EXECUTIVE SUMMARY

REPORT OF AN INDEPENDENT INQUIRY

INTO THE CARE AND TREATMENT

OF MR R

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EXECUTIVE SUMMARY

1. Introduction

Mr R was convicted at the Central Criminal Court in May 1999 of:-

- wounding Mr Q in Ramsgate on 29 September 1998 and
- the manslaughter (on the grounds of diminished responsibility) of Mr S in Orpington on 30 September 1998

From December 1996, until his arrest on 2 October 1998, Mr R had received a range of mental health services from the National Health Service, local authorities and independent agencies in East Kent.

2. Background

National Health Service Guidelines HSG (94)27 requires that an 'Inquiry' be established which is independent of the service providers, when a person in contact with mental health services commits a homicide. The function of independent reviews is to thoroughly and objectively review the patients' care and treatment in order to ensure that services provided are safe, effective and responsive. This enables lessons to be learnt which may minimise the possibility of further tragedies.

This Independent Review was commissioned by the former East Kent Health Authority which ceased to function on 31 March 2002 because of NHS reorganisation. Therefore we are reporting to its successor body – the Kent and Medway Strategic Health Authority.

3. Terms of Reference

The role of our independent inquiry was to 'quality assure' the internal process rather than to duplicate it. Its terms of reference were:

1. To review the conduct and process of the internal inquiry, the evidence taken and conclusions and recommendations.

2. To identify areas where the independent inquiry feels there may be weaknesses or omissions in the process, outcome and recommendations of the internal inquiry.

3. To conduct its own detailed review of those areas identified at (2), and subsequently to draw additional conclusions and recommendations if appropriate.

4. To establish the extent to which the recommendations of the internal review and any recommendations of the independent inquiry are already being addressed by the relevant parties.

5. To provide a report to the East Kent Health Authority (now replaced by Kent & Medway Health Authority) Kent County Council Social Services Department and East Kent Community NHS Trust on their findings and recommendations.

4. Documentation

Documentation concerning Mr R was commissioned from the relevant agencies. This included material not available to the local clinicians or the internal review. The panel obtained copies of patient records and other relevant documentation from the local health bodies, social services department, general practitioner, army medical service, Special Hospital, criminal court, prison medical service, Mental Health Act Commission together with the internal review report and those transcripts used in its production. Inquiries were made of the local ambulance service, the psychiatric hospital in Hastings, and the day treatment unit to see if they had relevant documents in their possession. The Crown Prosecution Service was also asked to provide copies of certain statements and exhibits.

5. East Kent Community NHS Trust

The East Kent Community NHS Trust was formed on 1 April 1998, by the merger of two existing NHS trusts:

- The Canterbury and Thanet Community Healthcare NHS Trust which had previously covered Faversham, Whitstable, Herne Bay, Margate, Ramsgate, Broadstairs, Sandwich and Canterbury

- The South Kent Community Healthcare NHS Trust, which had previously covered Ashford, Shepway, Folkestone and Dover and Deal.

Mr R received health care from the Canterbury and Thanet Trust until the East Kent Community NHS Trust was formed. This Trust provides services to a population of around 600,000 people.

6. Chronology of Events

6.1 1995

Mr R first came to the attention of the police when he was charged with taking a motor vehicle without consent on 8 October 1995 and remanded in custody at HMP Winchester where it is believed he received a psychiatric assessment.

On 7 November 1995 he was released and two days later arrived in Dover around 10 pm. At 11 pm he burgled a shop, stealing a pair of scissors and leaving a note of apology. Some two hours later he attacked a black coach driver with the scissors and later that day purchased a knife which he used to threaten a stranger in the street (also a black man) before being arrested by the police and detained in Canterbury Prison.

6.2 1996

Whilst in prison it was apparent that Mr R was acutely ill, so he was examined by the local psychiatric consultant, Dr Wood, and subsequently made subject of a Hospital Order (Sec 37 Mental Health Act (MHA) 1983) when he pleaded guilty to the charges against him at Canterbury Crown Court. Mr R was eventually admitted to Dudley Venables House (St Martin's Hospital, Canterbury) on 22 February 1996 29 days after the Hospital Order had been made.

It is a condition of Hospital Orders that admission to hospital takes place within 28 days, MHA Sec 37(4), so the order was no longer valid at the time of admission but until our Inquiry its status was not recognised by anyone involved in the care of Mr R including hospital managers, clinical team, patient, or the Mental Health Act Commission. What follows assumes that his detention was valid, as was believed at the time.

Mr R's mental state and behaviour remained disturbed during February 1996. He twice attacked a fellow patient without any provocation, punching him in the face on the second occasion and was warned about his 'boisterous' behaviour towards a black patient. He felt that he had been set up and was being experimented with and was easily irritated. He did not believe that he had a mental illness and said that he would not take any form of medication or see a psychiatrist after he was released. The hospital senior house officer, Dr OKhai, was so concerned about his 'level of dangerousness' that he decided to discuss a forensic assessment with Dr Wood.

On 2 May he was assessed by Dr Sugarman, two psychologists, a social worker and a staff nurse from the Trevor Gibbens Unit. It was noted in the assessment report that 'if he stops taking treatment, then relapse and perhaps re-offending are highly likely'. Transfer to a medium secure unit was not suggested but support offered if Mr R was discharged into their immediate area.

In June Mr R was assessed at the Maudsley Hospital forensic psychiatric unit (south-east London) in view of his expressed wish to move near family in that locality. The medical report following that assessment included the points that:-

- continued medication was essential to prevent relapse
- in the event of relapse the risk of re-offending was high
- compliance with medication was likely to be problematic.

Assistance with follow-up arrangements was offered if Mr R were to be discharged in the future to a south-east London address.

At this point Mr R was offered temporary accommodation by the district council in Kent because he was homeless. An alternative to this option was sought and on 9 September he was discharged from Dudley Venables House to a one-bedroom first floor flat in Herne Bay in accommodation operated by a local housing association. The flat was not well equipped and Mr R did not have the use of a cooker.

On 13 August 1996 a Section 117 multi disciplinary meeting was held to plan Mr R's discharge. The Forensic Community Psychiatric Nurse (CPN), Steve Reynolds, (jointly managed with Glennis Hunt) in the local Mentally Disordered Offenders team (MDO) was appointed as Mr R's supervisor in the community – he was the first patient in East Kent to receive after-care under supervision within the provisions of section 25A of the 1983 Act. This new section of the Act had become operative on 1 April 1996.

The following requirements were imposed by Dr Wood in relation to his after-care under supervision:-

- He will reside at an address specified by his supervisor and will not change address without his supervisor's approval;
- He will accept medication as prescribed by his community RMO for as long as deemed necessary;
- He will attend appointments with his community RMO as directed;

- He will permit access to his place of residence by his supervisor.

Mr R was anxious about independent living and residing in a coastal area, so sessional support from Steward Sibley and Ray Porter, support workers, was arranged to provide additional support – for instance to take him shopping. Mr R was also registered with a local General Practitioner, Dr Ritchie.

The MDO team saw Mr R once or twice daily during the initial fortnight, then once every two days and subsequently on an individual needs basis. Mr R became increasingly housebound in his flat and it seems that he did not cook or eat properly. It was felt by Glennis Hunt that Mr R lacked motivation and although he had the skills to live more independently was not enacting them. It was decided to look for semi-independent accommodation. Although Mr R had been saving money towards the deposit on a flat in London the MDO team were not comfortable with him leaving their area. He was persuaded to seek supported accommodation in Ramsgate where he was accepted.

6.3 1997

Mr R moved to supported accommodation in Ramsgate - an eight bed-roomed house (with a basement flat) operated by Richard West who was experienced in delivering services for people with special needs.

In general Mr R's professional carers believe that this placement was beneficial, although negative symptoms and akathisia were evident. He was polite, pleasant and related well to other tenants when around them. Everyone in the house liked him. He did not leave the house much, although talked about seeking a job at some stage and moving back to London.

During the following months increasing concern about the effects of akathisia on Mr R led to a change in his medication. The last recorded depot injection was given in July but four months later he was acting strangely.

6.4 1998

During January and February 1998 concern was expressed by Mr R's current support worker, Rob Wells. He was increasingly restless, seemed agitated, appeared to be acting strangely and was pre-occupied. On 4/5 February Mr R left the house midway through cooking a meal for the other residents. On questioning he stated that he just needed to get away from it all and that 'it was going to happen and there was nothing anyone could do'.

Mr West phoned the MDO team to express concerns about Mr R's behaviour. A knife had been found on the living room table - Mr R said that he had been cleaning his nails that day. Mr West felt that he could

not take any chances with Mr R especially as he felt something was very wrong with him. The MDO team, Steve Reynolds and Glennis Hunt, visited the house and found Mr R asleep in the lounge. Upon waking he informed them that he felt very low and agreed to accompany them to an outpatient clinic to see his consultant, Dr Wood. Following a psychiatric assessment during which Mr R was examined by Dr Wood and another consultant, Professor Hale, it was decided to admit the patient under Section 2 of the Mental Health Act 1983 on 6 February 1998

The medical recommendation states: 'Mr R is suffering from a psychotic illness which has recently relapsed. In a previous episode he made an unprovoked serious attack upon a member of the public and in his present mental state there is a high probability that he will behave violently again unless immediately admitted to hospital for further assessment.'

On admission it was apparent that Mr R's health had deteriorated. He was dishevelled, lethargic, uncommunicative and had little interest in his personal hygiene. He challenged anyone who suggested that he was ill and did not accept that he needed medication.

On 11 March a medical note states 'withdrawn, blunted, residual schizophrenia'. On 17 March his 'lack of progress' was discussed with nursing staff: 'withdrawn, no self-care, no participation in ward activities, anhedonia, poverty of speech'. The relative merits of clozapine and pipothiazine were considered with regard to both likely compliance and relative efficacy. On 18 March the fact that akathisia had previously been prominent and was a risk factor for violence was noted. On 24 March olanzapine tablets were found in Mr R's room and it was thought that he was concealing them. The tablets were to be crushed for him to take in future.

In May 1998 it was considered that Mr R was not fit to provide consent for his treatment and the consent to treatment provisions of MHA Sec 58 were applied. Following a visit from a Second Opinion Approved Doctor, Dr Symonds, appointed by the Mental Health Act Commission, Mr R's medication was changed from olanzapine to clozapine.

Mr R's mental state improved and due to pressure on the beds within the Dudley Venables House, it was decided to transfer Mr R to Thanet ward (an open unit) on 1 June 1998. This ward change also meant a change in medical responsibility. Dr Kalidindi then took responsibility for Mr R's care. Dr Kalidindi had been employed in the trust as a locum consultant for several years. However, his substantive appointment was as associate specialist – a grade of doctor responsible to and supervised by a consultant. Dr Kalidindi did not have forensic psychiatric training or experience.

As consultant catchment areas were being reorganised, it was generally accepted that the care of Mr R would transfer in due course to Professor Hale (a consultant with forensic psychiatric experience) but this change did not occur.

Once again due to bed pressures, Mr R was then transferred to another ward (Flete) on 8 July 1998. He remained under the care of Dr Kalidindi. A multi disciplinary team (Dr Kalidindi, Sue Goldfinch (nurse), Mr Reynolds, Ms Hunt, Mr Wells and Mr West) reviewed Mr R's case at a Care Programme Approach (CPA) meeting on 13 July at which it was agreed to allow him to return to his supported accommodation in Ramsgate immediately.

The Steve Reynolds and Glennis Hunt took joint case responsibility for Mr R, although Glennis Hunt took the key worker role, and he remained on Level 3 CPA. It was agreed that his condition had improved and that he wanted to improve his quality of life. Support workers, Rob Wells and Angela Groves continued to provide Mr R with support for daily activities.

On 16 July a joint visit was undertaken by Steve Reynolds and Glennis Hunt during which it was noted that he "continues to present well. His bloods were taken". A supervision note the following day states 'CPA 13.7.98 … S25 MHA '83 not pursued as Mr R compliant with after care planning'

On 22 July he was seen by one of the support workers, Rob Wells, who reported that Mr R had purchased a tent and sleeping bag and 'said he was going to London' or that 'he was going camping/fruit picking'. It was noted by the MDO team a day later that Mr R had failed to collect his clozaril prescription and a telephone call to his supervised accommodation established that he had absented himself from there.

On Friday 24 July Mr R failed to attend his out patient appointment and Dr Kalidindi revoked the authority for extended leave.

Mr R eventually returned on Monday 27 July and Steve Reynolds and Glennis Hunt were notified. When they visited to assess Mr R his condition was found to be the same – 'laughing, joking and he apologised for not notifying anybody while he was away. He also told us he had not been taking his Clozapine'.

His leave was revoked and he was admitted to Elmstone ward, St Martin's hospital on 27 July 1998 where he was reported to be 'compliant; he didn't give staff any problem as such. He used to take his medication; he came down for meals. Maybe he didn't interact so much with the other patients'

On Friday 14 August Mr R was again granted extended leave. At that time the section 3 order was due to expire in four days. The timing of

this leave was significant in that his consultant, Dr Kalidindi, Steve Reynolds, Glennis Hunt, Richard West and Rob Wells were all due to take annual leave and would be absent from the area within that time frame.

Mr R was found to be absent from his accommodation for days during this period nor did he always attend the appointments made for him at the Day Hospital or for his bloods to be taken.

On Tuesday 1 September Mr R was seen by Rob Wells between 5 and 6 pm and the next day he appears to have had a clozaril blood sample taken. Rob Wells was concerned about Mr R's mental state so he informed his manager, Ms Groves. It was decided to request an outpatient appointment for Mr R.

On Friday 4 September Mr R collected his medication, which was next due for collection on 17 September. The supported accommodation holiday relief manager, Ruth Woodrow, was also concerned about his mood. Although Mr R attended the Mental Health Unit, his consultant, Dr Kalidindi, was on leave and there is no indication that an appointment with an alternative doctor was arranged.

As normal on Saturday and Sunday the supported accommodation was unsupervised and the MDO team were off duty. A rail ticket found following his arrest indicates that Mr R purchased a cheap day return rail ticket from Ramsgate to 'Borough Green & WRM'

Following the clozaril blood sample taken on Monday 7 September, no others were taken until 29 September. Glennis Hunt and Steve Reynolds returned from holiday and Angela Groves' notes state 'Told social worker information re Mr R. She will visit him today.'

These notes together with others described in this section were made in message book, pads, and on stick-it notes. They do not appear to have been given to the MDO team.

Although on Thursday 17 September Mr R failed to collect his clozaril, the pharmacy did not alert anyone of this fact for 12 days (until 29 September). Mr R was absent from his accommodation at this time.

On Tuesday 22 September Glennis Hunt was informed at 11.30am by staff at his supported accommodation that Mr R had returned. Steve Reynolds was informed and they visited together. This was the first time that Glennis Hunt had seen Mr R since 8 September and it was the last time that she saw him prior to Mr S's death. According to the notes 'Mr R had been to London, he had slept on a railway station. He stated he went to visit his father but decided not to when he got to London. Appeared reasonably well –Steve Reynolds suggested he would return tomorrow to take Mr R's bloods. Rob Wells to resume visits'

Dr Kalidindi had contacted the accommodation and learnt that Mr R had returned. He wrote a file note stating that 'the patient should come back to hospital to be re-established on Clozapine. Steve Reynolds is due to visit patient and will phone me. Steve Reynolds left a message saying patient relatively stable, will organise blood test and to be seen in OPC as early as possible. CPA arranged'

On Wednesday 23 September Steve Reynolds recorded that he was unable to call at 9am. When he did visit at 4.30 pm to take blood samples he recorded that Mr R was 'not in and no one had seen him. Further visit arranged for tomorrow'. Steve Reynolds notified Glennis Hunt by telephone and her contemporaneous note says that she 'alerted Dr Kalidindi. Requested that the Mental Illness Support Team (MIST) [an out-of-hours service] telephone to see if he was there after 5 pm'. The accommodation diary entry reads 'Mr R not seen all day'

Dr Kalidindi recorded that the planned 'CPA clashes with team day. Tried ringing the house at 5pm. Only answering machine, left message for patient'

On Thursday 24 September Glennis Hunt received a telephone call from Richard West stating that Mr R had not returned home. She discussed notifying the police with Dr Kalidindi. There appears to be confusion about responsibility for notifying the police - Glennis Hunt left Dr Kalidindi to do so.

Dr Kalidindi visited the house at lunchtime and with the help of another resident knocked at Mr R's door. As Mr R was not in, Dr Kalidindi left a message with MIST.

Mr R then returned to his supported accommodation at tea-time. Steve Reynolds was informed and said he would visit the next day 'to physically see him and ascertain for himself how well he was …' (A rail ticket found following Mr R's arrest indicates that he bought a single rail ticket from Sevenoaks to Ramsgate at 2.36 pm)

Dr Kalidindi was informed that evening about the return of Mr R and that Steve Reynolds said 'not to visit as he would keep an eye on him, and to visit on Friday'

On Friday 25 September Steve Reynolds visited Mr R at his home between 9.00 and 9.30am followed half an hour later by Dr Kalidindi so they examined him together. Mr R informed them that he had again been to London sleeping rough and was vague about his movements. He agreed to have his blood tested and was fully co-operative with the procedure. The reason given by Mr R for leaving Ramsgate was that he was flat hunting but had not found anything suitable so indicated that he would return to London over the weekend.

Steve Reynolds requested that Mr R should return to Ramsgate for Monday 28 September – a suggestion to which he agreed. In conversation it was noted that his speech rate and speed were normal and there appeared to be no evidence of abnormal thought content. However, he appeared tired and was in need of a bath and change of clothing. Dr Kalidindi asked Mr R if he wanted to enter hospital as an informal patient but he declined, promising to continue taking clozaril. On completion of this joint assessment, arrangements were made for a CPA meeting on 5 October as this would be the most suitable date for both Professor Hale and Dr Kalidindi to attend. It was agreed that Steve Reynolds would visit daily in the meanwhile.

On 28 September Mr Q was stabbed in Ramsgate. Mr S was stabbed and killed on 29 September. Mr R was subsequently arrested in Guildford on 2 October and charged with both offences.

7. Summary and Recommendations

Since the period when Mr R was cared for in Kent, government has generated major changes in the funding, organisation and delivery of mental health services across health and social care in both the statutory and independent sectors. Therefore some improvements to services in Kent we might have suggested are either already established or currently being implemented. Nevertheless we offer below some recommendations as well as a summary of our conclusions on the care provided by local agencies for Mr R.

7.1 Compliance with Medication

7.1.1 Mr R suffers from an enduring mental illness, which responds positively to properly monitored medication and effective supervision provided by appropriately trained mental health professionals. He was known to experience difficulty in complying with prescribed medication and it was also known that his illness would deteriorate rapidly if treatment regimes were broken. This was not always reflected in arrangements made for his care and support.

Recommendation

Where patients are known to have difficulty in complying with prescribed medication staff should ensure that regular, rigorous and appropriate monitoring of medication takes place and is recorded.

7.1.2 Successful treatment with clozapine requires meticulous monitoring to ensure the administration of an adequate dose. It is best used for patients whose compliance is beyond question. When he was taking clozapine this medication was found to be satisfactory in relieving a proportion of the symptoms of Mr R's illness whilst generating fewer side effects than the injectable long acting medication he had received

earlier. However medication supposed to be taken orally is inherently less reliable in controlling illness than an injectable form without the full cooperation of the patient.

Following the CPA meeting in July 1998 Mr R ceased taking medication and was therefore recalled from leave. He was thought by Flete Ward staff and others not to be reliably compliant. It appears that these circumstances were not fully considered in accepting Mr R's statement about his own compliance when visited by Dr Kalidindi and Steve Reynolds. In addition the pharmacy was aware in September that Mr R was not collecting his required medication regularly but did not report these circumstances to anyone in clinical authority.

Recommendation

All circumstances where non-compliance of medication is known or suspected should be reported immediately to the patient's key worker and consultant psychiatrist. In turn this information should be shared with all staff working with the patient and clearly documented together with an appropriate plan of action.

7.2 Dangerousness

7.2.1 Mr R was known to pose a potential danger to others if his illness became active. This potential risk was assessed independently by competent experts on several occasions. Although this risk was accepted earlier by members of the Mentally Disordered Offenders team it appears that in later stages they behaved towards Mr R as if he were recovering from his illness with a consequent reduction in his potential for dangerousness to others.

Recommendation

Where patients are identified as posing potential danger to others, this information should be stated clearly at the front of the case notes and consideration of potential risk should be regularly taken into account when managing the care of such patients by the care team.

7.2.2 The decision of the CPA meeting in July 1998 to register Mr R as an informal patient when his compulsory detention order expired was apparently based on a positive assessment of his current mental state without sufficient consideration of the index offences and earlier expert opinions about the risk of dangerous behaviour if he relapsed. It is also not clear that this action was discussed with the patient, contrary to best practice.

Recommendation

In assessing the needs of patients with a forensic history evidence of previous offending, dangerous behaviours and clear expert opinion must always be carefully considered alongside apparent recovery.

7.2.3 At a CPA meeting held on 13 July 1998 a CPA form and 'risk of harm assessment checklist' were completed. The outcome was 'low risk' (options being: low, medium and high) although in the 'area of concern' section of this assessment tool the status 'high' severity of concern relates to 'profile of present and previous offences'. We noted that a risk assessment on Mr R was completed using the same methodology at his CPA meeting on 9 September 1996 and find it unsurprising that the risk assessment applied to Mr R should be recorded as 'low' in 1998 as his assessment in 1996 (closer in time to the index offence) achieved the same result. Risk assessment is an inexact science but that assessment appears to be out of line with the repeated expert professional opinions predicting the potential for Mr R to exhibit dangerous behaviour if his illness recurred.

If the assessment made had been other than 'low,' additional questions on the checklist required answering – for instance an estimate of which individuals might be at risk. Considering these questions more thoroughly might have focused the treating team's thinking on the likelihood and possible nature of further attacks.

Recommendation

A review of the current Risk Assessment Tool needs to be undertaken. Monitoring of the completion of the forms should be undertaken by the Trust within the next six months and appropriate staff training needs identified and addressed within the next 12 months.

7.2.4 On 25 September 1998 there was concern about the vulnerability of Mr R, who had been absent from his supported accommodation. In response to requests from various individuals he was visited both by Steve Reynolds and Dr Kalidindi who arrived as Steve Reynolds was leaving. They then interviewed him jointly. As a result of this joint assessment Mr R was offered informal admission - which he declined.

Although it appeared that the mental health of Mr R had deteriorated, it is not clear to us that Dr Kalidindi and Steve Reynolds considered the possibility that a comparable incident to his index offence might occur - a circumstance which would clearly warrant his compulsory admission to hospital under the Mental Health Act 1983.

7.3 Racism

7.3.1 When not influenced by the symptoms of his psychosis, Mr R appeared no more racist than the average citizen. We were told that both at

school and in the Army he had non-white friends. However, when his illness is active then people from ethnic black communities become the object of his paranoid ideas. We found no evidence that these racist components of the illness experienced by Mr R received particular scrutiny during assessments conducted by members of his care team.

Recommendation

The potential impact of racist behaviour must be considered thoroughly during care planning and risk assessment then recorded within the case notes and risk assessment plan so that the safely and well-being of other patients and staff can be properly safeguarded..

7.4 Information Gathering

7.4.1 The Mentally Disordered Offenders team were not in possession of all information relevant to the care and treatment of Mr R. There was a failure to put in context the information regarding his history during the weeks immediately preceding the incident which led to his first admission. In particular it would have been beneficial for the care team to access Mr R's medical records from his: -

- military service
- earlier treatment by his general medical practitioner
- Winchester Prison Forensic examination following his offences in Hampshire.
- behaviour as known to the police in Dover, particularly the alleged incident for which he was not charged

We consider that the collation and maintenance of a comprehensive medical and social history is essential in order to ensure the effective assessment and safe treatment of people with mental health problems particularly in a forensic context.

Recommendations

When patients are referred to the mental health service without details of their past mental health history it must be part of the Trust's policy to identify, request and obtain all relevant history relating to the individual. This should be clearly documented within the case notes and reasons given if the information has not been obtained.

The Police, Prison and Crown Prosecution Services should ensure that information about people within their jurisdiction experiencing mental health problems is referred to local mental health services so that effective assessments and treatment plans can be made where necessary, particularly when that local service may become responsible for their care.

7.5 Application of the Mental Health Act 1983

7.5.1 Mr R remained in Canterbury Prison awaiting an available bed following the making of a Hospital Order (Sec 37 Mental Health Act 1983). Under this provision of the Mental Health Act the power to transfer a patient lapses at 28 days. As his transfer took place on day 29 it appears that Mr R was improperly detained between 22 February 1996 and 9 August 1996.

This situation was overlooked by his care team, hospital managers and the Mental Health Act Commission when they visited the hospital and was also not known to Mr R. However we do not doubt that if this error had been noted on admission to hospital there were grounds to detain him at that time under Part II of the Mental Health Act.

Recommendation

Training of both administrative and clinical staff should take place on a regular basis to ensure that their understanding of the Mental Health Act is up to date. Our finding should be brought to the attention of the Prison Authorities and also of the Mental Health Act Commission so that they can ensure that their procedures allow for the monitoring necessary to ensure that patients are properly detained.

7.6 Family Contact

7.6.1 It proved difficult to maintain meaningful links between Mr R and significant members of his family. On occasions during the period of relevance to our Inquiry he expressed a desire to live again in London. From the time in his childhood when his parents agreed to live apart Mr R had developed distinct relationships with his father and mother who each now had their own separate families. Before the acute episode of his illness during which he left London Mr R was supported by his father's family. We formed the view that the potential for contact with father and his family was not fully pursued by the care team. In addition potential residence qualifications in London enjoyed by Mr R were not recognised by the team and so not used effectively as evidence in support of his repatriation.

This contrasted with the regular contact maintained with mother who was considered his nearest relative under the Mental Health Act. We find that the viability of Mr R returning to London was never properly tested by the Mentally Disordered Offenders team, neither was its' impact on his care plan thoroughly assessed, nor was the potential of support for Mr R from his father and extended family adequately explored.

Recommendation

In making plans for rehabilitation the availability of members of the patient's extended family (and of friends), as potential carers should always be carefully evaluated and discussed with the patient and recorded, particularly when they have offered support in the past.

7.7 Team Work

7.7.1 The Mentally Disordered Offenders team did not always operate effective arrangements for management and professional supervision. Perhaps because they were experienced practitioners and the service was under pressure we consider that members of the Mentally Disordered Offenders team were sometimes 'left to get on with it'. The medical contribution lacked sufficient impact on service delivery. Team management often seemed distant and did not always produce sufficient cohesion. Professional supervision was not always applied with adequate rigour or consistency. Although a single manager from social services co-ordinated team activity some key managerial functions were undertaken by staff in other agencies. By way of illustration:

Because annual leave for all team members was not approved by the same manager, at a critical period in the care of Mr R annual leave was authorised for several key members of his care team resulting in their absence at the same time. This seriously reduced the effectiveness of his supervision.

We felt that the accepted practice of dual working was excessive and not necessarily a good use of resources.

Recommendation

Where more than one agency is responsible for the management of workers in a multi-disciplinary team a protocol should be agreed which ensures a coherent operation by clearly defining responsibility for key tasks including professional supervision, workload management and granting approval for leave – ideally identifying one person to take overall responsibility.

Relevant agencies should examine the possibility of establishing an organisation which provides a unified management structure for health and social care mental health services.

7.8 Transfer between Wards

7.8.1 Mr R was transferred between two wards so that a more equitable workload balance could be achieved for each service as another patient was exhibiting acute symptoms requiring higher levels of treatment and care. We accept that this procedure may be required

and is reasonable when the receiving ward team has knowledge of the transferred patient (either because ward care team members have prior knowledge of the patient or were properly briefed through a hand over process). But in the transfer of Mr R not only was he unknown to the receiving ward team, but the transfer procedure required a change in consultant psychiatrist responsibility from Dr Wood who had managed the care provided for Mr R throughout his stay in East Kent to that point and had special expertise in forensic work to Dr Kalidindi who was a locum consultant unfamiliar with the case.

When Mr R appeared to be enjoying improved mental health and beds on the acute ward were in high demand he was moved again – on this occasion to another in-patient ward and day service without the application of proper handover procedures. Consequently staff in the receiving units could only provide Mr R with a limited service.

Even when demand on resources is high the transfer of patients between services for 'administrative' reasons cannot be in their best interests. To provide an effective service, receiving care teams require comprehensive information about patients transferred in so that they are motivated to offer quality treatment and care with confidence.

Recommendation

All patients being transferred between wards should be properly handed over with both written and oral information provided to the new care team. This should be documented and monitored on a regular basis. Patients should be involved in the transfer process and not transferred in their absence.

7.9 Consultant Staffing

Dr Kalidindi) was employed by East Kent Community NHS Trust as a locum consultant psychiatrist at the time he had medical responsibility for Mr R. Locum doctors are often employed on a grade for which they are not qualified for short periods - for instance during a brief period whilst recruitment is arranged to a substantive consultant post. Dr Kalidindi was not a locum in this sense. As an employee of the Trust and its predecessors since 1980 his substantive (i.e. permanent) grade is Associate Specialist - that is a senior doctor who is responsible to and supervised by a consultant although working more independently than a trainee doctor. Although with extensive experience, Dr Kalidindi has never undertaken the higher training required for appointment as a consultant.

Reported resource constraints and recruitment difficulties by the Trust resulted in the application of locum arrangements for an extended period. Although contrary to guidance from the Royal College of Psychiatrists, we are aware that many health bodies engage in this

practice because of recruitment difficulties given a national vacancy rate of 10-15% for consultant psychiatrists.

We do not think Dr Kalidindi recognised adequately the potential dangers of a relapse in Mr R's illness. These indicators were noted by various consultant psychiatrists who examined Mr R during his care in East Kent. We believe this reflects Dr Kalidindi's lack of relevant higher training.

During a key period in the treatment of Mr R new arrangements for consultant catchment areas were being put in place. This change programme was controlled by the consultants themselves and we became aware that some tensions had been generated by this process. However both Dr Kalidindi and Professor Hale were in agreement that the latter (who coincidentally knew Mr R's psychiatric history as he had examined him earlier as an approved doctor) had declined to assume medical responsibility for Mr R without a proper handover session. As time for this handover could not be immediately identified, Mr R remained under the care of Dr Kalidindi.

We think it was unsatisfactory that Dr Kalidindi (who was least experienced in the care of patients like Mr R) was required by the procedures then in force to assume responsibility for the medical supervision of this patient without consultation but could not transfer that duty to another appropriately qualified medical colleague because it was not practicable to organise a proper handover session.

Recommendation

Where health bodies have to continue employing doctors under extended locum arrangements they should put in place an appropriate individual support plan for each situation in which a doctor is not fully trained for the position they occupy. These arrangements should be part of the medical appraisal system, be monitored and recorded on a regular basis and included within appropriate arrangements for Clinical Governance.

7.10 Joint Commissioning and Accommodation

7.10.1 We found a lack of clarity amongst practitioners about arrangements for interagency co-operation between health bodies, social services and the local district council in organising appropriate accommodation and care for Mr R upon his discharge from hospital.

Recommendation

To complement our earlier proposal that the statutory authorities establish a unified management system for the delivery of comprehensive, integrated and effective mental health services across health and social care we also recommend that:

Arrangements be established by the responsible authorities for the joint commissioning of mental health services within a common policy framework

Contributions to this process are achieved from service users, their carers and other key stakeholders in both statutory and independent sectors

Procedures for discharge planning include at the earliest possible opportunity a comprehensive assessment of accommodation needs of each patient so that the best possible response can be made within existing resources and that accommodation (and other) deficits identified through care planning for individual patients can be aggregated for conversion through the planning system into options for service development for the investment for new resources.

7.11 Mental Health Support to Prisons

7.11.1 The single route to mental health assessment provided by Dr Wood and the MDO team to HMP Canterbury was commended to us as a significant improvement on previous arrangements. Earlier referrals had been made by the Prison Medical Service to any of the catchment area teams as determined by place of residence. However for patients in East Kent this system replaced referral to a full forensic psychiatric service, which at the time was available to patients from West Kent from the forensic service at Maidstone.

Comment

We have no doubt that a single mental health team providing regular integrated support to a local prison is more effective than liaison from several non-dedicated services. Unfortunately the availability of this service resulted in it accepting a referral on behalf of Mr R following his committing a 'stranger in the street' assault. In the absence of the service provided by Dr Wood and his colleagues it is likely that Mr R would have been referred to a forensic psychiatrist. Forensic services are more accustomed to the rigorous interrogation of previous records and also considering the use of restriction orders when preparing their treatment plans and court reports than services provided by general psychiatrists. We think such consideration might have resulted in a different pattern of care for Mr R.