding Mr Regan's on-going treatment via the alcohol service.
27.12.2000	Mr Regan's file at the alcohol service is officially closed. Letter sent to GP but no communication with the prison medical service.
02.01.2001	Mr Regan under consideration for early release from prison under the home detention curfew scheme. Probation Service records refer to both severe alcohol problems and potential for self-harm. No evidence of any communication with Mr Regan's GP, the alcohol service or the mental health services.
20.02.2001	Mr Regan released from prison. No evidence of post-

	release communication between the forensic CPN service in the prison and the GP, the alcohol service or the mental health services.
11.04.2001 (Tuesday)	Mr Regan seen by Dr Beach and urgent request letter sent on same day to CPNs. Letter not received by CPNs until Tuesday, 17th April 2001 and patient not seen until Monday, 23rd April 2001. (nb 13th April was Good Friday and 16th April was Easter Monday). Referral by Dr Beach appears to have been sent by post, rather than an urgent referral being made by telephone and facsimile.

13.2 There was a period where effective joint working could have improved the quality of the health care available to Mr Regan . This was in 1999 when Mr Regan's GP refers him to the alcohol service and the alcohol service then referred to in-patient medical service for detoxification.
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13.3 There is no evidence of communication between the prison medical service and the mental health service following Mr Regan's release from prison in February 2001. In particular the forensic CPN did not communicate with the community mental health service or the alcohol team. The referral from Mr Regan's GP to the community mental health service occurred two months after Mr Regan's release from prison. The forensic CPN recorded that 'Mr Regan has apparently arranged to see his alcohol counsellor at Coleman house upon his release on Tuesday. Also apparently due to see a psychiatrist there to review his treatment.'[40] It appears that Mr Regan made this statement without any prior knowledge of a referral. There was no evidence that the arrangement was checked or followed up on.

13.4 Prior to his arrest for murder Mr Regan made contact with specialist mental health service on one occasion, in April 2001 following his release from prison. This was when he met with Dr Garcia. On this occasion his contact with mental health service was via a referral from his GP.

13.5 The most problematic systemic relationship that the inquiry team identified was between the alcohol service and the mental health service. Mr Lancaster told the inquiry that both then, and now, alcohol services were "working outside CPA"[41]. Dr Garcia was surprised at the limited relationship between the alcohol services and the adult mental health services. He had had few alcohol referrals, and was also aware that Dr

Plummer, who had responsibility for the alcohol services, was on sick leave. Whilst Dr Garcia maintained effective informal communication with Ms Thomasson, and indeed referred to her as a 'very experienced clinician and very proactive,'[42] because Ms Thomasson worked outside the CPA structure her involvement in the CPA process was non-existent.

13.6 Since that time, Rob Lancaster told the inquiry that the relationships between alcohol services and mental health services are closer and work being done following the Sainsbury Centre consultation review may progress this further.

14. THE VIEWS OF THE VICTIM'S FAMILY, MR REGAN'S FAMILY AND MR REGAN HIMSELF

14.1 The family of the victim were contacted by the inquiry team, but unfortunately felt unable to speak to the inquiry, or to enter into any correspondence.

14.2 The inquiry team did, however, hear evidence from Mr Regan's brother Keith. Linda Bolter, a member of the inquiry team, also spoke with his sister Julie, on the telephone. As indicated above, Dr Johns and Linda Bolter visited Manchester Prison and met with Mr Regan.

Keith Regan

14.3 Keith Regan said that he had been living with John (his brother – John Regan) immediately following his release from prison, in February 2001 until June of that year. He said that John was 'on a tag', which meant that he had to be at home by 6.30 pm, which he found frustrating. The AA groups, which were available locally, were held in the evenings and so John was consequently unable to attend.

14.4 He described John's drinking as being continuous, with binges of excessive drinking during this period. He was, however, never a violent or aggressive man. Keith was very shocked when John went into the kitchen one evening and slashed his wrists, which necessitated him attending Ashford Hospital for treatment. He said he had done something similar when he was imprisoned for the cannabis offence, but had previously never made attempts of that nature on his life. Keith Regan felt that his brother had been badly affected by the prison experience.

14.5 At times he said John was too depressed to leave the flat. Although he knew that John felt Ms Thomasson was helpful, he considered he would

have benefited from a worker visiting him at home. He also thought that a home help would have been useful.

14.6 In relation to the offence, Keith and his family do not believe that John committed it, as even though his drinking had been excessive for many years, he had never been violent. He had seen John on the day of the offence and noticed nothing different in his behaviour. Moreover, as the victim was a great friend, he could not conceive that he would have harmed him. Keith feels strongly that John should not be in prison, but considers he should instead be receiving treatment in a secure hospital setting.

Julie Regan

14.7 Julie Regan was at pains to express John's kindness and devotion to his family, for whom he cared for much of his life. She stressed the adverse effect on John of the abuse he and his mother suffered at the hands of his father.

14.8 In relation to the care, which he received, she felt communication had been very poor between all the authorities and herself, particularly regarding John's suicide attempts and other periods of ill-health. She felt strongly that John would have benefited from being visited at home, as sometimes he found it impossible to leave the flat, but nonetheless needed someone to talk to.

14.9 She said that it was completely out of character for John to have committed the offence, as he had never been a violent or aggressive man.

John Regan- subject of the inquiry

14.10 John Regan was complimentary about the care he received from the GP practice and particularly so about the input from Ms Thomasson. He described her as the first person he could open up to about his family and background. She also helped him with methods of relaxation and coping mechanisms. In relation to his in-patient admission to Buckland Hospital, he described this as being clearly an inappropriate setting, as he was getting severe alcohol withdrawal symptoms and was extremely frightened. He received no medication to assist in this process and took his own discharge, relapsing immediately into heavy drinking once more.

14.11 Whilst in Canterbury prison, he described being very unwell and receiving medication for 'de-tox'. He also described seeing a CPN, psychiatrist and psychologist whilst there, yet no follow-up plan was put in place on his release. It was on his own initiative, some months later, that through his GP, a referral was made to Ms Thomasson. He felt strongly that, were he

to have been able to see her whilst in prison, this would have helped him considerably. He drew attention to the fact that he cut his wrists two weeks after leaving prison, a period in which he was receiving no form of community support. He had not met a CPN, but felt that he may not have answered the door if one had called. Dr Garcia had apparently offered him day patient care, but he felt he could not cope with that as he was battling against drink and felt too agitated to attend.

15. COMMISSION FOR HEALTH IMPROVEMENT

15.1 Included amongst a number of documents that were supplied to the inquiry was the Commission for Health Improvement's (CHI) report of its clinical governance review of the East Kent Community NHS Trust. The CHI review took place between September 2002 and January 2003 and the report set out the main findings and areas for action from the review. The trust was required to prepare an action plan in response to the CHI report and its implementation was to be subject to monitoring.

15.2 There are a number of comments in the CHI report that appear of particular relevance to this inquiry; these are:

- The need for the trust to develop an up to date risk management strategy;
- An urgent need to clarify and improve leadership, roles and responsibilities for risk management and approaches to risk reporting;
- The need for the trust to focus on a few key priority areas, including implementation of robust serious untoward incident reporting arrangements;
- The importance of promoting and actively engaging staff in risk management and assessment training and the full utilisation of risk policies;
- The need for the trust to improve and coordinate leadership for clinical effectiveness and work towards a shared clinical effectiveness programme with partner organisations and service users;
- The need to improve the quality of clinical information, including information to effectively monitor quality of care, individual staff performance and patient experience and outcomes.

15.3 Whilst a copy of the action plan has not been made available to the inquiry, information has been supplied confirming that a new policy and procedure relating to the CPA is being rolled out which aims to improve documentation and outline standards to staff more clearly.

16. SHORTCOMINGS

16.1 The inquiry team identified a number of shortcomings in the care and treatment provided to Mr Regan between 2000 and 2001.

Detoxification

16.2 The inquiry regarded Mr Regan's in-patient admission in 2000 as a lost opportunity to engage him in an in-patient detoxification programme. In relation to Mr Regan's alcohol withdrawal symptoms, the medical staff appear to have laid a greater emphasis on diagnosis rather than treatment. Managing patients with alcohol withdrawal symptoms is not an uncommon task in general medical, surgical and psychiatric wards and should be within the competency of doctors working in these settings. It is accepted that in addition to physical symptoms of tremors, nausea and excessive shaking, psychological symptoms such as anxiety and paranoia commonly occur. The management of alcohol withdrawal is well described in recent editions of standard textbooks of medicine.[43]

Care programme approach

16.3 In 2000 and 2001 it is a measure of the isolation of the alcohol service from the mental health service that neither Ms Thomasson, or her manager Mr Reading, regarded the CPA as having any application to Mr Regan. They also demonstrated little understanding of the scope and purpose of the CPA. Dr Garcia was the care co-ordinator but regarded Ms Thomasson as effectively the care co-ordinator. The CPN Mr Mungar who was the original point of referral never met Mr Regan. When Dr Garcia discharged Mr Regan in July 2001 back to the care of his GP without seeing him, an opportunity for health intervention was lost. No formal mechanism that would detect failure to attend that follow-up was in place. Although Dr Garcia maintained that the letter to Mr Regan's GP constituted a care plan, it contained no review date.

16.4 Mr Regan was eligible for the CPA. Dr Garcia was his CPA care co-ordinator and assessed him and completed a risk assessment in April 2001.

16.5 If CPA requirements had been properly followed would that have made a significant difference to the care and treatment offered to Mr Regan? The inquiry team regard both Ms Thomasson's regular input, and Dr Garcia's assessment, as being effective. The inquiry team do however consider that a formal process of regular review, linked with clarity as to the identity

and role of the care co-ordinator, would in all probability have resulted in a more assertive evaluation of the care plan and, in particular a more robust approach to the missed psychiatric appointments.

File closure

16.6 On 27 December 2000 Mr Regan's alcohol service file was closed. This was unfortunate given that Mr Regan served a short sentence of imprisonment in a prison close to where he had been living. The maintenance of contact with local services, in particular from a professional that he had established a close relationship with, would have been beneficial. This also prevented the prison care system being able to draw upon Ms Thomasson's extensive knowledge of Mr Regan.

Prison service

16.7 When Mr Regan was released from prison in February 2001 there was no liaison between Mr Connor, the CPN who saw Mr Regan in prison, and either the alcohol service, the general practitioner, or the community mental health service. This inhibited follow up and left Mr Regan finally making contact with his general practitioner (who then re-referred him to the CPN service) some three months after release. The process of him seeing Ms Thomasson was delayed.

17 CONCLUSIONS

17.1 It was not until the inquiry team met with Mr Regan and further investigated the circumstance surrounding his care and treatment, that the complexity and severity of his physical and psychological problems became apparent.

17.2 The extent of Mr Regan's problems were not always fully understood by professionals working with him, and as a consequence opportunities to offer Mr Regan effective care and treatment were lost. [44]

17.3 Did these 'lost opportunities' contribute to the homicide? On the basis of the court reports and statements made available to the inquiry team, there was no indication that Mr Regan's relapses amounted to a material risk factor for serious violence.

17.4 To put this last paragraph in context. The National Clinical Survey published in 1999[45] aimed to estimate the rate of mental disorder in those convicted of homicide and to examine their social and clinical characteristics. Among 718 homicides reported, there were psychiatric reports on 500. Of these, 8% had been in contact with mental health services in the year before the index offence. The commonest lifetime diagnoses were affective disorder (11%), personality disorder (9%). 53% had a previous conviction for violence. Most perpetrators were male, single and unemployed. The commonest diagnoses were personality disorder and schizophrenia. Alcohol misuse or drug misuse or both, were present in most cases. Only 18% had been given the highest priority under the CPA. Mental health teams regarded the homicides as preventable in only 12% though 42% specified measures that could have reduced risk, particularly better compliance with treatment.

17.5 Dr Kingham, locum consultant forensic psychiatrist for the Kent Forensic Psychiatry Service, prepared an assessment of Mr Regan at the request of the prison service. In his report dated 5.5.04 (**Annex 6**) he concluded that Mr Regan suffered from alcohol dependence syndrome; that he probably showed features of a personality disorder with predominantly emotionally unstable and also avoidant traits. He probably suffered from depression in the past. It is evident, therefore, that Mr Regan, in his mental health problems and contact with psychiatric services, shares many of the personal characteristics of the homicide perpetrators in the Shaw et al (1999) study.

17.6 When the inquiry team completed their preliminary analysis in April 2003 the team's preliminary observations, based on reviewing documentation, were as follows:

a. *Mr Regan received a reasonable level of care and treatment from individual professionals during the period 1999 to 2001, particularly from primary care and alcohol services. We note that despite Mr Regan being a less than fully compliant client, Ms Thomasson apparently developed a good rapport with him and appeared to have done much to try and support him. We also read little to indicate that Mr Regan's propensity to violence was predictable on the basis of his past behaviour.*

b. *On the other hand our analysis indicates some shortcomings in the joint working of the agencies that were responsible for Mr Regan's care. We also find that his care did not always correspond to national guidance and local operational policies.*

17.7 Having heard oral evidence, and in particular meeting with Mr Regan, the team then concluded that the appraisal in a. and b.above needed to be

modified in the light of further material analysed, and evidence heard. The team then concluded ‘

> *There were shortcomings in the care and treatment offered to Mr Regan. More effective communication between agencies could, and should, have resulted in more effective care and treatment for Mr Regan. The team’s preliminary appraisal of Ms Thomasson’s role, as described above, remains unchanged as does the evaluation of the predictability of Mr Regan’s propensity to violence.’*

17.8 Having met with Dr Garcia, and having heard his evidence, the team were far less critical of his assessment, risk assessment and clinical management than they had been in the February report. As a result the report presented in February has now been amended.

17.9 Dr Garcia concluded that there was no imminent risk that would trigger an enhanced CPA assessment. His management plan involved GP prescription of a different antidepressant, advice to attend AA and to continue to see Ms Thomasson, and an offer of a follow-up appointment. This follow-up appointment did not occur but Dr Garcia apparently had sufficient informal contact with Ms. Thomasson to be satisfied that she would alert him to any problem.

17.10 The inquiry do not criticize the mental health assessment that was undertaken by Dr Garcia in 2000. Dr Garcia made sufficient time for the assessment. He elicited the main problems and identified a second episode of self-harm. He was able to rule out the possibility of serious mental illness such as schizophrenia or clinical ie severe, depression.

17.11 Dr Garcia was working within the current Trust policies and the eligibility criteria for standard and enhanced CPA. He accepted that the structural relationship between the alcohol services and adult mental health services was ill-defined, and that by default, he had to rely on *ad hoc* communications between himself and Dawn Thomasson, which appear to have been reasonably effective, although these were not recorded in the notes.

17.12 There was also no formal mechanism to detect failure to attend follow-up appointments, and although Dr Garcia argued that his informal contacts with Ms Thomasson constituted such a mechanism, the fact that a letter was written on 5 July 2001 to Dr Premnath by Dr Garcia ‘discharging him back to your care’ following a missed appointment indicates otherwise.

18 RECOMMENDATIONS

18.1 In late 2001 The Serious Untoward Incident Panel (SUI) did not appear to have a clear and authoritative place integrated within the trust's clinical governance structures. This should be reviewed

18.2 The protocols for inpatient detoxification should be reviewed in the light of the shortcomings identified.

18.3 The links between alcohol service and mental health service should be reviewed, both in the context of the CPA, and more generally with the aim of making sure that a case of this nature is properly assessed and reviewed. In particular the alcohol service worker should be involved in all CPA planning for the individual client. Mr Lancaster gave evidence (see para.13.6 above) that the relationship between mental health and alcohol services is now closer, and by implication more effective. To test this assertion, the inquiry team suggest that a case similar to Mr Regan's should be reviewed in the light of the changes identified by Mr Lancaster to establish whether the two agencies are now likely to work more effectively together.

18.4 Employees of the alcohol service should be made aware of the requirements of the CPA and the necessity to maintain effective communication with their colleagues in mental health services. Effective communication includes recorded communication within a structured framework.

18.5 In the light of the shortcomings identified in Mr Regan's case, the arrangements by PCTs to commission secondary prison medical health care should be reviewed. This is to ensure that adequate mechanisms are maintained to ensure the continuing medical and psychiatric care of prisoners following their release.

18.6 The practice of the alcohol service in closing files is reviewed – particularly where the client is CPA eligible.

18.7 Policies and procedures for linkage between alcohol service and both inpatient and community mental service, and the prison service need to be reviewed in the light of the shortcomings identified in this case.

18.8 All locum staff who may have care co-ordinator responsibility, or who are otherwise involved in the CPA process, should receive formal induction training in the application of the CPA.

18.9 Eligibility criteria for CPA should be reviewed, revised and updated

18.10 The obligations on medical staff in completing CPA documentation should be clarified.

Anthony Harbour
Linda Bolter
Michael Hill
Andrew Johns

Dated the day of 2004

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[1] Section 1(3) Mental Health Act 1983
[2] DT transcript page 35
[3] FM transcript page 27
[4] BR transcript page 6
[5] Dr W page 20
[6] Dr W page 21
[7] JG transcript page 10
[8] Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach para 17 Dept. of Health 1999
[9] Bundle 4-81
[10] RL transcript page 2
[11] Ibid
[12] Ibid
[13] Letter Dr Garcia to Inquiry dated 4 November 2004 para iv.
[14] Bundle 8-73 et seq
[15] Dr P transcript page 8
[16] Dr P transcript page 7
[17] Dr P transcript page 11
[18] Bundle 4-56
[19] DT transcript page 16
[20] Bundle 4 -56
[21] Dr G transcript page
[22] Dr G transcript page 11
[23] letter 24. 5.01 - *check*
[24] DT transcript 28
[25] DT transcript ibid
[26] DT transcript page 4
[27] Bundle 4 -51
[28] Bundle 6 -315
[29] DT transcript page 32
[30] Bundle 4 -15
[31] DT transcript page 5
[32] DT transcript pages 51 et al
[33] Bundle 5-202
[34] SR transcript page 13
[35] Bundle 4-12
[36] SR transcript page 9
[37] Dr P transcript page 9
[38] Bundle 6-319
[39] Bundle 14 -23

[40] Bundle 5-202
[41] RL transcript page 3
[42] Dr G transcript p 10
[43] Johns A. (1996) Management of Withdrawal Syndromes In: Weatherall D.J., Ledingham J.G.G. & Warrell D.A. *Oxford Textbook of Medicine*. 3rd. Edition. pp. 4290-4. (Oxford University Press, Oxford)
[44] The Department of Health's Dual Diagnosis Good Practice Guide...acknowledged that patients (or potential patients) with dual diagnosis have 'almost certainly been excluded from all the available services' because of a lack of integration between mental health and substance misuse services, clear care co-ordination pathways and a clear operational definition of dual diagnosis. *Department of Health (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. Section 1.1*
[45] Mental disorder and clinical care in people convicted of homicide: national clinical survey. Shaw J, Appleby L, Amos T, McDonnell R, Harris C, McCann K, Kiernan K, Davies S, Bickley H, Parsons R.(1999). *British Medical Journal*. 318: pp 1240–1244.