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“Looking Through the Reeds”

The Report of the Independent Inquiry into the Care and Treatment of Richard King

June 2008

CONTENTS

THE REPORT INTO THE INQUIRY CONCERNING THE CARE AND TREATMENT OF RICHARD KING

Looking Through the Reeds

We have given this report the title of 'Looking Through the Reeds' as this phrase was used to us by a sister of John West to describe the inherent difficulty of reconstructing events prior to the homicide. Our use of the phrase is also a recognition of the compassion and understanding of John West's family in the face of unimaginably challenging circumstances.

INTRODUCTION

1. This independent inquiry into the care and treatment of Richard King was commissioned by the East of England Strategic Health Authority in July 2006 in accordance with Department of Health Circular HSG(94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community* (as amended on June 15 2005) in July 2006. The inquiry was established following the homicide of John West by Richard King, a patient of Norfolk and Waveney Mental Health Partnership NHS Trust. The circumstances of John West's death are described in Chapter 3 of this report. On 21 January 2005 Richard King was convicted at Ipswich Crown Court of the manslaughter of Mr John West, his mother-in-law's partner, on 7 August 2004. He had pleaded guilty to manslaughter on the grounds of diminished responsibility. The Judge made an order for detention under s. 37/41 of the Mental Health Act 1983. Richard King is now detained in a medium secure clinic.

2. Richard King is a patient of the Norfolk and Waveney Mental Health Partnership NHS Trust (the Trust) and was receiving care in the community in Wells-next-the-Sea in North Norfolk when he committed the offence. In August 2004 the Norfolk Mental Health Care Trust (the previous name of the Trust) established an inquiry, the details of which are discussed in depth in Part Two of this report, Chapter 11. The terms of reference of this initial inquiry and its membership were agreed between the Trust and the former Norfolk, Suffolk, and Cambridgeshire Strategic Health Authority. But this body ceased to exist on 1 July 2006 and was replaced by the East of England Strategic Health Authority (referred to in this report as the SHA) on that date.

3. The SHA decided to commission a second and plainly independent inquiry in July 2006 as serious reservations about the composition and conclusions of the first inquiry had been expressed. Moreover, family members of John West and Richard King had not been interviewed by the panel of the first inquiry and this was also a matter of concern and required further investigation. Contacts with family members are discussed further in Chapter 11.

The independent inquiry

4. The SHA appointed a chair and three panel members in July and August 2006. The membership of the panel was as follows:

   Lady Wall, Chair, JP BA MSc DIC

   Dr Mark Tanner, Consultant Adult Psychiatrist, MB BCh Dip. Law, Barrister, MRCPsych, LLM, DipStat.

   Dr Susan Champion, Associate Director of Nursing D(N), MSc RMN DipHe.

   Gill Williams, Social Work Manager, Mental Health Practice Development Manager, Dip SW, ASW

The inquiry was managed by Mette Vognsen, SRN, Dip. Management Studies, Dip. Marketing, Postgraduate Dip. in Business Administration, for the SHA.

The Terms of Reference

5. The Inquiry's terms of reference are as follows:

   To provide an independent review and assessment of the investigation and inquiry into the care and treatment of Richard King prior to the homicide of Mr J West on 7 August.

   This review has been commissioned by the East of England Strategic Health Authority and will have access to the full report of the Norfolk and Waveney Mental Health Trust's own inquiry panel and all documents supplied to that internal inquiry.

   The review panel will indicate where, in its judgement, further detailed independent scrutiny is required which it will then conduct.

   The independent review and assessment will consist of stages.

   Stage 1 - a full and thorough review and assessment of the Trust's 'Richard King Inquiry' and its recommendations in the light of the evidence taken.

   Stage 2 - if the panel determines that in some aspects either the evidence taken was deficient or the recommendations were not consistent with the evidence taken, or if for any other reason that the original inquiry was deficient, a second stage will be instituted. This second stage may seek further evidence, including interviewing family and Trust staff and make further recommendations.

The decision of the panel to review the first inquiry as required by Stage 1 and the reasons for instituting Stage 2

6. At the first meeting of the panel on 5 September 2006 it was immediately clear to us that the report of the first inquiry did not include an account of the events leading to the homicide. A detailed history of the diagnosis and treatment of Richard King's illness was omitted. The panel were also very

concerned that no evidence had been taken from the relatives of John West or from Richard King and his family. There were other omissions and we did not consider that the report presented a detailed narrative account of events or an objective analysis. We analyse the report of the first inquiry in detail in Chapter 11. We were aware that there had been considerable coverage in the media, some of which was inaccurate. Mr Justice Davis stated in the case of Michael Stone and the South Coast Strategic Health Authority (and others) that: *'There is a true public interest in the public at large knowing of the actual care and treatment supplied (or as the case may be not supplied) to Mr Stone: and knowing, and being able to reach an informed assessment of, the failures identified and steps that may be taken to address identified deficiencies'*. We have therefore included details of the nature of the homicide and Richard King's delusions in this report as it is necessary for the public to understand the seriousness of the failure to treat him effectively. We have had regard to the requirements of Article 8 of the European Convention on Human Rights which concerns the right to a private life.

7. Following the first meeting, the panel read the documents that had been provided by the Trust to the first inquiry, transcripts of evidence and additional documentation relating to the management of the inquiry. The panel decided that its investigation and terms of reference required further documentation. Without such additional evidence and information, we did not believe that we could reach conclusions that would adequately support appropriate recommendations. Ten critically important pieces of additional evidence were eventually located and are listed in paragraph 12 below.

8. The panel was aware that the homicide had very seriously affected both the families of John West and Richard King. Moreover, there had been professional consequences for the some of the Trust staff who had been closely involved with Richard King.[1] It appeared to us that only a full and thorough investigation of the care and treatment of Richard King was a proportionate response to the broader effects of the homicide on all the individuals concerned.

9. We therefore concluded that it was incumbent upon us, as an independent and investigative panel, to interview additional witnesses and re-interview some staff who had been interviewed by the first inquiry. We decided that it was not necessary to re-interview all previous witnesses. The decision was taken not to re-interview staff of the wards of Hellesdon Hospital to which Richard King had been admitted between 2002 and 2004, as each admission had been brief and clearly some staff had moved to other posts by 2007. We have relied on the transcripts of the first inquiry and the nursing notes for our information.

10. Between October 2006 and March 2007, the panel interviewed nineteen witnesses, all of whom were encouraged to bring professional or personal support. All the interviews took place in private. They were recorded by an independent transcription service and every witness was sent drafts of their

[1] This aspect is considered in detail in paragraph 11.45

interviews in order that they could request factual amendments in confidence. A list of witnesses is appended to this report. The panel held three meetings (one member was unable to attend one meeting) to agree the contents of the report: no employee of the SHA attended at the panel's request as we wished to safeguard our independence. Where the panel has criticised an individual's performance in this report, an opportunity has been given to that member of staff to respond to our findings. The Trust were also given the penultimate draft of the report for 28 days in order to check it for factual accuracy and the Chair then met the Chief Executive to discuss matters arising from that exercise.

11. We were able to meet three members of John West's family and spoke to his sister, who lives abroad, on the telephone. We interviewed a relative of Richard King and spoke on the telephone to another family member. In Chapter 11, the value of such evidence is discussed in detail. Two members of the panel visited Mrs King, the wife of Richard King, in the sheltered housing where she now lives. Steven Potter, her Community Learning Difficulties Nurse, and Denise Appleton were present to give her support as Mrs King has learning difficulties and also suffers from mental and physical health problems. We were impressed by the quality of her evidence but we have been circumspect in our use of it and have sought corroboration where possible. It is plain that Mrs King was a very important influence on her husband and she was a witness to the disputes that immediately preceded the homicide, but she played no part in the homicide itself and is not the subject of this inquiry. We have therefore only included references to her which are actually necessary for the understanding of Richard King's motivation, the shortcomings of the risk assessment process and the actual course of events. We have had regard to her privacy wherever possible and have excluded some personal details on that basis.

Request for additional documentation

12. The panel decided to concentrate its investigations on the period between June 2001 and the homicide on 7 August 2004, and to consider the interface between the actions of individuals and the structures within which they functioned.

Documentation from the first inquiry was copied by the SHA and sent to the panel.

We requested further documentation from the Trust as follows :

The Minutes of the Northern Locality Community Mental Health Team;

The complete Social Services file and any additional social care notes that could be found that related to Richard King;

Computer Records (Alerts) from the Social Services Emergency Duty Teams (EDTs);

The report of the Norfolk Constabulary Investigation managed by the Independent Police Complaints Authority;

The report of the Commission for Health Improvement (2002), relating to the Trust;

Additional records from North Norfolk District Council Housing Office;

Records of any relevant serious untoward incidents;

Medical records for Mrs King;

The Trust Internal Audit Review, which was commissioned by the first inquiry panel, was provided later in the process on request;

The Selby Report which was commissioned by the Human Resources Department of Social Services;

The Medical Director, Dr Ball, provided training material in Risk Assessment which has been delivered to some Trust staff following the recommendations of the first inquiry. We have also corresponded with some witnesses.

13. The quantity and quality of the various forms of records on Richard King have caused considerable difficulties for the panel, and we have made serious criticisms of record keeping in our analysis in Chapter 7 and of documentation in general in Chapter 12.

Further evidence gathering

14. The panel visited Wells-next-the-Sea in North Norfolk and were able to see for themselves the flat where Richard and Mrs King had lived. We did not enter it as it is occupied by new tenants. The flat is on the first (top) floor of a purpose built block of four flats. It has a separate entrance which is accessed from an external staircase leading from the garden. We took evidence from Dr McAnsh, who was Richard and Mrs King's general practitioner, in his surgery during our visit.

15. The panel hoped that it would be possible to visit Richard King and wrote to Dr Shetty, his Responsible Medical Officer, at the Norvic Clinic regarding his patient's capacity to make a decision on the matter. Dr Shetty has assured us that Richard King does have the required mental capacity but has refused to meet the panel. Dr Shetty was able to give us a report on the management of his patient for which we are most grateful. We refer to his report in Chapter 3, paragraph 3.19.

16. However, Richard King agreed at a late stage of the preparation of the report to accept legal assistance in understanding the final draft. Mr Paul Veitch, solicitor, visited him and wrote us a short letter which included some specific points that Richard King wished to make. It concluded with the following statement:

Finally and most importantly, Mr King wishes to stress that at the time of the offence he was ill but irrespective of that, he deeply regrets his actions and

the effect that this has had on Mr West and his family, on his family and all those involved in his care.

17. In order to gather information from previously unidentified sources, the panel arranged for an advertisement to be placed in the local newspaper requesting any members of the public who believed that they had relevant information to contact the manager of the inquiry. A fellow patient of Richard King and a member of Mrs King's family responded. Subsequently we interviewed that family member and his partner.

18. The additional documentation and interviews provided a considerable amount of new evidence which was not available to the first inquiry. This has enabled the panel to analyse events and clinical decisions in greater detail although this has necessarily been a lengthy process. The panel is extremely grateful to all the witnesses who gave evidence, some of whom provided additional information which has enabled us to discern the outline of events more clearly. We acknowledge that giving evidence to a second inquiry more than two years after the events of 7 August 2004 was inherently stressful: we will consider these issues in more detail in Part Two, Chapter 11.

This report was unfortunately delayed by the serious illness of a panel member but all the interviewees were kept informed of the inquiry's progress. The report was presented to the Strategic Health Authority on 20 March 2008.

EXECUTIVE SUMMARY

Richard King, born in 1969, has had a long history of mental illness and substance abuse. He has been a patient of the Trust since 1991. He had been informally admitted to psychiatric hospitals on a number of occasions between 1992 and 1994 and had been diagnosed with schizophrenia. Richard King's mental illness was stabilised by effective medication. He lived in sheltered accommodation in Fakenham and married Mrs King in 1998. He received depot injections of zuclopenthixol under the care of Dr Nicol. The Kings moved to independent accommodation in Wells-next-the-Sea. In June 2001 the care team changed and his new consultant Dr Thomas reduced the dose of zuclopenthixol in stages over the next few months. In January 2002 he relapsed into psychosis. In December 2002 he was detained formally for the first time under s.2 of the Mental Health Act.

During 2003, Richard King's mental state deteriorated and was characterised by increasingly violent and paranoid delusions. Changes of medication were generally ineffective. He was admitted to hospital several times for short periods but often absconded. This included one period of detention under s.3. The Trust discharge policy was not followed and there was little effective coordination with the community team. The local police sent a fax detailing their contact and expressing their concern about his state of mind and the safety of his wife. Neither Dr Thomas or the CMHT responded. There was a serious incident regarding Richard King's wife which was associated with psychotic delusions in January 2004. Dr Thomas left the Trust shortly afterwards for a new post. Richard King was seen on one occasion in February by a locum consultant, Dr Fadlalla, who increased his medication. The community team were clearly concerned by his deteriorating condition in succeeding months but did not respond with an effective plan of intervention. Although there was no substantive consultant in post during this period, Richard King could have been referred to a locum consultant. A Care Programme Approach Annual Review due in May was not held. Following a serious incident in July 2004, Richard King was admitted to hospital informally. He absconded shortly afterwards and was discharged in his absence on 26 July by Dr Coogan, a newly appointed consultant. On 7 August Richard King stabbed John West, the partner of his mother-in-law, in Sheringham in a frenzied attack and later told the police that his motivation concerned events in his wife's childhood.

We have identified six points in time which were missed opportunities for social and healthcare professionals to take an overview of the deterioration in Richard King's mental state. In the chronology of events in Chapter 2 these six points are identified. They are analysed in Chapter 13.

In this case, the homicide was not the consequence of a lack of engagement with health or social care. Richard King had been well known to services for many years and he had continued to live in North Norfolk. Nor was the homicide caused by a refusal to take prescribed medication. Although Richard King did not comply with medication on occasions, he was generally compliant. The legal framework of the Mental Health Act was adequate for the nature of his illness, but the powers of detention were not always fully considered by the clinical team. There is no reason to believe that lack of resources contributed in any way to the shortcomings we have

found. The policies of the Trust were generally adequate but they were not followed on many occasions. Management scrutiny and supervision of staff to ensure compliance were ineffective. We have found that the organisation failed to identify the shortcomings of individuals or to remedy them by further training.

In this report we have commented critically on the performance of some managers and practitioners, although we have also found that some community staff provided care of a high standard. All individuals have been given the opportunity to respond to our criticisms. The Trust has had the opportunity to correct matters of fact. We have used the criteria of good professional practice and the reasonableness of actions and omissions in making these criticisms. We have had regard to the perspectives of family members and the general public in addition to those of the Trust and members of staff.

We have been critical of aspects of Richard King's medical and nursing treatment in Chapters 4 and 5. We find that the change in dosage and delivery of medication resulted in a relapse into psychosis, and in spite of further changes he did not recover his previous stability. Clozapine should have been considered. Richard King was only tested once for the use of cannabis. The issue of substance abuse and the possible interaction with prescribed medication was not addressed. During the periods of inpatient care, he was not referred for any non-medication based therapeutic interventions. The nursing notes were only of a basic standard. Information regarding serious incidents was not shared with the Community Mental Health Team. Richard King frequently absconded or took unplanned leave. We find that the Trust discharge policy was not observed. There were no multidisciplinary meetings prior to discharge and there was no effective coordination between the inpatient and community teams. We have recently been told by a witness that there has been no improvement in this crucial area since 2004: we have been unable to check this, but it is extremely disturbing information. We have made formal recommendations (numbers 7 and 8) regarding these findings and it is our view that the Trust must address this issue urgently.

We find that there were serious shortcomings in the provision of care by the Community Mental Health Team: details can be found in Chapter 7. The specific matters on which we comment include: poor implementation of the Care Programme Approach; lack of clinical leadership; confused line management; personal hostility; ineffective decision-making; minimal assessments and management of Richard King's risk to others; inadequate management of weekly meetings; lack of a formal liaison with Richard King's general practitioner and the local police; and the ineffectiveness of supervision arrangements for staff. We have made several recommendations to address these matters.

We are critical of the quality of social care documentation and of CMHT record keeping which undoubtedly precluded a comprehensive understanding of Richard King's psychiatric and social history. The lack of comprehensive records readily available to all professionals was a major factor in the underestimate of risk. We have made a formal recommendation for the introduction of a single case file and a review of the progress of the Electronic Patient Record.

Poor practice in all these areas amounted to a cumulative failure to assess and manage the risk posed by Richard King to others. There were no multidisciplinary risk assessments undertaken when he was an inpatient and none at all in the community. Such an assessment would have been complex but was an essential undertaking; further details can be found in Chapter 10. Following the recommendations of the first inquiry the Trust ensured that staff have received training but we have been told that this has not been extended to consultants: this is addressed in Recommendation 19.

We have commented on the inadequacies of the first inquiry in Chapter 11 and made recommendations on future investigations following death or serious injury of a patient in the care of the Trust. The need to give consideration to interviewing family members is also the subject of Recommendation 21.

We have found that no individual and no single act or omission led directly to the killing of John West. Neither the nature of the multiple stabbing or the decision to kill him could have been predicted. Aspects of the homicide are closely examined in Chapter 13. We consider that the cumulative failure to treat Richard King's psychosis effectively, the increase in disturbing and persistent delusions of death and violence, compounded by the absence of intervention at six key points, created a situation in 2004 when a dangerous act was becoming more probable. We have concluded, on the balance of probabilities that better quality care and treatment would have substantially reduced the increasing risk of Richard King committing a violent act. But the frenzied killing of John West could not have been reasonably foreseen.

A full list of recommendations, with appropriate timescales can be found at the end of the report.

PART ONE: A FACTUAL ACCOUNT OF THE MAIN EVENTS IN RICHARD KING'S LIFE FROM 1991 TO 2004

This report is in two parts**.** **Part One** is essentially factual. Chapter 1 briefly describes the structure of services provided by the Trust to Richard King and Chapter 2 is a chronology of events based on documents and verbal evidence. Chapter 3 relates the details of the homicide.

Part Two is a critical analysis of the care and treatment provided by individuals and organisations to Richard King. An analysis of the first inquiry can be found in Chapter 11.

CHAPTER 1
PROVISION OF SERVICES

Chapter 1 describes the organisation of the relevant parts of the Trust and the provision of care from June 2001 to August 2004. Readers of this report should therefore be able to follow the complex interplay between the actions of Trust staff, and the systems in which they operated in the chronology in Chapter 2. We include brief details of the agencies and individuals who provided care and treatment to Richard and Mrs King to aid understanding of the chronology. As we have used acronyms to describe organisations and job descriptions, we have included a Glossary at the end of the report. The roles of the agencies and individuals are discussed in full in Part Two.

Consultant care

1.1 Three consultants treated Richard King in the period in question. Dr Thomas was responsible for his care from June 2001 to February 2004. Dr Fadlalla, a locum consultant, saw him on one occasion in February 2004 as an outpatient. Dr Coogan was the consultant in charge of his care when he was admitted on 15 July 2004. A number of junior doctors also treated him during admissions. Richard King had previously been treated in North Norfolk by two consultants from 1990 to 2001.

General Practitioners at Wells Health Centre

1.2 Richard and Mrs King had both been patients of Dr McAnsh, General Practitioner (GP), at Wells Health Centre since 2000. Dr Ebrill was also a partner in the practice. From the list of attendances we have calculated that Richard King had contact with Dr McAnsh on average once every three weeks. When he visited the surgery he was often accompanied by his wife. Dr McAnsh also made domiciliary visits and so knew them both well.

The Community Mental Health Nurse and Care Coordinator

1.3 Gill Chambers was employed by the Trust as a Community Mental Health Nurse (CMHN) and she provided nursing care in the community to Richard

King. She was an experienced Staff Nurse who had been qualified for 27 years and who had worked on night duty for some 12 years. She applied for a post on the Community Mental Health Team (CMHT) and commenced in April 2003 as an *'E'* Grade nurse. Gill Chambers became Care Coordinator (CC) and was responsible for the application of the Care Programme Approach until the events of August 2004. Gill Chambers became an acting *'G'* Grade in April 2004. She made a total of 39 visits to Richard King either at his home, the ward, or in the GP surgery. The majority of the home visits were made in the company of Steven Potter or Jenny Cunningham to preclude accusations of inappropriate behaviour towards his wife.

1.4 In her nursing role, Gill Chambers regularly administered a depot (into the muscle) injection to Richard King. She also monitored his mental state. As Care Coordinator she liaised with other social and healthcare staff, and attended the Monday morning CMHT meetings. Gill Chambers was responsible for ensuring that the Care Programme Approach (CPA) was operationally effective and documented. The CPA is a structured framework to provide a *'network of care in the community'* for people with severe mental illness. Richard King was identified as being on the *'Enhanced'* level according to CPA criteria: this meant that he required greater monitoring and support.

The delivery of social care

1.5 Social care was provided to the service users of the Trust by employees of Norfolk County Council (NCC). After April 2004 this responsibility was transferred to the Trust: social workers were managed by the Trust but remained employees of NCC. Jenny Cunningham, social worker, was employed by NCC at the point at which she was allocated to the case of Richard King in December 2002. She was subsequently allocated to Mrs King in 2003. Jenny Cunningham was a very experienced practitioner, an Approved Social Worker (ASW) and a teacher of social work practice. She made regular visits to the Kings, sometimes alone, and sometimes with Gill Chambers, CMHN. Jenny Cunningham assisted Richard King with daily living tasks and ensured that his benefits were in place. She responded to any practical requirements. In addition, she liaised with other agencies such as housing and the local police. Jenny Cunningham was also expected to contribute to the CPA meetings and to ensure that information was shared across agencies and with family members. She was part of the CMHT and attended the regular Monday morning team meetings. Jenny Cunningham and other social workers completed computerised forms, known as *'Alerts'*, for the Emergency Duty Team (EDT) to warn other social workers of urgent concerns.

The community nurses for Learning Difficulties

1.6 Mrs King suffers from learning difficulties and two community nurses, Trudie Needham and Steven Potter, have provided support for her during her marriage to Richard King. Trudie Needham was the community learning disability (LD) nurse for Mrs King from 1999 when she lived in Fakenham.

Her professional role was to administer a depot injection to Mrs King and to help her with the problems of daily living. On 4 August 2003 Trudie Needham decided that Richard King was a threat to her personal safety in the confines of the flat and that she could not continue her visits.

1.7 Steven Potter became Mrs King's community LD nurse and Care Coordinator in August 2003 and remains in that role. He coordinated his visits with Gill Chambers to preclude any allegations made by Richard King and attended many of the meetings called by Jenny Cunningham. He is exceptionally experienced in mental health and learning disability, a field in which he has practised for thirty seven years.

The arrangements between Social Services and Fakenham Police Station

1.8 The information regarding the contacts between Fakenham Police Station and the health and social care services was given to both the first and second inquiry by Inspector Spinks. From 1997 to May 2004, Sergeant Spinks (his correct rank at that time) was based at Fakenham with responsibility for the town of Wells and its adjoining area. He confirmed that Richard King was not charged with any criminal offences during the period when he lived in Wells. Police officers were involved in Mental Health Act assessments, disturbances and telephone calls relating to his home address.

The housing agencies

1.9 Richard and Mrs King were tenants of North Norfolk District Council (NNDC) at the time of the homicide. They had moved to Wells on 29 May 2000. Janet Hare was their allocated housing officer and she was responsible for resolving tenancy related problems. She had known Richard and Mrs King since she had worked for Broadland Housing Association in Fakenham. The Fakenham accommodation was sheltered and a key worker lived on site. In the flat in Wells, the NNDC provided support services but they did not provide a key worker on site.

1.10 Elizabeth Fitzroy Support (EFS) is a charity which provides support for learning disabled patients. They visited Mrs King from August 2003 to January 2004 when they decided that the situation in the Kings' flat placed their staff at risk

CHAPTER 2
A CHRONOLOGICAL ACCOUNT OF SIGNIFICANT EVENTS

In this chapter we have recorded the main features of Richard King's psychiatric illness and his management in the community. We have not attempted to record every contact between Richard King and his consultants, CMHN, social worker and GP. Full analysis and discussion of the effectiveness of the medical and community management of Richard King is found in Part Two. We have included only significant incidents decisions and documentation in this history. We have highlighted six key points at which we believe intervention would have altered the sequence of events.

The personal history of Richard King

2.1 This history has been compiled because the panel became aware during the course of this inquiry that many of those who were interviewed did not have any knowledge of significant incidents or of other important indicators marking the deterioration in Richard King's mental state. In this compilation, we have used medical records for Richard King and Mrs King, inpatient notes from Hellesdon Hospital, CMHN notes, GP and out of hours GP service (Faredoc) notes, LD nurses' notes, social care files, EDT alerts, information from the Fakenham, Sheringham and King's Lynn police, NNDC housing records, Crown Prosecution Service documentation for the court hearing, and two opinions written by Dr Shetty and Dr Wood, consultant psychiatrists, for the court proceedings. The panel believes that it is not possible to analyse and comment on the decisions and actions of those most closely connected with these events without an understanding of this compilation.

2.2 Richard King has been known to mental health services in Norfolk since his admission to the David Rice Hospital in 1991. Clearly the early history of his illness is less relevant to the main issues of clinical management than the increasing seriousness of the events following the reduction of his medication in June 2001. Nevertheless we believe that there is some significant information in the early history of Richard King's illness and so we include a brief summary compiled from the documents available to us. In writing this section, we have tried to balance regard for the privacy of members of Richard and Mrs King's families against the public's need to understand the course of events and the family interactions which were involved in the homicide of John West.

Early life

2.3 Richard King was born on 21 January 1969 in Essex. The family moved house several times in his childhood including to locations in Germany. Richard King attended various schools, including a boarding school in Norfolk. He had problems with literacy. His parents separated when he was thirteen. There had been family difficulties, including some violence, and he was noted to be unhappy at school in the early eighties. An Educational Psychologist described him as a *'sad and disturbed boy'* when he saw him aged 15. He left school at sixteen without qualifications and his intellectual ability has been

described as limited. In May 1985 he joined a training scheme to become a fisherman. This was followed by a period of unemployment and various short term jobs.

2.4 Between 1985 and 1992, Richard King acquired a criminal record. He was first convicted for theft in 1985. He was sent to a Detention Centre for six weeks in 1986 for shoplifting and was convicted for burglary in 1998. There were two convictions for actual bodily harm in 1990 for which he was fined and ordered to pay compensation. These cases were all heard in magistrates' courts. In 1988 Richard King was found guilty of sending misleading messages and using wireless apparatus without a licence, but a report prepared for the court by Dr Evett, a consultant psychiatrist, in 1988 did not find any evidence of psychiatric illness.

The onset of mental illness

2.5 In 1991, Richard's father became concerned about his behaviour. His general practitioner referred him to the David Rice Hospital in Norwich. Richard King expressed delusional beliefs and was briefly detained. He returned home, but was later removed by the police and returned to the ward. At times he reported hearing voices and was started on a depot injection. Eventually his social worker found him accommodation at a hostel in Cromer: the diagnosis at this time was schizophrenia. He was discharged on a fluphenazine depot, but the dose was increased several times during 1991 as he continued to experience psychotic symptoms.

2.6 From 1992 to 1994, Richard King was admitted to hospital on a number of occasions. Although his symptoms fluctuated he continued to experience visual and auditory hallucinations including hearing a voice in his throat calling him *'perverse'*. This particular hallucination of throat signals was a persistent symptom to which Richard King later referred as one of the explanations for committing the homicide. The disturbing content of the hallucinations contributed to his name being placed on the Supervision Register. This was a list of patients who were causing particular concern.

2.7 There are occasional references to use of street drugs and alcohol in the clinical history. In Dr Barker's letter to the GP of 29 November 1991, he notes that Richard King had told him that he had been taking amphetamines and suggested a diagnosis of amphetamine psychosis. When Dr Barker wrote to Dr Hughes and Dr Reynolds, he noted that Richard King had been taking amphetamines and cannabis. Dr Barker had thought that his symptoms may have been caused by the drugs and not by the schizophrenia, but later he concluded that Richard King did suffer from the illness. There are passing references to tests for illicit drugs but no results are recorded in the notes. However, various changes and combinations of medication controlled his illness and Richard King remained well during 1995 and 1996 while continuing to live in a hostel. His name was removed from the Supervision Register in May 1997. Richard King became engaged to Mrs King and in January 1998 they moved into a supported housing association flat in Fakenham.

2.8 At the Care Programme Approach meeting on 22 November 1997, it is recorded that all members of the care team were concerned about Richard King moving out of the hostel and living in independent accommodation with Mrs King. The carers were concerned that Richard *'can be very unwell on occasion as can his fiancée. It is felt that Richard and Mrs King could not live independently without support'.*

It was recorded[2] that the care team believed that there would be a need for homecare every day and *'periodic respite care and a place to go in an emergency for Mrs King'*.

There is a also a comment to the effect that the next Community Psychiatric Nurse allocated to Richard should be female. We include this comment because we infer that it was a professional recognition of Richard's hostility to men which became a marked feature of his later relationships with healthcare professionals.

2.9 Richard King was married in February 1998. The medical record is lacking in detail at this point but by October 1998 he was under the care of Dr Nicol, consultant psychiatrist. Dr Nicol reported that *'Mr King was currently well'*[3] and not taking alcohol and illicit drugs. He was taking zuclopenthixol 500mg weekly. In 1999 Richard King asked about reducing his medication, but accepted Dr Nicol's advice that he would need to remain on it *'for the foreseeable future'*[4]. In May 2000 Richard and Mrs King moved to a NNDC flat in Wells-next-the-Sea. They were still living at this address at the time of the homicide.

Psychiatric history and clinical management: June 2001-December 2002

2.10 In 2001 the care team changed and Richard King's new consultant was Dr Huw Thomas. He met Richard King for the first time in June 2001. His current dosage of zupenthixol was 400mg weekly. A CPN had agreed to Richard King's request on 2 March to reduce the dosage by 100 mgs. This was agreed by Dr Nicol on 9 March with the proviso that the dosage should be increased in the event of deterioration. On 13 June Dr Thomas reduced the zupenthixol from 400mg weekly to 600mg fortnightly again at Richard King's request. The patient was complaining of pain at the injection site and varicose veins, but Dr Thomas did not examine him: this matter is considered further in Chapter 4 in Part Two.

2.11 On 12 December 2001 there was a CPA meeting. Dr Thomas noted that he had agreed to Richard King's request for a further reduction to 600mg every three weeks and noted that there could be a further reduction to 500 mg. However, John Purdy, his CMHN, recorded on 6 December that: *'feelings and memories of the past have been resurfacing as medication has been reduced'*[5].

[2] See CPA meeting,22 November 1997
[3] See CPA meeting, May 1999
[4] See CPA meeting November 1999
[5] CMHN notes

2.12 In January 2002 Richard King relapsed into psychosis and experienced auditory hallucinations (hearing voices). John Purdy noted on 31 January that he had *'heard a voice telling him to leave home'*, and that he was not sleeping well. He noted *'Feels reduction in medication is now too much'*. The CPN discussed this with Dr Thomas and the depot was increased to 600mg fortnightly. Dr Thomas did not arrange to see Richard King at this time. On 22 January 2002 Dr McAnsh made a home visit following a call from Richard's father saying that Richard was suicidal. He found Richard King to be *'friendly, relaxed and calm, not psychotic or suicidal*[6]*'*.

2.13 On 5 February Dr Thomas wrote to Dr McAnsh on 5 February 2002 suggesting that: *'we all keep an open mind as to the reasons for his apparent deterioration … it is common for long term psychiatric patients to experience anxiety when their medication regime is changed'.*

The relapse into psychosis in January 2002 following the reduction of medication in June 2001 is the first key point in the sequence of events.

2.14 On 29 April Dr Thomas reduced the depot to 500mg fortnightly after a discussion with John Purdy, CMHN. Dr Thomas next saw Richard King on 27 June: he noted that he was doing well. When Richard asked whether he could change to oral medication , Dr Thomas commented *'In view of his excellent compliance over the years I do not think this will be a problem*[7]*'*. The zuclopenthixol was reduced to 500mg at four weekly intervals and he added 100mg of chlorpromazine at night. Dr Thomas advised that the depot could be discontinued after three months *'if he remained stable'* [8] and arranged to see him five months later. The community nursing notes record mental stability at the times when the depot was administered during this period.

2.15 On 28 November 2002 Dr Thomas saw Richard King again. He noted that there was *'no evidence of active schizophrenia'*, and he agreed to the discontinuation of the depot. A review was planned for six months' time. On 17 December Richard's father rang the Access Team based at Hellesdon Hospital expressing concern about Richard: this was passed to John Purdy who visited him the next day. He recorded that Richard was complaining of low mood, tearfulness and early waking, and noted *'for medical discussion'*.[9]

2.16 On 21 December the Social Services Emergency Duty Team (EDT) received an 'alert' It refers to an unidentified caller who reported that Richard King was seen on the previous day by an 'Assessor' (unidentified). She was concerned that Richard King's wife might be at risk as he *'sees a past employer in her face when he looks at her'* and has delusions that he was *' responsible for bombing the World Trade Centre'.* The following page in the alert refers to the Home Treatment Team (also known as the Access Team) which described

[6] GP notes
[7] Letter to Dr McAnsh from Dr Thomas 2 July 2002
[8] Letter to Dr McAnsh from Dr Thomas, 2 July 2002
[9] CMHN notes

him as *'very deluded, paranoid with grandiose ideas.*[10] These messages record the emergence of Richard King's underlying psychotic beliefs during the process of assessment. Although he claimed to have been taking his medication, the alert records that this was not borne out by the amount of medication that remained.

2.17 On 21 December Dr Ebrill visited Richard King at home as he had been contacted by two different social workers to consider whether there should be an Mental Health Act (MHA) assessment. The record is dated 22 December: we believe that this was when the record was put into the system and that the domiciliary visit was made on 21 December as this was the date of the section. He wrote: *'Obvious schizo thoughts … offered to fill in forms anytime except when starting Co-op … not acceptable they will arrange suitable after psych assessment.'*[11]

First admission under s.2 of the Mental Health Act 1983: 21-24 December 2002.

2.18 On 21 December Richard King was admitted to Hellesdon Hospital on s.2 (a 28 day section mainly intended for assessment). This was his first formal admission under the 1983 Mental Health Act, although he had been suffering from paranoid schizophrenia since 1991.

2.19 On 24 December Dr Thomas discharged Richard King. Dr Thomas wrote to Dr MacAnsh on 31 December and described Richard King's psychotic delusions relating to needles and voodoo and his paranoia against his father on admission. He recommended an increase of 300mg daily, in divided doses, to 500mg of chlorpromazine in divided doses. He informed Dr MacAnsh that he would review his long term management in January 2003.

This formal three-day s.2 admission for assessment is the second key point in the sequence of events.

Psychiatric history and clinical management: January 2003- 7 January 2004

2.20 On 14 January 2003 Dr McAnsh recorded in his notes a home visit to Richard King as follows: *'has been agitated ALL day was threatening violence towards Mrs King; has now locked her out: access team have been asked to visit by CPN but are now not coming; referred to ASW for consideration of section'.* On 14 January an EDT note[12] refers to information given by Louise Holden, his current community nurse, regarding a home visit by Dr McAnsh. Reportedly Richard King had grabbed a knife, threatened to kill himself and locked his wife out of the house, and would not let the doctor in. Richard King denies that he threatened violence or locked his wife out.

2.21 On 21 January 2003 Dr Thomas, accompanied by Jenny Cunningham, Richard King's newly appointed social worker, saw his patient at home. Richard King had not attended the out patients' appointment on either 9 or 16

[10] Undated but adjacent to the EDT dated 21 December
[11] GP notes
[12] The EDT has a hand written date of 14. 1. 03 added to it.

January. He had caused a disturbance on 19 January and had broken some windows outside an address where he had claimed he had once lived. The EDT alert[13] noted that: *'the police found him very strange and angry (their words) he was jumping up and down talking in a manner that did not make sense'.* He was detained by police under s.136 of the MHA, and charged with criminal damage: this was subsequently dropped. The alert noted that the Forensic Medical Examiner *'felt able to allow Richard King to return to his home'.*

2.22 On 21 January Dr Thomas wrote to Dr McAnsh that Richard King had admitted not taking the chlorpromazine and *'displayed rather more excitability and pressure of speech than I have seen him show in the past'.* Dr Thomas did not *'think he presented any immediate risks'.* Dr Thomas believed that he should remain under review by Jenny Cunningham and the community nurse.

The letter from Richard King's father to Jenny Cunningham

2.23 On 22 January Richard King was visited at home by his brother and sister, They reported to his father that the Kings' flat was in turmoil and referred to Richard King making gestures with knives. He telephoned the Access Team at Hellesdon Hospital and described his fears concerning allegations of that Richard was concealing knives, carving *'wife's name in hand'*, speaking irrationally and not taking medication or food. He was advised to telephone his GP, but said that he felt unable to do this as he was using his employers' telephone. In the social services file, there is a note from Jenny Cunningham which recorded a telephone conversation with Richard King's father on 31 January which he described his fears for himself and his family. She wrote *'Mr King will write a letter detailing above'* from which we infer that the letter from his father, which is described in the following paragraph, was written at the instigation of Jenny Cunningham. Richard King has told us via his solicitor that he has always taken his medication.

2.24 On 2 February Richard King's father wrote to Jenny Cunningham and described his attempts to communicate with Dr Thomas *'via his secretary'* as follows: *'I related my concerns to her (*the secretary*) but after a brief interlude told me that nothing could be done'*. He then described Richard King's psychotic beliefs at length and his concerns that his son was not taking medication. He related that his daughter had seen *'large knives hidden behind cushions with stab marks in the sofa'.* His son had imitated stabbing himself with a knife and carried out the same motions on his brother and sister. This three-page letter vividly described his fears of Richard's future violence and specifically warned Jenny Cunningham not to visit his son without a police escort or *'one or more of you can end up badly injured or 'DEAD''.*

2.25 On the final page of the letter, there is a handwritten note dated Monday 3 February which referred to a telephone call made to Richard King's father at 9 am, in which he gave further examples of his son's psychotic delusions. This

[13] EDT 19 January

note is incomplete, unsigned and it is unclear whether any action was taken. However, an EDT Alert dated 3 February and headed *'Referral Actions'*, noted that Jenny Cunningham told his father that he should call Referral and Reception (R&R) to have his son assessed under the MHA, and we infer that Jenny Cunningham had made the note on the letter. The alert also recorded that she spoke to Dr McAnsh who was not aware of Richard King needing to be assessed again as he was *'OK'* [14] ten days ago.

Circumstances of the Mental Health Act Assessment on 3 February

2.26 On 3 February 2003 Dr McAnsh visited Richard King at his home. The GP recorded in his notes that the patient was *'hearing voices and is worried about the Mafia/IRA etc, has not been taking his tablets, house is a tip, will try to get hold of CMHT.'*

2.27 On 4 February John Stone, a duty Approved Social Worker (ASW), filed an alert. He recounted contact between the Home Treatment Team (HTT also known as the Access Team) and Richard King following information from his father concerning knives. The HTT found Richard King to be paranoid with grandiose ideas. John Stone and Dr Thomas, accompanied by a police officer, attempted to visit Richard King. He was not at home, but was eventually located in Fakenham. With consultant and ASW approval, Dr McAnsh completed the medical recommendation for an admission under the MHA. [15]

Second admission under S2 under the Mental Health Act 1983: 5 February-discharged 5 March 2003

2.28 On 5 February Richard King was again detained under s.2 of the Mental Health Act. The MHA assessment was made by Sheila Endresz, an ASW from Kings Lynn. There were problems recorded in the file in finding a bed, one of which was the Bed Manager's reluctance to accept the patient *'because of the threats of violence and knives'.*[16] Richard King had delusions of drug dealers going to kill him and was thought disordered and hearing voices. When he was refused leave from the hospital he was extremely aggressive and abusive. However, several risk assessments were completed by nursing staff which indicated that the risk of self harm and harm to others was low. Dr Thomas changed the medication to risperidone in depot form and discharged him on 5 March.

2.29 On 8 April a CPA meeting was called. The unsigned minutes identify the purpose of the meeting as a need to discuss risk factors and the amount of professional input, and to formulate a crisis care plan to be used by the Community Mental Health Team. The risk to Richard King or others, when medicated, was not felt to be high.[17]

[14] EDT Alert
[15] GP notes, 4 February
[16] Note in Social Services file dated 5 February
[17] Comment in file note of crisis plan meeting regarding Risk

Third admission (informal): 26 April, discharged 14 May 2003

2.30 On 25 April Richard King's father telephoned Dr McAnsh to report that Richard had become aggressive and violent. The GP informed the Access team of the situation. Faredoc (GP out of hours service) had received a call from Mrs King saying that her husband was suicidal. Richard King was admitted to Hellesdon Hospital informally on 26 April. According to Dr Thomas' letter to Dr McAnsh[18], Richard King was experiencing bizarre delusions. For example, he believed that his grandfather had died and was buried in Buckingham Palace having left him £100 million. Other delusions and visual hallucinations relating to zig zags, the royal family, rape and death were also recorded. The letter also refers to auditory hallucinations coming from his stomach. Risk assessments by the nursing staff generally indicated low risk in most areas.

2.31 On 28 April Gill Chambers, the new CMHN and Care Coordinator, visited Richard for the first time on Yare Ward at Hellesdon Hospital. She recorded being told by the staff that Richard King's father had rung the hospital and expressed concern about his son. The unsigned minutes of a Ward Round meeting attended by Dr Thomas, Gill Chambers, Jenny Cunningham and other social workers on 7 May record *'a number of overlapping risk factors directed to self harm (Mrs King); accidental harm (Richard King) and possible risk to the alleged abuser if Richard's paranoid thoughts overwhelm the situation'*. Gill Chambers completed a CPA Care plan on 13 May in which she noted that bizarre ideas were an early warning sign and that there was *'no history of risks recorded'*. Richard was discharged on 14 May after a satisfactory home leave. When Gill Chambers visited Richard King at home the following day, she noted that he was still expressing bizarre ideas.

Fourth admission under s.3 of the Mental Health Act 1983: 23 May, discharged 30 July 2003

2.32 On 23 May the Emergency Duty Team received a message that Richard had become agitated and aggressive and believed that Mrs King was *'being preyed upon by other men'.* Dr Ebrill (Dr McAnsh's GP partner) visited Richard King at home with Andrew Collins, an Approved Social Worker. He noted *'flights of fancy, very aggressive'*[19], and decided to admit him to Yare Ward, Hellesdon Hospital**.**

The admission of Richard King on 23 May was under s.3 of the Mental Health Act. This was the first time he had been detained under this section which gives legal authority for detention up to six months initially and emphasises treatment as well as assessment.

Richard expressed psychotic delusions such as the rape of a deceased member of the royal family by his father-in-law. He also believed that voice signals were being sent through his throat to Tony Blair.[20]

[18] Dated 14 May
[19] GP notes
[20] Letter to Dr McAnsh from Dr Thomas 11 August

2.33 On 29 May Dr Thomas discontinued the risperidone and substituted a zupenthixol depot injection of 500 mg to be given fortnightly. The nursing risk assessments raised the possibility of harm to others as moderate as Richard King had recently been threatening to his wife and the ASW who had assessed him. At some point on 27 May Richard King left the ward: when he returned he explained that he had been to London to sort out his inherited money. He did not accept that as a sectioned patient he could not leave the ward without permission.[21] On 3 June Richard King absconded from the hospital. There is no reference to this in the nursing notes, but an EDT alert recorded that the police found him at his home and returned him to hospital.

2.34 On 30 June he left the hospital and went to a garage where he shouted abuse and threw pound coins at the attendant. According to the manager of the garage this was the second time that he had caused a disturbance.[22]

2.35 On 30 July Richard King was discharged home following some home leave and at a S117 meeting (a statutory meeting to arrange aftercare) Dr Thomas increased the zupenthixol depot to 600mg fortnightly. In the discharge summary, addressed to Dr McAnsh dated 11 August, Dr Thomas wrote as follows:

Richard's progress on the ward was increasingly disturbed and remained paranoid. He became very demanding and pushed the boundaries being very aggressive and angry. He refused to talk to staff and became increasingly threatening, so much so that it was safer to allow him to leave the ward than risk physical violence. He returned later and was fairly pleasant and co operative. He denied any suicidal ideation … and that he was not being affected by any delusions. He very soon became unsettled. He was very psychotic, verbally abusive and aggressive towards staff. He wanted to return home and said if we did not allow him to he would slash his wrists … He was allowed leave which went well … his home leaves were extended. His delusions stopped, he did not admit to any thoughts of voodoo or the IRA.

2.36 On 4 August Trudie Needham (Community Learning Disability Nurse for Mrs King) wrote to Dr Verma expressing her concern over the anger expressed towards her by Richard King. In view of his volatility and potential violence she decided, with the support of her manager, that she should withdraw. She informed Dr McAnsh regarding the administration of Mrs King's depot injection. She also arranged for Elizabeth Fitzroy Support, a charitable group, to provide support for her. At this point Jenny Cunningham had been allocated to Mrs King as her social worker.

2.37 On 12 August the EDT received a telephone call from a family member reporting that Mrs King had arrived at their home and was claiming that her husband had threatened to kill her. Mrs King disputes this information. Mrs King was able to stay the night at the relative's home. The family member

[21] Entry in nursing notes 27 May
[22] Entry in nursing notes 30 June

was advised to report the incident to the police**.** There was a request to pass on the information to the social worker for the case. On 14 August, according to her clinical notes, Mrs King took a specific action which usually indicated that she was under stress.

Fifth admission (informal) on 23 August - Richard King left on 24 August 2003

2.38 On 23 August Richard King contacted Dr McAnsh complaining that he felt suicidal. Dr MacAnsh contacted the Home Treatment Team and the patient was admitted informally to Hellesdon Hospital. He believed that someone had pulled a voodoo doll out of his chest and that he could communicate through *'throat signals'*[23]. According to the admission notes *'he has been using regular cannabis and drinks one and a half bottles of rum a week'.* A Senior House Officer (SHO) allowed Richard King to go on leave on the day of admission for five days and to return for a ward round. He did not return and no action was taken.

2.39 On 28 August there was a *'*Network*'* meeting at Carrobreck (an office at which mental health staff were based) attended by Jenny Cunningham, a representative from Elizabeth Fitzroy Support (EFS) and an additional social worker. Gill Chambers recorded a decision for Jenny Cunningham and herself to do a joint visit *'to redefine the roles of each agency and discuss alternative coping skills'.* No specific action was taken*.* The social services minutes of this meeting do not record the date when it took place. On 30 August Mrs King repeated the action referred to in 2.37.

2.40 On 13 September the EDT were called by a member of Mrs King*'*s family. The police had brought Mrs King to their house in Cromer as Richard had *'thrown Mrs King out'*. Jenny Cunningham discussed the situation with Millie Kelsey (her supervisor) and contacted Richard King and arranged for Mrs King to return to the flat. Jenny Cunningham raised the matter at the CMHT meeting for discussion: the minutes record *'both not well'.*[24]

2.41 On 15 September the same family member also telephoned and wrote to Jenny Cunningham concerning stressful and delusional telephone calls from Richard and Mrs King. They had been *'bombarding'* them with telephone calls and requesting pornographic material which had caused them to change their telephone number twice. The panel has seen this letter dated 15 September. Attached to it is a note from Trudie Needham describing Richard King when she went to the flat to collect Mrs King*'*s clothes. It ends: *'He's not taking his meds. I've never seen him like this before, he scares me'.*

2.42 On 18 September Richard King failed to attend the out patient clinic, but Dr Thomas reviewed his medication and continued the zupenthixol at 600 mg fortnightly.

[23] Entry in medical notes 23 August
[24] CMHT minutes 15 September, the first reference to CMHT minutes in the panel's documentation

Sixth admission (informal) on 24 September - discharged 22 October 2003

2.43 On 24 September Richard King was admitted informally again to Hellesdon Hospital. Gill Chambers was told by Mrs King that Richard had taken a taxi to the hospital to be admitted. The GP notes record: *'Referred to Access Team by Faredoc for hallucinations>admitted Hellesdon Hospital'.* Richard King was acutely psychotic expressing delusions concerning the rape of a deceased member of the royal family abuse by Gordon Brown, hearing voices and talking to God '[25]. Unfortunately he was given flupentixol, 600mg, in error on 30 September and remained in hospital for three weeks observation.[26] A risk assessment indicated low risk in spite of recorded paranoid beliefs. A drug screening test taken on 3 October was positive for cannabis. A Senior House Officer (SHO) gave Richard King leave on 17 October: he refused to return and was discharged in his absence on 22 October. The ward round notes on 22 October record a comment made by the same SHO that Richard King felt: *'intensely jealous towards anyone connected with his wife'.* It was agreed that medication on discharge should be given as a depot injection of 150 mg of flupentixol fortnightly as Richard King had felt it was more helpful to him than zupenthixol.

2.44 On 16 October there was a 'Strategy Meeting' attended by Dr McAnsh, Jenny Cunningham and a representative of EFS. The meeting attempted to assess the risks presented by Richard King and the unsigned and undated minutes record that: *'There is an obvious danger to staff as discussed. Furthermore unmedicated Richard is extremely menacing. I suggest that he does not show this to doctors because he knows that they have the power to use the compulsory powers of detention under the MHA. It should not be underestimated that the degree of potential and actual physical and litigious danger which exists for community staff is real and should not be minimised*'.

Richard King's contacts with Fakenham Police Station

2.45 On 14 November, Jenny Cunningham (duty ASW) recorded telephone calls from the police expressing concern that Richard King had informed them on three occasions that day that he knew where bodies were buried, and he told them that he was waiting with his book, flask and spade as he wanted the police to go with him. Sergeant Spinks then telephoned again to inform Jenny Cunningham that Richard had arrived at Fakenham Police Station demanding that the police go with him to dig up bodies. Jenny Cunningham made a number of telephone calls including two to Dr Thomas: his secretary confirmed that he had received the first message but he was *'in supervision'*[27], and she did not know when he would be free. Jenny Cunningham faxed an Alert to EDT and referred to Richard King's *'experience of a psychotic episode and is very unstable'*[28]*.* She also wrote to his father offering assistance at any time and included a contact telephone number. On Sunday 16 November Mrs

[25] Letter from Dr Thomas to Dr McAnsh 24 October.
[26] See Chapter 4 for full discussion
[27] File entry 14 November
[28] Alert dated 14 November

King was removed by police to a hotel as she was upset. The date of her return to the flat cannot be established from the social care file[29].

2.46 On 20 November Richard King attended Dr Thomas' out patient clinic in Cromer. In his letter to the GP he noted that the patient's mental state was relatively good:

'He does continue to express some odd ideas relating to events in the distant past. I would hesitate to describe these as psychotic as I suspect they are more to do with Richard's limited IQ and tendency to misinterpret real events and mix these in with a little fantasy and imagination.'[30]

Richard and Mrs King left Norfolk for a short holiday in Spain.

Allegations of violence towards Mrs King

2.47 Jenny Cunningham noted a telephone call with Mrs King on 10 December in which she claimed that *'Richard had hit her and pulled her hair when they were on holiday'.* She retracted these allegations later the same day. Mrs King telephoned again on 15 December and reported *'that she had smashed a mirror over her head and had been taken to hospital by the police on 14 December'*.[31]

2.48 On 21 November, the Housing Support Worker, Robert Johnson, wrote to Jenny Cunningham to inform her that neighbours of the Kings were reporting intimidation and shouting and banging on doors. A family member had also informed him that he had received some extremely offensive telephone calls. Robert Johnson had advised the tenants to ring the police if they perceived further intimidation. The letter ends*:*

'I don't know if there is anything you can do Jenny but Richard's actions are really upsetting a lot of people and it sounds to me and to other colleagues who have known Richard a long time that he is unwell again and a significant risk to himself and others'.

The fax from the Adult Protection Unit

2.49 On 24 November a Detective Constable from the Eastern Area of the Adult Protection Unit, Norfolk Police faxed a letter to Dr Thomas as Richard King had been making numerous telephone calls to the police. The letter is reproduced in Chapter 4, paragraph 4.16 and discussed in detail. It described Richard King's delusions of dead bodies and other very disturbing material and emphasised the risks to Mrs King.

This was the third key point at which no decisive action was taken.

[29] File entry 14 November
[30] Letter from Dr Thomas to Dr McAnsh dated 24 November
[31] Social services file

2.50 On 23 December Richard King's father contacted the Fakenham Office with concerns that his son was becoming unwell and not taking his medication. Mr King had spoken to Jenny Cunningham on the telephone just before Christmas about his concerns that his son was becoming unwell again and she had registered his concerns with in an alert on 23 December.

Seventh admission (informal): 28 December 2003 - discharged 7 January 2004

2.51 On 28 December Richard King was admitted informally to Hellesdon Hospital This admission followed concerns by Richard King's family as he had attempted to strangle his father and had injured other members of the family.[32] Richard King denies attempting to strangle his father but accepts that there was a struggle. In his subsequent letter to Dr McAnsh, Dr Thomas described that Richard King had reported that his *'brain was clicking'* but had denied auditory and visual hallucinations[33]. He also believed that he had been abused by Gordon Brown and was turning into him. He repeatedly demanded discharge and was verbally abusive. There was an assault on another patient[34]. At the ward round on 7 January Dr Thomas noted that Richard King appeared quite settled, had no further thoughts of sexual abuse and was no longer a management problem. He increased the flupentixol to 200mg fortnightly. Inpatient risk assessments rated the risk as generally low although risk to others was moderate. Richard King was mentioned at the CMHT meeting on 5 January. The information column of the minutes record that he had had been admitted informally and had *'threatened to leave hospital last Wednesday'*.

Psychiatric history and clinical management from 7 January to 7 August 2004

2.52 Janet Hare, North Norfolk District Council (NNDC) Housing Officer, had received a written complaint from an elderly tenant in November 2003. Another letter was received on 17 January 2004 complaining of arguments, fights and screams emanating from the Kings' flat and asking for a transfer on medical grounds. Janet Hare gave evidence to the panel that she had also been concerned about the safety of the male contractors who had been frequently called in to repair utilities in the summer of 2003. No housing problems had been reported to her prior to this period. As the NNDC were considering serving a notice seeking possession of the Kings' flat, a multi-agency case conference was called by Jenny Cunningham.

Case conference 26 January 2004 concerning Richard and Mrs King

2.53 This case conference was chaired by Jenny Cunningham. It was attended by three representatives from EFS, Sergeant Spinks, Gill Chambers, Janet Hare, Steven Potter and Roger Howe, Practice Manager from the Legal Section of NNDC. Dr Thomas was not present. He had been sent a notification *'For information only'* as he was on annual leave. There are five pages of detailed minutes which reflect the wide-ranging multidisciplinary discussion. We

[32] Entry in nursing notes regarding telephone call from Richard King's father 28 December.
[33] Letter to Dr McAnsh from Dr Thomas, 8 January.
[34] Risk assessment comment in the nursing notes on 31 December

believe that these were taken by Jenny Cunningham. However, Roger Howe also made a detailed file note for NNDC which recorded additional information.

2.54 Jenny Cunningham explained that the meeting was precipitated by the distress of the adjoining tenants, particularly the harassment of an elderly neighbour, and serious concerns about the Kings' welfare. Janet Hare reported that Council workmen had also expressed reluctance to visit the Kings alone. Richard was considered to be extremely paranoid about any man coming near Mrs King and so Janet Hare offered to be present when utilities required repairs.[35] Following the meeting she instigated a protocol whereby contractors attended in pairs.

2.55 The EFS representatives complained that they had not been fully informed of the seriousness of the mental illnesses of Richard and Mrs King and their staff had been therefore been put at risk. It was agreed that they would no longer visit Mrs King. Gill Chambers and Steven Potter agreed that they would make joint visits. Sergeant Spinks confirmed that the situation with the Kings had been deteriorating since November and the risks that they presented were recorded on the police computer system. Furthermore, the police only attended the address in pairs. The minutes record that Sergeant Spinks would liaise with Jenny Cunningham in the first instance if the police received any violent calls. Jenny Cunningham specifically recorded that she would continue to visit alone*. 'I have not felt personally threatened but I can see that the potential for physical abuse / physical harm is ever present'.* Roger Howe agreed to write a letter to Richard King's consultant to express NNDC's concern about under-medication and the tenancy agreement.[36] This letter was not sent.[37]

The incident concerning the shaving of Mrs King's head

2.56 On 26 January 2004 Jenny Cunningham received a telephone call from Janet Hare (following the case conference) concerning the report of the downstairs tenant that there had been *'a big argument'*. Jenny Cunningham visited at 3 pm and found that Richard had shaved Mrs King's head and his own. He claimed he had done it *'to get the thoughts out'* (of her head). Richard King had *'seen his wife's abuser'* (William Hague) in her face. Jenny Cunningham copied the file note of her visit to Dr Thomas, Gill Chambers, Steven Potter and Sergeant Spinks and telephoned the NNDC. She also sent an Alert to the EDT warning of Richard King's instability and potential risk of harm to social service personnel.

This was the fourth key point at which decisive action could have been taken.

[35] Minutes of the meeting.
[36] NNDC minute of the meeting.
[37] See Chapter 9 for further information.

2.57 On 30 January Gill Chambers visited Richard King at home. He seemed *'quite unwell'* and refused the depot because he felt he no longer needed it[38]. He was discussed at the CMHT meeting on Monday 2 February. Dr Thomas agreed to telephone Richard King but was unable to contact him. The information column of the CMHT minutes record: *'Richard (Stewart) and Gill to discuss suitability for Assertive Outreach Team.'* The last entry by Dr Thomas is as follows: *'suggest write up for increased for increased dosage at CMHT mtg'.*[39] But in the event, Gill Chambers was able to persuade Richard King to accept the depot on 5 February. Dr Thomas left the Trust on 6 February.

Increase of medication by Dr Fadlalla

2.58 On 9 February Richard King was discussed at the CMHT meeting. Dr Fadlalla (locum consultant), who worked in the relevant catchment area from 9 February to 24 March, was present. The minutes of the meeting read as follows: *'Deluded. Involvement of housing/police. Need to be aware impact psychotic behaviour has on community. Also involve GP. Medication to be reviewed'* When she heard of the concern of the team and the number of short admissions in the previous year, Dr Fadlalla decided in principle to increase his medication. She then reviewed his recent notes for possible contra indications.

2.59 On 19 February at the CPA review, Dr Fadlalla asked Richard King about his mental state and in a subsequent letter to Dr McAnsh concluded that: *'today Mr King did not display any acute symptoms but he definitely suffers from negative symptoms of schizophrenia'*[40]. Dr Fadlalla increased the prescription of flupentixol to 250 mg fortnightly and arranged for him to be seen in six months time when she anticipated that a substantive consultant would have been appointed. The letter was copied to Jenny Cunningham and Gill Chambers.

Mrs King taken by Richard King to a residential home

2.60 On 22 February Mrs King was taken to a residential home in Cromer by Richard King. Mrs King told the duty social worker that he was*' saying he did not want to be with her'*, and alleged that there were marital problems. Following a check by the local police and the Access Team on Richard's presentation, this was resolved by Mrs King apologising and agreeing to return to Wells in a taxi.[41]

Follow up strategy meeting at Fakenham Social Services office on 22 March 2004

2.61 This meeting was called, we believe, by Jenny Cunningham as the minutes were written in her style and the meeting followed what had been agreed on

[38] Entry in the community nursing notes.
[39] Medical notes 5 February.
[40] Letter from Dr Fadlalla to Dr McAnsh dated 1 March
[41] EDT note on 22 February

26 January. It was attended by Gill Chambers, a representative from EFS, Janet Hare, and Steven Potter. There was general agreement that Richard and Mrs King were *'less troubled'*, and this was recorded in the minutes. The police had not made any visits since the previous meeting. No action was minuted and it was decided not to meet again but to maintain communication. There was no reference to the failure to implement the previous decision that Roger Howe should write to Richard King's consultant.

Home visits between 25 March and 14 July 2004

2.62 On 25 March Gill Chambers visited to administer the depot injection without incident. Joanne Braisby administered it on 6 April. Joanne Braisby had qualified in 2003 and had worked at Hellesdon Hospital so she knew Richard King from her experience of nursing him as an inpatient. She then joined the Northern Norfolk CMHT. She noted that Richard *'continues to present as stable.'*[42] On 15 April Joanne Braisby noted that Jenny Cunningham had been telephoned by Mrs King stating that her husband had *'gone psychotic again',* and was fixated on William Hague. Jenny Cunningham sent a warning message to that effect to the EDT.[43] However, Joanne Braisby contacted Richard and Mrs King on 15 April and, according to her notes, was reassured by his presentation.

2.63 On 19 April Richard King was discussed again by the CMHT according to the minutes of the meeting. He was thought to be reasonably stable on medication but Jenny Cunningham and Steven Potter believed he was becoming psychotic again. The action column records that Gill Chambers would see him on 22 April. Richard King was not discussed again until 12 July. Gill Chambers visited Richard King on 22 April and noted *'he did express a few bizarre ideas but nothing to cause concern'*[44]*.*

2.64 On 19 April Janet Hare recorded in a file note that problems with two close neighbours have unsettled Richard and *'he is now quite psychotic'*. Mrs King was *'very upset because of this'*[45]*.* An unsigned note (probably from Jenny Cunningham) made on 30 April records Mrs King's concern: *'about two people who are known drug users, have a history of violence and are known to the police (verified by Janet Hare Housing Officer).*[46]

2.65 Gill Chambers visited Richard King to administer the depot on 22 April, 6 May, and 20 May: she reported him as well. In May 2004, the CPA Care Plan was due to be reviewed by the Care Coordinator. This was not done and we discuss this further in Chapter 6 and Chapter 13.

This critical omission is the fifth key point in the sequence of events.

[42] Entry in the community nursing notes
[43] EDT 15 April
[44] Entry in the community nursing notes
[45] This information was passed on in a telephone call from Jenny Cunningham
[46] Social Services File

2.66 On 2 June Mrs King contacted Steven Potter in the afternoon and again in the evening, but it is not appropriate to include the reasons for these contacts. He arranged for her to be taken to A&E: she was allowed to go home later. When he visited her with Gill Chambers on 3 June, Mrs King told him that she had had her head shaved again but denied that Richard King had done it. Steven Potter recorded that Richard King was displaying acutely psychotic symptoms and paranoia against himself, Steven Potter. He wrote to Dr Verma (Mrs King's LD consultant) the same day and recorded his request to Gill Chambers to *'discuss Richard with his RMO today'*.[47] The letter was copied to Dr McAnsh, Jenny Cunningham and Millie Kelsey.

2.67 On 4 June Joanne Braisby visited and found: *'Richard King quite unwell - verbally aggressive towards Mrs King who was quite tearful - telling her 'it was not her face' and very thought disordered around Mrs King being pregnant and references to Gordon Brown'*[48]*.* She gave the depot injection as prescribed. On 4 and 10 June Richard King saw Dr McAnsh in the surgery for minor physical complaints. Dr Ebrill made a domiciliary visit on 14 July. Neither doctor recorded any psychiatric symptoms in their notes.

2.68 There is an undated unsigned note in the Social Services' records which we believe was written by Jenny Cunningham in early June (it is stamped 'Received 18 June 2004') which refers to Steven Potter, calling into the Fakenham Social Services Office: *' to express his concerns about Richard's state of mind. Steven Potter felt that Richard was very psychotic when he visited and further he thought that Richard had begun to be suspicious of him'.* Jenny Cunningham commented in a file note on 9 June: *'It is extremely difficult to assess what is at the root of Richard and Mrs King's difficulties'.*

2.69 On 18 June Gill Chambers noted that Richard readily accepted the depot although she also noted that he was *'rather suspicious and anxious'* regarding a possible move to Fakenham. Jenny Cunningham, supported by Millie Kelsey (Team Manager) and Janet Hare, tried to persuade Richard and Mrs King to move to Fakenham. The purpose of this was to move the Kings into a bungalow away from the activities of their neighbours in order to reduce the complaints regarding noise. However, Richard and Mrs King returned to the flat on 21 June after one night in Fakenham and the problems with the neighbours remained unresolved. On 19 June Mrs King was taken by ambulance to A&E.

1 July to 7 August

2.70 On 1 July Richard King refused his depot and told Gill Chambers that he felt well[49]**.** On 7 July there is a note in the social services file (probably from Jenny Cunningham) that he had told a social worker that Gill Chambers had agreed to him taking oral medication. Richard King does not accept that he refused his medication. On 12 July there was a discussion in the regular Monday CMHT meeting and it was agreed that Gill Chambers and Steven

[47] Letter to Dr Verma dated 3 June
[48] Entry in the community nursing notes
[49] Entry in the community nursing notes

Potter should visit on 15 July to clarify the situation. The Actioned By column included *'Find out when CPA review is for longer term plan for future needs'*, but did not identify who should take this action.

2.71 On 15 July Gill Chambers recorded a telephone call from Jenny Cunningham from Hellesdon Hospital informing her of the incident described below.

The 15 July incident and eighth admission (Informal) to Hellesdon Hospital: discharged in absence 26 July 2004

2.72 The events of 15 July were a crucial point in the narrative of Richard King's mental deterioration. Jenny Cunningham made a contemporaneous account of the sequence of events at Wells in her notes and accurately described events when she was interviewed by the first inquiry even though she did not have access to her original notes.

2.73 Jenny Cunningham told the first inquiry that she received an urgent call at home from the Fakenham office receptionist on 15 July to the effect that Mrs King was hysterically upset and Richard had locked her out of the house. She went to Wells immediately, and found Mrs King in the garden saying that Richard had locked her out, that he had a knife and he was going to kill himself.

Jenny Cunningham told the first inquiry that her first thought was that she had to gain entry to the flat and so she persuaded a North Norfolk District Council worker who was working next door to break down the door: it sprang open. Richard rushed down the (external) stairs and Jenny Cunningham told the panel that she had never seen him look so menacing. But she looked him in the face and (in her words) said *'Richard, it's Jenny'*, and he appeared to recognise her. Richard then said (in her words) *'She is trying to kill me'*. Meanwhile Mrs King was distraught and (in Jenny Cunningham's words) saying *'I am not, I am not'.* Jenny Cunningham realised that Richard had completely lost all contact with reality and was about to ring 999 to invoke the local arrangements with the Fakenham police. A police officer arrived on the scene. (Jenny Cunningham had asked her administrative assistant to call the police en route to the flat). Richard King continued to claim that his wife was trying to kill him, and accordingly Jenny Cunningham decided she had to work within his delusion and suggested taking him to a place of safety. She asked the police officer for help and he called for back up which arrived very quickly. She told the police that Richard King should be taken to hospital, to which he agreed. She did not see Richard King in possession of a knife. Richard King denies that he was suicidal and that he ever said that his wife was trying to kill him.

2.74 Richard (who had been searched for weapons by the police) sat in the back of Jenny Cunningham's car and a police officer sat next to her as she drove to Hellesdon Hospital. She was escorted by a second police car. She took Richard King to the hospital and encountered a secretary who told her that she had no right to bring a patient to the hospital. The secretary eventually agreed that a doctor was available, but could not be summoned immediately.

Jenny Cunningham decided that she would take Richard King to the hospital café. She rang Gill Chambers, as Care Coordinator, and passed over her phone to Richard King so that Gill Chambers could reassure him. They sat in the café for at least an hour until Richard King was seen by Dr Emore, a SHO, on the last day of his placement.

2.75 Dr Emore took a full history and admitted Richard King informally. He did not record the incident at the flat in detail, but noted *'not homicidal, auditory hallucinations'* and *'very paranoid and suspicious'.*[50] Jenny Cunningham told us that she gave the ward staff the same account of the precipitating incident that she gave to the first inquiry but there is no record of this in the nursing notes. Meanwhile Mrs King had presented herself again to A&E.

On Friday 16 July, Jenny Cunningham had a full and wide ranging discussion with Dr Coogan, a newly appointed consultant who was responsible for Richard King. According to her notes[51], he told her that Richard King was *'chronically schizophrenic',* and he expected him to remain in hospital for five to seven days. Jenny Cunningham began to make arrangements for Mrs King to visit her husband in the following week. But when she telephoned her on Monday 19 July, she discovered that Richard had returned to Wells. When questioned by the panel, Jenny Cunningham told the first inquiry that she was not consulted regarding the discharge on the 26 July.

2.76 On 16 July Dr Coogan saw Richard King and he described him as fairly settled and decided to continue his current medication [52]. Gill Chambers had given him a depot injection on 15 July on the ward after admission. On 19 July Richard King approached the ward staff and asked to return to his home. He was asked to wait until he was reviewed by a doctor but refused. He agreed to return for the ward round on Wednesday 21 July. On 21 July Richard King returned to the ward but would not wait until 11.00 for the doctor to see him. A Home Treatment Team nurse contacted him at home on 22 July. To the nurse he appeared bright and cooperative and willing to return to the hospital[53]. The same nurse attempted unsuccessfully to contact the medical team on two occasions on 23 July. The leave was therefore allowed to continue over the weekend.

2.77 On Monday 26 July Dr Kelly, a locum SHO, recorded that Dr Coogan was happy for Richard King to be discharged on that day while on leave. Neither doctor saw him in person on the day of discharge. The medical plan was for 250 mg of flupentixol fortnightly to be continued, and for the CMHN (Gill Chambers) to be informed and arrange follow up.[54] A detailed discharge letter dated 3 September was sent to Dr McAnsh from Dr Coogan. It was unsigned.

[50] Admission clerking in the medical notes
[51] Entry dated 16 July on social care file
[52] Note of consultation made by Dr Emore
[53] Entry by D Mitchell, Acting Senior Charge Nurse
[54] Last entry in the medical notes

The discharge of Richard King in his absence is the sixth key point in the sequence of events.

2.78 On 19 July Richard King was listed for information/recommendations at the CMHT when Gill Chambers was present, but there is no mention of any discussion or action. The minutes are blank. He was also referred for discussion at the CMHT meeting on 26 July and the information/recommendation column includes the following: *'Ready for discharge following review of medication. Presently on leave.'* The 'Actioned By' column reads 'Gill' but she was not present at the meeting and was probably on holiday. However, Dr Coogan and Joanne Braisby were present. Jenny Cunningham was not present at either meeting and there is no record in the minutes of the circumstances of the July 15 incident which precipitated Richard King's admission.

2.79 On 29 July Joanne Braisby gave Richard King his depot injection as Gill Chambers was on holiday. She carefully recorded[55] that Richard King was settled and the situation appeared calm. Joanne Braisby had clearly not been informed of the troubling circumstances of Richard King's admission by either the hospital or the CMHT and her personal safety had thus been placed at some risk. We comment further on the absence of documented risk assessments in the community and the failure to pass on significant information to those who for whom it was relevant in Chapter 11.

2.80 On 2 August Steven Potter recorded two telephone calls from Mrs King. She told him that she had attended the GP surgery but left when she could not get an appointment: she described her mood as low. She described Richard as *'well'*.

2.81 On 3 August Jenny Cunningham made the last documented visit to the Kings. She visited the flat for approximately ten minutes or so to assist Mrs King who was having difficulties with recycling household waste. Jenny Cunningham spoke to Richard King, but recorded that he *'seemed rather distant and detached. This was not so unusual but Richard did seem preoccupied with his thoughts'*[56]*.*

2.82 When Sheila Endresz made a MHA assessment of Richard King at King's Lynn police station on 7 August she included the following details in the 'Circumstances leading to Assessment Section*': '5/8 6.30 pm request to EDT for assistance re incident of D.V. wife stating that he was threatening to kill her.'* She recollects that this information came from the Duty Care Manager at the hospital. In the running record Sheila Endresz noted: *'EDT request 5/8 from wife re Domestic Violence incident resolved 6/8/04. No further info'*.

[55] Entry in community nursing notes
[56] Entry in social care file

2.83 In October 2007 these EDT alerts were finally located. On 5 August, Mrs King telephoned the GP surgery in the evening when they were about to close *'in a state'*. The surgery administrator telephoned the EDT and they recorded the message at 18.28 as *'history of domestic violence and husband threatening her again surgery closing and asking for us to contact Mrs King*.' This was graded Priority 1 - IMMEDIATE ACTION REQUIRED. The next print out recorded ' *advice provided'*, and was timed 16.40 on 06-08-2004. The lack of detail means that it is impossible to ascertain the exact nature of Mrs King's concerns or the response to them.

2.84 On 7 August at 09.20, the EDT received information from the police that Richard King had killed John West.

CHAPTER 3
THE HOMICIDE

Introduction

The panel have decided that this report should contain a factual account of the homicide in order that readers should be informed of details relevant to later discussion of the adequacy of the care and treatment given to Richard King prior to the homicide. The absence of information in the first inquiry about the index offence was criticised by witnesses. We agree that this omission constituted a deficiency in the previous report and our terms of reference allows us to seek further evidence. We do not believe that the inclusion of this information breaches Richard King's right to privacy.

Sources of information

3.1 In this chapter we have reconstructed the events of that night from statements given by Richard and Mrs King, police officers, and transcripts of 999 calls. Additional information is drawn from the files of the Norfolk Constabulary and the Crown Prosecution Service (CPS). The most important sources were the statements of Mrs King who was interviewed twice on 7 August 2004 by a police interviewer, who had been trained in questioning learning disabled witnesses, in the presence of an appropriate adult. The panel has also had access to an investigation undertaken by the Norfolk Constabulary on behalf of the Independent Police Complaints Commission (IPCC). Richard King has refused to be interviewed by the panel. We rely on the report of Dr Simon Wood, consultant forensic psychiatrist, who interviewed him on 11 January 2005 at the request of the Crown Prosecution Service for his opinion of the state of mind of Richard King at the time when he committed the offence

Mrs King's evidence on events at the flat preceding the homicide

3.2 Mrs King gave an account to the interviewing police officer of a visitor to the flat who had brought cannabis for her husband to smoke that night. She had seen a £10 note on the table. She told the officer that he had done this before and she knew that cannabis was harmful in conjunction with his medication. Mrs King gave specific details of acquaintances and neighbours who, according to her, supplied her husband with cannabis and possibly other street drugs. These details have been corroborated by other witnesses to this inquiry. Mrs King told the police officer who interviewed her that they both had been arguing and screaming about alleged events in her childhood until about 2 am. In her interview she described her husband's delusions as follows: *'Things are stabbing his heart … that's voodoo'*

3.3 At 01.57 she made a call to Hellesdon Hospital lasting nine minutes and nineteen seconds, (see para 3.14). According to the GP medical file she telephoned the GP out of hours service, NHS Anglian Medical Care, (previously known as Faredoc) at 02.20. The duty doctor noted symptoms *'of not sleeping, vomiting, suicidal'* for Mrs King at the top of the single page record. He also appears to have recorded a second call at 02.30 on the lower

right part of the page as follows: *No suicidal component according to husband-weird story of being raped at age 18????'…* [illegible] … *husband says he will* … [illegible]*….in the morning*.

A separate note on the lower left of the page reads: *'Wife says she does not need visit right now, she just wants to talk …* [illegible] *… no acute psychotic situation or hallucination'.*

We have reproduced these notes in full because they are the only independent evidence of the marital arguments and the state of mind of Richard King immediately before the homicide.

3.4 In her interview, Mrs King described seeing Richard King open the drawer and pull something out of it. She was able to describe the set of knives in their flat and to identify the missing one. The owner of a hardware shop in Wells was later shown a photograph of the remaining knives in the flat by a police officer. According to his statement to the police the owner recognised the knives and the case as being a set which he used to sell *'around two years ago'.*

3.5 Mrs King told the officers at several points in the interview that Richard said *'*I*'m going out to kill your father and John'.* He then slammed the door and ran down the stairs. John West was the partner of Mrs King's mother. They lived in the same block of flats, Old Craske Flats in Sheringham, as Mrs King's father, Colin Craske, and his partner.

The journey to Sheringham

3.6 Richard King then drove from Wells to Sheringham, a journey which would have taken 30 minutes in the early hours. After he had left Mrs King dialled 999 and told the call taker in the control room at 03.24 that her husband Richard King had left home to kill John and had taken a weapon with him. She gave the address as *'*Old Craske Flats, High Street in Sheringham*'*, where John West lived, but the call taker did not record the information that the flats were located in Sheringham.[57] As a result the dispatcher directed the police to Wells at 03.30.

The actions of the police officers

3.7 Police Officers Money and Baxter were stationed at Holt when they received a call to attend The Old Craske Flats, High Street, Wells, following information that the caller's husband, Richard, had left to kill someone there. On arrival at Wells, they were unable to locate the address and went to the Kings*'* flat where they spoke to Mrs King who was known to them. They ascertained that the correct address was in Sheringham and immediately informed the control room at 03.51 who dispatched police officers at Sheringham to the Old Craske Flats in the High Street.

[57] Norfolk Constabulary Investigation for the Independent Police Complaints Commission, 8 Oct 2004

3.8 At 03.53 Maureen Bastard, partner of Colin Craske (Mrs King's father), who lived at Old Craske Flats, told the panel that she heard John West saying: *'get off me, get off me. What did you do that for?'*. Then she heard him say: *'Get Colin, I've been stabbed'*. She dialled 999 to call for an ambulance for John West. According to the pathologist's report John West was stabbed nine times, one wound was in the front of the chest and eight were in the back of the chest.

3.9 The Assistant Director Field Operations from the East Anglian Ambulance NHS Trust was called by ambulance control at 03.56 hours to attend a stabbing at Flat 2, 36 High Street Sheringham which is the correct postal address of the Old Craske Flats. He arrived at the scene and was met by a police officer. When he examined John West, there were no signs of life. He attempted resuscitation without success and pronounced life extinct at 04.35.

3.10 Officers Money and Baxter drove from Wells to Sheringham on the A149 and heard the radio report at 03.54 of a male being stabbed at an address they knew to be the Old Craske Flats in Sheringham. They stopped to put on body armour and saw a vehicle approaching them from the direction of Sheringham which they recognised as Richard King's car. He was in the driver's seat. The officers recognised him from previous calls to the flat in Wells and arrested him at 04.05. Richard King asked whether the victim was dead and told the officers that he went to kill him[58]. On the journey to the King's Lynn Police Station, Richard King stated that he had thrown the knife in the ditch. It has never been found. The statements of the officers refer to various comments made by Richard King during the journey, to the effect that a deceased member of the royal family told him to do it, that he had helped the Americans to develop throat signals and that he had been abused by Gordon Brown.

3.11 When interviewed at King's Lynn Police Station in the presence of his solicitor and an appropriate adult, Richard King admitted that he had killed John West with a knife in the context of allegations about his wife. Several of his responses clearly suggest psychotic ideation. He also admitted that he had had *'three joints'* although later he told the officer that he had only smoked two joints[59].

3.12 PC Money was familiar with the problems at the Kings' flat as he had been called there between five and ten occasions in the previous two years. The statement made by PC Money for the CPS includes the following comment: *'Every time I have spoken to Richard, he has always mentioned to me that Mrs King had been abused'*.

Telephone calls from Mrs King to the Norfolk Constabulary control room

3.13 We have read the transcripts of Mrs King's call to the police control room in which she gave a considerable amount of accurate information and conveyed

[58] Statement of PC Money 7 August 2004
[59] Interview with Richard King on 8 August 2004

a very real sense of urgency. We have also read the IPCC investigation as it was a possible source of further information relevant to this inquiry. However, the misdirection of the police officers to the wrong address is plainly outside the terms of reference of this panel. We are aware that our decision to exclude this matter will disappoint the relatives of John West.

Telephone call to Hellesdon Hospital

3.14 Mrs King also gave evidence to the police that she had rung the 'Active Team' for assistance for Richard King. This is thought in fact to be a reference to the Access Team in Hellesdon Hospital and the police confirmed that she made this call at 01.57, which lasted nine minutes and nineteen seconds. She claimed that she was told to telephone her doctor. This call therefore precedes the call to the out-of-hours duty doctor. Unfortunately none of the staff at the hospital who gave statements to the police have any recollection of this call. We refer to this matter again in Chapter 12, paragraph 12.6.

The report of the pathologist

3.15 Bodily samples were taken from John West and Richard King and examined by John Slaughter, Forensic Scientist. He did not find any evidence of cannabis compounds in the body of John West and levels of alcohol were too low to have given rise to any signs of intoxication. However, levels of cannabis compounds were found in samples from Richard King but Mr Slaughter was unable to say whether Richard King was under the influence of them at the time of the offence.

The response of the Social Services to the homicide

3.16 For the information, in this section we are dependent on the very detailed notes made by Sheila Endresz. She received a phone call from EDT at 11.25 on Saturday 7 August informing her that Richard King was in custody in King's Lynn police station and agreed to undertake a MHA assessment. She attempted to assemble the information required by the police and solicitors but the medical notes could not be located at Hellesdon Hospital. There is an entry in her notes of a telephone call on 7 August from the Duty Patient Care Manager who gave her information about Richard King's last admission and referred to staff stating that *'past admissions triggered by illicit drugs misuse; after taking medication he recovers quite quickly'.* Sheila Endresz made an assessment under the MHA, which was necessary to ascertain Richard King's capacity and fitness for interview, and made a very full note of his mental state. He had to remain in custody at the police station during the weekend as it was not appropriate to admit him to a NHS hospital. Sheila Endresz advised the police and solicitors on the need for observation, regular tea breaks and agreed to act as the formal link with the local psychiatric services until Monday morning. Richard King appeared at King's Lynn Magistrates' Court on Monday 9 August. Sheila Endresz remained at court with Richard King until he was transferred to HMP Norwich at 16.30. She had worked (or been on call) continuously since Saturday morning.

Psychiatric report for the Court hearing

3.17 Richard King was interviewed by Dr Simon Wood at the request of the Crown Prosecution Service on 11 January 2005. Dr Wood concluded that his illness had incompletely responded to treatment over the years and had been characterised by abnormal beliefs regarding God and sexual abuse for which others were responsible. Dr Wood regarded the use of cannabis as a contributory factor. The mental illness from which Richard King suffered is discussed at length in Chapter 4. Dr Wood noted Richard King's claim that his wife had told him about abuse but also notes that her statement does not support that contention. In his report for the CPS he observed that:

Whether any such statement was ever made is unlikely to be known, and the truth of it less so, given the mental states of each of them. Even if it had been made, I consider that Mr King's pre-existing ideation in relation to sexual abuse would be such that he could not properly process such a statement and make rational judgements as to how he should proceed.

We do not believe that our terms of reference require us to provide further details of the conviction at the Crown Court or of the Coroner's inquest. Both hearings were held in public.

Richard King's progress since the imposition of the MHA s.37/41 hospital order

3.18 Dr Shetty, consultant forensic psychiatrist, is currently responsible for the care and treatment of Richard King. Richard King has given consent for Dr Shetty to write to the panel concerning certain matters. In the opinion of Dr Shetty, he has the mental capacity to give consent for that information to be given to the panel. Richard King is also able to consent to a meeting with the panel but has refused to do so. He has made comments on the report as described in the Introduction. The panel has written to Dr Shetty and asked him to provide any appropriate information on Richard King's progress. In his response[60], Dr Shetty has told us that that Richard King's mental state has improved significantly, but that he is not free of symptoms. He tends to deny these in brief interviews, but detailed examination usually reveals the presence of current or recent psychotic symptoms. Richard King repeatedly expresses regret for his offence. He is compliant with clozapine which is currently prescribed.

[60] Letter dated 1 February 2007

PART TWO

In this part of the report we will discuss the management of Richard King's illness by the consultants and inpatient staff, the Community Mental Health Team and other agencies. We have adopted this approach because the various agencies and individuals involved with Richard and Mrs King were poor at coordinating the provision of care and treatment and can therefore be discussed separately within the context of the chronology in Part One. The consultants and GPs are analysed in Chapter 4. Chapters 5 and 6 concern admissions to hospital and care via the CPA. Chapter 7 discusses the Community Mental Health Team and social care. Chapter 8 describes the Kings' relationships and Chapter 9 deals with other statutory agencies. Chapter 10 concerns Risk Management. As required by our remit we will comment on the first inquiry and associated matters in Chapter 11. Chapter 12 analyses the shortcomings of documentation provided to the panel by the Trust. In Chapter 13 we reach final conclusions followed by a list of recommendations to the Trust.

CHAPTER 4
AN ANALYSIS OF CLINICAL MANAGEMENT 2001-2004

Introduction

In this chapter we consider the clinical management of Richard King's illness. We have relied on Trust policy documents, Department of Health Guidance, medical notes and letters, and interviews with clinicians. Risk assessment and management are mentioned only briefly as we consider the subject in depth in Chapter 11. Inevitably there is some repetition of admissions and incidents already described in Chapter 2 in the following analysis. We refer to them again only when it is necessary to provide a context for discussion.

The diagnosis of schizophrenia

4.1 Richard King suffers from schizophrenia. Schizophrenia is a mental illness that affects approximately one percent of the population. Schizophrenia most often develops between the ages of 15 and 35. The symptoms of schizophrenia are often categorised into 'positive' and 'negative' symptoms. Later in the course of his illness Richard King was identified as having negative symptoms but throughout his adult life he has suffered from the positive symptoms of hallucinations, delusions, thought disorder and feelings of being controlled. An hallucination is often defined as a 'perception without an object'. The person hears, sees or feels something which is not there. The commonest hallucination in schizophrenia is of hearing voices. Hallucinatory voices are often critical and abusive, which is how Richard King experienced them.

A delusion is an abnormal belief which is held with complete conviction and can be based on a misinterpretation or misunderstanding of actual situations or events. Richard King had delusional beliefs about the Royal Family, prominent politicians and the IRA. He also had beliefs that other men had been, or were intending to be, involved sexually with his wife Mrs King.

4.2 Thought disorder is often observed or experienced as muddled thinking. Concentration is more difficult and thoughts seem to wander and drift from idea to idea without an obvious connection between them. Feelings of being controlled include feelings that one's mind is being controlled by someone else, or that part of one's body is being controlled. Often people who are suffering from schizophrenia will have an abnormal experience or thought and it is difficult for them to describe or for other people to understand in terms of the simple definitions given above. An example of this is the 'throat signal' that Richard King suffered from intermittently.

At times Richard King understood that he was unwell and at times he did not. When the symptoms of schizophrenia become severe the person can no longer understand that it is an illness and does not accept the need for medication. Richard King's insight varied. After he relapsed, it was more difficult for him to understand that he was unwell and needed help. The cause of schizophrenia is unknown. Several factors have been identified as increasing the risk of developing schizophrenia but it is rarely possible to say with any confidence why an individual person has become unwell.

Treatment of schizophrenia

4.3 Most people who suffer from schizophrenia benefit from treatment. Part of that treatment is medication. The medication that is given to treat the symptoms of schizophrenia has developed since the 1950s. For many years Richard King was treated with regular injections of zuclopenthixol which is one of the older 'typical' antipsychotic drugs. He was then treated with tablets of another 'typical', chlorpromazine. He was then treated with risperidone, one of the newer 'atypical' antipsychotics. He later went back onto zuclopenthixol and then changed to injections of flupentixol, which is another 'typical'. He is now being treated with the antipsychotic clozapine. Clozapine is the only antipsychotic drug which has been shown to be more effective for people who have not responded to other antipsychotics. The symptoms of schizophrenia can also be treated with cognitive behavioural therapy. Although this is known to be effective, it is not universally available.[61]

Reduction of medication in 2001

4.4 Richard King received medical care from five substantive consultants from the time of his first admission and diagnosis in 1990 until he killed John West. From 1990 until 1994, he had six admissions but then had a period of stability until a new cycle of admissions started at the end of 2002. In June 2001, Richard King was seen in the outpatient clinic by a new consultant, Dr Huw Thomas. Dr Thomas told the panel that when he started working in Norfolk he thought that a lot of the patients were over-medicated, and Richard King was one of many patients whose medication he reduced or stopped. Dr Thomas told us that in the majority of cases his approach was successful. However, it is clear that the reduction and subsequent cessation of the depot led to a deterioration in Richard King's mental health from which he did not

[61] The Royal College of Psychiatrists leaflet: 'Help is at hand- Schizophrenia'

recover. Dr Thomas considered the dose of the depot was too high and, as he considered Richard King to be stable and symptom free, reduced the zuclopenthixol depot injection from 400mg weekly to 600mg fortnightly. In December 2001 Dr Thomas reduced the dose again to 600mg every three weeks.

Richard King's complaints regarding varicose veins

4.5 Richard King had complained of aches and varicose veins in his legs in June 2001 and Dr Thomas thought that these could have been a result of induration (hardening) of tissue around the injection site. During the panel's interview with Dr Thomas, he accepted that he did not examine the injection site or look for evidence of varicose veins. Richard King had gone to see Dr McAnsh in August 2001 complaining of varicose veins in his legs. Dr McAnsh recorded *'some mild varicose veins in the right popliteal fossa'* (behind the right knee), and prescribed an ointment. The panel could find no entry in the medical record of induration at the injection site.

However, Dr Thomas clearly states in a letter of 12 December 2001 to Dr McAnsh that this consideration was relevant to his decision to reduce the depot. He wrote:

I understand that Richard has complained of aches and varicose veins in his legs and I wonder if these could be a result of induration of the tissue around the injections sites in his buttocks which has become gradually worse over the years. Therefore I am keen to maintain Richard on the lowest dose of depot medication possible.

When interviewed by the panel Dr Thomas said that he was not aware of any relationship between antipsychotic depot injections and varicose veins. He also said that he *'did not think the fact that he had varicose veins or not would have influenced'* his *'decision to reduce his medication'*. It is difficult to reconcile what Dr Thomas later told the panel with what he wrote at the time.

Richard King had asked for his medication to be reduced and Dr Thomas was correct to consider his request. However, Dr Thomas should have considered the risk of relapse and discussed this with Richard King. There is no indication in the notes that he did so.

Relapse into psychosis in January 2002

4.6 Richard King relapsed into psychosis (a mental illness) characterised by delusions and hallucinations) in January 2002. He experienced auditory hallucinations. He asked his CMHN if his medication could be increased. The CMHN discussed this with Dr Thomas and the zuclopenthixol depot was increased back to 600mg fortnightly. Dr Thomas did not arrange to see Richard King at this time but wrote to Dr McAnsh on 5 February 2002:

It is of course rather unusual for patients with a genuine relapse of psychotic symptoms to be insightful enough to request an increase in their medication.

Therefore I think it is best if we all keep an open mind as to the reasons for this apparent deterioration…. It is common for long term psychiatric patients to develop an anxiety state when changes are made to their prescriptions and this may be the case with Richard.

Dr Thomas could have arranged to see Richard King at this time to examine his mental state. He had a long history of schizophrenia and was developing symptoms of schizophrenia for the first time in several years after a major reduction in his antipsychotic medication. To attribute Richard King's insight to an anxiety state without making any assessment for symptoms and signs of an anxiety disorder is particularly unfortunate. If proper attention had been paid to Richard King's symptoms at this time it is would have been clear that he should have continued on the zuclopenthixol depot at the dose of 600mg fortnightly. Instead, Dr Thomas continued to reduce the depot and stopped it altogether in November 2002 and Richard King was given the oral antipsychotic chlorpromazine at a dose of 100mg twice a day. The following month Richard King was admitted to hospital under the Mental Health Act. He was seriously unwell with delusions and hallucinations.

Guidance from the National Institute for Clinical Excellence (NICE)

4.7 In our interview with Dr Thomas, he said that he was obliged to reduce Richard King's medication because he requested it and that this was *'entirely in keeping with the guidelines in force at the time'.* But prior to the NICE process there were no widely accepted guidelines in the sense that they are now understood: there was a spectrum of opinion amongst psychiatrists and other professionals. In June 2002 the National Institute for Clinical Excellence (NICE) published Technology Appraisal Guidance No 43: *'Guidance on the use of newer Atypical Antipsychotic Drugs for the Treatment of Schizophrenia'*. The Guidance was issued to resolve questions about the place of the newer, more expensive, drugs in the treatment of schizophrenia.

Paragraph 1.1 of the Guidance states: *'The choice of antipsychotic drug should be made jointly by the individual and the clinician responsible for treatment based on an informed discussion of the relative benefits of the drugs and their side-effect profiles. The individual's advocate or carer should be consulted where appropriate'*.

Paragraph 1.4 states: *'It is not recommended that, in routine clinical practice, individuals change to one of the oral atypical antipsychotic drugs if they are currently achieving good control of their condition without unacceptable side effects with typical antipsychotic drugs*.'

4.8 In December 2002, NICE published broader Guidance on the treatment of schizophrenia which incorporated the Guidance of June 2002. Paragraph 1.1.5 addresses the issue of consent and states:

'Whatever treatments are offered, it is essential to engage the service user in a collaborative, trusting and caring working relationship at the earliest opportunity. Professionals should take into full account the particular nature

of schizophrenia: namely, that the illness may affect people's ability to make judgements, to recognise that they are ill, to comprehend clearly what professionals might say to them and to make informed decisions about their treatment and care'.

Richard King did have good control of his condition and the June 2002 Guidance would have supported a decision to continue prescribing the depot. The Guidance did not recommend changing to chlorpromazine. There is no indication that Dr Thomas entered into *'an informed discussion of the relative benefits of the drugs and their side-effect profile'* [62]. There is no evidence in the notes that he discussed the side-effects of chlorpromazine. Similarly, there is no indication that Dr Thomas warned Richard King that making major changes to his treatment involved a risk of relapse. When we questioned Dr Thomas about these issues, he repeatedly told us that he could not remember. We therefore focused on asking him to comment on what was recorded in the notes.

The admission under s.2 on 21 December 2002

4.9 Richard King was detained under s.2 of the Mental Health Act on 21 December 2002. He had delusions of persecution and hallucinatory experiences of being stabbed in the heart with needles which he believed to be caused by voodoo. Dr Thomas discharged him from the Section and allowed him home three days later. Although Richard King was expressing paranoid ideas about his father, Dr Thomas felt that he did not show symptoms of active psychosis. Although aware of doubts about Richard King's compliance with oral medication, he recommended that he continued on oral chlorpromazine at an increased dose of 100mg three times a day. The following week Dr Thomas was informed by Richard King's CMHN that he was *'rather excitable and over-talkative and expressing some unusual beliefs'*. Dr Thomas recommended that the oral chlorpromazine be increased to 500mg a day in divided doses.

4.10 This admission was unusually brief, and Richard King was still psychotic when Dr Thomas discharged him. The medication regime of oral chlorpromazine was plainly not working. We note that this was the Christmas period and within the NHS there is usually some pressure to enable inpatients to return home for Christmas. However, Richard King was still psychotic and represented a risk to his father. Consideration of this risk does not appear to have entered into the decision-making and no attempt was made to involve Richard King's father in the discussion. Dr Thomas told the panel that he did not think that Richard King's father had been at risk during the time that he was treating him. This episode could have been an opportunity for Dr Thomas to reconsider the overall care and treatment of Richard King. It was probable at this time that stopping the antipsychotic depot had led to a relapse of schizophrenia.

[62] DoH Guidance June 2002

Dr Thomas visited Richard King at home on 21 January 2003. Richard King told him that he had not been taking the chlorpromazine tablets. Dr Thomas advised him to continue taking them.

4.11 After Richard King was admitted under s.2 of the Mental Health Act on 5 February 2003, Dr Thomas prescribed the antipsychotic risperidone. This was given in tablet form and then as a depot injection every two weeks. The manufacturers of the risperidone depot recommend that patients are given oral risperidone first and then started on the depot. The oral risperidone is then tailed off as the patient is stabilized on the depot. This is what Dr Thomas did. The dose range of risperidone depot is 25 to 50mg fortnightly. Richard King was prescribed 25mg fortnightly. Dr Thomas reviewed Richard King in his outpatient clinic on 24 April 2003 and advised that the oral risperidone tablets be discontinued. Two days later, Richard King was admitted voluntarily to hospital exhibiting many psychotic symptoms. This was the second time that Dr Thomas had seen Richard King and not elicited psychotic symptoms shortly before he was admitted to hospital acutely psychotic. This pattern was to continue and will be discussed later. Richard King was discharged from hospital by Dr Thomas on 14 May 2003. He was taking the risperidone depot at the increased dose of 37.5mg fortnightly.

The admission on 23 May 2003

4.12 On the 23 May 2003 he was readmitted under s.3 of the Mental Health Act. While hearing evidence from other witnesses to the inquiry, the panel were alerted to particular concerns about Dr Thomas' behaviour relating to this admission. Consequently we interviewed Andrew Collins, the Approved Social Worker, who carried out the assessment. Andrew Collins was the duty ASW on that day. He was asked by the police to arrange a Mental Health Act assessment of Richard King. Andrew Collins attempted to contact Dr Thomas who was unavailable, but left a message with his secretary to inform him of what was happening. Andrew Collins then arranged to carry out the assessment with Dr Ebrill, a partner of Dr McAnsh, and Dr Kerr, a Forensic Medical Examiner. While Andrew Collins was then driving to Wells, he received a phone call from Dr Thomas. Dr Thomas told Andrew Collins that there was no need for him as an ASW to be involved. Dr Thomas told him that the situation with Richard King was one of a domestic problem between him and his wife. Dr Thomas told Andrew Collins that if he were to detain Richard King, Dr Thomas would discharge Richard King from hospital immediately. After Andrew Collins, Dr Ebrill and Dr Kerr had assessed Richard King and had concluded that he did need to be admitted under s.3 of the Mental Health Act, Dr Thomas rang again. Again Dr Thomas stated that they were making a mistake and that he would discharge Richard King immediately when he arrived at the hospital.

4.13 In the event Dr Thomas did not discharge Richard King from the s.3 at that time. He wrote to Dr Ebrill on 2 June 2003 stating:

'Just a brief note to express my apologies for being less that enthusiastic about admitting the above named patient to hospital recently. He does

appear to be acutely psychotic at the present time but I am pleased to report that he is complying with treatment and I am hopeful that during this admission we can re-establish the stability which characterised his mental state form some time before he was weaned off his depot injection … With the benefit of hindsight I now know it would have been better for him to remain on a depot injection despite his complaints of pain and other complications at the injection site.'

We asked Dr Thomas about this occasion when we interviewed him. He told us that he could *'vaguely remember'* writing the letter, but could not remember anything *'specifically'*. Throughout the interview, Dr Thomas frequently said that he could not remember the matters on which he was questioned. He expressed this difficulty more than anyone else that we interviewed.

During this admission, Dr Thomas reinstated the zuclopenthixol depot and Richard King was discharged on 30 July on 600mg fortnightly. At that time, Richard King was recorded as being free of psychotic symptoms. However, he was expressing delusional ideas when he was admitted on 23 August 2003 and again when he was admitted on 24 September 2003.

The admission on 24 September 2003

4.14 On one occasion during this admission Richard King was prescribed by a junior doctor the antipsychotic flupentixol instead of zuclopenthixol. This was an error. The trade name of flupentixol is Depixol and that of zuclopenthixol is Clopixol. Consequently he was given 600mg of flupentixol. The British National Formulary (BNF) states that 40mg of flupentixol is equivalent to 200mg of zuclopenthixol. From this 600mg of flupentixol would be equivalent to 3000mg of zuclopenthixol. The BNF states that these equivalences should not be extrapolated beyond the maximum dose for the drug. The maximum dose of flupentixol is 400mg and the maximum dose of zuclopenthixol is 600mg. Richard King was given a supra-maximal dose of flupentixol. He was monitored for three weeks on the ward and did not suffer any ill effects. He actually told the clinical team that he thought that the flupentixol had been better for him and asked to stay on it. He was discharged on 150mg of flupentixol fortnightly.

4.15 When Dr Thomas reviewed Richard King in his outpatient clinic[63] on 20 November 2003 he referred to Richard King having odd ideas but did not consider him to be psychotic. At this time his neighbours, his family and the police were all concerned about Richard King's behaviour. Richard King told Dr Thomas that he had booked a holiday in Spain with his wife. Although Richard King had been admitted to hospital six times in the previous twelve months, Dr Thomas did not consider advising him of the potential difficulties should he become acutely unwell while in a foreign country. He told the panel that: *' I was not convinced enough that I would want to stop him doing something very enjoyable like going on holiday*'.

[63] 20 November 2003

The fax from the Adult Protection Unit

4.16 On 24 November DC Tyrrell from the Adult Protection Unit sent a fax to Dr Thomas which is reproduced below in full.

'Dear Dr Thomas

Jenny Cunningham, Social worker from Fakenham asked me to contact you in relation to the above named (Richard King) who has been making numerous telephone calls to our control room. Jenny felt it might be useful if I summarised the content of these calls which she believes he is unwilling to share with you.

He seems to make his calls in the late evening or early morning and generally talks about women who have been murdered. He gives quite a lot of detail such as the full name of the alleged victim, how long ago they were murdered and has asked police officers to go to his house so that he can take them to their graves. He has also spoken about his sister being murdered 17 years ago in Wells and says he has just seen the person who murdered her that day. He says he gets his information from the spirit world.

*On another occasion he asked for the SAS to be sent to Wells because he has had a 'float (*sic*) signal' and is surrounded by voodoo and has not slept for two days.*

On 17 November 2003 Mr King contacted police at Sheringham to make an allegation on behalf of his wife. During that conversation he spoke about Lady Diana's death, murdered babies, speaking to the dead, talking through the throat and seeing things happen through his wife's eyes. He mentioned receiving messages from Prince Harry.

His wife Mrs King regularly rings police expressing her concerns about Richard's behaviour and saying that she is frightened of him and worried about his behaviour.

I hope that this information is of some use to you. If you need to know any more or would like to discuss the matter further, please ring me on the number at the head of this FAX.'

4.17 We questioned Dr Thomas about this letter. He told us that he remembered receiving it but he could not remember whether he had taken any action. Dr Thomas accepted that he had not made an entry in the notes but disputed that such an omission indicated inaction. We have been unable to locate any record of actions such as telephone calls or letters in other sets of notes and we conclude that Dr Thomas did not respond to the fax from the police. We find it extremely difficult to understand how a clinician directly responsible for a patient could fail to act or reply to such a serious letter from the Norfolk Police Adult Protection Unit.

The panel identifies the absence of a response from Dr Thomas, and a follow up from Jenny Cunningham, as a missed opportunity to assess Richard King's mental state and the risk that he may have presented to his wife or others.

The admission on 28 December 2003

4.18 Richard King was admitted again on 28 December 2003. He was acutely psychotic and had assaulted his father. His father informed the ward staff that Richard King had tried to strangle him and injured other members of his family. Dr Thomas discharged him on 7 January 2004 on 200mg of flupentixol fortnightly.

Dr Thomas left the Trust a month later. Shortly before he left there was the incident when Richard King shaved his wife's head. Dr Thomas was on leave at the time. The last entry Dr Thomas made in the notes was dated 5 February 2004 having attempted to contact Richard King by phone without success. He wrote: *'write up for increased dosage at CMHT mtg'.*

Clozapine

4.19 Several witnesses expressed the view that Dr Thomas did not give Richard King an adequate dose of the antipsychotic depot. When Dr Thomas started, Richard King was receiving 400mg of zuclopenthixol weekly. When Dr Thomas left, Richard King was receiving 200mg of flupentixol fortnightly: using the BNF guide this would be equivalent to 500mg of zuclopenthixol weekly. However, we emphasise that estimating the equivalence and hence the effectiveness of antipsychotic medication is an inexact science. The cessation of the zuclopenthixol depot in 2002 led to a relapse of Richard King's schizophrenia which was not controlled by reinstating antipsychotic depot medication. But it is important to note that Dr Thomas did increase the antipsychotic medication to the level that it was before Richard King relapsed. This appears not to have been recognised by the CMHT.[64] We asked Dr Thomas if he had ever considered offering Richard King the antipsychotic clozapine. Clozapine is an antipsychotic which is accepted as being effective in treatment resistant schizophrenia. It can only be given in tablet form and its use is restricted because of a risk of serious side-effects which require special monitoring. In June 2002 NICE issued guidance that clozapine should be introduced if schizophrenia is inadequately controlled despite the sequential use of two or more antipsychotics. Dr Thomas told us that he did not consider that clozapine would have been appropriate. His intention was to continue with the depot flupentixol and increase the dose up to the maximum before he would consider clozapine. He did not offer it to Richard King.

Use of cannabis

4.20 One factor which worsened Richard King's mental state was the use of cannabis. In recent years research evidence has indicated that cannabis is a

[64] Minutes of the Strategy Meeting 26 January 2004 and the proposed letter from NNDC.

risk factor for the development of schizophrenia. However, it has been widely accepted for some time that for people who suffer from schizophrenia, cannabis generally provokes relapse and aggravates existing symptoms.[65] He had a history of substance misuse earlier in his life and the use of illicit psychoactive drugs is a common cause of instability in people who suffer from schizophrenia. Richard King had tested positive for cannabis when a urine sample was taken in October 2003, which was apparently the only time he was tested. Screening urine samples is considered by some to be a routine part of the admission procedure. Such screening was indicated in Richard King's case but only happened once. Dr Thomas did not discuss cannabis use with Richard King. He confirmed this during his interview with the panel. Dr Thomas should have explored the possibility of substance misuse by asking Richard King about it. He should also have discussed the possibility with other professionals in the community team. He could have asked Dr McAnsh who was aware of Richard King's use of cannabis.

The involvement of consultants with risk assessment procedures

4.21 The formal risk assessments of Richard King were recorded by nursing staff on the ward. We comment elsewhere about the process of risk assessment in the Trust at the time. We asked Dr Thomas about his involvement in the process. He told us that it was not the Trust policy for consultants to follow a formal risk assessment procedure. He told us that whenever he was seeing a patient he was making a risk assessment and that risk assessment is *'a dynamic thing, not a piece of paper you fill in and file away'.* While this argument has some force, it is clear that Richard King represented a risk to others and particularly to his father. We heard evidence from several witnesses, Trudie Needham, Steven Potter, Gill Chambers and Jenny Cunningham that Dr Thomas was reluctant to recognise this. Richard King had been violent towards his father and had expressed paranoid ideas about him. However, Dr Thomas told the panel that he did not think that his father was at risk. The panel is concerned that according to the letter from Richard King's father to Jenny Cunningham, he related his concerns to Dr Thomas' secretary but no action was taken.[66] Dr Thomas should have considered the risk that Richard King posed to others and there is no indication that he did so at any time.

4.22 When Dr Thomas was interviewed by the panel he told us how he was concerned that others took a simplistic view that Richard King's only problem was that he had schizophrenia. Dr Thomas considered that Richard King also had borderline intellectual functioning and that many of his problems were due to the difficulties in his marriage to Mrs King. We heard evidence from other witnesses that Dr Thomas had firmly expressed the view that Richard King did not suffer from schizophrenia. Throughout the time that Dr Thomas was responsible for Richard King's care, he repeatedly failed to recognise that his patient was acutely psychotic. We have referred to this in relation to the domiciliary visit on 21 January 2003 and the Outpatient clinic appointments on

[65] Ref: The Royal College of Psychiatrists statement 1 February 2001
[66] See Chapter 2, paragraph 2.24

24 April and 23 November 2003. Although Dr Thomas saw Richard King many times, he never recorded a formal mental state examination. Even after Richard King had been admitted to hospital acutely psychotic six times, Dr Thomas preferred alternative explanations for his *'odd ideas'*[67].

Workload and availability of beds

4.23 Throughout his interview Dr Thomas reminded the panel of his workload and the lack of resources that he had to work with. He had a catchment area of 47,000 and a caseload of 300. His catchment area covered a large geographical area. However, these problems are not unique. When he was appointed, he had a Staff Grade doctor supporting him part time. He gave up this support to another consultant and did not consider it appropriate to ask for this allocation to be returned to him. He was also assisted by junior doctors. The panel asked Dr Thomas whether he had expressed his views regarding resources in the medical staff committee meeting or to the Medical Director. He told us that his views were well known to his lead clinician, Dr Craig, but that he had not put them in writing because he doubted that the Trust would make any significant changes.

4.24 The panel interviewed Dr Hadrian Ball, who has been Medical Director of the Trust since 2000, and questioned him on the issues raised by Dr Thomas. He gave us details of the number of beds available at the time and comparative length of stays for the four Norfolk teams. Dr Ball compared the number of beds in the Trust, 30.3 per 100,000 weighted population, with the English average of 35 beds per 100,000, and accepted that the Trust provided fewer beds than the average figure. However, he emphasised that the Trust had taken the decision in 2000/1 to transfer the resources into community care, so he did not believe that the service as a whole was under-resourced. But he did not doubt that consultants felt under pressure to discharge patients. The first inquiry found that Dr Thomas' post was not significantly under-resourced compared with others around him. We have also come to the conclusion that resources or lack of them, did not account for the shortcomings in the clinical management of Richard King which relate essentially to clinical judgement.

Whatever the pressures upon Dr Thomas, we heard evidence from several witnesses that Richard King was a patient who caused great concern in his area: as a patient with schizophrenia who had been admitted so frequently he should have been a priority.

Record keeping

4.25 Whenever Dr Thomas saw Richard King in his outpatient clinic he made clearly legible notes and wrote promptly to Dr McAnsh (the letter following Richard King's first appointment with Dr Thomas has not been found and Dr Thomas himself was concerned about this). However, these records do not indicate that Dr Thomas appreciated the complexity of Richard King's

[67] Letter to Dr McAnsh, 24 November 2003

problems or subjected them to any in depth analysis that would have been appropriate for someone whose illness was so obviously out of control.

Relationships with colleagues

4.26 It has become clear that there were major differences of opinion between Dr Thomas and other members of the clinical team who found him difficult to work with. One colleague described him as having a *'tendency to become unnecessarily belligerent'*. We saw something of that during the interview.

Findings

4.27 Dr Thomas left the Trust in February 2004 to undertake different responsibilities in the private sector. Whatever issues his involvement in this case raises, there is no indication that he was other than hardworking and genuinely concerned for the welfare of Richard King. We accept that he saw Richard King at clinically appropriate intervals. We heard how he had effected significant improvements in the functioning of the CMHT in that he instituted weekly team meetings which he chaired. It is unfortunate that no one else was able to provide clinical leadership for Richard King. The CMHT manager should have been more closely involved and was not. Dr Thomas tried hard to overcome the difficulties of working across such a large geographical area. He cannot be held responsible for the death of John West.

Dr Thomas told us that he had reviewed decisions in his care of Richard King and could not see anything that he could have done differently. The panel are unable to agree with him. The panel finds that Dr Thomas repeatedly failed to appreciate the severity of Richard King's mental illness and consequently the associated risks were unmanaged. The panel do not make any recommendations regarding his practice.

Dr Fadlalla (Locum Consultant)

4.28 When Dr Thomas left, there was a gap of several months before Dr Coogan was appointed. Dr Fadlalla was a Staff Grade Psychiatrist who had worked for the Trust for several years and had previously acted up as a Consultant. She was asked to cover the vacant post for six weeks. For three of those weeks, she also covered another Consultant post. Dr Fadlalla told us how she was asked to advise on Richard King's medication on her first day in post (9 February 2004) at the meeting of the Community Mental Health Team. On receiving the information that was given to her by Gill Chambers and Jenny Cunningham, she agreed that his depot could be increased to 250mg of flupenthixol decanoate every two weeks. She did not have his notes available at the meeting but afterwards she read through them carefully. She saw Richard King as planned in the clinic on 19 February 2004. She saw Richard King accompanied by his wife, Mrs King, with Gill Chambers and Jenny Cunningham.

4.29 Dr Fadlalla found that Richard King had responded to the increased dose of the flupenthixol decanoate and she did not elicit any positive symptoms of schizophrenia. However, she noted the presence of negative symptoms of schizophrenia. She was concerned about his excessive smoking and talked to him about cutting down. Dr Fadlalla recalls asking him about illicit drugs which he denied. Dr Fadlalla advised him to continue on flupenthixol decanoate 250mg fortnightly.

The arrangements for the following appointment

4.30 Dr Fadlalla also arranged for him to have another outpatient appointment in six months time, although her normal practice was to review her patients every three months. Dr Fadlalla told the panel that because of the caseload, consultants had been told to space out the outpatient appointments to four months. Although she would have arranged to see him sooner if she were to remain in that post, she arranged a six month follow up in the clear expectation that a substantive consultant would be in post by then. She understood that two other doctors were scheduled to be locum doctors in that post and did not consider it would be helpful to have frequent planned appointments in those circumstances. The panel has made enquiries about the apparent delay in appointing a substantive consultant. We are satisfied by the explanation given to us by the Medical Director.

4.31 Dr Fadlalla knew that Gill Chambers and Jenny Cunningham were going to be monitoring Richard King closely and could arrange a medical review as needed. She told the panel that she expected the Care Coordinator to seek an appointment with whoever had the consultant responsibility at the time if she had any concerns regarding Richard King's stability. We believe that this was a reasonable expectation in terms of the Care Programme Approach.

In the report of the first inquiry there was some criticism of Dr Fadlalla because of this decision. We take a different view. We consider that Dr Fadlalla's decision was perfectly reasonable one.

Overall, the Panel were impressed by Dr Fadlalla's involvement in Richard King's care. She demonstrated that despite all the difficulties of working in that service it was possible for individual professionals to pull everything together and make a sensible assessment. In the short time available to her, she was able to review Richard King's history, examine him and agree a coherent plan with the other professionals in the team.

Dr Coogan

4.32 Dr John Coogan took over the care of Richard King when he started working for the Norfolk Mental Health Care Trust on 5 July 2004. He came to the Trust as a consultant of considerable experience. Dr Coogan emphasised to the panel that he had not had any induction training before undertaking his duties at the Trust. Dr Thomas made the same point, and we accept that such training should have been provided by the Trust. Dr Ball assured the panel that all consultants newly in post now receive induction training.

4.33 The full circumstances surrounding the eighth admission of Richard King to hospital in July 2004 have been described in considerable detail in Chapter 2, and therefore it is not necessary to repeat them in this section. Dr Coogan first met Richard King on 16 July 2004, the day after he had been brought to Hellesdon Hospital by Jenny Cunningham and admitted informally by Dr Emore, a junior doctor. Dr Emore took a full history but did not make a note of the details of the incident which precipitated the admission. He described Richard King's presentation as *'not homicidal'* and *'very paranoid and suspicious'*. There is no record of this incident in the nursing notes. Dr Coogan saw Richard King with Dr Emore. He had been able to look at the admission notes and some of the previous records. As well as seeing Richard King, he also met his wife Mrs King who had been brought to the hospital by Jenny Cunningham to see Richard King. Dr Coogan was present when Mrs King arrived and saw them together.

4.34 Dr Coogan told the Panel that his assessment at that time was that Richard King was a man who suffered from schizophrenia whose mental state had deteriorated after refusing a depot injection. He was aware that Richard King was acutely psychotic, experiencing auditory hallucinations. Dr Coogan told the Panel that he was aware that Richard King was using illicit drugs, although Richard King had denied this to the junior doctor. Richard King was not tested for cannabis or other illicit drugs. Dr Coogan was told by Jenny Cunningham that there had been an incident between Richard and Mrs King and that Mrs King also had mental health problems. However, he was not told that Jenny Cunningham had got the council workman to break the door down or that or that Mrs King had said that Richard King had taken a knife and threatened to kill himself. Dr Coogan told us that he heard of these details for the first time when he was being interviewed during the first inquiry. There is a conflict of evidence at this point as Jenny Cunningham assured the panel that she told Dr Coogan of the circumstances which had caused her to transport Richard King to hospital.

4.35 Dr Coogan made a note in his personal diary that he was considering recommending detention in hospital under s.3 of the Mental Health Act with a view to placing Richard King under supervised discharge under s.25A of the Act. Dr Coogan did not record this in the medical notes. Dr Coogan did not inform the previous inquiry of this note in his personal diary as he believed that he had mislaid it.

4.36 Despite this, Richard King left the ward on 19 July 2004 without any medical review. He was asked by a nurse on the ward to wait to see a doctor but refused to do so. He did tell the nurse that he would return for the ward round (which was on 21 July 2004). Although he came back to the ward on 21 July, the ward round was delayed and he left before he was seen.

4.37 A discussion with Dr Coogan was noted in the medical records by Dr Kelly, a locum junior doctor, on 26 July 2004. Dr Kelly had not seen Richard King[68] [69]

[68] Dr Kelly's response to questions from the First Inquiry, sent from New Zealand 16 March 2005.

as he was newly in post, and had replaced Dr Emore who had completed his term of employment at the Trust. We make no criticism of Dr Emore or Dr Kelly. Dr Coogan told the panel that he was happy for Richard King to be discharged from hospital in his absence. At interview Dr Coogan seemed uncertain as to the precise plans for follow up arrangements in the community even though he attended the CMHT meeting on 26 July.

4.38 Dr Coogan told the Panel that he was happy for Richard King to be discharged at that time because he believed Richard King *'had been settled'*. It was difficult for the Panel to understand how Dr Coogan had come to that view. In giving evidence Dr Coogan spoke of what would have influenced his decisions without recalling what actually had influenced his decisions. The panel asked Dr Coogan whether he should have relied on very sparse nursing notes and the absence of information on the incident that precipitated the admission. It was suggested to him that Richard King had the ability to mask his psychotic symptoms and he was asked whether he was confident that he had seen a true picture of his patient. Dr Coogan stressed that he had confidence in the mental state examination carried out on admission by the SHO, Dr Emore.

Discharge process

4.39 In 1994 the Department of Health issued Guidance (sic) on good practice to be followed when patients are discharged from hospital, HSG(94)27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*. The Guidance was explicitly based on the Care Programme Approach, with particular emphasis on the need for risk assessment prior to discharge. The guidance was issued as a response to public concern following a series of homicides by people suffering from mental illness which had attracted media attention.

Paragraph 23 of the Guidance stated:

Patients with longer term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking behaviour need special consideration both at the time of discharge and during follow-up in the community. No decision to discharge should be agreed unless those taking the clinical decisions are satisfied that the behaviour can be controlled without serious risk to the patient or to other people. In each case it must be demonstrable that decisions have been taken after full and proper consideration of any evidence about the risk the patient presents.

Paragraph 24 of the Guidance states:

Before discharge there must be a careful assessment by both the multidisciplinary team responsible for a patient in hospital and those who will be taking responsibility for his or her care in the community. Those involved must agree the findings of a risk assessment, the content of a care plan, and

[69] See Chapter 2, paragraph 2.77

who will deliver it. In accordance with good practice in the delivery of the Care Programme Approach generally, there must be a contemporaneous note of the outcome of any risk assessment and of any management action deemed necessary and taken.

It is difficult to see how the decision to discharge Richard King, which was taken by Dr Coogan as the consultant in charge of his care, could be construed as fulfilling the requirements of this Guidance. There is no documented evidence that Dr Coogan raised the matter of planned discharges with the Trust.

4.40 The Norfolk Mental Health Care NHS Trust Planned Discharge Policy published in October 2003 stated that:

All staff will follow a structured and logical planned discharge procedure that will meet the needs of the patient and ensure consistency of practice. The policy envisages a *'pre-discharge meeting'* which *'will include all disciplines and agencies involved in the individual's care plan'.*

There is nothing in the Trust's Discharge Policy which indicates that it did not apply to patients who have chosen to leave hospital without the agreement of the clinical team. If such a meeting had taken place it would have enabled a sharing of information between those who had known Richard King well over a long period of time and Dr Coogan, who had only met him briefly on one occasion. Those attending such a meeting could not have predicted that Richard King would have gone on to kill John West, but they may have decided that Richard King needed a more in depth assessment of his mental state and a period of treatment under the Mental Health Act.

4.41 Dr Coogan clearly made a mistake in agreeing to Richard King's discharge in these circumstances without following the requirements of HSG(94)27 and the Planned Discharge Policy of the Trust. However, he had only been in post for three weeks on the day that he discussed Richard King's discharge with the locum SHO. There is no indication that anyone else in the clinical team considered this mode of discharge inappropriate. Richard King had been discharged in his absence many times before and this appears to have been normal practice in the Trust at this time. The panel considered that Dr Coogan's flawed decision was one that other newly appointed doctors could have made in these circumstances.

The role of Dr McAnsh

4.42 Dr McAnsh was Richard King's general practitioner. The Panel interviewed Dr McAnsh in his surgery in Wells-next-the-Sea. He told us that Richard and Mrs King had registered with his practice in May 2000. Richard King attended about once a month, usually with physical complaints. He often saw Richard and Mrs King together and visited them at home on occasions. On three occasions Dr McAnsh was involved in sectioning Richard King. The out-of-hours GP service, named Faredoc at the time, received 20 calls from Richard King between 2001 and 2004. This is above average usage for a young

adult. Mrs King made a slightly lower number of calls to the service over the same period of time

4.43 Dr McAnsh told us that he never felt threatened by Richard King. He described Richard King as *'perfectly charming'*, and even when Dr McAnsh was involved in Mental Health Act assessments, he never saw any violence. He told us that had never seen any indication that Richard King had been violent towards Mrs King but his notes recorded on 14 January 2003 refer to threats made by Richard King against her.

4.44 Dr McAnsh was aware that Richard King smoked cannabis regularly. He recalled that Richard King had told him he was using cannabis and he thought that he had been doing so for some time. Dr McAnsh was also aware that sometimes Richard King would drink to excess. Dr McAnsh saw a relationship between Richard King's bouts of heavy drinking and his psychosis. Dr McAnsh was the only clinician interviewed by the panel who had this perception of Richard King's use of cannabis and his episodes of heavy drinking. Dr McAnsh did not recall passing this information on to the community mental health team and assumed that they knew as well.

4.45 In exploring the relationship between primary and secondary care, it became clear to the panel that there were no formal liaison arrangements between the surgery and the community mental health team. Jenny Cunningham would call into the surgery on an ad hoc basis, but there were no scheduled meetings and no one in the community mental health team had a particular role in liaising with the surgery. The general practitioners would be involved in arranging an admission and would get a discharge summary some time after the patient had left hospital. The consultant psychiatrists wrote to the general practitioners every time they saw the patient in outpatients but they had no other contact. It seems that the two parts of the health service were working in parallel. In this particular case, if there was a closer working relationship between primary and secondary care the knowledge of Richard King's substance misuse could have been shared.

4.46 We are aware that the mental health services in North Norfolk have been reorganised in the last few years. We do not know whether they have a better arrangement for liaison with primary care but this is such an important area that we make the following recommendation.

Recommendation 1

The panel recommend that the Trust review the relationships and communications between Community Mental Health Teams and primary care within six months.

Conclusions on the quality of medical care and treatment provided to Richard King

4.47 The panel have reviewed the medical care of Richard King by studying his medical records and interviewing the doctors and other staff who were involved from 2001 onwards. The panel have not met Richard King who refused to be interviewed. Although we enquired into the workload pressures of those that we interviewed, our remit required that the care of Richard King was considered in isolation from all the other day-to-day demands on the professionals involved. While identifying shortcomings in relation to one patient we have not looked at the care of the many other people who were being seen at the same time.

4.48 We have concluded that the change in medication in 2001 and 2002 is the most likely cause of Richard King's relapse into psychosis. This was not controlled by increasing the dose of antipsychotic medication back to the 2001 level. Clozapine should have been considered and discussed with him. Dr Thomas did not record a formal mental state examination at any point. He should have explored the possibility that Richard King was using cannabis or other illicit substances which could have affected his mental state. He should have responded effectively to the fax from the police.

4.49 After Dr Thomas left in 2004 Richard King was seen once by Dr Fadlalla but he was not seen again until Dr Coogan saw him when he was admitted. It is clear that Richard King's mental state deteriorated after Dr Fadlalla left but this was not brought to medical attention. We understand that a series of locum consultants were appointed until Dr Coogan took up his post. The lack of continuity at consultant level occurring at the same time as organisational change left a dysfunctional CMHT without any effective clinical leadership. The CPA annual review in May would have provided a very timely opportunity for a locum consultant and the CHMT to review his mental state and risk assessment. Dr Coogan has told us that the admission of Richard King to a different ward from the one used for North Norfolk patients caused him difficulties, but this does not alter our conclusion regarding the July 15 admission. We have already concluded that Dr Coogan should not have discharged Richard King when he had taken unplanned leave and the appropriateness of the discharge had not been assessed.

4.50 It is entirely possible that Richard King could have relapsed into psychosis and gone on to kill John West even if his care and treatment had been exemplary. While the panel acknowledge that complete elimination of risk is impossible, we find that some of the clinical decisions made by Dr Thomas and Dr Coogan were wrong.

We conclude that the medical care and treatment provided by the Trust between 2001 and 2004 was not an appropriate response to the increasingly complex needs of Richard King. However, we accept that medical care and treatment should have been more closely integrated with the care provided in the community by the social worker and the Care Coordinator: this is examined in Chapters 6 and 7.

CHAPTER 5
THE DELIVERY OF INPATIENT NURSING CARE

Introduction

This section reviews the care and treatment of Richard King from December 2002 to July 2004 during the eight admissions to Hellesdon Hospital. Given the brevity of most of the admissions, the inevitable staff changes and the passage of time, the panel decided that no useful purpose would be served by re-interviewing ward staff. The information in this chapter therefore is derived from the written inpatient nursing notes and the transcripts of evidence given by nursing staff to the first inquiry.

Quality of nursing care

5.1 There is evidence throughout the admissions in the inpatient primary notes of attention to basic needs such as diet, sleep, personal hygiene and medication. But little attention was paid to the psychological and therapeutic needs of Richard King. The *'Nursing Report for Ward Rounds',* a useful form which is completed in preparation for the ward rounds, summarises nine key components of care. The form relating to Richard King refers to his non-attendance at occupational therapy as either not applicable or unsuitable. There was no evidence in the notes of assessment of psychological or therapeutic needs or indeed any referrals for such interventions. On occasions, nurses provided one to one time for Richard King to ventilate his feelings. But there is no evidence of provision of appropriate activities such as occupational therapy.

Recommendation 2

The panel recommends to the Trust that within three months they initiate a plan for implementation of Protected Engagement Time for each clinical area and allocate a specific amount of time to staff so that they have protected time away from administrative duties to spend with patients.

Recommendation 3

The panel recommends that the Trust reviews within six months the activities provided for inpatients to ensure that adequate and meaningful activities are available in order to manage the issues of boredom and thus reduce the risk of absconding, violence and aggression.

Quality of the nursing notes

5.2 Throughout the periods of admission the nursing notes were of a basic standard in that they were dated, timed and signed. Regrettably some of the content and signatures were illegible. The Norfolk Clinical Standards: Health Records Policy, published in February 2004, requires the following standards from each practitioner:

Standard 5 *'Meticulous and timely documentation provided evidence of practitioners' actions and the patient's or client's response to those actions, therefore demonstrating chronology of events'*.

5.3 We acknowledge that this requirement only applies to the July 2004 admission but good nursing practice has always emphasised careful record keeping. The panel found that meticulous and timely documentation was not always evident in the notes. Some complete days in May, September, and December 2003 had no entry at all. There are similar omissions in the July 2004 admission. Many entries recorded assessments of Richard King's mental state but there was little evidence of the patient's own perception of his situation. The entries should have been linked to the care plan and the assessment of risk. Appropriate interventions should then have been agreed. The panel read the transcripts of the interviews with the Charge Nurses in which they explain in detail that assessment of risk should include the ward doctor and at least one nurse. The nurses told the previous inquiry that post-event risk assessments were updated weekly ensuring a multidisciplinary perspective.

5.4 It was evident from the notes that there were inconsistencies in the quality of these recordings. This was demonstrated for example in nursing note entries on 28 May 2003. The risk assessment identifies risk of absconding as low and yet Richard King had left the ward without permission the previous day to go to London but this was not recorded until his return in the late evening. Throughout the admissions there were similar gaps in recording events. There were also inconsistencies between behaviour demonstrated by Richard King and the level of risk identified and the documentation of care provided. There was little evidence of a management plan for the risks identified such as absconding. Although most of the admissions show evidence of CPA paperwork being used, the quality of written entries should have included more detail and multidisciplinary input.

The nursing notes of the 15 July admission

5.5 We have previously described the events of the admission of 15 July, but it is appropriate to investigate and comment in detail on the nursing record at this juncture. The CPA Inpatient Record and the Preliminary Assessment were in the file but only pages 1 and 4 could be found, and therefore we have to conclude that the remainder were not completed. The Summary of Risks and nursing admission notes were comprehensively completed by Charge Nurse Ron Mills on 15 July. However, the details of the precipitating events at the flat in Wells were not included. There is no evidence that this information was ever made available to the ward staff. The risk assessment was recorded as *'low'* in spite of Dr Emore's record that Richard King *'can't take it anymore and wants to kill himself'.* There is no evidence in the primary notes of a care plan prescribing the nursing management. Other than medication, there was no indication in the primary notes of any psychological or other therapeutic interventions in place on the ward during this admission.

5.6 For ease of reference, some details of the admission described in Part One are repeated. On Monday 19 July Richard King requested to go home for a few days and refused to wait to see the doctor. There is no evidence in the nursing notes made on 19 July of reporting this incident of unplanned leave to Dr Coogan or to the SHO or the duty manager. There is no recording by the Staff Nurse on duty of the decision-making processes involving other professionals of the assessment of mental state, or of any risks, other than to note the fact that Richard King stated he had medication at home.

5.7 There is an entry on 19 July that a message was left for Gill Chambers informing her of the unplanned leave. Gill Chambers cannot remember whether she was on leave at this time, and there is no documentation which confirmed that the message had been accessed by another CMHN. There is no note of the decisions taken on 21 July (when Richard King returned to the hospital to see a doctor but left before he had arrived), either by the nursing staff or medical staff. On the following day Richard King was telephoned at home by the acting senior charge nurse who wrote that he *'appears bright and cooperative…and is willing to come back to see medical team if required'*. According to the nursing notes it was not until Friday 23 July that the medical team were contacted regarding the unplanned leave. The nursing notes state: *'No formal decision was made – therefore leave to continue over w/e and MDT to be re-contacted Monday'.*

5.8 On Monday 26 July, Dr Kelly, locum SHO, discussed the situation with Dr Coogan and wrote: *'Happy for Mr King to be discharged today while on leave'*. There is no evidence in the nursing notes of either a telephone conversation with Richard King, his CMHN, SW or GP, as to his level of functioning, his current mental state or the state of his relationship with his wife. Dr Kelly wrote *' CPN to be informed and arrange F/U' (follow up*). Joanne Braisby provided follow up care for Richard King.

Findings

5.9 The panel finds that the nursing notes and recording of the decision making process in this admission was not explicit and was not of a professional standard.

Recommendation 4

The panel recommends to the Trust that the quality of all nursing notes and the use of CPA documentation are audited through Management Supervision and the Trust wide audit of CPA documentation. The audit should monitor the adherence to the standards set out in the Norfolk CPA policy within six months.

Incident reporting

5.10 We were concerned by inconsistencies in the reporting of serious incidents through the Trust incident reporting system. During the admission beginning

28 December 2003, Richard King was involved in three violent incidents which were recorded in the nursing notes and reported through the incident reporting system. But we have not been able to find any evidence referring to these incidents in the community notes. Only those on the inpatient ward were so recorded. We heard evidence from Andrew Bailey and Linda Phillips that incident forms were not stored in the patient's notes: one copy was retained in the incident book, one sent to the safety manager and the third kept by the relevant manager. The incident reporting system should have ensured that all serious incidents were accurately documented and then filed in the patient's health and social care records so that all professionals had access to them. Theoretically, these records should then inform risk assessments Linda Phillips told us that there were separate computer systems for health and social services to record activities. We have not heard any evidence that information from incident forms, and subsequent investigations, has been placed on inpatient and community notes or given to the professionals involved. The Commission for Health Improvement (CHI), now the Healthcare Commission, reported in December 2002, following their inspection earlier in the year. It recommended that:

Action is required to create a system for sharing important information for example on critical incident reviews.

Findings

5.11 We conclude that there is confusion regarding the completion of incident forms in the community setting and action is required to ensure that all incidents are recorded and readily accessible to all the care team. Such records then should feed into the risk assessment process.

Recommendation 5

The panel recommends that the Trust ensures within three months that a copy of all the incident report forms for every inpatient and community incident is located in the relevant patient's health and social care notes.

Use of illicit substances

5.12 The panel was told by Dr McAnsh that he was aware that Richard King used substances such as alcohol and cannabis. Given the frequent admissions and the rapidity with which the symptoms often improved, there appeared to be little consideration for testing for substance misuse on admission. There is evidence in the inpatient primary notes of screening on only one occasion. The panel questioned Gill Chambers regarding Richard King's use of illicit substances as there are no entries in her notes to possible usage. She told us she asked him about illicit substances on several occasions, but he always denied using them.

Recommendation 6

The panel recommends to the Trust that a policy on screening for the use of illicit substances by patients is developed as a matter of urgency within three months.

Unplanned leave, absconscions and discharges

5.13 These terms are not synonymous for healthcare professionals. Unplanned leave is used for patients who are in hospital voluntarily and are not detained under the MHA, but who leave the hospital. As they are in hospital for assessment and treatment, such patients should not leave the ward without the agreement of staff for their own safety. Absconscions refer to patients who are formally detained and who must not leave the ward without permission. Unplanned leave was a feature of Richard King's inpatient care which placed a particular burden on community care as he often returned to his flat without the CMHT being informed that he had left the hospital. He also absconded on 27 May and 3 June 2003 while he was detained on s.3 of the MHA. The latter absconscion is not recorded in the nursing notes.

We have heard evidence that many patients were discharged not in accordance with the discharge policy. We have already quoted extensively from the Trust discharge policy in Chapter 4, but for ease of reference we refer again to the requirement for full assessment by the multidisciplinary team, consistent practice and a pre-discharge meeting.

5.14 When we interviewed Bridget Collins, Team Leader on the CMHT, she told us that there was *'huge pressure on beds'* resulting, in her opinion, in the discharge process not being followed. Patients were often discharged without the CMHT being informed. Bridget Collins told us it was common practice for patients to be sent on leave, for the CPN then to visit them at home and for the patient to be discharged while on leave. Other witnesses have commented on the unprofessional attitude to the practice whereby patients left and returned to the hospital at their own behest, apparently without regard to the therapeutic purpose of their original admission.

We acknowledge that community staff were invited into the ward on 4 June and 2 July 2003. Gill Chambers and Jenny Cunningham attended a MHA s.117 meeting although Richard King was on leave. At the CPA meeting on 22 October 2003 Dr Thomas, Gill Chambers, Jenny Cunningham and Steven Potter were present. Richard King was discharged in his absence while on leave as he refused to return. Gill Chambers and Jenny Cunningham were also present at the CPA review on 19 February 2004.[70] The final admission and discharge of Richard King is a telling example of the failure to implement the discharge policy and the prevalence of unplanned and unrecorded leave in Hellesdon Hospital at the time of these events.

[70] All the meetings referred to in this paragraph are recorded in the patient notes.

Recommendation 7

The panel recommends that the Trust audit the incidence of unplanned leave and absconsions and that the Trust takes action within three months to reduce the prevalence of this practice. The Trust should ensure that all patients who are absent without leave should be assertively followed up. The Trust should refer to the work of Len Bowers[71] for alternative management strategies.

Recommendation 8

The panel recommends that the Trust review the current practice of the discharge policy within three months and ensure that the discharge of patients should only take place according to the DoH circular HSG(94)27.

Conclusions

5.15 For the purposes of this inquiry our criteria for standards of good inpatient care require that there should be a comprehensive initial assessment of the patient to identify needs and determine a person-centred therapeutic programme. We have been unable to find any assessments or referrals for therapeutic interventions. We have also found shortcomings in record keeping and the dissemination of serious incident forms. There was no policy for testing patients for illicit drugs. Richard King took unplanned leave from the hospital. When he was formally discharged, the Trust policy was not followed. The panel finds that the nursing care and treatment provided to Richard King when he was an inpatient lacked leadership and direction and did not reach the standard that could reasonably have been expected.

[71] Bowers, L., Jarrett, M., and Clark, N (1998) Absconding: A Literature Review. Journal of Psychiatric and Mental Health Nursing 5:343-353 and related articles in the same journal, 6: 199-206, 6:207-212, and 6:213-218.

CHAPTER 6
THE DELIVERY OF CARE AND TREATMENT THROUGH THE CARE PROGRAMME APPROACH

Introduction

In this chapter we describe the Care Programme Approach in detail. We have referred to Trust policy documents, the report of the Commission for Health Improvement, CPA documentation and evidence given in interviews. The CPA is at the heart of mental health care in the community and, when well managed, enables people with serious mental illnesses to live in the community with minimal risk to themselves and others. The key to the successful use of CPA is a full assessment of initial needs and the flexibility to adapt to changed requirements as time passes. Therefore, the monitoring and coordinating roles are critically important. Coordination of care with other agencies and documented information sharing is essential. These functions are the responsibility of the Care Coordinator and we examine this role closely later in this chapter.

Care Programme Approach

6.1 The Care Programme Approach is a structured framework to *'provide a network of care in the community'* for people with severe mental illness (DH 1990). From 2001, CPA applied to all adults with mental health problems. The Norfolk Mental Health Trust CPA Policy became effective from April 2003.

The key principles of CPA are:-

- A systematic assessment of health and social care needs.
- Written care plans identifying assessed needs and the support and services provided to meet need.
- Care Coordinator delivers personal care and coordinates, oversees and monitors the care provided.
- Regular review of progress and care provided.

The enhanced level

6.2 The Trust policy is consistent with DH guidance and operates two levels of CPA, *'standard'* and *'enhanced'*. Standard CPA applies to those people who are identified as being at a lower level of risk and are likely to maintain appropriate contact with services. Enhanced CPA applies to those people who meet some of the following criteria: have multiple care needs requiring inter-agency co-ordination, only willing to cooperate with one professional or agency, in contact with a number of agencies, requires frequent and intensive interventions, co-morbid substance use, at risk of harming themselves and/or others and are likely to disengage from services.

Richard King was identified as being on the enhanced level of CPA because he met the criteria as described. The panel was surprised to learn that his complex case was allocated to a relatively new member of the community

mental health team, Gill Chambers. She was at that time an E grade nurse, new to the CMHT albeit that she had considerable experience of working on night duty on an acute inpatient ward. There was no clear direction in the CPA policy at that time as to what grades of staff could take on this role. We asked Linda Philips, Director of Nursing, whether this omission has been addressed. She assured the panel that the introduction of a new banding system for nursing competencies (Agenda for Change) now clarifies the appropriate levels of responsibility for each band. In the light of this assurance we do not make a recommendation on this matter.

CPA training

6.3 Bridget Collins and Gill Chambers both confirmed to the panel that training in CPA was delivered to the teams in 2003. Linda Phillips stated that the focus of the earlier training in 2001 was on documentation and that here was some resistance to it as each form contained thirty six pages. It was clear from Linda Phillips' evidence that there was confusion from some practitioners regarding the role of the Care Coordinator and that the training did not address that issue as it largely focussed on paperwork.

Commission for Health Improvement report, December 2002

6.4 The Commission for Health Improvement (now the Healthcare Commission) report was published in December 2002, following a visit to the Trust in April, and found that:

The National Care Programme Approach has not been wholeheartedly welcomed within the Trust and insufficient progress has been made. The process for CPA is not effective. Staff are concerned about the cumbersome and time-consuming paperwork which is not unified across the Trust and a number of staff do not understand it. Inpatient services have had difficulty integrating care planning with the care programme approach. There needs to be better staff education, more rigorous compliance and checks, especially for Care Coordinators.

6.5 The report recommends that:

Action is needed to ensure that staff are trained in the CPA and that they are committed to it. The Trust also needs to ensure that the CPA is monitored.

6.6 The visit of the Commission for Health Improvement took place in April 2002 and we have heard witnesses describe continuing problems in the team up to August 2004. The evidence that was given to the panel in interviews supported the conclusions of their report. No witnesses spontaneously mentioned a programme of change following the CHI recommendations concerning the CPA. We cannot be confident, even at the time of writing, that the CPA is currently being monitored adequately. But we are confident that the conclusions of the CHI report were correct.

There is no evidence that the recommendations of the Commission for Health Improvement to the Trust were robustly addressed in the 20 months prior to the death of John West. They should have been implemented immediately.

Recommendation 9

The panel recommends that the Trust reviews the implementation of the Care Programme Approach across both inpatient and community settings within six months.

The role of the Care Coordinator

6.7 The effectiveness of the CPA depends on the Care Coordinator (CC): it is a key liaison role. The CC is usually the person who is best placed to oversee care planning and resource allocation. According to the Trust CPA Policy the CC is responsible for:-

- monitoring the delivery of the care plan
- being a point of contact
- organising CPA meetings
- CPA documentation completion and distribution
- review of care plan at appropriate intervals
- making regular contact with all involved in the CPA
- monitor progress

The Trust CPA Policy states that caseload management and supervision processes are critical to maintaining effective practice. Risk assessment, recording and managing risk are also essential components of the CC role within the CPA process. The CC should make a preliminary risk assessment in all cases and should cover the following – suicide, self-harm, neglect, abuse or exploitation, risk to children, violence to others, sexual offending and absconding or withdrawal from treatment. A full risk assessment should be completed for areas that are identified as *'clinically significant'*. The criteria for *'clinically significant'* is not given in the Norfolk CPA Policy and thus only serves to confuse those who are completing the assessment.

Recommendation 10

The panel recommends that the Trust gives guidance on the phrase *'clinically significant'*, as used in the CPA policy, so that all staff understand its meaning and subsequent requirements for specific actions within three months.

Allocation of the role of Care Coordinator to Richard King

6.8 We have already alluded to the allocation of Gill Chambers to the CC role for Richard King. This role would normally have been taken by a G Grade or another professional nurse with an equivalent qualification. Gill Chambers could not remember the rationale for the allocation of cases although she believed that the actual decision would have been made at a multidisciplinary team meeting. Gill Chambers was an extremely experienced nurse. She told

the panel that she herself had sought the change to community nursing and was adequately supervised initially by her senior, Louise Holden, who was a more senior (G grade) nurse. Gill Chambers *'felt thoroughly prepared to work with Richard King'* as her supervisor was well acquainted with his case.

Understanding of the role of the Care Coordinator

6.9 We asked Gill Chambers to define the role of a CC, and she replied:

'It is somebody who can facilitate things and make referrals and try to make sure that everything is necessary for that individual is in place, but not to do it yourself'.

The panel noted that this is a very narrow definition of the CC role compared to that set out in the job descriptions for both E and G Grade nurses.

She described significant differences in understanding between nurses and social workers regarding the whole concept of CPA and documentation, and told us that the nurses thought *'it was a paper exercise'.* When we asked her about the absence of letters and referrals in her notes, she recollected that most aspects of the case had been discussed in the Monday morning meetings and that she would have recorded them in her running notes. Gill Chambers told us at interview that she would have regarded writing a subsequent letter as a duplication of information. She did not perceive that her role required active management and overview of the case, and did not dispute that there was a complete absence of letters and referrals in the CPA documentation relating to Richard King. We refer to her training in paragraph 6.14. We note that the inadequacies in the CPA process continued after the departure of Dr Thomas in February 2004.

6.10 Gill Chambers accepted at interview that she had been aware of the police concern about Richard King's delusions of buried bodies, but specifically denied knowing about the fax from the police Adult Protection Unit. She told us that the incident concerning the delusions about the bodies was the only time that she was aware of police involvement. We questioned her about the police practice of attending the address in pairs but she could not remember such information being given to her, even though we reminded her that, according to the minutes of the Strategy Meeting on 26 January Sergeant Spinks stated that *'the risks that they presented were recorded on the police system'* and that *'furthermore the police only attended in pairs'*.

Care Programme Approach reviews

6.11 We understand that in the event of deterioration in a patient's mental health, the CC is responsible for arranging an urgent review. If new and significant risk factors are identified, the CC must consider calling a review meeting with all care providers concerned according to the Trust CPA policy. Furthermore, the policy states that all service users on enhanced CPA will have in place a crisis plan. This should set out the action to be taken if the service user becomes unwell or the mental state deteriorates rapidly. A CPA Care Plan

was completed by John Purdy on 28 November 2002 which was updated by Gill Chambers when she completed a CPA Care Plan, Preliminary Risk Screening and Crisis Plan on 13 May 2003. This was good practice as she had been allocated the case of Richard King in April. The Care Plan should have been reviewed at least annually. Given that Richard King experienced frequent admissions over this time, there should have been a six-monthly review of documentation. The updating should have followed two meetings identified as CPA reviews by Dr Thomas in November 2003 and Dr Fadlalla in February 2004. These reviews considered Richard King's home situation, mental state and gave a plan of care. But deterioration in mental state, frequent admissions, and serious incidents should also have been recorded. We have emphasised in the chronology in Part 1 that the omission of the annual CPA review in May 2004 was extremely serious and we discuss this further in Chapter 13, paragraph 13.11.

Recommendation 11

The panel recommends that the Trust ensures that there is a system in place within three months to check that annual CPA reviews are undertaken.

Care Programme Approach documentation

6.12 Documentation was the responsibility of Gill Chambers. She should also have monitored the quality and effectiveness of care, support and treatment provided. Each review should have been recorded and a date set for the next review. Richard King was seen frequently in the community by Gill Chambers and Jenny Cunningham. He was also seen by medical staff as a result of the numerous admissions. But there is no evidence of any letters in the patient's notes that Gill Chambers organised a CPA meeting to review his care. The Strategy Meetings and Case Conferences were all instigated by Jenny Cunningham. There is very little documentation of her CC role. The notes of the nursing care she provided are in contrast extremely clear. However, as CC she did not respond to or review the escalating series of incidents in 2003 and 2004. These incidents and admissions should have alerted her to call a CPA meeting in order to confer with her colleagues and the medical staff, and then for the team to have taken appropriate action. There is no documentation of any concerns that may have been raised at CMHT meetings. The Care Plan, Risk Assessment and Crisis Plan were not reconsidered in May 2004 and there is a note in the CMHT minutes of 12 July 2004: *'Find out when CPA review is for longer term needs'.* It is unclear who should have taken this action. There is no further mention of the absence of a new Care Plan in the CHMT minutes of 19 and 26 July 2004. To omit the annual review was serious as the deterioration in Richard King's illness would have been recorded, and the risks that he presented might have been assessed and better managed. This was a key omission by Gill Chambers and the team but it also demonstrates the general failure of the implementation of the CPA.

Risk assessment

6.13 There was no formal risk assessment made in the community for Richard King between 2001 and 2004 with the single exception of the preliminary screening on May 2003. Although some members of the CMHT were aware of the risks presented to his wife and to Trust staff, they are only recorded sporadically and in separate files. As the CMHT minutes for 2002/3 have been destroyed (apart from six brief references in June 2003), it is impossible to check whether there were any records of informal discussions. But collating information and then assessing risk with the multidisciplinary team was the specific responsibility of the Care Coordinator. However, we accept that the Trust had not provided sufficient training for Care Coordinators in this very complex area.

Recommendation 12

The panel recommends that the CPA framework and risk assessment training should be reviewed by the Trust to ensure that practitioners are clear as to how risk assessments should be conducted i.e. taking into account the views of all professionals involved with care, within three months.

Findings

6.14 It is clear to the panel that the nursing care provided by Gill Chambers was of high quality. She was responsive to Richard King's multiple needs and engaged with him well. She visited him very frequently and maintained careful and legible records. Gill Chambers made recordings of good quality which are properly dated and timed. Her notes provided a concise account of clinical care and the administration of medication to Richard King. But while Gill Chambers provided competent community psychiatric nursing for Richard King, she did not adequately fulfil the requirements of the Care Coordinator role. The responsibility for this must be shared jointly between Gill Chambers' limited concept of the CC role, and the inadequate training and supervision provided by the Trust. She was obliged to follow the policies of the Trust. The panel believes that Gill Chambers did not at the time fully understand the requirements of the CC role and may still define it in reactive rather than proactive terms. Given the complexity of Richard King's illness, the allocation of his case to an E grade nurse was questionable and a decision for which the Trust must take responsibility. Gill Chambers has told us that she only attended specific training for the CC role for one day. She was not consulted about major decisions in Richard King's treatment, eg, the proposed move to Fakenham in June 2004 or some of his discharges into the community.

Supervision by Bridget Collins

6.15 Bridget Collins was employed as the Team leader for the CMHT. She was responsible for supporting , mentoring and providing management supervision and checking that CPA was being administered effectively. She should have supervised Gill Chambers when she became an acting 'G' Grade, but told the first inquiry that she had not done so. She gave evidence to the panel that

while she attempted supervision on a monthly basis this had not always been possible[72]. Gill Chambers identified that she had not had any appraisals for some time. This was confirmed by Bridget Collins who stated that a date for appraisal had been booked at the time of the homicide. She was unaware of when Gill Chambers had last been appraised. Bridget Collins kept records of supervisions in her own book which she believes would have been destroyed during relocation of offices. Gill Chambers had previously been supervised by Louise Holden. Bridget Collins told the panel that she expected that she would have been informed if there had been problems with Gill Chambers' practice during the previous supervision period, but she had no received any indication of concerns. Focussed supervision from Bridget Collins should have identified shortcomings in the performance of the CPA role. Gill Chambers told the panel that her notes had not been audited, and no manager appears to have been aware that the CPA documentation was not completed and that there were gaps in her understanding of the CC role. However, we note that Gill Chambers was professionally accountable to the Director of Nursing: she told the panel that, with hindsight, she should have approached the Director for support.

6.16 Bridget Collins also recognised with hindsight that the risks presented by Richard King were underestimated, and that she should have been reviewing the paperwork within management supervision and then questioning the frequency of his admissions.[73] The role of the Team Leader is to provide clinical and managerial leadership, to implement Trust policies and procedures and to raise any difficulties with the line manager. While we acknowledge that Bridget Collins did attempt to raise concerns regarding lack of capacity, she has to accept responsibility for not providing leadership and ensuring that her staff were properly supervised.

Conclusion regarding the role of the Care Coordinator and the Care Programme Approach

6.17 We conclude that failures in appropriate allocation, role specific training, and inadequate supervision all exacerbated a fundamental lack of understanding of the CC role. We are therefore not surprised that Gill Chambers was not able to fulfil the crucial monitoring and reviewing role of the CC. Neither Gill Chambers nor any other member of the team were able to take an overview or any effective action when Richard King's condition deteriorated. The panel finds it extremely difficult to understand why there were no risk assessments in the community after April 2003, and the reasons why this was not identified during supervisions. This aspect is discussed further in Chapter 10. These conclusions raise issues for the Trust about the training and development of nurses and the systems in place to support nurses and indeed other professionals to move up the career ladder. We recommend informally to the Trust that the competencies for all practitioners and the Knowledge and Skills Framework should be addressed within management supervision and the personal development review process.

[72] First inquiry interview
[73] Second inquiry interview

6.18 During the time that Richard King received care with the Trust, there were only a minimal number of CPA documents within the Primary and Community notes. More importantly, many of those interviewed did not fully understand the processes of CPA. We heard evidence that nurses and social workers held differing concepts of the CPA processes. The training did not address the fundamental theory of CPA which emphasises the roles and responsibilities of the CC of the team and the practitioners became mired in resentment of the lengthy documentation. We conclude that confusion over roles and deeply rooted resistance to change resulted in members of the team and the managers losing sight of their operational purpose and the overarching importance of the CPA framework. The management of the case of Richard King was an example of the failure to apply the principles of the Care Programme Approach.

CHAPTER 7
THE DELIVERY OF SOCIAL CARE

Introduction

This chapter is concerned with the delivery of social care to Richard King by the Community Mental Health Team. The sources of information for this chapter are interviews with personnel employed by the Trust at the time of the homicide, some minutes from CMHT meetings and entries in the social services file. Paragraphs 1-29 analyse the operation of the team, and paragraphs 30-45 discuss the role of Jenny Cunningham.

7.1 The panel has attempted to locate operational policies for the CMHT between 2001 and 2004. The Acting Locality Manager, Gwen Ford, who has only been in post since May 2006, has written to the panel in the following terms: *'I have been unable to find an Operational Policy that was in existence in 2003/4'.* We have therefore assumed that no policy existed in 2003/4, and believe that it is extremely unlikely that a policy existed in 2001/2. No witnesses have spontaneously referred to operational policies.

7.2 The panel has also sought the minutes of team meetings for 2002 and 2003. We have been provided with the minutes from January to August 2004. Ten months after the panel began its task, six copies of minutes in the second half of 2003 were discovered and passed to the panel. Dr Ball has informed the inquiry that the remaining documents are missing and may have been destroyed. We consider the absence of these documents in terms of the Trust policy in Chapter 12.

The organisation of social care between 2001 and 2004

7.3 In 2001, social care services in North Norfolk were delivered from a variety of agencies, and referrals were received via a number of routes. The Social Services Department of Norfolk County Council (NCC) provided social care services for people with mental health support needs, including an 'approved social work' (ASW) service. These services and the people providing them were managed by the County Manager for Mental Health, who was employed by the Social Services Department. Community psychiatric nurses, psychiatrists who were employed by the Norfolk Mental Health Trust, and occupational therapists were based in a number of centres in North Norfolk. They provided mental health services in the community and at the inpatient unit at Hellesdon Hospital

Integration of health and social care services

7.4 Following the publication of the National Service Framework for Mental Health in 1999, statutory agencies providing mental health services, predominantly health and social services departments, were required to join together to ensure that patients could receive care from a multidisciplinary team, based together in one place. This national process became known as integration. In

May 2003, Harold Bodmer was appointed as Assistant Director of Social Services in Norfolk. Harold Bodmer told the Inquiry Panel that integration of mental health services, a process well underway in much of the country by 2003, had, in his view, *'stalled to some extent'*. He determined, in conjunction with Amanda Hedley, Director of Integration, to effect integration in North Norfolk by April 2004.

7.5 Thus in the months prior to the homicide, the North Norfolk and Waveney Mental Health Trust (renamed in April 2004) was in the midst of organisational change. Following integration and secondment of social care staff, the post of County Manager was deleted. Millie Kelsey, senior social worker, was appointed Team Leader and was subsequently supervised by, and accountable to, Andrew Bailey, Locality Manager. The area covered by the Trust is geographically large and so was divided into districts. Teams were still based separately. Some personnel were in North Walsham, others were based in Fakenham. The inpatient unit was at Hellesdon Hospital, close to Norwich.

The referral of patients to community care

7.6 Referrals to the CMHT came from a variety of sources, although general practitioners were probably the primary source. They referred large numbers of patients. Psychiatrists also received work via the team. The CMHT was a *'*secondary*'* mental health service, and as such would have dealt with people with more serious mental illness, particularly those suffering from severe and enduring conditions. In North Norfolk in 2004, the criteria used to judge whether work was suitable for a secondary mental health service was not formally established or written down. Prior to 2004, Millie Kelsey told us that referrals would be made for a social work service if someone, usually a GP or a member of staff from the inpatient unit, felt it appropriate for the referred person to receive such a service. Andrew Bailey told us that he referred staff to the *'Building Bridges'* document published by the Department of Health, as he felt this contained helpful guidance on accepting someone for secondary services.

The Community Mental Health Team prior to 2004

7.7 Dr Thomas told the panel that he established multidisciplinary team meetings when he was appointed to North Norfolk. This team has been referred to in various ways and therefore we have adopted the term *'*CMHT*'* throughout this report to simplify matters. During this period, a range of health and social care staff attended meetings but the management arrangements for each group were different. The CMHT met on Monday mornings at Carrobreck although most community staff were based elsewhere. Dr Thomas told us that the purpose of the meeting was to discuss all new referrals to the team, and for staff to discuss patients with whom they were experiencing difficulties. He provided clinical leadership and assured us that the establishment of these meetings was a priority for him and he always attended. The agenda was led by the staff who would raise issues of concern. Bridget Collins, the Team

Leader, would also attend. Millie Kelsey told us that she did not attend frequently.

7.8 The team undertook first assessments, brief interventions and worked with continuing care cases. The community psychiatric nurses were linked to GP surgeries and would do most of the initial assessments from their 'link' surgery, also taking on the ongoing work if necessary. Bridget Collins told us that caseloads were high, due to *'high demand, no criteria'*. At one point she carried a caseload of 20 cases in addition to her duties as team leader.

The Northern Locality Community Mental Health Team

7.9 The Northern Locality (Richard King lived in north Norfolk) Community Mental Health Team was formed early in 2004 as part of the integration process. However, the social workers were seconded to the Trust in April 2004, but were still based separately from their health colleagues, and were line-managed by their professional team leader, Millie Kelsey. We will analyse the line management of the team in paragraph 7.16. We have already referred to the absence of formal policies and procedures in the operation of this team, but in general terms its function was to care for and treat patients such as Richard King in his home using the CPA. The principle of care in the community is that there should be continuing communication between all members of the team, the patient and carer and any other agencies involved. The inpatient and community episodes should be seamless, that is the inpatient and community staff share information so that a care plan can be agreed and understood by everyone.

Community Mental Health Team records

7.10 Between 2001 and 2004, social workers kept their own files as did staff working for the Trust. Information was not shared unless someone saw fit to do so. Inpatient notes were kept at the Hellesdon Hospital site, separate from the community files. When the service integrated in 2004, the records remained separate. Health and social care staff continued to keep their own documentation, with each professional recording contacts separately in their own file. These records were not shared following integration, but CPA documentation should have been distributed to everyone involved with the patient. However, there was little documentation as we have already observed. It is clear from the different sets of notes that information and observations from the CMHN, the social worker and the consultant were not routinely cross filed. We accept that the distances of north Norfolk are considerable, but the difficulties of multidisciplinary working were clearly exacerbated by the failure to maintain good records.

7.11 Andrew Bailey told the panel that there was serious resistance to integrated notes from the social care senior management. The compromise was to place health and social care notes together in the same sleeve: this did not count as integration which required the amalgamation of notes in date order. We consider that the inevitable effect of this failure to integrate notes was that staff could not follow incidents and track changes chronologically.

Recommendation 13

The panel recommends that the Trust introduce the use of a single case file to be used by all professionals working with a case. Such a file would follow the patient so that inpatient and community staff would have access to the same information, and all entries would be made to a single file in the interim period before electronic files become available. The Trust should also review progress of Electronic Patient Records.

The minutes of the Community Mental Health Team meetings

7.12 The CMHT meeting minutes prior to 2004 are nearly all missing and have probably been destroyed. No copies of the minutes relating to Richard King were cross filed in the community nursing or social care records. Six mislaid extracts relating to Richard King in 2003 were discovered by Gwen Ford in July 2007, but unfortunately they do not provide any useful evidence. In evaluating the work of the team, the panel is therefore reliant on evidence from those interviewed and on seven brief references in the minutes of CMHT meetings in 2004. There is no information whatsoever minuted regarding the referral of Richard King to the CMHT meeting on the 19 July 2004. The meetings were not chaired by the same individual and they were not attended consistently by the same community staff. It is difficult to understand how any continuity could be maintained. The minutes do not include a distribution list. The actions that were to be taken by the team were documented although the columnar format precludes a full record of details and discussions. There is no clear recording of decisions and actions or of any time scales for action to be taken following the meeting. Consequently the minutes were not used to actively follow up decisions or to return to them in subsequent weeks to check progress and outcomes.

Recommendation 14

The panel recommends to the Trust that the minutes of the CMHT meetings record clearly all decisions of the meetings and actions to be taken regarding patients. The minutes should identify the member who should take action and set an agreed time by which that member should report back to their manager and the next meeting. The meetings should be chaired by the same member of staff for a designated period. This recommendation should be implemented within three months.

Recommendation 15

The panel recommends to the Trust that the minutes of the CMHT should be formatted so that notes on individual patients can be separated and filed appropriately without compromising the Data Protection Act 1998 within three months.

The managerial context

7.13 The panel requested that evidence should be given by the Director of Nursing, Linda Phillips, in order to understand the managerial context of the CMHT. At the time of the homicide, she was also joint lead for clinical governance and had responsibility for nurse education. Previously she had been 'acting' Director but appeared unsure of the dates of either appointment. She assured us that she had had no responsibility for line management or operational responsibility. Nevertheless, she was able to give us information about the management of the CMHT. An understanding of the management and operation of the CMHT is an essential part of contextualising the actions of Jenny Cunningham and Gill Chambers.

7.14 Linda Phillips emphasised that resistance to change was a particular feature of the Northern Locality CMHT. There were personality difficulties in the hierarchy of the team and this hindered restructuring and integrating the team functions. Linda Phillips accepted that this had been only latterly acknowledged and not addressed at the time. The panel encountered some difficulties in summarising the evidence from Linda Phillips concerning the Northern team as her evidence was very general and she was uncertain of the actual dates of some of the organisational changes in the team.

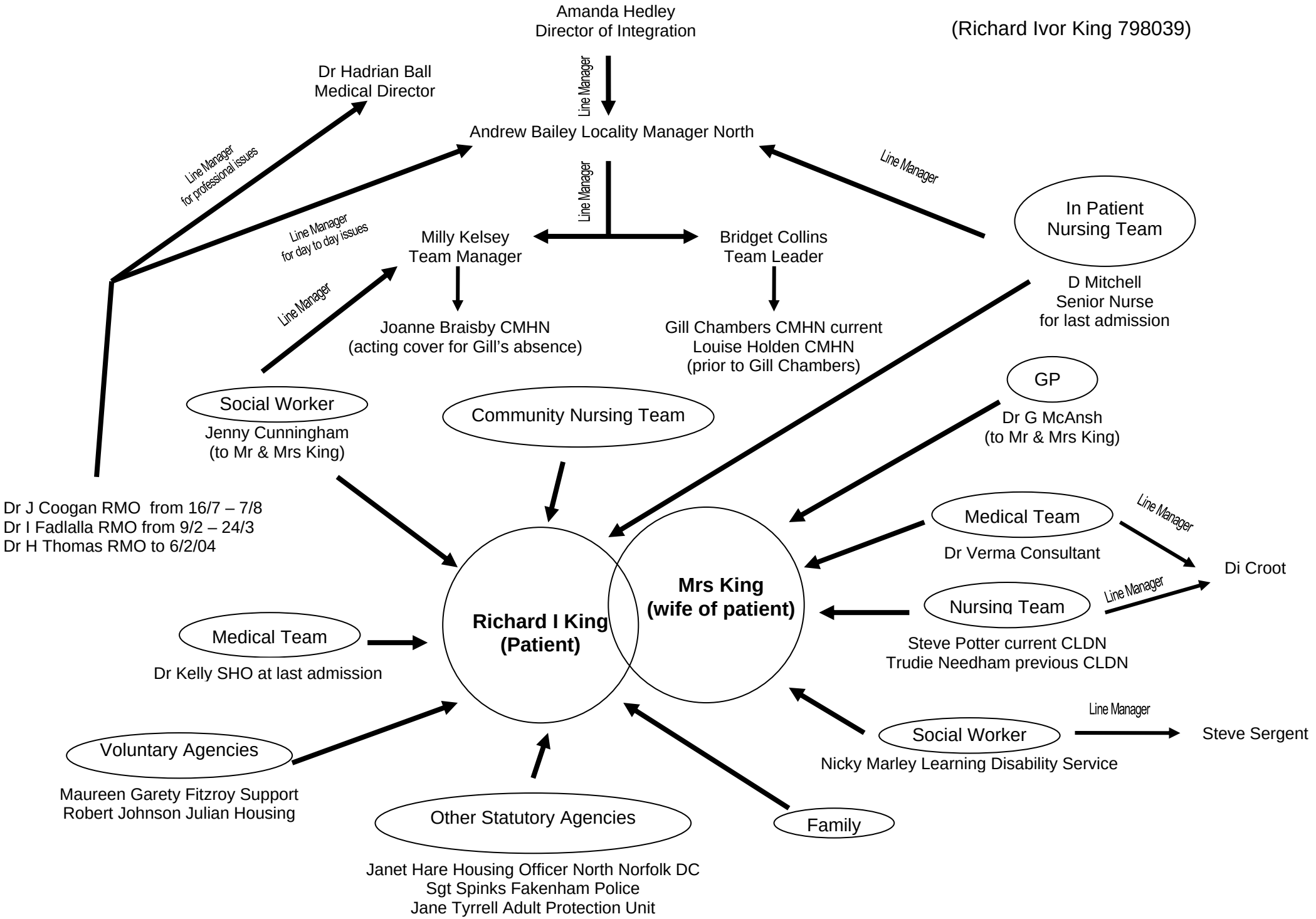
7.15 Linda Phillips told the panel that she only became aware of problems in the culture and practice of the team through the process of integration of social and health care. Because there had been no serious untoward incidents reported and only limited professional nursing advice had been requested from this team, she had concluded that the difficulties were not sufficiently serious to impact on patient care. We have discussed the shortcomings of the Trust incident reporting system in Chapter 5, in the Introduction.

Line management in the Community Mental Health Team

7.16 The structure of the CMHT was very complex. We include an organisational plan on the following page which we believe was prepared for the first inquiry. It is undated and included information regarding Dr Coogan and Dr Fadlalla's responsibility for Richard King which is completely wrong: this has now been corrected. The plan illustrates the problems in understanding the complexity and ineffectiveness of the line management of the CMHT. Andrew Bailey was the Locality Manager of this team. Following integration, Andrew Bailey supervised and managed both Millie Kelsey and Bridget Collins. In his evidence to the Panel he told us that Millie Kelsey would have had overall responsibility for the Richard King case for two reasons. Firstly, the case was a continuing support case and this came within her management remit. Secondly, Millie Kelsey was the more senior manager. Between 2001 and 2004, Millie Kelsey was a team manager for Adult Social Services, Mental Health. In this role, she supervised and managed social workers, including Jenny Cunningham.

7.17 In early 2004, when services integrated, Millie Kelsey was seconded to the Mental Health Trust. Initially as Team Leader, she managed and supervised only the social care staff. The nurses were supervised and managed by Bridget Collins, the Team Leader. Millie Kelsey subsequently became Team Leader and Bridget Collins' line manager. When questioned by the panel, neither Bridget Collins or Millie Kelsey was sure when the change actually took place. Millie Kelsey also assumed the management of nurses working with cases identified as needing continuous support. At the point of integration and for some period after, the management of such a disparate service was extremely challenging. Millie Kelsey told us in her evidence to the panel that at one point she was managing 18 staff plus six ASWs on seven different sites, some of which were 30 miles apart.

(Richard Ivor King 798039)



The role of the Locality Manager

7.18 Andrew Bailey was the Locality Manager responsible for the Northern Locality at the time of the homicide. He managed Bridget Collins and Millie Kelsey. He was responsible for leading the development of integrated services and providing clear leadership to all professional staff. He should also have ensured that practitioners received supervision, that case loads were monitored and operational policies were in place and properly implemented[74]. His job description was undoubtedly large and he faced a challenging agenda in that there was resistance to integration. Andrew Bailey told the panel that he saw his role as essentially strategic, but as he had a nursing background, he expected the team members to raise difficult matters with him. He identified the problems as *'mostly staffing rather than client issues'.* The resource issue was frequently raised by Bridget Collins. Andrew Bailey recognised that she had concerns about the level of resources available to her to enable the team to function effectively. His response was that it was necessary to change the practice and function of the team. He believed that she had difficulty in understanding the need for change. He acknowledged that he should have ensured that records of her supervision should have been documented. In professional terms, Bridget Collins should have followed up these concerns in writing to both her line manager and to the Director of Nursing, but she did not do this.

7.19 Andrew Bailey told the panel that he was extremely troubled that nobody had raised the case of Richard King with him and *'he knew nothing about Richard King or his problems until after this tragedy had happened'.* According to his evidence neither Millie Kelsey nor Bridget Collins had mentioned Richard King during supervisions with him. Andrew Bailey told us that supervision notes followed headings agreed with the Trust and were not in a detailed form. As the minutes of the CMHT were not automatically sent to him he had been completely unaware of the case. However, both Millie Kelsey and Bridget Collins told the panel that they raised with him in supervision sessions the lack of coherent operational protocols, the poor relationships within the teams and the disagreements with Dr Thomas. Andrew Bailey was responsible for assisting his managers in addressing these difficulties.

7.20 When questioned about CPA, Andrew Bailey told us that the training had been inadequate and specifically there had been no training in risk assessment. He was unsure whether differences between health and social care staff was significant. But he identified personal antagonism towards himself from the social workers and antagonism between Millie Kelsey and Bridget Collins as almost insuperable factors in the management of the team. According to Bridget Collins, she did not discuss the management of Richard King with Millie Kelsey. He acknowledged that cases could have dual management, but did not recognise that this might present difficulties. Nevertheless, he believed that the team was working effectively. The panel was surprised by this comment.

[74] Job Description: Northern Locality Manager

7.21 It is clear from the evidence of Bridget Collins, Millie Kelsey and Gill Chambers that they shared a sense of confusion as to who had ultimate responsibility for the cases in North Team. Millie Kelsey told us that she did not meet with Bridget Collins to discuss Richard King. She relied on the weekly meetings at Carrobreck to devise a shared management plan. She did not attend these meetings regularly before April 2004 and had not been present when some of the fraught exchanges between Jenny Cunningham and Dr Thomas took place. Millie Kelsey described Bridget Collins as *'not the easiest person to get on with'.* More specifically, she felt that Bridget Collins had *'run the CMHT, and then post integration I was to become her supervisor, and this was difficult for her'.* Millie Kelsey told us that she had made Andrew Bailey aware of these difficulties, and he felt that giving Millie Kelsey clear line management responsibility for Bridget Collins was the way to resolve them. Most witnesses were surprisingly uncertain about the actual times when their responsibilities and line management changed and sometimes there were conflicts in their evidence. We observe that the organisational confusion was plainly aggravated by personal hostility.

The practice of supervision

7.22 Clinical supervision is an arrangement between clinicians; a supervisor and supervisee discuss current clinical issues on a regular basis. This provides an opportunity for a less experienced practitioner to raise specific and challenging cases and to be advised by a senior professional. Supervision is recognised as an essential part of professional development. There are two types of supervision commonly in practice in mental health trusts. The first is management supervision. This consists of a meeting between the practitioner and his/her manager. The purpose of the meeting is to review cases, and assist in problem solving and decision-making. This meeting will also address managerial issues such as leave arrangements, training and sickness absence.

7.23 Clinical supervision provides an opportunity for practitioners to reflect on their work in some depth, their personal feelings and their professional development. Staff are encouraged to identify their own clinical supervisor, whereas a managerial supervisor is always identified by the employing authority. The separation of managerial and clinical supervision is a practice more familiar to nurses than social workers, the latter being more used to management supervision only. Most social workers would expect to discuss all facets of their work and professional development with their line manager.

Supervision of Jenny Cunningham by Millie Kelsey

7.24 Millie Kelsey supervised Jenny Cunningham via a formal supervision meeting every six to eight weeks. She told us that she also operated an 'open door' policy, where staff could call in and see her to discuss issues outside of the formal supervision structure. She was also available by telephone. Richard King was discussed frequently both in supervision meetings and outside of them, and from time to time at the CMHT weekly meeting. Supervision notes

were made by Millie Kelsey and sent to Jenny Cunningham following the meeting. The internal Selby Report[75] found that: *'supervision records show that supervision took place on 8 occasions between March 2003 and July 2004 and that Richard King was discussed on 6 of these occasions'*.

7.25 During one such supervision meeting, Millie Kelsey told Jenny Cunningham that she should not visit Richard King *'*alone*'*. When she was interviewed by the panel, Millie Kelsey clarified that she meant Jenny Cunningham should not visit Richard King when he was alone in the flat, she had not intended that Richard King should only be visited by two members of staff. Thus, if Richard and Mrs King were in the flat together, it was permissible for Jenny Cunningham to visit them alone.[76] The lack of definition of the meaning of *'*alone*'* in the context of domestic visits is also evident in the EDT alerts. Millie Kelsey told the panel that she found Jenny Cunningham difficult to manage at times; paperwork was a particular difficulty and she would frequently have to remind Jenny Cunningham of her duties in this area. Millie Kelsey told us that she did look at files during supervision, though she acknowledged that her ability to do this was limited when she had supervisory responsibility for seven sites.

Conclusions

7.26 We have heard evidence that supervision standards were not adhered to for either Jenny Cunningham or Gill Chambers. The shortcomings in supervisory practice for Gill Chambers have been discussed in detail in Chapter 6, paragraphs 6.15 and 6.16. This paragraph and paragraph 7.24 considers supervision practice in terms of Trust policy and CMHT line management. Neither practitioner had monthly supervisions and the supervisions themselves appeared to be unstructured. Supervisors necessarily rely on difficult cases being brought to their attention, but when cases involve risk and are frequently discussed, the supervisor must accept some responsibility for taking action. Millie Kelsey showed the panel the notes that she made when she supervised Jenny Cunningham. As a matter of good practice, she would give her a copy and they would both sign their copies. In contrast, Bridget Collins relied on her own notes which have been destroyed. There was an inherent weakness in a system in which Jenny Cunningham was supervised by Millie Kelsey and Gill Chambers was supervised by Bridget Collins.

7.27 The Panel consider that two supervisors managing the same case, but not communicating with each other on a joint management plan, was a serious error. Jenny Cunningham told us that she regularly raised, in supervision, her concerns regarding Dr Thomas's attitude and the challenges posed by Richard King's fluctuating mental state, but there appears to have been few strategies offered by Millie Kelsey to assist Jenny Cunningham to resolve these difficulties. We find that inadequate supervision of Gill Chambers and Jenny Cunningham contributed to the poor management of Richard King by the CMHT.

[75] See Chapter 11, Paragraph 11.22 for a full explanation of the origin of this report.
[76] See Chapter 11, Paragraph 11.17 for further comment.

Recommendation 16

The panel recommends that the Trust should ensure that the standards and practical arrangements for supervision are audited by the Trust within six months.

Conclusions regarding the effectiveness of the Community Mental Health Team

7.28 We have commented that the CMHT should have provided seamless care and treatment of Richard King and considered the appropriateness of his care plan at regular intervals according to the principles of the CPA. Any risk that he presented to his wife and family, Trust and NCC staff or the general public should have been considered and evaluated by the team. The team was hampered in its effectiveness by differential line management for health and social care staff, and it was in the midst of Trust wide organisational change. Entry criteria was unclear and there were high case loads.. There was no operational policy. Documentation systems were not integrated and team meetings were not comprehensively minuted. Although documentation has been lost, there is no evidence that the team made clear decisions on action to be taken and followed up.

7.29 We have concluded in the previous chapter that the critically important role of Care Coordinator was not fully understood by Gill Chambers. There was an absence of clinical leadership when Dr Thomas left the Trust. Differing views were held by key members of the team involved in the case of Richard King. Consequently individuals carried out their professional duties but did not integrate well with other members of the team. Senior managers were aware of the personal dynamics and restricted professional views of team members, but failed to intervene effectively to address these difficulties. The principles of supervision should have identified the fragmented approach to patient care, but failed to do so as discussed in the following paragraphs. We conclude that the team, as an entity, did not function effectively and that therefore it did not have the capacity to respond to the escalating and complex difficulties of Richard and Mrs King in the months prior to the homicide.

Recommendation 17

The panel recommends that the Trust should ensure, as a priority, that there is a single line management within the CMHTs within three months. This should be clear and accountable, and every member of the team should understand which manager is clinically responsible for the management of an individual's care.

The role of the Social Worker

7.30 Jenny Cunningham had been Richard King's social worker since December 2002, and she was subsequently allocated to work with Mrs King in May 2003. She was not a Care Coordinator to either Richard or Mrs King and therefore did not have those specific responsibilities which we have discussed in the previous chapter. Jenny Cunningham was a very experienced practitioner. Because of the paucity of social work notes, much of the evaluation of Jenny Cunningham's work with Richard King has been gleaned from correspondence, from meeting minutes and from interviews with staff, including Jenny Cunningham herself. She told us that she made regular and frequent visits to Richard King, sometimes alone and sometimes with Gill Chambers. We accept her evidence even though the documentation of the visits was poor. The focus of Jenny Cunningham's work with Richard King encompassed a number of different areas, and has been described in Chapter 1. Along with other colleagues, Jenny Cunningham monitored Richard King's mental state and sought to intervene when things appeared to be deteriorating. She liaised with other professionals involved in Richard King's care, and also with other agencies such as the Housing Department and the local police as described in Chapter 9.

7.31 Jenny Cunningham, in common with other colleagues, had the complex task of supporting Richard and Mrs King's relationship, but also recognising when a period of separation was necessary. As she was the allocated social worker for both of them this was a difficult professional issue. On these occasions, Jenny Cunningham would alert colleagues in the Learning Difficulties service of the need to organise respite care for Mrs King. She would then seek to allay Richard King's concern for his wife when he was away from her by facilitating hospital visits. She did not assess him under the Mental Health Act on any occasion, though a number of her ASW colleagues did. The panel heard that there was no expectation in North Norfolk that ASWs would assess their own clients, though there were occasions when it happened Essentially, ASWs worked on a rota basis, and whoever was on duty on a particular day would respond to requests for Mental Health Act assessments.

7.32 It was also part of Jenny Cunningham's role to document her involvement with Richard King, to record contacts and visits, both with him, his family and with other members of the care team. She would be expected to contribute to CPA meetings and to ensure information was shared across agencies and, where appropriate, with Richard King's family, particularly information relating to risk.

Risk assessment and management

7.33 Jenny Cunningham identified a number of risk factors in relation to Richard King, and she told us she always recorded her concerns on file and sought to discuss her concerns with other members of the CMHT at the Monday morning meetings. In the absence of the minutes and the omissions in the social care file, there is no corroboration of her claim. Nevertheless, we are satisfied that she did raise her concerns since other another witness who was

present at the meetings referred to her strongly expressed views. Jenny Cunningham told us that Dr Thomas was dismissive of her assessment of the risks she felt Richard King presented, that he was *'utterly resistant to the fact that Richard had schizophrenia'.* Although Jenny Cunningham, in common with some of her other colleagues, recognised the risks presented by Richard King when he was psychotic, it is the panel's view that she did not demonstrate a sufficiently robust response to the increasingly concerning behaviour presented by Richard King. The social work notes and other files document numerous incidents of concern including a number of *'*alerts*'* passed to the Emergency Duty Team. As we have demonstrated in Part One, there was an obvious escalation of serious events and increasingly psychotic behaviour.

7.34 To her credit, Jenny Cunningham did convene a number of meetings with other members of the care team in addition to the CMHT meetings. But the purpose of these meetings was not clear. The minutes are headed, variously, *'*Strategy Meeting*'* (undated); 'Case Conference' (26 January 2004); and *'*Follow up Strategy meeting*'* (22 March 2004). They record discussion and make some reference to events, but do not record a clear strategy to manage the escalating risks. The absence of the consultant would indeed have made this very difficult and there is no explanation in the minutes for his absence, or any apologies recorded. Jenny Cunningham should have enlisted the support of her manager in securing the involvement of the consultant in a change of management plan.

Events in August and September 2003

7.35 Events in the second half of 2003 further illustrate this. By the summer of 2003, Richard King had had three admissions to hospital under the Mental Health Act within the previous seven months, and one detention at a police station under a s.136. An undated and unsigned document in the social work file gives an account of a *'*network*'* meeting held some time in 2003. It refers to a range of *'alarming events'* over the previous ten days, but does not describe these in any detail. In August 2003, Mrs King left the flat in Wells saying that Richard King had threatened to kill her.[77] On 19 August a home visit is documented in Jenny Cunningham's notes. She is informed by Richard King that the police had been called the night before and Mrs King had been admitted to hospital, but is to be discharged later that day. There is no record of Jenny Cunningham seeking any further information about this incident, either with the police or with the hospital. On the 13 September, Mrs King again claimed that Richard King had thrown her out of the flat. She sought refuge with family members. They further reported to Jenny Cunningham that Richard and Mrs King had been *'bombarding them with telephone calls requesting pornographic material'*[78]. There is no entry on the file documenting a discussion of marital difficulties with Mrs King following her departure from the flat. Jenny Cunningham discussed the situation with Millie Kelsey and she then visited Richard King with Gill Chambers. There is no

[77] EDT 12 August
[78] 15 September 2003

written record of either Jenny Cunningham or Gill Chambers having asked Richard King during this visit about the telephone calls or the incidents with Mrs King.

The fax from the Adult Protection Unit

7.36 By November 2003, the local police were sufficiently alarmed about the content of telephone calls they received from Richard King, to send a fax to Dr Thomas which is reproduced in Chapter 4. It is clear that the police did this on Jenny Cunningham's advice. Although it was proper to share this information with Dr Thomas, Jenny Cunningham, as an experienced professional, had a responsibility to instigate action herself when given this information. On the 14 November, Jenny Cunningham was made aware of an incident where Richard King presented himself to the police in Fakenham demanding that they accompany him to *'dig up the body'*. Jenny Cunningham requested an urgent visit from Dr Thomas, via his secretary. The next entry on the social work file is three days later and makes no reference to any urgent intervention regarding the previous incident, or any further discussion with Dr Thomas. Jenny Cunningham asked Richard King to discuss his thoughts with Dr Thomas at his appointment on the 20 November. The panel find that her response was inadequate given that this incident suggested a serious deterioration in Richard King's mental state. An admission to hospital should have been considered at this point, under compulsion if necessary, and the safety of Mrs King should have been given greater priority.

The shaving of Mrs King's head

7.37 Of greatest concern is the incident in January 2004 when Jenny Cunningham visited Richard and Mrs King, and discovered that Mrs King's head had been shaved by Richard King *to 'get the thoughts out'.* Her written account of this visit does not document Mrs King's state of mind, whether or not she is distressed or frightened, and it contains no reference to any action Jenny Cunningham planned to take in response to such a serious incident, including whether an alternative place to stay should be sought for Mrs King.

Illicit substances

7.38 Jenny Cunningham demonstrated an awareness of the risks inherent in a situation where both Mrs King and Richard King had substantial personal difficulties, compounded by Richard King's fluctuating mental state, the nature of his delusional beliefs and his suspected drug use. Jenny Cunningham told the panel that she had had suspicions that Richard King was using cannabis because *'Richard was so volatile, because his mood was so changeable'.* Although not recorded, these suspicions were also shared by Gill Chambers and Janet Hare, both of whom referred to them when interviewed by the panel. But Richard King denied that he used illicit substances and the team members did not see any evidence of use at the flat. Jenny Cunningham described a plan to us which would have enabled Richard and Mrs King to move to a bungalow in Fakenham in June 2004. This strategy would have removed them from the housing estate where there were suspected drug

dealers but the Kings returned to Wells after spending only one night in Fakenham. Millie Kelsey supported the plan and it represents one of the few attempts to resolve the difficulties of the case.

The 15 July admission

7.39 Jenny Cunningham did take decisive action on 15 July 2004 when she drove Richard King to hospital accompanied by the police. We have already referred to Richard King's unplanned leave and subsequent discharge without Jenny Cunningham's knowledge. It is perhaps not surprising that Jenny Cunningham did not regard herself as working within an effective team given the reception she received when arriving at the hospital and the subsequent abrupt discharge, without consultation with the community staff. The 15 July incident was subsequently investigated by Sue Selby, Acting Locality Manager, in April 2005. She found that Jenny Cunningham had not breached departmental policies and procedures, or acted unlawfully in failing to use the Mental Health Act on this occasion.[79]

The panel has itself considered whether Jenny Cunningham should have requested an assessment under s.3 of the MHA on 15 July 2004 as was suggested by the first inquiry report. We have come to the following conclusions.

S.3 is an admission for treatment. It provides for the compulsory admission of a patient to hospital for treatment and can last for an initial period of up to six months. An ASW in deciding whether or not to make an application must have regard to their professional responsibilities as outlined in s.13. This includes deciding that *'detention in hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need'*. In addition, the ASW must have regard to the Code of Practice and always follow the guidance therein unless there are valid reasons for not doing so. The Code of Practice states at s.2.6: *'A patient may only be admitted for treatment under S3 if the treatment cannot be provided unless he or she is detained under the section. In judging whether compulsory admission is appropriate, those concerned ... should take account of whether the patient would be willing to accept medical treatment in hospital informally…'*. The Code goes on to state: *'Where admission to hospital is considered necessary and the patient is willing to be admitted informally this should in general be arranged'.*

Jenny Cunningham was faced with a situation where she believed action was needed to be taken urgently to protect both Richard and Mrs King. She acted swiftly in securing the help of police colleagues to take Richard King to hospital. At no point is there the suggestion in her account or anyone else's that Richard King was unwilling to go to hospital. Indeed, Jenny Cunningham told us that when they arrived at Hellesdon. She had to wait for an hour with a psychotic patient before a doctor could see them and arrange an admission. Richard King could have left at any point. That he waited patiently would

[79] See Chapter 11, paragraph 11.22

seem to us to indicate that he was willing to agree to an informal admission. It would therefore have been contravening the Code of Practice and her s.13 responsibilities for Jenny Cunningham to have left Richard King at home whilst she set up a MHA assessment.

We are not in agreement with findings of the previous panel in this regard. A s.3 could have been arranged at any time if Richard King had tried to leave the hospital. It was not.

Liaison with family members

7.40 There is little evidence in the social care file of regular liaison with Richard King's family. It is possible that Richard King's family did not wish to be involved in his care, though there is a letter dated 2 February from Richard King's father to Jenny Cunningham, outlining his concerns about his son and the risks he believed Richard King presented. Jenny Cunningham made a note on the letter on 3 February 2003 to follow up these concerns. She told us that she had responded but the letter is missing from the file. There is a copy of a letter to Richard King's father from Jenny Cunningham dated 17 November 2003 in the social care file, asking him to contact her if he has concerns about his son. In the letter, she states that Richard King has given his permission for this to happen. There is no further documentation in the social care file to suggest that Richard King's father was in regular contact with Jenny Cunningham.

Social Services documentation

7.41 Jenny Cunningham was not the Care Coordinator for Richard King. However, she still had a clear professional duty to produce written documentation and to contribute to risk assessment documents. The social work file does not contain a running record in date order, there are few CPA documents, and there are no incident forms. We understand from Jenny Cunningham that she retrieved some documents relating to Richard King shortly after the homicide that had been filed under the name of another relative. There are some ASW reports which are not legible**.** There are no clear dividers indicating where different information should be stored and information is not chronological. Many documents are duplicated.

The files we examined contained many print outs from the Emergency Duty Teams relating to Richard and Mrs King. This documentation was not particularly informative as the lack of detail precludes an assessment of the concerns or the nature of the response to them. The volume of calls should have prompted the further investigation and comment from the care team. Such an investigation should have ascertained whether Mrs King needed simple reassurance or whether she was under threat of serious harm.

The overall impression is of a file which is not conducive to use as a working tool, and would be difficult for anyone else to gain a clear picture of events and access a coherent care plan.

Conclusion

7.42 In summary, Jenny Cunningham was committed to her work with clients and clearly demonstrated tenacity and skill in working with Richard King. She worked well with Gill Chambers and Steve Potter and with staff from other agencies involved in Richard King's care. However, it is the panel's view that Jenny Cunningham did not see herself as part of an integrated team delivering multidisciplinary care to Richard King. She saw herself rather as an isolated voice in a team dominated by a medical model of care. However, a number of people who appeared before the panel commented on the particular personalities involved as contributing to communication difficulties. Both Jenny Cunningham and Dr Thomas were described as *'difficult'*, and prone to disagreements with colleagues.

7.43 We were impressed by Jenny Cunningham's determination to raise the concerns she felt in relation to Richard King. Of all the members of the CMHT, Jenny Cunningham did attempt to draw together the various agencies involved in Richard King's care, in the absence of support and involvement from Dr Thomas, and at least meet with others to share information and devise a way forward. With hindsight, her judgement of the risks presented by Richard King was correct. In spite of this, she did not act assertively in the face of this escalation, or indeed consider interventions such as compulsory detention. Jenny Cunningham sought to manage the risks by initiating strategy meetings, and communicating with other agencies. But the CMHT did not respond adequately to the risks Richard King presented, and Jenny Cunningham as a key part of the professional team should accept a degree of responsibility for the failure to take decisive action.

7.44 On the evidence we have heard regarding supervision, we are satisfied that Jenny Cunningham was not properly supported by her managers. It is the role of the supervisor to help the supervisee to devise an effective strategy, and also to insist that policies and procedures are followed. The social services files we saw contained no community CPA documentation, incident forms or risk assessments. The lack of community CPA meetings about someone so challenging should have been pursued by Millie Kelsey in supervision. She was in a position to raise this with Bridget Collins and Dr Thomas. Millie Kelsey told us that Richard King was discussed in almost every meeting she had with Jenny Cunningham and frequently in between meetings. In view of this and the number of calls to EDT, we would have expected Millie Kelsey to have asked to see a clear multidisciplinary management plan which comprehensively addressed needs and risk, and which included a crisis and contingency plan. Jenny Cunningham did discuss this in supervision with Millie Kelsey, who was sympathetic but not able to facilitate a resolution. Millie Kelsey could have approached Dr Thomas directly or she could have advised Jenny Cunningham to put her concerns in writing, copied to the Medical Director and the Locality Manager.

7.45 It is in this context that Jenny Cunningham's actions have to be viewed. We were left with the impression that she did not respond positively to the integration process. A number of her colleagues shared her negative views

and managers did not initiate a team building process to counter the resistance to change. The CMHT was unclear as to the nature of its task and was working without clear policies and procedures. In these circumstances, the panel are not surprised that the team failed to recognise and adequately respond to the seriousness of the escalation in Richard King's behaviour. But the CMHT's ultimate failing was to give insufficient weight to the views of Jenny Cunningham, the team member who had had most contact and engagement with Richard King.

CHAPTER 8
THE RELATIONSHIP BETWEEN RICHARD AND MRS KING

Introduction

The sources of information for this chapter are panel interviews with Steven Potter, Trudie Needham, and a file of letters written in 2003 and 2004 by Steven Potter to Dr Verma, Mrs King's Learning Difficulties consultant.

8.1 The care provided to Mrs King by the Norwich Primary Care Trust is outside the scope of this inquiry. But she was such a critically important person in the management of her husband's illness that we must make some observations on her role. We have heard evidence from several community-based witnesses of the impossibility of understanding Richard King in isolation. Our remit is to consider his care and treatment but an understanding of their relationship is necessary for that consideration. We will only include details relating to Mrs King that are necessary for a full understanding of the deterioration in Richard King's mental stability and the management of his psychosis. Mrs King was Richard King's carer and 'Nearest Relative' (in MHA terms) and was considered to be at risk by professional staff. In the Introduction we have referred to the physical and mental health problems from which Mrs King suffers. Sometimes she self-referred to the local A&E department: we cannot be more explicit in the interests of her privacy. These attendances reflected personal stress and became more frequent in the period preceding the homicide. The attendances were an important indicator of the strains in the Kings' household. In Chapter 2 we have referred to Mrs King seeking refuge with a family member in August and September 2003. Medical records refer to two further instances of stress-related actions in August. Richard King took her to a residential home in February 2004. On 2 June, 19 June and 15 July 2004, Mrs King was seen in A&E. We heard evidence from the police of their concern for her wellbeing.[80]

Both Richard King and Mrs King were preoccupied with their childhood experiences and made allegations that flowed from these beliefs or delusions. It is not the role of this panel to explore this area further, but we note that there have not been any legal proceedings in relation to these beliefs.

8.2 Mrs King's care was provided by the Learning Disabilities Service via Norwich Primary Care Trust and her consultant was Dr Verma. But on 2 March 2004, Richard King and Mrs King were seen together by Dr Marley, a locum consultant. This was unusual as Richard was rarely seen by a doctor in the presence of his wife. Dr Marley wrote to Dr McAnsh at length and commented on the complexity of the relationship. Many witnesses commented on the relationship between Mrs King and Richard King. The panel was particularly interested in Steven Potter's observation that *'Mrs King was not the catalyst for his paranoid behaviour: she was the focus of his paranoid schizophrenia'.* He also commented that Richard King's paranoid

[80] See Chapter 9

ideas diminished when he was away from his wife, possibly an explanation for Richard King's rapid improvement when admitted to hospital.

8.3 Several witnesses have told us of the great affection that the Kings felt for each other. But the relationship was very volatile. Richard King was extremely suspicious of any man who approached his wife. This suspicion was of long-standing, as in 1997 the care team recommended that the next CPN allocated to him should be female. There are perceptive references in the clinical notes to the risk to any man visiting the flat due to Richard King's intense jealousy. The decision made by Gill Chambers and Steven Potter to make joint visits to the Kings was a explicit recognition of the risk of Richard King making allegations of inappropriate behaviour. Similarly, the police officers' decision to only attend the address in pairs and the housing officer's instruction to male contractors to visit in pairs was based on the fear of similar allegations. When Richard King was interviewed by police officers following the homicide, he claimed that he killed John West because of his beliefs concerning incidents in Mrs King's childhood. As we have previously commented in Chapter 3 there is no evidence or corroboration of his belief. But it underlines the fears of male healthcare and other members of staff who visited the flat that Richard King might make allegations of inappropriate behaviour.

The evidence of the Learning Disability nurses

8.4 The evidence of the LD nurses was particularly helpful to the panel because they observed Richard King in his home when they were caring for Mrs King. Trudie Needham, Community Learning Disability Nurse, had known Richard and Mrs King and other family members since 1999. It was in December 2002, when Richard King was admitted to Hellesdon Hospital, that Trudie Needham first became concerned about the change in Richard King. She discovered the couple had financial difficulties and attempted to work with the couple to resolve their problems. Richard King found this assistance intrusive. His behaviour subsequently became often very unpredictable, threatening and angry and within the confines of the small flat forced the nurse to consider her personal safety. Trudie Needham also observed that Richard King was unpredictable in his relationship with his wife but she did not witness Richard King harming Mrs King.

8.5 After discussion with her manager, Trudie Needham withdrew her services in August 2003 and arranged for Mrs King to receive her treatment from the GP surgery. Trudie Needham told the panel that she communicated her concerns verbally regarding the level of risk presented by Richard King to Jenny Cunningham, Gill Chambers, and Dr Verma. There were, however, a number of concerns that Mrs King needed more care than the GP surgery could offer and Steven Potter, Learning Disability Nurse, took over her care. Steven Potter mostly visited the couple in the company of Gill Chambers. On the rare occasions when he visited alone he would make a *'risk assessment'* while talking with Richard King on the doorstep to assess his mental state and decide whether it was safe to enter. Steven Potter told the panel that *' you had to be aware of what words to say to Richard to find out how he was*

thinking. If you could mention things like Princess Di, Iain Duncan Smith, or William Hague it usually gave you an insight into how he was thinking'. Both Trudie Needham and Steve Potter identified a number of concerns relating to Mrs King, the details of which cannot be included in this report, which were communicated to Jenny Cunningham. After his allocation to Mrs King in August 2003, Steven Potter wrote frequently to Dr Verma giving specific details of incidents and his continuing concern for her physical and mental health. Trudie Needham was only invited to one CPA review. The CMHT did not ask her to contribute to a risk assessment.

8.6 Both Trudie Needham and Steven Potter were in agreement that Richard King could appear very well but felt he masked his psychosis and, within his own home, often presented a significantly different picture from his presentation as an inpatient. They believed that the seriousness of his illness was not always recognised as the underlying psychosis was only elicited by skilful probing. Even on the occasions when Richard King was stable, Steve Potter told us that in his opinion he was never totally free of psychosis.

8.7 There was an overall concern expressed by both Trudie Needham and Steve Potter that the communication between Hellesdon Hospital and their service *'was not as good as it should have been'.* When Richard King was admitted to hospital, additional care was provided for Mrs King to enable her to stay at home, which needed to be taken out quickly when Richard King was discharged as *'he did not always like having this care around Mrs King'.* On a number of occasions this did not happen because of a lack of communication between inpatient and community services. We have previously commented on the lack of discharge planning, and will refer to the poor flow of information between agencies in Chapter 12, paragraph 12.1.

8.8 Jenny Cunningham was also the social worker for Mrs King. This dual role may have presented professional conflicts as Jenny Cunningham had to focus on Richard King's needs, but also to respond to Mrs King whose needs may have differed from her husband. The rationale for allocating Jenny Cunningham to work with both Mrs King and Richard King was to reduce the number of professionals who visited the flat as this placed additional stress on Richard King. The panel felt this approach demonstrated considerable sensitivity, but should also have been subject to review and discussed during supervisions as the complexity of the problems increased.

8.9 It is also the view of the panel that there were occasions when Mrs King was at physical risk from Richard King, though there is no corroborated evidence of actual injury. A number of professionals involved with Mrs King and Richard King have told us of their concern that Mrs King was at risk. In Part One, we have described the noise and screaming described by a neighbour and frequent calls to the police. Richard King shaved his wife's head on two occasions. It is impossible to establish whether she consented, or whether she possessed the capacity to do so. But there were also occasions when she left the flat and sought respite with family members as we have related in Part One. On 5 August 2004, she contacted the GP surgery *'in a state'* just as the surgery was closing. They contacted the EDT for assistance at 18.28,

noting a *'history of domestic violence and husband threatening her again'*. This call was categorised as Priority 01- IMMEDIATE ACTION. The response is timed at 16.40 on 6 August, less than twelve hours prior to the homicide, but no details other than *'advice given'* are recorded.

8.10 Consideration should therefore have been given to Adult Protection Procedures. We have been told that Mrs King withdrew allegations against Richard King once crises had passed and this made it difficult to proceed, but we believe that an Adult Protection meeting should have been convened nonetheless, particularly following the incident where her head was shaved in January 2004. Dr Marley wrote to Dr McAnsh on 2 March 2004, copied to Steven Potter, and requested that Steven Potter considered implementation of a *'vulnerable adults policy'*. Steven Potter completed an Adult Protection Referral Form on 10 March and gave the contact details for Dr Marley. Our remit does not permit the panel to investigate this matter further.

The role of carer

8.11 In recent years, the role of carer to those who suffer from mental disorder has been recognised both within a legal framework (The Carers Recognition and Services Act 1995), and increasingly within policy and practice. The Care Programme Approach, The Mental Health Act Code of Practice and the Mental Capacity Act, all refer to the importance of the carer's role, the need to consult with the carer, to seek their views and involve them in the care plan. Mrs King was her husband's carer, as he was hers. There is a wealth of evidence to support this. A number of professionals involved with Mrs King and Richard King told us that Mrs King would contact professionals on many occasions to seek help for her husband, she would offer him medication when she felt he needed it, and she sought to curb his use of cannabis which she felt was detrimental to his mental health. Mrs King was also Richard King's 'Nearest Relative', within the meaning of the Mental Health Act 1983 (s.26), and as such would have been consulted on each occasion when Richard King was detained.

8.12 The panel believes that the professionals involved with Mrs King and Richard King were very aware of the challenges presented by two people with their particular difficulties living together and caring for one another. Nonetheless, the team had to work with these difficulties and support Mrs King, whilst recognising that she had complex needs of her own which would inevitably impact on her ability to exercise the role of carer. Consideration could have been given to displacing Mrs King as Richard King's 'Nearest Relative' under the Mental Health Act 1983 (s.29). This would have been difficult as Mrs King did not object to Richard King being compulsorily detained; indeed, she positively recognised the importance of Richard King receiving care and treatment.

8.13 However, we do believe that Mrs King should have been offered a Carer's assessment. This was her statutory right and may have identified additional ways to support her. Consideration could have been given to sharing some of the caring role with other members of the wider family network although this

may not have been appropriate, or welcomed by them. Mrs King could also have delegated her 'Nearest Relative' role to someone else or simply written (or dictated) a statement saying that she did not wish to exercise this role, but the absence of any written documentation in the file leads us to conclude that neither sharing the Carer's role or delegating the 'Nearest Relative' role was considered.

CHAPTER 9
EVIDENCE FROM THE POLICE AND HOUSING AUTHORITY

Introduction

This chapter considers the verbal and documentary evidence provided by Janet Hare, NNDC Housing Officer and the documents submitted by the NNDC Legal Officer. Detective Sergeant Spinks was interviewed by the panel and provided us with copies of emails to colleagues.

Housing provided by the North Norfolk District Council

9.1 Although accommodating Richard King and Mrs King was not the responsibility of the Trust, and therefore not specifically within our remit, housing issues were a key part of Richard and Mrs King's care. The problems with utilities in particular reflected the increasing difficulties within the King's household. We have already described in full the Case Conference on 26 January 2004[81]. The panel interviewed Janet Hare, NNDC Housing Officer, who was an objective and valuable witness. She was able to add some useful comments to the documentary evidence as she had worked with Richard and Mrs King for several years. Janet Hare described the couple as model tenants until the middle of 2003: subsequently problems with neighbours and workmen became more frequent.

9.2 Richard and Mrs King had frequent and noisy arguments which caused neighbours to call the police. The arrival of a second letter in January 2004 from an elderly neighbour (which we have read), complaining about the effect on her health, precipitated the case conference. We heard evidence from Janet Hare that there were informal suggestions that other neighbours were also affected but that they were too intimidated to complain formally. At the conference various options were considered, including legal proceedings, but the consensus was that neither Richard or Mrs King would be able to understand the nature, or the consequences, of such actions. Janet Hare and Jenny Cunningham had agreed prior to the meeting that Richard King was far too irrational and aggressive to be served with a notice seeking possession. The NNDC representatives decided that the tenant who had made the original complaints was living in intolerable conditions and should be moved as soon as possible.

9.3 The NNDC legal officer minuted the decision of the meeting on 26 January 2004 that:

'all agencies who have had recent dealings with Richard accept that he is currently undermedicated and should not have responsibility for taking his own medication. [The legal officer] *is to prepare and circulate a draft letter to all parties addressed to Richard's consultant, strongly recommending that his Consultant be made aware of the present difficulties and asked to consider*

[81] Chapter 2, paragraph 2.53-55

increasing his medication and making one of the agencies responsible for its administration'

We made enquiries from NNDC as the proposed letter was apparently not sent. The legal officer responded and referred to a copy of an email to Janet Hare explaining that he had not actually written to the consultant as the situation appeared to have improved, and he was keen not to seek to influence medical decisions. He was unable to attend the next meeting on 22 March. His decision not to send the letter was not discussed at that meeting, according to the minutes. We regard this omission as another example of lack of coordination and follow up.

Security of contractors

9.4 At the meeting Janet Hare also expressed her concern about the safety of contractors (workmen who were subcontracted to NNDC) who were frequently called to the flat to investigate alleged faults in the utilities. Following the case conference, she sent an email on the same day to the person in charge of setting up the out of hours service warning him as follows*: 'I am really concerned for the safety of your contractors'* She was referring to Richard King's belief that *'men were after her'* (Mrs King) and asked the person in charge of the out-of-hours service whether there was a protocol in place for potentially dangerous tenants. Subsequently she instructed the contractors not to visit the address alone.

9.5 Janet Hare told the panel that she herself did not feel threatened by Richard King but Jenny Cunningham had advised her not to visit on her own. She described her good working relationship with Richard King and Mrs King, but she believed that she could tell when Richard King was not well from his general behaviour. Although Janet Hare was not a health care professional, she had known the Kings for several years and we believe that her personal observation is useful. She told us that *'I would know that Richard was unwell and I could also see that Mrs King was unwell because if Richard was not happy Mrs King was not happy and they seemed to feed off each other's emotions'*. We asked Janet Hare whether she had known of a plan for managing the social difficulties of Richard and Mrs King. She told us that she was not aware of a management plan.

We find that information about the increasing noise emanating from the flat, the complaint from the neighbour and Richard King's paranoid suspicions of council workmen should have been included in a risk assessment process. It was not.

The police

9.6 The panel interviewed Detective Sergeant Spinks (Sergeant Spinks) in 2004 because he was able to provide an independent and objective account of Richard and Mrs King in the community until from 2001 to May 2004 when he was transferred. Initially the police regarded Richard King as eccentric: Detective Sergeant Spinks thought that this was in 2002/3. Detective

Sergeant Spinks told the panel that the police received 44 calls in 2003 and 2004 which related to the Kings' address. He put a marker on the computer database to alert officers to potential difficulties. Some calls were made by Mrs King when she had problems or feared for her safety. Others were made by Richard King and the remainder were made by concerned neighbours and members of the public. We have not incorporated the details of these calls into the following narrative but the frequency of them indicates the close involvement of the local police officers with the Kings' address during 2003 and 2004. Detective Sergeant Spinks recollected that childhood abuse, particularly concerning Mrs King, was the predominant theme. When Mrs King contacted the police his impression was that the messages were along the lines of *'Richard's gone funny again, I am concerned for my safety'* and *'Richard is not taking his medication, I think he is going to be violent'.* Some of the 44 calls were made by neighbours concerned about noise as the computer recorded the calls according to the specific address about which complaints were made. The calls were then retained on the database.

9.7 Detective Sergeant Spinks initiated an out-of-hours protocol which he emailed to officers who might be called to the address. This ensured that Jenny Cunningham and himself were informed of incidents and that officers attended the address in pairs. We asked Detective Sergeant Spinks about reasons for instigating the police out-of-hours protocol for Richard King as this was the only such protocol in Wells, Holt and Fakenham, an extensive area of north Norfolk. He told us that it was required because of the persistent calls and the need to share information with other agencies. Detective Sergeant Spinks and Jenny Cunningham had agreed that they would inform each other of warning signs and behavioural changes. The protocol was emailed to officers who might attend the address. He told us that local police officers found it difficult to understand why Richard King was only admitted to hospital for short periods.

9.8 Detective Sergeant Spinks attended the multi agency meeting on 26 January 2004 and described to us a *'really healthy interchange of information'* between the police and other services. He commented on the usefulness of understanding that Richard King's presentation to the nurses differed significantly from his interaction with police officers. There was discussion at the meeting of Richard King's resentment of men in the flat. Detective Sergeant Spinks told us that he had developed a good working relationship with Jenny Cunningham in particular and was grateful for her availability outside working hours when a crisis arose.

9.9 Detective Sergeant Spinks told us that he had given the instruction to *'go double-crewed'* because of Richard King's history, and he particularly remembered that the police had realised that he was becoming more unstable and unpredictable. The main concern of the police officer was *'how he was dealing with Mrs King and also strangers who visited his home'.* He could not recollect any reference to the use of knives. Detective Sergeant Spinks told us that his *'primary concern was for public safety, the safety of the Kings and his officers'.* When he heard of the homicide it was not *'a huge surprise'* but he had expected Mrs King to be the victim. When questioned by the panel he

could not recall any previous mention of John West, but he was not surprised that the victim was a member of the family circle rather than a complete stranger.

9.10 The panel found Detective Sergeant Spinks to be a valuable and impartial witness. However, we are concerned that so little of the valuable communication with Jenny Cunningham was documented. There was no evidence that information from the police concerning the frequency, and the disturbing contents of the telephone calls was communicated to medical and community staff.

We find that this information should have been documented and incorporated into a risk assessment.

Recommendation 18

The panel recommends to the Trust that a senior manager should establish a regular liaison meeting with the Norfolk Constabulary to consider any operational issues within six months. This arrangement should ensure that all relevant information is passed on to the CMHT.

CHAPTER 10
RISK ASSESSMENT AND MANAGEMENT

Introduction

In this chapter we consider firstly the risks posed by Richard King and secondly the attempts to manage them during the key period between January 2002 and August 2004. The sources for this chapter are inpatient risk assessments, interviews, research on the incidence of homicides and a recent discussion paper from the Royal College of Psychiatrists.

General principles of risk assessment

10.1 Contrary to popular opinion, homicides committed by patients who are mentally ill are not frequent occurrences. In general terms, mentally ill people are more likely to injure or kill themselves than others. The statistics published by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in 2006 concluded that *'there was no clear evidence for either a rise or fall in the number of homicides with* (sic) *people with mental illness'*.

10.2 In this report, we are concerned with the problem of whether it was possible to make a reasonable and continuing assessment of the risk posed by Richard King to himself or others. However, estimating the probability of violence is an extremely difficult task. The Royal College of Psychiatrists has written a discussion document[82] to emphasise the key principles of risk assessment. It recommends that: *'risk assessment should combine actuarial approaches with clinical evaluation and should not be seen as a one-off duty discharged by completion of risk assessment forms'.* The actuarial approach refers to the use of various clinical checklists such as the HCR20[83] to systematise information about a patient which is then used to produce a numerical score which indicates the risk of violence. This process is reasonably successful in broad populations, but is less useful in individual cases. But such actuarial prediction should be integrated with clinical judgement: ultimately it is an inexact science.

10.3 For the purpose of this inquiry, we must consider whether clinical staff considered approaches to risk assessment appropriately. With hindsight, the question arises of whether Richard King should have been considered a *'*forensic*'* patient i.e. one who has received a court order. Such patients have committed violent offences and are often accommodated in secure hospitals. The research which underpins checklists is largely based on forensic patients. It is important to emphasise that the case of Richard King was not in this category. He had a criminal history, but he had not committed a seriously violent crime or used weapons. He was 16 at the age of his first offence, which is not unusually young, and had only appeared in magistrates*'* courts. The offences, while regrettable, were minor. His criminal history was similar

[82] Risk Assessment and Risk Management in Psychiatric Practice, Dr John Morgan, February 2007
[83] Historical Clinical Risk using a 20 point score.

to that of many young men and there were no features in the criminal record available to us from which a clinician could reasonably have predicted a homicide 12 years later. The panel agrees with the opinion of the doctors whom we interviewed that there were no grounds on which Richard King should have been referred to a specialist forensic psychiatrist while in the care of the Trust.

Structured prediction of risk

10.4 Predicting the incidence of violence in non-forensic mentally ill patients is a more difficult task as usually there is no significant criminal record to indicate whether the patient has a propensity to violence. However, many of the predictive factors are common to both groups. Some factors which may predispose a patient to violence are historical and may be unlikely to respond to later treatment. For example, childhood experiences of abuse are an indicator of subsequent violent behaviour. Gender is also a strong predictor: men are statistically more likely to be violent than women. Low intelligence is also a predisposing factor. These are termed *'static'* factors, but serious mental illnesses (dynamic factors) may increase the probability of violence.

10.5 Identifying certain factors can help to predict those patients who are more likely than others to commit violent acts. The most important dynamic factors are poorly controlled anger, violent thoughts, hallucinations in which the subject is commanded to act violently, and delusions specifically those associated with suspiciousness and violent thoughts about harming others. In addition, substance abuse is strongly associated with violence. Admission to hospital is statistically associated with risk. Almost everybody who encountered Richard King knew of his deep suspicions of others, particularly other males. This general paranoia escalated between 2002 and 2004 causing some professionals to visit in pairs and others refusing to visit him at home. Although Richard King was generally compliant with medication, the dosage of the depot failed to control his symptoms following the reduction in June 2001. He did not always comply with oral medication. This was an important additional risk.

10.6 All of these factors were to be found in Richard King*'s* personal background and clinical history although others, such as personality disorder, previous violence and head injury, were not part of his clinical history. There is no evidence that the fax from the police was taken into account when his risk was considered. Given the absence of CMHT minutes, the panel cannot be sure whether any CMHT members actually saw the fax or discussed it at the weekly meetings. The CMHT should have appreciated that risk assessment is cumulative and therefore should have taken into account all past and present triggers and factors, but there is no evidence that this was done. But had a structured risk assessment been undertaken at any point after December 2002, it may very well have indicated Richard King*'s* risk of violence to others as *'medium'*.

The interview with Dr Ball

10.7 The panel interviewed Dr Ball at the beginning of our investigation as he is the Medical Director of the Trust. We asked him to return in order to discuss the question of risk assessment which could not be covered in the time available for the initial interview. Dr Ball emphasised that, in his opinion, the longitudinal (historical) component of risk assessment was poor. The risk assessments which were made when Richard King was an inpatient only concentrated on the point in time when they were documented. There were a considerable number of these assessments, the majority of which described the risk as *'low'.* Dr Ball advised the panel that had the use of cannabis and the reduction in antipsychotic medication been taken into account an assessment might have reached the threshold of *'medium'*. He commented that a further weakness was that the inpatient assessments were usually carried out by nursing staff without contributions from medical staff or the CMHT: such assessments were not multidisciplinary.

10.8 Dr Ball also emphasised to the panel that there should have been a greater recognition of the historical factors in Richard King's clinical and social history which contributed to his risk status. He had been known to services in Norfolk since 1991. Staff should then have considered the manner in which the dynamics of his mental illness increased his risk state at any given time. With hindsight, Dr Ball believed that the *'risks were always underestimated'*, and inappropriately ascribed to social difficulties or *a 'modest level of intellectual performance'*. He was also critical of the lack of attention paid to the violent content of Richard King's delusions.

Previous assaultative incidents

10.9 The panel has commented on the absence of seriously violent offences in early years followed by 12 years in which there were no convictions. But the reported attempted strangulation of his father in 2003 and the shaving of Mrs King's head on two occasions in 2004 were serious assaults. They were known to health and social care staff although not referred to the police. Richard King was reported to have committed minor assaults when he was an inpatient in May and June 2003, but we are hindered in assessing their significance by the lack of detail in the nursing notes. There is no evidence that the incidents were reported to the police.

References to knives

10.10 We questioned witnesses about the availability of knives in the flat, as the use of weapons is a very significant factor in a risk assessment. Steven Potter described the interior of the flat to us: *'It was quite a dodgy environment to be in if things weren't okay, because you had to bypass the kitchen to get to their little lounge, and when you looked into the kitchen from the hallway there was a block of wood with half a dozen knives in it.'* An EDT alert dated 14 January 2003, reportedly attributed to Dr McAnsh, includes a mention of possession of a knife. Richard King's father also reported that knives were used on cushions and gestures made with the knife to his brother and sister. There is

no note of a discussion of the use of gestures and knives on cushions during the subsequent admission. Mrs King alleged that her husband had a knife during the incident on July 15, but he was not seen with one in his possession. While we acknowledge that it is normal to have kitchen knives in the kitchen, these references could be construed as additional indicators of the need for a thorough risk assessment.

10.11 However, there is no documented evidence that the incidents referred to in the previous paragraphs were explored and followed up, and the results then recorded in a risk assessment document. The Summary of Risks, a standard tick box in the nursing notes completed on 15 July, rates the risk as *'*low*'* in all categories. A further handwritten note (signature illegible) emphasises the absence of any risks presented by Richard King. However, as we have already found in Chapter 5, there is no evidence that the nursing staff knew of the circumstances of the precipitating incident in the flat or of the reference to a knife. In terms of Richard King*'*s history of the use of weapons, the transition from these relatively minor and uncorroborated references to knives to the use of a knife to stab John West several times in a frenzied attack could not reasonably have been foreseen. We have not found an escalating pattern of behaviour relating to the use of weapons which could have been reasonably identified as a major factor by clinical staff.

Use of cannabis

10.12 Clinicians generally accept that substance misuse is strongly associated with the risk of violence in those who suffer from major mental illnesses. In the recent review of homicides by mentally ill patients[84], Tony Maden, Professor of Forensic Psychiatry, at Imperial College states: *'There is a vast criminological literature on the connection between alcohol/drugs and violence and the only simple message to emerge is that the links are strong but complicated'.* There was one positive test on Richard King for cannabis in 2003, but otherwise there are no references in the medical or social record to substance misuse. Dr McAnsh told the panel that he knew his patient was using cannabis and alcohol. Jenny Cunningham and Gill Chambers both had strong suspicions but did not see any evidence of usage. Steven Potter also told us that he had never seen or smelt cannabis in the flat. Mrs King described Richard King*'*s purchase and use of drugs in considerable detail to the police in 2004[85], and to the members of the panel who interviewed her in 2006. We conclude that Richard King*'*s use of cannabis was underestimated by the CMHT and that the suspicions of key staff should have been discussed at meetings and minuted. We have noted in Chapter 4 that Dr Thomas did not ask Richard King about his use of cannabis. There is no evidence that his use of cannabis was discussed with Mrs King who told panel members that she was very well aware that it affected her husband*'*s mental health. The use of cannabis would have exacerbated Richard King*'*s psychosis and was a contributing factor in the homicide.

[84] Review of Homicides by Patients with Severe Mental Illness, March 2006
[85] Statements made to the CPS on 7 August 2004

Risk assessment and management

10.13 The panel must consider whether risk management would have reduced the risk of violence to those who were potential victims and we evaluate these specific risks in the following paragraphs. But effective risk management is plainly dependent on a robust and continuing process of risk assessment by trained staff. The panel has found little evidence of any understanding by Trust staff of structured risk assessment and, at the time of the homicide, the Trust had not provided specific structured training beyond the NHS mandatory training. The inpatient assessments were superficial and we believe that it was unlikely that the inpatient risk assessments were seen by the CMHT. No documented risk assessments were made in the community while Richard King was in the care of the Trust. We find this an extraordinary aspect of this inquiry. The CPA risk documentation should have been comprehensively completed and available to the whole team, but this was not done. This omission should have been identified and addressed in supervisions.

10.14 However, Jenny Cunningham, Trudie Needham and Steven Potter, all very experienced practitioners, did recognise the risk posed by Richard King even though Jenny Cunningham herself did not feel threatened. Her professional judgement regarding risk assessment was correct, but she was not specifically responsible for ensuring that risk assessments were undertaken and subsequently documented and shared. This was the task of the Care Coordinator, though all staff had a responsibility to contribute to identifying and managing risk. The absence of documentation should have caused concern to other members of the CMHT. We note that Sir Louis Blom-Cooper[86], Chair of the Jason Mitchell Inquiry, commented as follows:

It seems very important to recognise that the hierarchical nature of criminal justice and mental health care agencies serves to limit the contributions of those at relatively lower levels of the hierarchy.

10.15 We note that the very language of risk assessment was not agreed within the Trust. Terms such as *'low'* or *'high'* were not defined. We have made a recommendation in Chapter 5 for clarification of CPA risk terminology. A common understanding of clinical terms is a prerequisite for good communication within a team and requires further discussion between professionals. The emphasis should be on more precise recording and better communication of incidents and factors which might indicate increased risk. Electronic patient records facilitate the centralisation and accessibility of risk related information.

10.16 But we must ask what actions could reasonably have been taken to manage risk if an assessment had been completed. By risk management, we refer to the production of a realistic plan which was documented and shared. Firstly, there was a pressing need to explore Richard King's mental state in greater depth to establish the architecture of his delusional beliefs and paranoia in order to establish whether any individual was at risk. Secondly, community

[86] Blom et al, Chair of the Jason Mitchell Inquiry, 1996

staff may then have been successful in developing a plan to reduce the levels of stress and risks associated with Mrs King and his family. Thirdly, some therapeutic family intervention might have been attempted. Fourthly, his use of cannabis, and possibly other illicit substances, should have been addressed. Finally, all mental health staff and those working in statutory agencies could have been explicitly alerted to risks to their personal safety.

Specific risk to John West

10.17 The panel asked most witnesses to analyse their reaction when they heard the news of the homicide via the media. Some were surprised by the violence of the offence, but others told us that they were not surprised because they had always believed that Richard King was capable of violence. But none of the interviewees would have predicted that John West would be the victim. Most of the witnesses who considered that Richard King presented a risk believed that Mrs King was likely to have been a victim. They spoke of their confusion concerning John West's identity and relationship with Richard King when they heard of the homicide. The panel understands this reaction as there is no reference whatsoever to John West in any of the health and social care records. Significantly, there is no mention of John West in any of the descriptions of Richard King's delusions. But in his witness statement to the CPS following the homicide, PC Money refers to comments by Richard King concerning alleged incidents involving John West in Mrs King's childhood. PC Money stated that he had been called to the flat on five to 10 occasions, but he had never heard Richard King make threats against anyone or show any signs of violence. The only possible explanation of the motive for the homicide lies in Richard King's own statement to the police in which he made an allegation concerning John West and his wife. There is no previous reference in any document or transcript to this allegation. It was therefore not possible to predict that John West could have been identified in advance as a potential victim.

Risk to others

10.18 The panel has heard evidence of avoidable risks to others resulting from the failure to assess and then manage the risks presented by Richard King. We have already commented on the underestimation of the risk to Mrs King, particularly as carers or relatives are statistically the most frequent victims of violence. Community staff visiting the flat were also at risk, although Steven Potter and Gill Chambers visited together. Jenny Cunningham was adamant that she never visited Richard King when he was alone although she did not feel personally threatened. Dr MacAnsh and Dr Ebrill did undertake domiciliary visits occasionally. Even though they were not part of the CMHT, the GPs should have received information relating to risk, but they did not, due to the non-implementation of the CPA process. They should have been able to contribute to an assessment of risk to themselves and their staff.[87] We have already commented on the pre-emptive decisions of the local police officers to visit in pairs, and Janet Hare's similar instructions to workmen

[87] See Recommendation 1 concerning communication between primary care and CMHTs.

subcontracted by the district council. Some individuals intuitively sensed that Richard King presented a risk of violence, others did not.

10.19 But there was one person who was put at risk avoidably by the poor communication within the CMHT. Joanne Braisby, CPN, administered Richard King's depot unaccompanied on 29 July when Gill Chambers was on leave. During the interview with her, we became aware that Joanne Braisby had not been informed of the troubling circumstances of the incident on 15 July. Although she was at the CMHT meeting on 26 July, the case of Richard King could not have been discussed in detail or she would have been aware of his recent history. Her personal safety had unnecessarily been placed at risk. The volunteers at Elizabeth Fitzroy Support were also placed at a degree of risk before they withdrew their services in January 2004. Their workers provided support to learning disabled clients and were not trained to deal with mentally ill patients or partners. These are further examples of poor communication within the CMHT.

Risk to Richard King

10.20 Richard King frequently commented that he felt suicidal but there is no clinical evidence that he attempted suicide or self-harmed. Although the nursing notes mention some assessments of these risks, they were not integrated with the treatment plan. This is a significant deficiency in good mental health practice since patients with severe mental illness often commit suicide or seriously harm themselves.

Risk assessment documentation

10.21 The panel asked Dr Ball whether the documentation had been improved since the comments of the first inquiry. He told us candidly that it had not been amended. The CPA form, on which risk is recorded, had been reviewed by the Trust in an attempt to simplify it, but the users and carers involved in the process were opposed to any reduction. The Trust had therefore decided to await the outcome of a national review of the CPA documentation.

Risk assessment training

10.22 Following the recommendations of the first report, the Trust embarked on a rolling programme of risk assessment training. We accept that the Trust has provided some training from an external firm. Dr Ball told us that all the Care Coordinators should have been trained by the end of 2007 and the feedback has been very positive. We have seen some of the feedback forms. Given the general nature of the training, it is unclear whether an actuarial system was recommended for use in conjunction with clinical judgement. The Trust may consider making an IT version available to social and healthcare staff in addition to the training package, particularly as there has not been any improvement in the Trust CPA documentation.

10.23 We learned from Dr Ball that some of the medical staff have not attended these courses as they *'feel that their consultant time is better spent on other*

things rather than going on risk assessment'. While the panel acknowledge that the consultants might require a more sophisticated course than that provided for community staff some of whom *'have a very low base in terms of awareness of risk assessment'*, we cannot agree that doctors should choose to be exempt from training. Neither Dr Thomas, Dr Fadlalla or Dr Coogan assessed Richard King in terms of risk. While Dr Ball assured us that all junior doctors should have studied risk assessment as part of their training, he accepted that it was possible that consultants, or locums, whose risk assessment training was inadequate, or could not be ascertained, could be appointed by the Trust.

Conclusions

10.24 On the basis of the evidence we have heard and the documentation we have read, the panel considers that risk assessment and management was the responsibility of the consultants and all of the health and social care members of the community team. Nevertheless, no one undertook a comprehensive and fully informed assessment of Richard King at any point during the deterioration of his mental state from 2002 to August 2004. Millie Kelsey and Bridget Collins, supervisors of the front line staff, failed to identify this fundamental weakness in the CPA process. They should have ensured that risk assessment procedures were followed via the supervision process and clinical audit with the purpose of managing and reducing the risk as far as possible. We understand from Dr Ball that the Trust has accepted responsibility for this failure to provide appropriate care for Richard King and protection for its staff and the public following the publication of the report of the first inquiry.

Recommendation 19

The panel recommends to the Trust that the Medical Director should within three months engage the consultant staff in developing risk assessment training which is appropriate to their needs to ensure that they attend.

CHAPTER 11
THE FIRST INQUIRY AND ASSOCIATED MATTERS

Introduction

The panel's terms of reference require us to review the first inquiry and its recommendations in the light of evidence taken. We believe that readers of this report should firstly understand the public response to the inquiry and the reasons for the SHA's action in establishing the second inquiry. We will then consider the statutory basis for the first inquiry, followed by an analysis of the inquiry itself. The analysis necessarily involves considerable repetition as many readers of this report will not have access to the original report.

In this chapter we have also included comments and conclusions on evidence from family members, and the response from Unison to the first inquiry.

The first inquiry and the public response

11.1 The first inquiry was chaired by Barry Capon, a Non-Executive Director of the Trust. Dr Hadrian Ball, Medical Director, was also a member of the inquiry but the four other members were drawn from organisations unconnected to the Trust. The SHA accepted the membership of the panel. The inquiry was administered by Paula Bourthis, Corporate Services Manager to the Trust. The panel interviewed 15 Trust employees, a police sergeant and took written evidence from a further nine employees.

11.2 When the first inquiry was published in June 2005 it attracted considerable interest and criticism from the media and the general public. Norman Lamb, MP for North Norfolk, wrote on 9 August to the Chief Executive of the Trust, Patricia Holman, to express concern that information given to the Trust regarding the risk presented by Richard King by a family member had been ignored.

The actions of the Strategic Health Authority in 2006

11.3 The SHA decided to establish a second, completely independent inquiry on July 2006. In order to understand the reasons for this decision and the apparent delay in reaching it, the Chair of the second inquiry wrote to the SHA requesting an explanation. Dr Paul Cosford, Regional Director for Public Health, responded on behalf of the SHA and assured the panel that *'initially no significant concerns were received by the SHA, from either Trust staff or family members'*. However, he then explained that a Trust staff member did raise concerns in November 2005. The SHA also became aware that Trade Union representatives had expressed disquiet. The Senior Steward (Social Services) of Unison submitted a full, but undated, response to Harold Bodmer, Director of Adult Social Services, Norfolk County Council on 29 November 2005. It was widely copied to senior figures in the SHA and the Trust and also to the Coroner. In January 2006, John West's brother telephoned Geronimo Communications (a Public Relations company) to express his extreme concern that he and other family members had not been contacted

by the first inquiry and his views were passed to the Trust. The SHA readily accept that the delay in establishing the second panel was *'clearly regrettable'*. We agree. Dr Cosford emphasised that the SHA was anxious to discuss matters with the complete West family, one member of whom lived abroad, before making a decision to institute a second inquiry and this caused additional delay. The panel have read the correspondence with the family and the minutes of their meeting with Dr Norman Pinder, Interim Head of Clinical Governance and Patient Safety, which took place in 5 July 2006. We accept that it was right that the inquiry was not fully commissioned until the views of the West family had been taken into account, but we emphasise that any unnecessary delay in these circumstances is regrettable.

The first inquiry and circular HSG(94)27

11.4 We will first consider the appropriateness of the joint SHA and Trust decision to establish the inquiry. We will then consider the inquiry process and procedures itself and summarise the main conclusions and recommendations. The panel has not interviewed members of the previous inquiry as we believed that this would extend the whole process of investigation and reporting. We were anxious not to compromise our independence. We discussed some aspects of the findings with Dr Ball when we interviewed him. These discussions and some consequent correspondence with the chair of the first inquiry were very helpful to the current panel.

Guidance from the Department of Health

11.5 The first inquiry was established according to the guidance in the Department of Health (DoH) circular HSG(94)27 applicable at that time. Paragraph 33 states that following a violent incident:

action by local management must include: an immediate investigation to identify and rectify possible shortcomings in operational procedures.

Paragraph 34 continues as follows:

Additionally, after the completion of any legal proceedings it may be necessary to hold an independent inquiry. In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved.

Trust managers were therefore correct to cause an immediate investigation to be held to identify any shortcomings following the homicide. However, the investigation was set up on 16 August 2004 according to the Trust's Serious Incident Policy which required that a 'Scoping Exercise' was undertaken. Decisions relating to the first inquiry were made by the Trust and the SHA. It is not possible, or necessary, that this report should determine the exact balance of responsibilities, particularly in view of the changes in SHA personnel in the last four years. The Trust commissioned a large scale inquiry which did not report until June 2005. Consequently the Trust were not able to derive the benefit of its conclusions until ten months after the

homicide. The first inquiry cannot reasonably be construed as an *'immediate investigation'* as intended by the DoH guidance to identify and rectify possible shortcomings in operational procedures.

11.6 In addition, the first inquiry was established in August 2004 before the legal proceedings were complete. The terms of reference were set in August 2004 and the inquiry began the interviewing process.

Following the court proceedings concerning Richard King in January 2005, the terms of reference had to be expanded to include all aspects of the homicide relating to the care and treatment of Richard King. Amending the Terms of Reference while an inquiry is in progress is not good practice. The inquest did not take place until August 2005, two months after the report was published. We understand that the delay in holding the inquest was due to the travelling difficulties of a member of the West family who lives abroad.

The membership of the first inquiry

11.7 The membership of the inquiry was not independent of the providers (the Trust) of the care and treatment of Richard King. We are aware that the Trust has argued that the appointment of a non-executive director of the Trust as Chair distanced the inquiry from the providers, and that four additional panel members were drawn from external organisations, including one from the former Norfolk and Suffolk and Cambridgeshire SHA whose role was to quality assure the process. However, the Medical Director of the Trust was also a member. We cannot accept that this composition would appear to external observers to be independent. There is no suggestion that the members of the first inquiry did not act in good faith, but the conclusions of their report were plainly not perceived as impartial and independent by some of those who scrutinised them and certainly not by the relatives of John West.

11.8 The panel concludes therefore that the establishment of the first inquiry did not comply with the guidance of the DoH circular as it was neither an immediate investigation nor an independent inquiry. The newly constituted East of England SHA was correct to decide to appoint a new panel to conduct a second inquiry and to ensure that none of the members appointed either live or work in the area covered by the Trust, or have any professional or personal connection with the area.

The effect on members of staff

11.9 But it is clear to us that there have been very serious consequences as a result of two separate inquiries. The most important effect has been on staff who have been interviewed twice, although we acknowledge that the Chair of the previous inquiry had advised them that a second inquiry was always a possibility. Many witnesses have described vividly to the panel the stressful effect of giving evidence on a second occasion following a lengthy period of delay and uncertainty. Some witnesses also had to give evidence to the Coroner's inquest, and the internal Selby Report. There is also the effect of delay on witnesses' memories, particularly where statements were not taken

immediately following events. There has obviously been a duplication of resources, which must always be a consideration for NHS organisations. Much of this could have been avoided.

Amendments to circular HSG(94)27

11.10 The circular HSG(94)27 was amended in June 2005 which clarifies the criteria for independent investigations. For the purposes of this inquiry the most relevant criterion is as follows:

When a homicide has been committed by a person who is or has been under the care, ie, subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

This amendment was not in force at the time that the Trust made its initial decision to undertake a scoping exercise. The Circular provides guidance to SHAs and Trusts but it is not mandatory. We therefore make the following recommendation:

Recommendation 20

The Panel recommends to the SHA that following any incident involving death or serious injury the Trust should undertake an immediate investigation, and the SHA should commission a fully independent inquiry as soon as possible so that the inquiry may start its investigations as soon as any legal proceedings have been completed, according to the current DoH guidance.

Procedural aspects of the first inquiry

11.11 The first inquiry was established in August 2004 and approved by the Trust Board on 20 June 2005. It was published three days later.

The Terms of Reference were as follows:

i. To assess the quality of care received within the framework of the Care Programme Approach, specifically to examine the following:

Multidisciplinary working

The Role of the Care Coordinator

Discharge process and decision-making

Quality of care planning and risk assessments including crisis plan

Recording, storage, and access to Health and Community Care records

Adequacy and appropriateness of communication, both internally within specialist services and externally with other agencies

Quality of Carer's assessment

ii. To examine the clinical effectiveness of the treatments and intervention provided. Does the treatment comply with the Best Practice and NICE Guidelines?

iii. To undertake an audit of the Health and Social Care records from the time of arrest to the date of the scoping exercise

iv To review the adequacy of the communication and support between Health and Social Care provided to the relative

v. Did the care and treatment comply with the statutory requirements as laid down by the Mental Health Act

vi. To review the adequacy of the support provided to team members

vii. To identify any indicators pointing to deficits in the wider service in relation to capacity, capability, supervision and training.

Following the conviction of Richard King these Terms of Reference were expanded as follows*:*

viii. To examine all aspects of the homicide insofar as they may relate to the care and treatment of Richard King by the Trust.

The structure of the report of the first inquiry

11.12 The report consists of 51 pages of which 23 are appendices. An Introduction, Executive Summary and general background to the inquiry comprise the first three sections. The background describes the undertaking of the *'*scoping exercise*'*, the terms of reference and the details of the conviction. Unfortunately, the date of the homicide is given as 6 August 2004 which is wrong. There are other inaccuracies, eg, paragraph 4.06 in which some of the dates for Richard King*'*s criminal record are wrong. The fourth section records a brief history of Richard King*'*s early years up to 2000, but it does not include a full chronological account of Richard King*'*s mental illness or the sequence of events which preceded the homicide. The fifth section is headed *'General Issues and Findings',* and subsumes both factual material and clinical themes. It also includes some conclusions. The sixth section explains the panel*'*s response to the terms of reference and the seventh section lists recommendations.

The term *'*panel*'* refers to the panel of the first inquiry in following paragraphs. *'*We*'* refers to the panel of the second inquiry. We have used the headings and numbering system of the first inquiry which are in bold italics. We have summarised the findings of the first inquiry and then added our comments. The first inquiry panel used *'*service user*'* in preference to *'*patient*'*.

The connections between evidence, conclusions and recommendations

11.13 Our terms of reference require us to determine whether the evidence was deficient or whether the recommendations were not consistent with the evidence taken. The following paragraphs analyse the evidential aspects of the first inquiry and the relationship between that evidence, conclusions and the recommendations. We believe that it is necessary to evaluate the first report in detail as it contains serious omissions and inaccuracies. In addition, many witnesses have told us of their great concern about the report's language, inconsistent use of personal names and references to individuals. Other witnesses have criticised selective conclusions. Therefore, we will consider every section separately (excepting some that are very brief and uncontentious) and then comment on the content and the supporting evidence.

AN ANALYSIS OF THE FIRST INQUIRY

Nature and degree of Richard King's Illness - 5.1

11.14 The first three paragraphs of this section, 5.1, consist of generalisations about schizophrenia. Under the sub heading, 5.1.1, *'Medication Issues'*, the inquiry briefly described psychotic episodes and refers to community team members and persons in other agencies who expressed the view that Richard King was *'undermedicated'.* There is a reference to Dr Thomas' evidence regarding the initial reduction of the depot injection and his failure to investigate the complaints of varicose veins. The panel concluded that the decision to reduce the dosage was in accordance with best practice and an appropriate action according to paragraph 1.4.5 of the NICE guidelines of December 2002. A quotation from the guidelines is included:

The Service User and clinician should jointly decide the choice of drug, but Service User preferences are central.

The panel noted that there was no record of an informed discussion with Richard regarding the reduction of his depot medication.

Under the subheading, 5.1.2, *'Medication 2004'*, the report stated that by July 2004 Richard King's medication had reached the dosage equivalent to that he was receiving prior to the phased reduction in June 2001, and that his *'depot medications were up to date'*. The panel referred to a report by the Chief Pharmacist in Appendix 3.

The final paragraphs of this section, *Illicit Drugs,* 5.1.3., discuss Richard King's use of cannabis and state *'throughout the files there are references to discussions with Richard King about taking excess alcohol, or using cannabis or other illicit substances'*. There is a long quotation from Appendix 3 on the effect of cannabis and alcohol on schizophrenics, and a further lengthy extract from Dr Shetty's report prepared at the request of the defence solicitor. The

panel considered that Richard King used illicit drugs over many years and believed that the CMHT should have taken this matter into account. No recommendation was made following this conclusion.

Comment*: *The generalised description of schizophrenia in the opening paragraphs of Section 5.1 is helpful to lay readers of the report but, in spite of the heading, it is not followed by a close analysis of the care and treatment provided to Richard King by the Trust.

The NICE guidelines were not published until December 2002. We consider that the use of such an isolated quotation from paragraph 1.4.5. is unrepresentative of the guidance and is positively misleading as it was issued after Dr Thomas' decision to reduce the dosage in June 2001.

Appendix 3 (referred to in subsections 5.1.1 and 5.1.2) consists of six pages of technical explanations written by Stephen Bazire, Chief Pharmacist to the Trust, who was neither independent nor a member of the Panel. We understand that it was included for information only.

In the discussion of Richard King's use of illicit substances in subsection 5.1.3, we agree that here are frequent file references in the early history of his illness. We have heard oral evidence that Richard King always denied taking cannabis. The panel did not investigate the absence of screening for illicit substances when he was admitted to hospital or consider the one recorded instance when he tested positively for cannabis: this is a serious deficit in the evidence in this subsection.

Generally very little evidence is adduced in Section 5.1, 'Nature and degree of Richard King's illness'. Critical treatment and medication issues are not analysed. The concept of 'degree' in mental illness is not considered at all, and no consideration was given to the violent nature of Richard King's delusions. Apart from a single reference to Dr Thomas' interview, there are no further references to evidence given by other doctors. Dr Fadlalla's decision to increase Richard King's dosage is not mentioned.

Social situation and family relationships - 5.2

11.15 This section examines Richard King's social relationships and emphasises the closeness of his marriage. The relationship with his father and his father's concern for his son's stability is discussed. The inquiry considered that *'it is clear that Richard King's father regularly expressed concern about Richard King to the Trust and other agencies'.* His views regarding community care are discussed and the inquiry notes that he was not his son's 'carer'. However, the inquiry concluded that those responsible for the Care Plan should have recognised the need to refer to a broader base of people concerned with Richard King's care.

Comment*: *We are surprised that so little attention is drawn to Mrs King and the close connection between the relationship and aspects of her husband's illness. The inquiry did not interview Mrs King on the advice of her Care Coordinator. The reference to 'regular' expressions of concern by Richard King's father surprises us. In the documentation for this inquiry, there is only one letter from Richard King's father and one telephone call to Jenny Cunningham. Jenny Cunningham wrote to Richard King's father offering to discuss his son on 17 November 2003, but there is no response in the documentation supplied to the inquiry. He clearly was concerned for the welfare of his son but there is no evidence from files, or from our telephone interview with him, that it

was expressed on a regular basis. There may have been undocumented contacts given the poor state of the social care files. He did communicate with Dr McAnsh on occasions. We cannot conclude on the evidence available to us that Richard King's father 'regularly' expressed concern, although we agree with the panel that the CMHT should have referred to the views of a broader base of people concerned with his son's care. We note that the first inquiry was advised by the police that Richard King's father should not be interviewed while the court hearing was pending.

Location and suitability of independent living arrangements - 5.3

11.16 The inquiry discussed the appropriateness of Richard and Mrs King living in the community in Wells where the support arrangements were less structured than in their previous accommodation in Fakenham. The inquiry concluded that the proper operation of the CPA should have compensated for the previous intensive support. This section notes the decision to house Richard King near known drug users but finds that the NNDC were not responsible for the decision as they had not been advised of the risk of having access to illicit drugs.

Comment*: *We agree with the first inquiry that Richard and Mrs King should have had some choice in their accommodation, but we note that Mrs King had always needed a considerable amount of support in managing ordinary life. When her husband's condition deteriorated she had severe difficulties in managing the flat: we have already referred to the problems with neighbours in the second half of 2003. We cannot accept that housing Richard King in Wells near drug users was a flawed decision. Cannabis and other illicit substances are available everywhere and North Norfolk was no exception. The District Council should not have required advice on this matter. In any event, Janet Hare and Jenny Cunningham were well aware of the presence of drug users. They worked together to find alternative accommodation in Fakenham in June 2004, but Richard and Mrs King refused to live there. The inquiry does not refer to that strategy.

Care planning - 5.4
Risk assessments - 5.4.1

11.17 This section consists of general explanations of the nature of the risk assessment process. The inquiry found that there were 25 risk assessments documented between December 2002 and July 2004, but that it was not apparent that they were completed as a team exercise. The inquiry comments that multidisciplinary care planning is essential in order to influence management. They comment that: *'the risk assessments were in the main inadequate and inappropriate'*

The inquiry finds that the assessments (with the exception of six) designate Richard King's risk to others as low, but that there was sufficient evidence, even without the homicide, that the history of aggression should have led to the conclusion that his risk should be ranked as moderate. The risk factors are then listed:

a. *Previous incidents of violence, both verbal and physical to:*

His wife

His father

A fellow service user

Trust staff

A garage attendant

b. *Use of knives referred to:*

In a letter from his father (February 2003)

In notes relating to a knife on a home visit by Dr McAnsh (GP)

The incident at the flat in Wells prior to his last admission

c. *Expressions of suicidal intent*

d. *The nature of the psychotic episodes and the aural hallucinations*

e*. Use of alcohol, cannabis, and possibly other illicit drugs*

The panel then commented that if this assessment of violence had been taken into consideration, a care plan should have involved closer supervision of Richard King. There was a reference to the evidence of some witnesses who told the inquiry that they did not feel threatened by him. But other witnesses disagreed. The inquiry then commented: *'An agreement had been established that following threats by Richard King to some of the team members, that particularly if one of the team was male, visits should always be by two members of the team and never by one on his/her own'*. The section concluded: *'The Panel strongly recommends that once agreed actions such as this are in place, they must be followed by all team members.'*

<u>Comment</u>: We agree with the description of the general principles of risk assessments. However, the inquiry did not mention that the 25 assessments were all completed when Richard King was an inpatient and that no assessments were completed in the community. This is a significant omission. We are also surprised that the list of previous incidents of violence does not distinguish between physical and verbal aggression. There was no evidence that Richard King was physically violent towards Trust staff and no corroborated evidence that he assaulted his wife. There is no evidence of the use of a knife in Dr McAnsh's medical notes: we assume the inquiry is referring to an unattributed EDT alert, but the panel should have cross-checked with Dr McAnsh's notes. The inquiry was right to conclude that the care plan would have been more robust if these incidents had been taken into account.

We also encountered differing views of witnesses to any threat presented by Richard King. However, we have been unable to trace any team agreement or clear instruction that he should only be visited by two members of staff jointly. There were informal arrangements between Gill Chambers and Steven Potter to make joint visits. Had there been such an instruction, Joanne Braisby would have known that she should not have visited Richard King on his own. Millie Kelsey gave evidence to the inquiry that she had instructed Jenny Cunningham not to visit Richard King on her own and the inquiry concluded that she had not followed this instruction. But Millie Kelsey told us that she had meant that Jenny Cunningham should not visit Richard King on her own when his

wife was absent. She apologised for her lack of clarity. Moreover, the Selby Report[88] found that the instruction given on a supervision note by Millie Kelsey not to visit Richard King on his own, was given in the context of Mrs King living in residential care and Richard King being alone in the flat. There was therefore no specific and unambiguous instruction that team members should not visit on their own and so the final recommendation in this section was not founded on clear evidence.

Care Coordinator issues - 5.4.3

11.18 This section emphasises the crucial importance of the CPA and the Care Coordinator. The report states: *'The files demonstrate that the driving force for the meetings and reviews of Richard King's care was not the CMHN (Community Mental Health Nurse) but the Social Worker allocated to Richard King and his wife'*. The inquiry found that the CMHN, Gill Chambers, was unclear whether she was the CC but agreed that she had not been specifically trained for that role or in assessing risk. They were clear that she was a committed and competent nurse and, when *'*acting up*'* as a G Grade, received insufficient support. The training for CPA provided by the Trust related solely to paperwork rather than the fundamental aspects of CPA.

Comment*: *We agree with these findings which follow from the documents and evidence heard by the first inquiry. But we do not accept that this important issue was analysed in depth. The failure to implement the CPA in full was not the sole responsibility of Gill Chambers. We have commented on the responsibility of supervisors and Trust managers in Chapter 6. The lack of substantive training for CPA and risk assessment has been examined in the same chapter. It appears to us that the panel failed to reach the correct balance between individual responsibilities and the shortcomings of management, although there was ample evidence of the latter from the interviews which they had conducted.

Carers' assessment and plans - 5.4.4

11.19 This subsection examines the law relating to carers. Mrs King was the legal carer of her husband and the inquiry found that no consideration had been made of the appropriateness of her designation. The required carers' assessment had not been made, and therefore no care plan had been put in place for Mrs King.

Comment: We accept the inquiry's findings on this matter which we have discussed in the last Chapter 8, paragraphs 8.11 and 8.13.

Admissions (General) - 5.5

11.20 The inquiry described the various sections of the Mental Health Act in detail. There is no need to repeat them. The panel made the point that a s.117 meeting should be followed by a care plan and that the plan drawn up for Richard King on 30 July 2003 was *'far from complete'*. It was not reviewed or

[88] See paragraph 11.22

revoked. The inquiry attributed responsibility for this omission to the team, particularly the Care Coordinator *'and/or the consultant'.*

***Comment**: It was unnecessary to include legal details of the MHA unless they were clearly related to the treatment and admissions of Richard King. But the inquiry did not make the connection nor did it analyse the number of times he was admitted for short periods of time between 2002 and 2003. In our view, the inquiry should have discussed his admissions in terms of effective treatment and the use of s.2 and s.3. The inquiry rightly concluded that the s.117 plan was inadequate and that the CMHT and consultant were responsible. But the management shortcomings which contributed to the lack of CPA reviews were not analysed.*

Admission July 2004 - 5.6

11.21 This admission was described in detail. The section contains a timeline of events but there is no mention of Mrs King's allegations of a knife. The inquiry found a number of errors in the circumstances of the admission. They were:

i. *Forced entry into the flat*

ii. *Method of transport to hospital … notwithstanding the presence of a policeman*.

iii. *Admission as an informal user*. *Despite Richard King's accepting the need to attend hospital this occasion was clearly one for which a formal MHA assessment should have been requested.*

iv*. Inadequate briefing of ward staff, exacerbated by transfer from Yare Ward to Glaven Ward.*

v. *Agreeing to home leave on 19 July (by nurse without reference to Doctor).*

vi*. Failure to ensure he remained for ward round and allowing him to leave on 21 July on an unauthorised basis.*

vii. *Agreement to discharge while he was at home without further face-to-face contact, discharge plan or review of CPA.*

The inquiry concluded that Richard King should have been assessed and possibly admitted under s.3. Such detention would probably have meant a longer period of treatment and no early home leave. In this section the inquiry stated:

'Any discharge plan would have been subject to a s.117 meeting with a higher level of supervision and multidisciplinary review following discharge and agreement on action to be taken in the event of non-compliance or deterioration of mental state. Furthermore, a decision to discharge without him having been seen by a psychiatrist, which the panel considers was a major error, could not have occurred'.

***Comment**: We agree that this incident was serious and we have discussed it in detail. We do not, however, accept all the conclusions of the panel as summarised above and we analyse them sequentially.*

The actions of Jenny Cunningham (i and ii)

11.22

***Comment**: The question of whether the forced entry into the flat was lawful is a serious one. Following the evidence given to the panel, the Human Resources department of Social Services commissioned a separate internal report from Ms Selby, an Acting Locality Manager of the Trust, into the actions of Jenny Cunningham on 15 July 2003. A copy of the report, dated but not signed, was provided to us. This internal report concluded that Jenny Cunningham's actions in forcing an entry to the flat were lawful as Mrs King, a co-tenant, had right of entry. Ms Selby concluded that Jenny Cunningham was placed in a very difficult situation by the police refusal to use their s.136 powers and that transporting Richard King (who had been body searched) in her car accompanied by a police officer followed by a police escort in a second car, was appropriate in the circumstances, albeit not normal good practice. Ms Selby commented that Jenny Cunningham 'showed great skill in managing and de-escalating the patient'. The inquiry does not mention the existence of the Selby Report.*

Possibility of detention (iii) and (iv)

11.23

***Comment**: The panel's finding that an MHA assessment should have been undertaken on 15 July (iii) is not accepted by the current inquiry. The question of the s.3 detention has been discussed in detail in Chapter 7. We agree that the briefing of ward staff (iv) was inadequate, but the wider issue of the shortcomings of recording on the ward should have been analysed in greater detail.*[89]

Unplanned leave (v and vi)

11.24

***Comment**: The assumptions in (v) and (vi) were not reached in accordance with the evidence. There is no evidence in the nursing notes that a nurse agreed to home leave on the 19 July or that there was a failure to ensure Richard King remained for the ward round on 21 July. The inquiry did not criticise the absence of records of decision making by nursing staff.*

Discharge (vii)

11.25

[89] See Chapter 5, paragraph 5.9

***Comment**: The crucial decision to discharge Richard King in his absence is not analysed. We consider that the panel should have discussed the role of Dr Coogan in greater detail, as the transcript of his interview discloses that he was closely questioned about the 15 July admission and discharge. We are surprised that there is no mention of the decision to discharge in this section. We cannot agree with the inquiry's conclusion, that had Richard King been detained under s.3 he would probably have spent longer in hospital and would not have been given early home leave. Scrutiny of previous admissions would have demonstrated that his admissions were, with one exception, extremely short whether voluntary or involuntary. He had left the hospital without leave on other admissions. In our view, the panel reached its opinion on this point against the weight of the evidence.*

We consider that it was reasonable for the panel to discuss the July admission in detail. But the attention given to this incident is disproportionate to the inadequacy of the section in which Richard King's illness and treatment is evaluated. The report gives the impression that the homicide could have been avoided if Richard King had been detained and not discharged in July 2004. We take the view that the shortcomings so evident in his care and treatment were longstanding and deeply rooted.

Communication: written and other - 5.7

11.26 The inquiry concluded that communication between the wards and the CMHT was inadequate, and that information was not systematically disseminated. The inquiry mentioned various possible reasons for poor communication, but did not find it possible to reach conclusions. Filing and maintenance of documentation were criticised. Social services records were highlighted as being particularly disorganised as they contained unsigned and undated entries. In contrast, the entries by the CPN and the Learning Disability nurse were of a good standard.

Comment: We agree with the findings of the inquiry regarding communication and record keeping. However, we believe that the failure to exchange and record information between the inpatient nursing team and the CMHT is crucially important. We find that the failure to analyse this omission constitutes a deficit in the inquiry as required by our terms of reference.

The inquiry requested that an audit be undertaken of Health and Social Care records from the time of Richard King's arrest to the date of the Scoping Exercise, according to the terms of reference. The inquiry agreed that the Counter Fraud Officer of the Trust's Internal Auditors should produce such a report. The report concluded in March 2005 that record management was not in accordance with the Trust's policies, but that there was no indication of improper practice. The first inquiry members read the report and accepted its findings..

We are surprised that the report by the Internal Auditors actually focussed on the various records and notes from August 2003 to August 2004 which does not accord with the inquiry's terms of reference to undertake an audit from the date of the arrest (7 August 2004) to the Scoping Exercise (16 August 2004). The report compared the various Trust and Norfolk Social Services record keeping systems and was a thorough piece of work. We agree that there is no evidence of improper practices. We observe that the report of the first inquiry should have described the remit and content of the internal auditor's report in greater detail as the reference to the Counter Fraud officer could lead to misunderstandings.

Interagency communications - 5.7.1

11.27 The inquiry commented that the informal arrangements between agencies was good but informal. The conclusion was drawn that relevant information was not collated by the Care Coordinator and therefore not available to strategy meetings.

Comment: ***We agree, but add that there should have been a better filing and disseminating system for records in order to support the Care Coordinator. The following paragraph, 5.7.2 is no longer relevant.***[90]

Continuity of professional support - 5.7.3

11.28 The inquiry emphasised the need for continuity of services to patients, but recognised the inevitability of changes in the range of professional staff involved in the provision of care. Such changes required good practice in briefing in handovers. The inquiry then considered Dr Fadlalla's assessment of Richard King in February 2004 after reviewing the files in depth. According to the report Dr Fadlalla told the inquiry that she was satisfied that his mental state was stable. The inquiry report stated: *'It was understood that Richard King became very anxious, suspicious and paranoid when seeing different people and that is why it was planned to have no contact with short term locum consultants in the following six month period when the substantive consultant would be in post. Dr Fadlalla referred to a 'comprehensive package of care in the community' which, inter alia, provided for 'at least two visits per week to the couple''.*

11.29 The inquiry concluded that the CPA plan did not provide for two visits per week and that the file notes did not refer to concerns regarding Richard King's contacts with different people. The inquiry also concluded that although the file notes on visits after February 2004 record stability, by 15 April 2004, the social worker was concerned regarding psychosis. Further notes record conflicting views and the inquiry found that his mental state was *'clearly not stable'.*[91]

The inquiry concluded that Dr Fadlalla contributed to the team decision to not to book any outpatient appointment for Richard King following his discharge from hospital in January 2004 which *'the panel considered was an error'*.

Comment**:** ***We agree with the initial finding of the inquiry that good handover practices are essential for continuity. But we do not understand the reason for concentrating on Dr Fadlalla's alleged shortcomings. There is no reference to the fact that Dr Fadlalla was a locum Staff Grade doctor who was acting up as consultant for six weeks to cover the vacant post. The inquiry does not refer to her increase of medication for Richard King on 9 February (her first day in post) or her subsequent CPA review on 19 February 2004.***

[90] The paragraph 5.7.2 relating to problems with Mental Health and Learning Disabilities services has now been resolved, see 11.77.
[91] Section 5.7.3, (ii)

In the transcript of Dr Fadlalla's interview (first inquiry) she specifically refers to the view of the CMHT that Richard King 'had been unstable for over a year'. She also described how she had asked the team whether they considered that he should be admitted, but that they did not favour that option 'because of the nature of the suspiciousness of Mr King and his relations with strangers'. In her evidence to the first inquiry, Dr Fadlalla stressed the instability of Richard King's mental state and her opinion that he was undermedicated, which in conjunction with his frequent admissions had caused her to increase his medication.

We do not agree with the inquiry's conclusion concerning Dr Fadlalla. There is no mention of her locum status nor of the short period of time she was responsible for Richard's care although this was discussed at her interview. The inquiry's finding that she believed Richard King's mental state was stable was in direct contravention of her evidence. Furthermore, Dr Fadlalla referred to her impression that: 'three visits a week done for the couple between the Learning Disability and our Community Mental Health Team which was good in a way because Mr King would be seen at least three times a week'[92]. She was not questioned on this statement. Dr Fadlalla gave evidence that in the absence of a substantive consultant and a the prospect of a series of locums, she believed that the CMHN or the social worker could refer to the locum in post. As we have discussed in Chapter 4, we believe that this decision was reasonable in the circumstances.

We do not understand why the inquiry referred to notes on Richard King's fluctuating mental state in April since Dr Fadlalla ceased to be responsible for his care on 24 March. We accept that the team told Dr Fadlalla of their belief that Richard King did not relate well to the numbers of health and social care professionals involved in the care of himself and his wife since other witnesses made similar comments.

We find that the conclusions regarding Dr Fadlalla are not consistent with the evidence heard and seen by the inquiry.

Line management supervision - 5.8, 5.8.2, 5.8.3, and 5.8.4

11.30 This section and subsections relates to the management structure of the Trust. They refer to matters of fact. The inquiry found that there was confusion over the Locality Manager's responsibility for consultants and that this should be resolved. Additionally, the inquiry were concerned that management had not identified shortcomings in community nurse and social work practice and had referred these matters to the Trust in advance of publication. The Locality Manager was found to have had an inadequate grasp of the practices and information systems of the team. The inquiry was concerned that the Trust had no central mechanisms to record appraisals nor were any records kept on a Locality basis, but hoped that regular appraisals would be undertaken as part of the Agenda for Change guidelines from November 2004.

[92] Interview with first inquiry, page 4.

Comment*: *We agree that management structures require clarification. We are concerned that superficial generalisations should be made concerning the community nurse and the social worker as we do not believe that such comments reflect the balance of good and poor practice that we have analysed carefully in Chapters 5, 6 and 7. We accept that criticism of the role of the Locality Manager and records of appraisals was based on evidence.

Clinical supervision - 5.9

11.31 The inquiry commented that consultants are not required to have clinical supervision. Doctors in training have structured supervision of their clinical practice. The Trust has a policy for nursing staff of one hour clinical supervision per month. Evidence was heard that these requirements could not always be complied with due to pressure of work. In contrast, the inquiry found that clinical supervision for Jenny Cunningham took place regularly and was recorded.

Comment*: *We agree that this is an important aspect of professional practice and therefore should have been investigated thoroughly. In Chapter 7, we have considered the responsibilities of the supervisors of Gill Chambers and Jenny Cunningham at length. The first inquiry interviewed their supervisors and should have utilised this evidence to show how they reached their conclusions. The inquiry did not discuss the extent to which supervisors of relatively junior staff may share responsibility for subsequent events.

Training - 5.10

11.32 The inquiry considered that Trust training had not addressed identified weaknesses of individual employees or the needs of the service. Appraisals should indicate specific areas of training. Risk assessment and the CPA were particularly important areas and the inquiry was told that full training had been provided. The inquiry suggested that training should take account of audit of outcomes, managerial concerns, complaints, accidents and incidents. Appendix 9.6 consists of six pages of examples of training courses provided by the Trust in considerable detail.

Comment*: *We agree that there was considerable evidence that training in core competencies was either ineffective or not available and we endorse the provision of a focussed schedule of courses. But we do not accept that lack of training accounted for the incidence of poor professional practice that we have encountered in the investigation of the care and treatment of Richard King.

Responses to Terms of Reference - 6.0

11.33 The inquiry summarised its findings in relation to the terms of reference. We have recorded them briefly so that we can comment on the connection between them and the recommendations in the final section. Repetition of some findings in this section and the previous sections is inevitable, but, as

our terms of reference require a full and thorough review, we have included all the responses to the terms of reference of the first inquiry. We have used the subheadings of the first inquiry.

To assess the quality of care received within the framework of the Care Programme Approach

- **Multidisciplinary working**

11.34 The inquiry found this to be *'generally good'* with the exception of the formal communication between the hospital and the CHMT.

***Comment**: We do not agree and have discussed this area in great detail in Chapters 5, 6 and 7.*

- **The role of the Care Coordinator**

11.35 The inquiry found that the CC was acting above her grade with little support, and that her role was *'partly usurped by the Social Worker'*.

***Comment**: While we agree with the factual finding, we do not accept the use of the term 'usurped'. There was no evidence of poor working relationship between Gillian Chambers and Jenny Cunningham in the transcripts of the previous inquiry and we cannot endorse the use of an unsubstantiated critical term.*

The inquiry found that 'formal communication to the multidisciplinary team' was inadequate. We agree, but we comment that this finding is in conflict with the previous finding (see paragraph 11.59) that multidisciplinary working was 'good' since formal communication is essential for effective team working.

- **Discharge process and decision-making**

11.36 The inquiry found that the discharge process was *'not always adequate'*, particularly following the last admission.

***Comment**: We agree but consider that the inquiry should have analysed the seriousness of the shortcomings of the discharge process, and the failure to implement the Trust policy in detail.*

- **Quality of care planning and risk assessment**

11.37 The inquiry reiterated its findings of weakness in both areas and noted that the risk assessments, although inadequate, were regularly carried out.

***Comment**: We comment that there is little point in emphasising regularity if the assessments themselves were inadequate.*

- **Recording, storage and access to health and community records**

11.38 The inquiry found that record keeping practice did not always comply with policy.

Comment: ***We agree, but note that there is no analysis of the absence of certain key records or of the disorganisation of the social services file. The destruction of the minutes of the CMHT meeting in contravention of the Trust's policy is not mentioned.***

- **Adequacy and appropriateness of communication, both internally within specialist agencies and externally with other relevant agencies.**

11.39 The inquiry repeated the previous findings in relation to discharge procedure and CPA.

Comment: ***There is no reference to the quality of communication with the external agencies, such as housing officers, the EFS charity or the local police, all of which were relevant to the management of the case.***

- **Quality of carer's assessment**

11.40 The conclusions of 5.4.4 are repeated and we have already referred to Chapter 8, paragraphs 8.13 and 14.

- **To examine the clinical effectiveness of the treatments and Interventions**

11.41 The original terms of reference required the inquiry to consider whether the treatment complied with *'the Best Practice and NICE Guidelines'*. Best practice was not defined and the inquiry simply referred to previous findings in Section 5.1. The inquiry found that there were no obvious failures to adhere to NICE Guidelines except for the omission of an explanation to Richard King of the risks and benefits of a change to medication.

Comment: ***We do not consider that these brief comments address the crucial matter of treatment and medication of Richard King. They are a disproportionate response to the fundamental issues which we have discussed in detail in Chapter 4.***

- **To undertake an audit of the health and social care records from the time of the arrest to the date of the scoping exercise**

11.42 The inquiry found that the management of the records were not in accord with the policies of the Trust.

Comment: ***We agree***.

- **To review the adequacy of the communication and support between health and social care provided to the relative**

11.43 The inquiry concluded that there was no systematic contact with Richard King's father and that there should have been *'more notice'* taken of his views when the risk assessments were prepared.

Comment: ***We agree with this finding***.

- **Did the care and treatment comply with the statutory requirements as laid down by the Mental Health Act**

11.44 The inquiry concluded that the legal requirements of the MHA were met.

Comment: ***We agree***.

- **To review the adequacy of the support provided to team members**

11.45 The first inquiry concluded that the Trust's policy for providing support after an incident was *'appropriately implemented'*. Although it was not part of our remit to look specifically at the support given to staff members in the aftermath of the tragedy, if the purpose of an inquiry is to help the NHS learn from serious untoward incidents, it is relevant to look at how the professionals who were involved in the care of Richard King were treated by the Trust. We therefore asked the members of staff who gave evidence to us about the support that they had received from the Trust following the homicide.

John West died in the early hours of Saturday morning and most of the staff involved heard about the tragedy from the local media during the weekend. There was no formal supportive debriefing session for the Community Mental Health Team and no individual who had worked closely with Richard King had any formal counselling or support from the Trust. Andrew Bailey, the Locality Manager, told us that support was made available through occupational health. If that was the case, it was not made available in such a way that the staff members could recall it being offered.

In reading the transcripts from the first inquiry, we noted that some of those who were responsible for the care of Richard King only heard about key events from that inquiry panel. It was only then that Dr Coogan heard that Richard King had been admitted to hospital after council workers had broken down the door. Joanne Braisby, who visited Richard King on her own after he had been discharged, was not told of this until we told her during the second inquiry. While this is a reflection of poor communication before the tragedy it is clear that no useful attempt was made by the Trust to help those involved understand what had happened.

Several members of staff that we interviewed told us how they were affected by criticism from the first inquiry and were not given any formal support to help

them cope with the devastating effect of public criticism. While some moved to different posts and some were told of competencies that should be achieved, no one received any specific training to address deficits in their practice. Several felt victimised.

Every professional that we interviewed was invited to bring someone with them. Several brought a union representative and one brought a relative. Only one was supported by a colleague within the Trust. There was no indication that the Trust had helped staff to prepare for the external inquiry and support them through the process.

The Department of Health *Guidance on the discharge of mentally disordered people and their continuing care in the community* (HSG(94)27 as amended in June 2005) states that an independent investigation should be undertaken when a patient has committed a homicide. It also states that the local adverse event policies should address the communication, information and support needs of affected staff.

The report of the National Confidential Inquiry into suicides and homicides by people with mental illness (Dec 2006) speaks of the need *'*to give up the culture of blame*'*. While an inquiry should follow a systems approach, the identification of errors by individuals cannot be avoided. The Trust should respond constructively to help staff address these criticisms and continue with their professional work.

In the light of the evidence given to us we find it difficult to understand how the first inquiry concluded that the policy of support was properly implemented. The Trust should review its policy and practice in supporting staff after a serious incident.

- **To identify any indicators pointing to deficits in the wider service in relation to: capacity, capability, supervision, and training**

11.46 The inquiry criticised the lack of comparative data relating to staff numbers and skills, common to other mental health trusts, and concluded that they could not reasonably respond to the question of any deficit in capacity. The other elements in this term of reference have all been discussed in previous sections on which we have commented.

- **To examine all aspects of the homicide insofar as they may relate to the care and treatment of Richard King by the Trust**

11.47 The inquiry examined the legal material relating to the offence and concluded that Richard King was, and has remained, psychotic at the time of the homicide. The report refers to his disclosure of his motivation as revenge for alleged actions against his wife by John West and his use of cannabis, *'generally'*, and at the relevant time.

Comment: ***We comment that these brief findings are an entirely inadequate response to the term of reference 'all aspects of the homicide', and do not even attempt to explain the sequence of events leading to the homicide. The evidence for the assertions that Richard King remained psychotic and generally used cannabis are absent. However, Mrs King's telephone call to the 'Active Team' and the absence of tapes and logs of incoming calls were discussed in full. The inquiry refers to the inability of Trust staff to recollect her call and suggests a review of recording telephone records. There is no reference to the police evidence that Mrs King made a call lasting nine minutes and 19 seconds to Hellesdon Hospital on 7 August. We do not understand why this evidence was omitted as it provided considerable support for the inquiry's recommendation for a review of the practice of logging incoming calls.***

Summary 6.1

11.48 The inquiry found that the policies of the Trust were *'good'*, but members of staff failed to work in accordance with the policies. Lack of effective leadership at all levels was found to have had an impact on the care received by Richard King and his family.

Comment: ***We find it difficult to understand how the inquiry could have so readily concluded that the Trust policies were adequate when compliance with them was so fragmented. Monitoring performance is an inherent element of health and social care policies. But we note that the inquiry refers to 'lack of effective leadership at all levels' even though the named individuals selected for criticism were relatively junior members of staff.***

Summary of the Panel's recommendations -7.0
The Care Programme Approach - 7.1

11.49 Ensure all relevant staff are trained as a matter of urgency in the underlying philosophy and the practice of:

Leadership

Communication

Historical service user information from Health and Social Care

Risk assessments

Chairing meetings/CPA reviews

Care planning

Carer's assessments

Such training to include clarifying the function and role of the Care Coordinator.

Comment: ***We agree with these broad recommendations, but we note that there is no time scale or system of priorities attached to any of them. We understand that the Trust Action Plan would have addressed these aspects.***

Risk assessment - 7.2

11.50 Ensure all clinical staff and managers are trained in this discipline as a matter of urgency.

Such training should emphasise that risk assessment is a team process and must be an integral element of care planning.

Comment: ***We agree and have made similar recommendations.***

Record keeping - 7.3

11.51 All staff are reminded that Trust policies on record keeping are to be complied with. It is also important that staff adhere to Professional Standards for records and record keeping.

Comment: ***We do not accept that this reminder is a recommendation. The inquiry did not analyse the shortcomings in record keeping and did not address the causes of the lost and destroyed documents. There is no reference to specific responsibilities or the need for regular or random audits.***

Line management - 7.4

11.52 Line Managers must ensure that there is regular appraisal and that clinical supervision is undertaken according to Trust standards.

The Trust should assist them by establishing adequate information systems to be able to oversee and evaluate the work of those for whom they are responsible.

The line management arrangements for consultant medical staff should be clarified and understood by Locality Managers.

Comment: ***We agree with the broad thrust of these recommendations***.

Handover - 7.5

11.53 The Trust should establish clear protocols for the handover from one clinician to another.

Comment: ***We agree***.

Communication - 7.6

11.54 The Trust policies on communications from Community Mental Health Teams to Acute Wards and vice versa must be followed. It is inevitable when there is a shortage of beds that patients may be admitted to wards which do not serve

their geographical area. In these circumstances both teams must pay particular attention to communication.

Comment: ***We agree with the first recommendation. In the absence of analysis of the several failures in communications between the CMHTs and the inpatient wards, the second and third exhortations to follow policies are unlikely to be effective.***

Training - 7.7

11.55 As we believe is now to be done (sic) - all training should be determined after assessment of personal and professional needs by appraisal. Training in core competencies should not be optional and necessary resources should not be optional and necessary resources should be allocated to provide the required training. Risk assessment and CPA should be mandatory for all staff working with service users.

Comment: ***We agree***.

Staff support - 7.8

11.56 Where staff are 'acting up' to a higher post than their normal grading justifies, line managers must provide, for an appropriate period, suitable monitoring and support.

Comment: ***Only one staff member was affected and this aspect was not critically important and therefore we comment that this recommendation is disproportionate to the evidence heard.***

Illicit drugs - 7.9

11.57 After taking appropriate advice, the Trust should consider and develop policies (if possible) to address the problem which the use of illicit drugs carries to mental health care service users, in particular, those suffering from schizophrenia.

Comment: ***We agree, but note that the need to develop a policy for testing admitted patients for drug use is not addressed[93].***

Professional conduct - 7.10

11.58 It is essential that all staff understand and accept that all elements of an agreed care plan should be adhered to unless changed following a review. If, as in this case, it had been agreed that no single team member should visit Richard King on his own, then all team members should comply with this. The elements of poor practice set out in section 5.0.6. should be the subject

[93] See Recommendation 6

of discussion, evaluation and practice advice by the Training and Appointments Board for Approved Social Workers and the Service Improvement Board.

***Comment**: This statement appears to be based on a misunderstanding of Millie Kelsey's instruction to Jenny Cunningham[94]. The section '5.0.6' does not exist and we do not therefore understand what should be discussed in the forum to which the inquiry makes reference.*

Inter-service referrals - 7.11

11.59 The discussion currently taking place between the Norfolk and Waveney Mental Health and the Learning Disabilities service about the protocols for referrals between services should be brought to a conclusion and monitored by a Service Improvement Board.

***Comment**: We understand that this discussion has now been concluded*.

Crisis resolution and Home Treatment Team (CRHT) 0 7.12

11.60 The practice of the CHRT for the recording of incoming calls and requests should be reviewed.

***Comment**: We agree; however this recommendation would be improved by the requirement for regular monitoring.*

What if…? - 8.0

11.61 This final section attempted to answer two crucial questions. Firstly, whether the killing of John West was predictable, and secondly, whether it was preventable. For completeness, we will record and comment briefly on the final paragraphs of the first report although we discuss the matter in full in our conclusions in the final chapter.

The inquiry concluded that the risk to John West was not predictable since there were no references to him by Richard King on any records held by the Trust. Although Richard King was more violent than indicated by risk assessments and experienced psychotic episodes in which aggression could occur, there was no indication that he had a specific victim in mind. We agree with this conclusion although we note that the statement given by PC Money to the CPS refers to hearing allegations made by Richard King concerning John West before the homicide.[95]

The question of preventability is much more complex and required considerable analysis of Richard King's clinical history and an assessment of

[94] See paragraph 7.25
[95] See Chapter 10, paragraph 10.17

his delusional beliefs. This analysis was not undertaken (there is no mention in the report of the fax from the police) but nevertheless the inquiry speculated that Richard King was only in a position to kill John West because he had not been *'correctly'* admitted to hospital in July 2004 and had left without permission. The panel believed that he would not have been discharged or given leave until it was safe to do so, although there is considerable evidence that this had happened on previous occasions.

We believe that this reasoning is simplistic and do not accept that it could ever be a sufficient basis for the assertion that the *'homicide of 6 (sic) August 2004 was preventable'.*

Failure of the first inquiry to take evidence from family members
The family of Richard King

11.62 We have referred in the Introduction to the absence of evidence from the King family in the report of the first inquiry. The first inquiry panel contacted members of the King family, some of whom, including his father, declined to be interviewed. We understand that Mrs King's consultant and her Care Coordinator advised the panel against interviewing her. Similar advice was given regarding Richard King and his brother. It is unfortunate that this was not made clear in the preamble to the first inquiry for the benefit of the public. We were able to interview Richard King's brother, father and Mrs King, but we accept that two years later circumstances have changed significantly. We have already referred to the remarkably good evidence given by Mrs King. Mrs King's father and his partner also gave evidence to us.

The family of John West

11.63 Patrick West, the brother of John West, was able to speak on the telephone with the Chief Executive of the Trust shortly after the homicide. There are no further references to the family other than a mention in a letter to a police officer on 13 September 2004 to the effect that if the any of the victim's family wish to meet the panel, it could be arranged. There is no clear response by the police and it appears that the matter was not considered again by the panel. According to a file note dated 22 June 2006 of a discussion between Barry Capon, the Chair, with Paula Bourthis, Corporate Services Manager, secretary to the inquiry, the Trust only became aware of the existence of the wider West family when the police informed them during the preparation of the launch of the report. The note records the Chair's view that even if the panel had been aware of the family of John West, he *'reaffirmed that our TOR were to review the care and treatment of RK to the point of the homicide … If we had been aware of siblings of John West not sure that we would have contacted them as part of our review as to our knowledge no direct link to RK'.* John West's partner did not want any contact with the inquiry.

11.64 We observe that the previous panel took a narrow view of their remit concerning the family of John West. In principle, making assumptions in advance concerning the nature and usefulness of evidence is hazardous.

Many reports of inquiries have found that vital information has come from unlikely sources (for example the evidence of an unqualified art therapist in the Jason Mitchell inquiry), and we believe that it is better practice to interview a wide spectrum of witnesses in order to ensure that crucial information is not lost. Following the publication of the report, Richard King's father complained to Norman Lamb MP that he felt his views and warnings to the Trust had been ignored. He was able to give information about family history to the panel. This matter has already been referred to in paragraph 11.15 but we believe that we should reiterate our view of the importance of inviting non-healthcare staff individuals who are close to events to give evidence to an inquiry. For close relatives this may be a painful experience so the panel should continue to encourage their participation, over a period of time if necessary.

11.65 Members of the West family were able to give us some helpful background material. We heard about the circumstances in which the family heard of the death of John West from members of the public and telephoned the police before the police contacted the relatives. They found it difficult to understand why they were not contacted by the first inquiry as the family is very well known in Sheringham. The panel was told that John West was a much loved man and that the court hearing was moved from Norwich Crown Court to Ipswich Crown Court because of strong local feeling.

11.66 We were impressed by the family's understanding of Richard King's illness and the shortcomings that they perceived in his care. They were very pleased that they had an opportunity to discuss their views with the current panel and emphasised that they expected a thorough investigation of the responsibilities of Trust management as well as the role of healthcare staff. They told us *'we just want the right thing to happen'* in terms of the second independent inquiry. The West family had never met Richard King but we asked them whether they could give us any indication of his possible motive for the homicide. They were not sure that their brother was actually the intended victim or whether Richard King intended to kill someone else living in the Old Craske Flats.

11.67 In the case of Richard King, there remains uncertainty at the core of events as to why John West was killed. This may never be known as we were unable to interview Richard King. But it is possible that family members would have been able to shed light on family history which might have been relevant to the motivation for the homicide. It is our view that family members should always have the opportunity to express the significance of their loss and the effect on them to an inquiry. Such an opportunity parallels the use of victim impact statement in courts and affords recognition of the human costs of a homicide and respect for the victim.

Recommendation 21

The panel recommends to the SHA that in future inquiries commissioned by the SHA the panel should always give serious consideration to interviewing relatives and close associates.

The Unison response to the first inquiry

11.68 Unison submitted a response to the report of the first inquiry. It is undated and unsigned but it was accompanied by a covering letter, dated 29 November 2005, from Alison Birmingham, Senior Steward, Social Services and was addressed to Harold Bodmer, Director of Adult Social Services, Norfolk County Council. We have read and considered the contents of the response. Although written from a particular perspective, we have found the Unison document helpful. The panel believes that it is appropriate for us to comment briefly on the main assertions within this document although most of the important points have already been addressed within the main body of this report.

11.69 The first substantive point refers to risk assessment: the Unison comments have been fully addressed in Chapter 10. Similarly we have discussed the role of the CC in extensive detail in Chapter 6 and have recognised the limitations and difficulties of the role. The implementation of CPA and the lengthy CPA documentation has been described in Chapter 6. We have disagreed with the findings of the first inquiry in relation to Jenny Cunningham in paragraphs 11.22 in this chapter. The decision to admit Richard King informally on 15 July 2004 has been considered carefully in Chapter 7. The availability of cannabis is referred to in 11.14. Paragraphs 4.23 and 4.24 refer to the evidence of Dr Ball on the pressure on beds at the relevant time and subsequent improvements. We have criticised the shortcomings in the implementation of the Trust discharge policy.

11.70 We have not mentioned the question of resources in general in this report. Our reasons are twofold: firstly, few witnesses spontaneously mentioned shortages of resources, and secondly, even fewer were able to make a direct connection between failures in the care and treatment of Richard King and a lack of resources. We have already commented on the frequency of social and healthcare professionals' visits to the Kings' flat. In Chapter 13 we consider with great care the balance between the policies of the Trust and the actions and omissions of those who implemented them. We are unable to conclude that responsibility for the shortcomings in the care and treatment of Richard King was mainly due to the inadequacy of Trust policies.

CHAPTER 12
DOCUMENTATION

Introduction

We have included a chapter on documentation because our inquiry has been seriously hampered and delayed by the absence of information and records. We remain concerned by the casual attitude to the security of documents following the homicide and the destruction of records relating to patients. We refer to Trust policies on the preservation of records and the Memorandum of Understanding published by the Department of Health.

12.1 The panel has encountered considerable difficulties with documentation directly related to the care and treatment of Richard King during the investigation. In contrast, the documentation of the procedures and correspondence of the first inquiry was meticulous. Initially the panel were given large quantities of health and social care records, many of which were duplicates. The records were disorganised. Some were in chronological order, some in reverse chronological order. Some files contained papers on several different subjects without headings or dividers. For example, we were unable to ascertain who had had sight of two critically important letters from the Adult Protection Unit and from Richard King's father as they were discovered in a random collection of papers. While this presented problems for the panel, the more important consequence was that it would be a barrier to staff who needed to track the flow of information. The records entered by the community nurses, medical records, and GPs were careful and detailed but the quality of the nursing notes of inpatient admissions can best be described as basic. The CPA documentation was poor and the social services file is considered in full in the following paragraph. Our real concern is that information on Richard King was recorded in different files and in several locations. We doubt that any witness to the inquiry was aware of the full sequence of events in Part One. We believe that lack of organised records must have impeded the transmission and overview of information and that this may apply to patients in general as well as to Richard King. We have made a strong recommendation to improve the quality and availability of paper based information on an individual patient before the advent of the electronic record. We accept that it is difficult to ensure that all clinical staff see all the relevant documents but electronic patient records should help resolve this problem. The Trust should review progress in this area as a matter of urgency (see Recommendation 13).

The Social Services file

12.2 Initially the panel members were told that a slim bundle of papers given to us was the complete record of social care for Richard King from January 2003 to August 2004. As we interviewed witnesses, it became clear that there was a bulky file in existence which had been available to the first inquiry. Managers made efforts to locate the file: nothing was found. Our last witness, Millie Kelsey, disclosed that she had made a copy of the full social services file

before handing it over to the Trust following the homicide. The copied file was located in the Norvic Clinic. Meanwhile, the panel had asked the solicitors for Richard King whether they had a duplicate file as Jenny Cunningham had suggested to us. Richard King consented to the disclosure and the solicitors sent the file to the panel. We compared it with the copy in the Norvic Clinic: the files were identical. We concluded that there had not been any wrongdoing in relation to entries in the files. The absence of this file caused avoidable delay to this inquiry.

12.3 The panel interviewed Millie Kelsey about the delay in passing the social services file to the Trust following the homicide. This delay had also exercised the first inquiry and a confidential review had been commissioned from the chair of the Audit Committee of the Trust. The review (which is now in the public domain) confirmed that both health and social care maintained their own sets of notes which at the time were *'held in a number of formats and locations'*[96]. However, the current panel's investigation of documentation has been extremely thorough and there is no significant conflict between the two sets of conclusions regarding the quality of record keeping.

12.4 According to the internal audit review, the Trust held a number of meetings on Monday 9 August as required by the Trust Serious Untoward Incident (SUI) Policy and a Trust officer was tasked with locating and retrieving health records. It was unclear from the note of the meeting whether this included the social services records. The panel questioned Millie Kelsey about the transfer of the file to the Trust headquarters. She told us that following the homicide she *'came in on the Monday and pulled the file'*, and placed it within a locked cabinet inside a locked office. She assumed that this was the correct action although she told us that she had not been informed that she was responsible for securing the file. Although the Trust SUI policy was dated June 2004, it may not have been available to Millie Kelsey in social services. In any event, Millie Kelsey's response to the situation was correct. But she was unable to recollect the date when she received a message from the Trust to send the file to Trust headquarters at Hellesdon Hospital. She told us that she decided to take it in person in case it was lost in the post, and on an unrecorded date left the file in an administrative office for Paula Bourthis' attention. Millie Kelsey did not obtain a signature from the person who accepted it. The Selby Report also investigated this matter and concluded that the file *'was being obtained'* on 12 August but had not arrived by 23 August. The file arrived at some point during the week commencing 23 August. Because of the inadequate record keeping it is not possible to ascertain the cause of the delay. We are surprised at the casual attitude of both Millie Kelsey and the Trust in failing to secure a critically important document following a homicide. The Internal Audit Review commented that the notes should have been *'documented throughout their transition from Norfolk Social Services to the Trust.'* We agree. We recommend informally to the Trust that the reference in the SUI policy checklist to *'original copies'* is amended to *'original documents'* since *'original copies'* in a contradiction in terms and could lead to confusion in a future investigation.

[96] Internal Audit review-04/26,issued March 2005

Memorandum of Understanding

12.5 Since the events of August 2004 in Norfolk, a *'Memorandum of Understanding: Investigating patient safety incidents'*, has been published in February 2006 by the Department of Health. Guidance was published in November 2006. This is a protocol which was developed by the Health and Safety Executive, the Association of Chief Police Officers and the NHS. It does not appear to relate specifically to very serious offences committed by patients on the general public and therefore is of limited assistance to this panel. Nevertheless, it provides some guidance on the management of evidence. It emphasises *'the need to secure and preserve evidence'*. The accompanying guidelines advise that a risk manager, in conjunction with a senior manager or clinician, takes responsibility for assessing whatever evidence is to hand. An example is given of records, notes and letters, drug charts, printouts etc. The guidance then recommends that once evidence has been identified all efforts need to be taken to protect it and an identified person, usually the risk manager, needs to take responsibility for safeguarding evidence. Clearly, a criminal offence committed by a patient must be investigated by the police but Trust documents may be very relevant to possible future civil proceedings relating to negligence. In the light of evidence given to us on the insecurity of important documentation in this case, we commend the approach of the *'Memorandum of Understanding'* to the Trust.

Loss and destruction of documents

12.6 We have already mentioned our concern regarding the absence of a key piece of evidence, the hospital telephone log, in the hours before the homicide. The first inquiry considered the loss of the log in which Mrs King's incoming call on 7 August should have been recorded. None of the staff who gave statements to the police recalled speaking to her. We hope that the hospital's recording and retention practices of telephone logs have been reviewed.

The panel has referred to the probable destruction of almost all the CMHT records from 2001 to December 2003 in Chapter 7. The Norfolk Mental Healthcare Trust policy document, dated 1995 but revised in 1999, states that the destruction of records *'worthy of permanent preservation or required for litigation purposes is an irreversible act'*. The policy requires that the Trust *'must therefore ensure that the procedures outlined are followed'* and identifies Directors as responsible for nominating *'a member of staff to take responsibility for this area of work within their service'*. The procedural guidelines state that: *'At the point of destruction a final check should be made to ensure that the documents should not be preserved or retained and that subsequent legislation has not been passed which affects retention periods'*. Appendix 1 of the policy gives minimum retention periods before destruction. For Patients' Health Records the minimum period is eight years after the *'end of treatment'*. The Chief Executive is the designated responsible director and the task is delegated to the Corporate Services Manager.

12.7 In his capacity as the Caldicott Guardian of the Trust, Dr Ball wrote to the panel on 24 September 2007 and explained that the CMHT minutes were classed as minor documents in 2002/3, and that there was no statutory retention periods for such papers. Therefore the Trust has not contravened its policy even if they have been destroyed. Nevertheless he apologises for the absence of the records and continues: *'The Trust expects that any clinically relevant material discussed at team meetings would be properly recorded within the relevant case record. We have recently reviewed Trust policy and minor documents are now retained for a period of two years in line with the Records Management Policy NHS Code of Practice Part 2'.*

The panel has been unable to find any CMHT minutes in other files or records and we conclude that they were not cross-filed in other case records, contrary to the expectations of the Trust. We do not consider that the minutes of clinically significant discussions, decisions and actions by the CMHT should have been classed as minor documents as they are essential to any unforeseen future investigation or litigation. It is the view of the panel that the Trust should consider this matter further as it has implications for other past and current patients.

Recommendation 22

The panel recommends that the Trust review the Norfolk Mental Healthcare (NHS) Trust policy relating to Preservation, Retention and Destruction of Records within three months.

CHAPTER 13
CONCLUSIONS

The purpose of this chapter is to provide an overview of the care and treatment provided by the Trust to Richard King and to consider whether the homicide could have been averted. During the 17 months that the panel has been considering documentary and verbal evidence, we have concluded that no one person and no single act or omission in the care and treatment of Richard King led directly to the killing of John West. But failures to respond to significant events in Richard King's history and shortcomings in the provision of services require some general observations in terms of our terms of reference.

Effectiveness of treatment, medical, nursing and community

13.1 The concept of effective treatment for mental illness is a vast subject and necessarily any comments made by the panel at this point in the inquiry can only be brief and related to the psychosis of Richard King. We will apply a definition which includes treatment that *'alleviates or prevents a deterioration of the symptoms of the mental disorder, but not the disorder itself which gives rise to them'*[97]. Following the change of dosage and delivery of medication in 2001, Richard King's mental stability declined and the subsequent administration of different medication regimes did not reverse the deterioration. He relapsed into psychosis in January 2002 from which he did not recover. Although at the time of the homicide the level of his medication was higher than in 2001, it no longer alleviated the symptoms of his psychosis. The effectiveness of the medication was almost certainly affected by Richard King's use of cannabis. The use of Clozapine was not considered although Richard King has benefited from accepting it (in terms of symptom reduction) in the clinic where he is currently accommodated. The concluding paragraphs of Chapter 4 relate shortcomings in the medical treatment of Richard King.

13.2 We have considered the nursing aspects of Richard King's inpatient treatment in full in Chapter 5 and have concluded that he was not referred for any non-medication based therapeutic interventions. When considering events prior to the homicide, we emphasise that Richard King received very little active treatment, except medication, during his last admission. There is no evidence in the nursing notes of any discussion of the circumstances of his admission and no recording of an assessment of his mental state. We find that Richard King did not receive sufficient treatment as an inpatient: the frequent, often informal, admissions were too short to establish stability and he often absconded or took unauthorised leave. Consideration should have been given to assessment and detention under section to ensure that his psychosis was adequately treated. Communication and liaison between the inpatient and community teams was poor and impaired the effectiveness of treatment. We conclude that overall the quality nursing care given to Richard King was

[97] Reid v Secretary of State for Scotland [1999] All ER 481, (Lord Hope).

not an adequate and consistent therapeutic response to the complexity of his illness.

13.3 We consider that Richard King was an appropriate patient to be cared for in the community. His clinical history could not possibly have justified continuous detention in hospital. There were no legal grounds for continuous detention under the MHA although we consider that he could have been appropriately detained at certain junctures following a marked deterioration in his mental state. S.3 was only used once in May 2003.

13.4 The immediate care that Richard King received from individual members of community staff was of a high standard. He was visited very frequently, sometimes two or three times a week, and we heard evidence that community staff established a good therapeutic relationship. This is not a case where a patient disengaged from care or was lost to services or refused to accept medication. The administration of depot medication and monitoring of his mental state was regular and properly documented. The shortcomings in community care related to lack of clinical leadership, ineffective decision-making in the CMHT, failure to assess and manage Richard King's increasing risk to others, and the poor implementation of the Care Programme Approach. There was a joint failure to produce an effective care plan. Our final conclusion is that treatment provided by the Trust did not alleviate or prevent a deterioration of the symptoms of his mental illness.

Absence of management scrutiny

13.5 The panel's exhaustive investigation has disclosed many errors and shortcomings in practice to which we have referred in earlier chapters. But we have not found that any individual members of staff were corrupt, malicious or wilfully abrogated their professional responsibilities. In most cases, these individuals were not properly managed and supervised by more senior staff who must also accept a degree of culpability. We conclude that the performance of senior managers was sometimes less than could reasonably have been expected. We have identified a general absence of clear line management of the CMHT, and we are sure that inadequate management scrutiny contributed to some aspects of poor individual performance.

Examples of good practice

13.6 During the course of this investigation, the panel has been heartened by some examples of high professional standards and devotion to duty. All the front line staff showed dedication, tenacity and commitment to patient care. We have been concerned by the stress placed on staff by two inquiries and the associated delay, and the lack of post incident care. This aspect has been considered in detail in Chapter 11, paragraph 11.45.

Accountability

13.7 We have considered our remit to investigate care and treatment in terms of accountability to local residents and the general public interest. The residents of North Norfolk have a right to expect that the Trust provides consistently good care and treatment for those suffering from mental illnesses. It is also reasonable to expect the Trust to operate an effective system to identify the very few patients who present a risk of violence to the public. When such systems fail, the Trust has a statutory obligation to set up an independent and impartial inquiry as soon as possible. The panel has made an important recommendation regarding the independence of future inquiries.

13.8 Our investigation, to which all witnesses and family members have contributed, has enabled the panel to follow chronologically, and thematically, the sequence of events in this case. We have spent many hours considering decisions which were sometimes made in a matter of moments. It is relatively straightforward to identify mistakes made by individuals, but it is more important to understand how these mistakes occurred in the context of the systems in which they were working. We are aware that some mental health professionals regard aspects of inquiries as inherently unfair. However, fair investigations should comment on good practice by individuals and systems. Evidence-based criticism from an independent body should be recognised by management as an invaluable opportunity to improve service provision. We have had a unique opportunity to review in detail the consequences of the acts and omissions of mental health care professionals and their managers in the care of one patient. If each individual member of staff, and their manager review their future actions in the light of this account, this inquiry will have served its purpose.

13.9 Some of the panel's recommendations may appear to replicate the rather imprecise recommendations and exhortations of the first inquiry. They do not. All are addressed to the Trust or to specific individuals in order to bring about changes in practice. We have indicated realistic timescales by which the recommendation should be implemented. Our remit concerns the relevant factors in the care and treatment of Richard King and therefore we are not able to investigate whether the recommendations of the first inquiry have been enacted. We are aware that the Trust has compiled an Action Plan with timescales.

ASPECTS OF THE HOMICIDE

Risk assessment

13.10 We must comment finally on the issue of whether actions by Trust staff could have prevented the homicide. In longitudinal risk assessment terms, we have already concluded that Richard King's action in killing John West specifically could not have reasonably been foreseen and therefore there was no obligation on the Trust to warn him or to alert the Norfolk Constabulary. In the chapter on risk assessment, we have established that Richard King could not

have been regarded as being a high risk, or a forensic patient, in view of the absence of a history of serious assaults and use of weapons. But he had made threats to kill his wife and had demonstrably assaulted her twice by shaving her head. He had attempted to strangle his father. Additionally, many of his delusions concerned violent death and he had demonstrated paranoid responses to a range of individuals. Witnesses have told us of fluctuating presentation, volatility, and the capacity to mask his symptoms on occasions. There were no multidisciplinary risk assessments undertaken when he was admitted to hospital and no risk assessments at all in the community. Richard King should have been formally assessed as medium risk and the possibility of committing further serious assaults should certainly have been considered and managed by the Trust staff who were responsible for his care and treatment. As part of our analysis we list key points in Richard King's care and treatment as follows:

Key points in the sequence of events

13.11 We identify the following six key points in the sequence of events when action should have been taken:

1. The failure to recognise the relapse into psychosis in January 2002 following the change of medication in June 2001.

2. The failure to assess and treat psychosis when admitted to hospital under s.2 in December 2002.

3. The failure to investigate and assess Richard King's psychotic delusions following the fax from the police in November 2003.

4. The failure to recognise the seriousness and inherent risks posed by the incident in which Mrs King's head was shaved in January 2004.

5. The failure to conduct an effective CPA review involving all the professional staff concerned with Richard King in May 2004.

6. The decision to discharge Richard King in July 2004 without a pre-discharge multidisciplinary meeting.

We have analysed the decision to reduce medication in Chapter 4 and concluded that Richard King never recovered from the deterioration in his mental health caused by this decision. Similarly, we have discussed the first point, the failure to recognise the significance of the relapse into psychosis in January 2002 in Chapter 4.

The second point concerns the brief admission under s.2 in December 2002 which we have criticised in Chapter 4. It is possible that reinstating the dosage in 2002 of the depot injection that that had enabled Richard King to live an independent and trouble free life for several years would have altered subsequent events.

The third point which concerned the fax from the police, represented a clear opportunity to assess the violent content of Richard King's delusional architecture and the possible threat to his wife. The failure to respond to this information and to intervene robustly was extremely serious: both the CMHT and the consultant must accept responsibility for this omission.

The fourth point concerns the similar failure to take decisive action following the shaving of Mrs King's head in January 2004. Given Richard King's delusional motivation, immediate consideration should have been given to the formal detention of Richard King and arrangements made for the physical safety of Mrs King.

The fifth point identifies a fundamental failure of the CPA approach. If the CPA review had been held in May 2004, the professional staff in the CMHT who knew Richard and Mrs King well should have been present. A consultant would have attended and the highly significant information from the housing agency and the police should have been considered. The vulnerability of Mrs King should have been brought into a risk assessment. Richard King's psychosis and the exacerbating effect of his cannabis usage should have been recognised as presenting a greater risk to others. We cannot be confident that a review would have been as effective as it should have been, given our criticism of the operational deficiencies of the CMHT, but it would have provided an opportunity for a strategic overview.

The sixth point at which the increased probability of violence to others should have been recognised would have been at a pre-discharge multidisciplinary meeting in July 2004. This did not take place when Dr Coogan discharged Richard King, a patient whom he had only seen on one occasion, in his absence.

Although we have stressed the aspect of escalating risk in these events, each of these points also represented an opportunity to treat Richard King's psychotic illness which caused increasing distress and anxiety to his wife, himself, her family, his family and neighbours in Wells.

13.12 The points at which we believe there should have been intervention must be seen in the context of other background weaknesses in the provision of care and treatment by the Trust. We have described the shortcomings of risk assessment and management, and commented on the absence of multidisciplinary pre-discharge meetings. The absence of continuity of medical responsibility in 2004 was very regrettable. Richard King's use of cannabis should have been openly discussed. Richard King's use of cannabis could not have been prevented by the CMHT, even if they had had clear evidence of its use. But he could have been offered counselling and given an explicit message that cannabis use would almost certainly worsen his symptoms. No one addressed this issue. We are particularly critical of the lack of decisive action by the CMHT. The situation was allowed to drift after the shaving of Mrs King's head in 2004 although the mental health professionals could reasonably have predicted that another serious incident was increasingly probable. The minutes of the CMHT on seven occasions in

2004 record some expressions of concern, but little action apart from further visits by team members. From the evidence heard by the panel the team also appeared to have lacked purpose and direction throughout 2002 and 2003. The documentation provided to us indicates that throughout this period, the flow of clinical information from and between the inpatient unit, the CMHT, GPs and consultants was sometimes seriously deficient and certainly precluded comprehensive risk assessments.

We cannot safely conclude that any single decision or action at any of these points would have prevented the homicide, but each subsequent point represents a missed opportunity to take an overview of Richard King's obvious deterioration and an associated increase in risk to others. We conclude that some members of the medical staff and CMHT must accept varying degrees of responsibility for inadequacies in the care and treatment of Richard King between 2001 and 2004.

Evidence concerning the period between 26 July and 7 August 2004

13.13 We have also considered whether there is any evidence of a clear deterioration in Richard King's mental state on the days following the discharge on 26 July, but preceding the homicide, when action should have been taken. The first inquiry does not mention this possibility, perhaps because the panel were unaware of vital pieces of evidence concerning this period. We have examined the nursing entry of Joanne Braisby which recorded the administration of the fortnightly depot on 29 July. She found that Richard King was settled and the situation appeared calm. He had therefore received appropriate medication at the time of the homicide. Mrs King telephoned Steven Potter twice on the 2 August but these contacts did not cause him any particular anxiety. Following Jenny Cunningham's visit to the flat on 3 August, she noted that Richard King was *'distant and preoccupied with his thoughts'*, but she did not regard that aspect of his presentation as unusual. Both these witnesses knew Richard King very well and did not record any significant concerns. There was no reason for Joanne Braisby, Steven Potter or Jenny Cunningham to suspect homicidal intentions.

13.14 On the 5 August the Duty Care Manager told Sheila Endresz that Mrs King had rung the EDT stating that her husband was threatening to kill her. The following note recorded *'resolved'* on 6 August and *'no further info'*.[98] The relevant EDT alerts were finally located in October 2007: this evidence was obviously not available to the first panel. The contact with the EDT was in fact made by Dr McAnsh' surgery following a call from Mrs King *'in a state'*, and referred to a history of domestic violence and threats to her by Richard King. The recorded outcome, *'advice provided'* at 16.40 on 6 August, regrettably does not enlarge on the King's domestic situation. Although this appears in retrospect an opportunity to have assessed any possible risk, without further information we are unable to conclude safely that decisive action should have been taken.

[98] Notes made by Sheila Endresz at Kings Lynn police station

13.15 There is no information available on the nine minute content of the telephone call that Mrs King made to Hellesdon Hospital at 01.57 on 7 August. The hospital telephone log is missing and, according to their statements to the police, none of the staff on duty recollect her call. At 02.20 and 02.30 the partly illegible notes of two telephone calls made by Mrs King to the out of hours GP service refers to *'no suicidal component…weird story of being raped at age 18???'*. A separate note on the same page reads *'Wife says she does not need visit right now, she just wants to talk'*… [illegible] … *'no acute psychotic situation or hallucination'.* At 03.24, Mrs King rang the 999 service to warn of Richard King's intention to kill John West. Thus, there is evidence that Mrs King was acutely distressed and fearful, causing her to seek help from the GP, and the hospital in the 48 hours before her husband killed John West. There is no evidence available to us that Mrs King told anybody of Richard King's intention to kill John West until she rang 999. We cannot speculate on the content of the missing log.

The homicide

13.16 We have concluded that neither the frenzied nature of the homicide using a knife or Richard King's choice of victim was predictable. But given the escalating seriousness of the assaults and incidents in 2003 and 2004, we believe that mental health professionals could reasonably have concluded that there was an increasing probability that Richard King might commit a violent act.

The ultimate question for the inquiry is whether the provision of better care and treatment, in the widest sense, by Trust staff would have reduced the risk of a seriously violent act which, potentially, might have had a fatal outcome. Plainly violent acts are relatively common, but homicides are rare. The probability of Richard King committing such an act in 2001 was extremely low. But the cumulative failure to treat his psychosis effectively, the increase in disturbing and persistent delusions of death and violence, compounded by the absence of intervention at the six key points, created a situation in 2004 when a dangerous act was becoming more likely. Smoking two joints of cannabis probably exacerbated Richard King's psychosis on the night of 7 August 2004.

13.17 The relationship between the factors described above and the homicide was cumulative and complex: there is no simple direct causative link. No single individual can be held responsible.

We conclude, on the balance of probabilities, that better quality care and treatment between 2001 and 2004 would have substantially reduced the increasing risk of Richard King committing a violent act. But the frenzied killing of John West with a knife could not have been reasonably foreseen.

RECOMMENDATIONS

Recommendation 1

The panel recommends that the Trust review the relationship and communications between Community Health Teams and primary care within six months. (Paragraph 4.46)

Recommendation 2

The panel recommends to the Trust that within three months they initiate a plan for implementation of Protected Engagement Time for each clinical area and allocate a specific amount of time to staff so that they have protected time away from administrative duties to spend with patients. (Paragraph 5.1)

Recommendation 3

The panel recommends that the Trust reviews within three months the activities provided for inpatients to ensure that adequate and meaningful activities are available in order to manage the issues of boredom and thus reduce the risk of absconding, violence and aggression. (Paragraph 5.1)

Recommendation 4

The panel recommends to the Trust that the quality of the notes of all practitioners and the use of CPA documentation are audited through Management Supervision and the Trust wide audit of CPA documentation. The audit should monitor the adherence of the standards set out in the Norfolk CPA policy within six months. (Paragraph 5.9)

Recommendation 5

The panel recommends that the Trust ensures within three months that a copy of all the incident report forms for every inpatient and community incident is located in the relevant patient's health and social care notes. (Paragraph 5.11)

Recommendation 6

The panel recommends to the Trust that a policy on screening for the use of illicit substances by patients is developed as a matter of urgency within three months. (Paragraph 5.12)

Recommendation 7

The panel recommends that the Trust audit the incidence of unplanned leave and absconsions and that the Trust takes action within three months to reduce the prevalence of this practice. The Trust should require that all patients who are absent without leave should be assertively followed up. The Trust should refer to the work of Len Bowers for alternative management strategies. (Paragraph 5.14)

Recommendation 8

The panel recommends that the Trust reviews within three months the current practice of the discharge policy and ensure that the discharge of patients should only take place according to the DoH circular HSG(94)27. (Paragraph 5.14)

Recommendation 9

The panel recommends that the Trust reviews the implementation of the Care Programme Approach across both inpatient and community settings within six months. (Paragraph 6.6)

Recommendation 10

The panel recommends that the Trust gives guidance on the phrase *'clinically significant',* as used in the CPA policy, so that all staff understand its meaning and subsequent requirements for specific actions within three months. (Paragraph 6.7)

Recommendation 11

The panel recommends that the Trust ensures that there is a system in place within three months to check that annual CPA reviews have been undertaken. (Paragraph 6.11)

Recommendation 12

The panel recommends that the CPA framework and risk assessment training should be reviewed by the Trust to ensure that practitioners are clear as to how risk assessments should be conducted i.e. taking into account the views of all professionals involved with care within three months. (Paragraph 6.13)

Recommendation 13

The panel recommends that the Trust introduce the use of a single case file to be used by all professional staff. Such a file would follow the patient so that inpatient staff and community staff would have access to the same information and all entries would be made to a single file in the interim period before electronic files become available. The Trust should also review the progress of the Electronic Patient Record. (Paragraph 7.11)

Recommendation 14

The panel recommends to the Trust that the minutes of the CMHT meetings record clearly all decisions of the meetings and actions to be taken regarding patients. The minutes should identify the member who should take action and set an agreed time by which that member should report back to their manager and the next meeting. The meetings should be chaired by the same member of staff for a designated period. This recommendation should be implemented within three months. (Paragraph 7.12)

Recommendation 15

The panel recommends that the minutes of the CMHT should be formatted so that notes on individual patients can be separated and filed appropriately without compromising the Data Protection Act 1998 within three months.
(Paragraph 7.12)

Recommendation 16

The panel recommends that the Trust should ensure that the standards and practical arrangements for supervision are audited by the Director of Nursing within six months. (Paragraph 7.27)

Recommendation 17

The panel recommends that the Trust should ensure, as a priority, that there is single line management within the CMHTs within three months. This should be clear and accountable, and every member of the team should understand which manager is clinically responsible for the management of an individual's care.
(Paragraph 7.29)

Recommendation 18

The panel recommends to the Trust that a senior manager should establish a regular liaison meeting with the Norfolk Constabulary to consider any

operational issues within six months. This arrangement should ensure that all relevant information is passed on to the Community Mental Health Team. (Paragraph 9.10)

Recommendation 19

The panel recommends to the Trust that the Medical Director should within three months engage the consultant staff in developing risk assessment training which is appropriate to their needs to ensure that they attend. (Paragraph 10.23)

Recommendation 20

The Panel recommends to the SHA that following any incident involving death or serious injury the Trust should undertake an immediate investigation, but the SHA should commission a fully independent inquiry as soon as possible so that the inquiry may start its investigations as soon as any legal proceedings have been completed, according to the current DoH guidance.(Paragraph 11.10)

Recommendation 21

The panel recommends to the SHA that in future inquiries commissioned by the SHA the panel should always give serious consideration to interviewing relatives and close associates. (Paragraph 11.67)

Recommendation 22

The panel recommends that the Trust review the Norfolk Mental Healthcare (NHS) Trust policy relating to Preservation, Retention and Destruction of Records within three months. (Paragraph 12.7)

GLOSSARY

ASW	Approved Social Worker
BNF	British National Formulary
CC	Care Coordinator
CHI	Council for Health Improvement
CHMN	Community Mental Health Nurse
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
DoH	Department of Health
EDT	Emergency Duty Team
EFS	Elizabeth Fitzroy Support
Faredoc	Out of hours service
GP	General Practitioner, family doctor
HTT	Home Treatment Team, also known to patients as the Access Team
IPCC	Independent Police Complaints Commission
LD	Learning Disability
MHA s.2, s.3 and s.117	Mental Health Act, Sections 2, 3 and 117
NCC	Norfolk County Council
NICE	National Institute for Clinical Excellence
NNDC	North Norfolk District Council
R&R	Referral & Reception
SHO	Senior House Officer
SUI	Serious Untoward Incident

List of witnesses who were interviewed by the panel

Andy Bailey
North Norfolk Locality Manager

Dr Hadrian Ball
Medical Director

Dr Harold Bodmer
Director of Adult Social Services
Norfolk County Council

Gill Chambers
Community Mental Health Nurse and Care Coordinator

Andy Collins
Specialist Practitioner – Approved Social Worker

Bridget Collins
Team Leader for the Community Mental Health Team

Dr John Coogan
Consultant Psychiatrist

Jenny Cunningham
Social Worker for Mr and Mrs King

Sheila Endresz
Senior Practitioner in Social Work

Dr Ikhlas Fadlalla
Locum Consultant Psychiatrist

Joanne Farnworth (neé Braisby)
Community Mental Health Nurse

Janet Hare
Area Housing Manager

Millie Kelsey
Team Manager - Community Mental Health Team

Dr Gordon McAnsh
General Practitioner

Trudie Needham
Community Learning Difficulties Nurse

Linda Phillips
Director of Nursing

Steve Potter
Community Learning Difficulties Nurse and Mrs King's Care Coordinator

Detective Sergeant Christopher Spinks

Dr Huw Thomas
Consultant Psychiatrist

Mrs King and two family members

Two close relatives of Richard King

Four members of John West's family