An Independent Inquiry into the care and treatment of RR and AT

A Report for NHS London and NHS South East Coast

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Abbreviations and references

A&E	Accident and Emergency Department
ASW	Approved Social Worker
AWOL	Absent Without Official Leave
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CSCI	Commission for Social Care Inspection
GMC	General Medical Council
GP	General Practitioner
HC	Healthcare Commission
K&M SHA	Kent and Medway Strategic Health Authority
MARS	Medication Administration Record Sheet
MHA	Mental Health Act
NCSC	National Care Standards Commission
PCT	Primary Care Trust
PRN	*pro re nata*, as necessary
PVH	Private and Voluntary Healthcare
RAF	Royal Air Force
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
RMO	Responsible Medical Officer
RNLD	Registered Nurse Learning Disability
S/N	Staff Nurse
SHA	Strategic Health Authority
SHO	Senior House Officer
SLaM	South London and Maudsley NHS (now Foundation) Trust
SWL SHA	South West London Strategic Health Authority

Acknowledgements

We would like to thank everyone who gave up time to give evidence to the Inquiry and who spoke so freely to us. We would also like to acknowledge the co-operation of the police whose assistance has been valuable in helping us complete our task.

We would also like to thank the staff at Verita who managed the Inquiry for us with great efficiency and diligence, as well as looking after all our needs on our travels to take evidence from witnesses.

1. Introduction

1.1 On 12 December 2004 RR killed AT. The sympathy of all involved in the preparation of this Report goes out to AT's family and friends and all those affected in this tragedy.

1.2 The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness provides a definition of a *"Mental Illness Homicide"* as one where the person convicted *"had symptoms of mental illness at the time of the offence."* From the evidence we have heard, set out at length in our Report, there is no doubt that the killing of AT was a *"Mental Illness Homicide"* within this definition.

1.3 RR has been convicted of AT's manslaughter, on the grounds of diminished responsibility. He is serving a life sentence.

1.4 At the time of the homicide, RR and AT were both residents at Shrewsbury Court, an independent hospital run by The Whitepost Healthcare Group and a part of the Whitepost Health Care Centre, Redhill, Surrey. AT had lived at Shrewsbury Court since 1 May 2001. Her placement was arranged and funded by Kent & Medway Strategic Health Authority (K&M SHA). RR had lived at Shrewsbury Court since 22 June 2004. His placement was jointly funded by Croydon Primary Care Trust (Croydon PCT) and by the London Borough of Sutton. Before his transfer to Shrewsbury Court, RR had, for a number of years, been under the care of what is now South London and Maudsley NHS Foundation Trust, but was then known as South London and Maudsley NHS Trust (SLaM). We use the abbreviation SLaM throughout this Report to refer to both of these entities.

1.5 At the time when this Inquiry was commissioned, SLaM and Croydon PCT were under the auspices of predecessor organisations to NHS London.

1.6 The Inquiry panel comprised:

Derek Holwill, barrister
Dr David James, consultant forensic psychiatrist
Gillian Chalder, consultant forensic nurse.

1.7 This Report quotes from contemporaneous documentation as well as from the evidence of witnesses to the Inquiry. In order to help the reader, we sometimes replace abbreviations used in the contemporaneous documentation with the full text, and we sometimes correct obvious spelling or grammatical mistakes so as to make the meaning

clear. Where, however, the existence of such mistakes is relevant to the issues discussed, the passages quoted appear precisely as in the original documentation.

1.8 In the course of this Report we summarise the relevant events, as disclosed by the evidence we have seen and heard, focusing in particular on the two year period prior to the homicide. We should make it clear that the conclusions we have reached as to what occurred represent the views of this Inquiry Panel and that, where there is uncertainty or controversy about issues of fact, the conclusions which we have expressed represent our view as to what, on the balance of probabilities, actually occurred.

1.9 This Report is the result of an inquisitorial process. In it, we comment, sometimes critically, upon the performance of some of those who were responsible for the care of RR and of AT. Individuals criticised in this Report have been given an opportunity to respond to those criticisms, but although a number of them have been legally represented, none of the contributors to the Inquiry have had access to the entirety of the documentation which has been placed before us; and they have not been privy to all of the evidence presented to us. They have not, therefore, had the opportunity to review the evidence placed before the Inquiry, to cross-examine witnesses, or to adduce their own evidence. We are self-evidently not a court of law. Neither our procedures nor the evidence enable us to make findings equivalent to those of a court adjudicating a disputed clinical negligence action and it is not our function to express a view on whether any of the participants in the events which we describe might, in the future, face any form of liability for any acts or omissions. We have deliberately refrained from describing the acts or omissions of any individuals as "negligent" or as "falling short of the standard to be expected of a reasonably competent practitioner".

1.10 The conclusions expressed in this Report about the actions taken, or the approach adopted, represent our considered views, following extensive discussions between us. Our conclusions are based on our collective experience, and a thorough consideration of the evidence which we have seen and heard.

2. Terms of reference

2.1 This statutory independent Inquiry is commissioned by South West London Strategic Health Authority with the support and co-operation of Kent & Medway Strategic Health Authority under Section 2 of the NHS Act (1977). It is commissioned in accordance with guidance published by the Department of Health in circular HSG (94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community*, and the updated paragraphs 33-36 issued in June 2005.

2.2 The Inquiry's Terms of Reference are as follows:

"Stage 1

1. To review the treatment and care provided to RR by the NHS and social services from January 2002 to the time of the alleged homicide, in the context of his previous history.

2. To review the circumstances under which AT became a resident of Shrewsbury Court, and the care and treatment she received there including considering the concerns expressed by AT's family about her placement.

3. To compile an accurate chronology of significant events prior to the alleged homicide.

4. To gain a clear understanding about individual organisations' responsibilities at the key points identified in the chronology.

5. To agree with the strategic health authority any areas (beyond those listed below) for further consideration.

Stage 2

6. To assess the adequacy of the risk assessments in relation to RR and AT and actions consequent upon those assessments.

7. To examine the nursing, medical and management issues associated with the care & treatment of RR and AT – both at Shrewsbury Court and in the relevant preceding period.

8. To examine in particular the extent to which the medical history of RR was communicated from one organisation to another when responsibility passed from one organisation to another.

9. To review the contractual arrangements between Whitepost and the purchasing authority for RR's care at Shrewsbury Court.

10. To review any inspection reports about Shrewsbury Court and consider what relevance their findings and recommendations have to the care & treatment of RR and AT.

11. To review the extent to which RR and AT's care conformed to statutory obligations and relevant national guidance.

12. To consider whether the matters raised by the Inquiry have implications and lessons beyond the commissioning bodies and, if so, what those are.

13. To make recommendations as appropriate to capture any learning about issues the Inquiry has considered.

14. To provide a written report to the strategic health authority."

3. Executive summary

3.1 This summary has been written in a form that can be read and understood independently, but it should not be relied upon in preference to the substantive text.

Introduction

3.2 On 12 December 2004, RR killed AT at Shrewsbury Court, an independent hospital which is part of the Whitepost Healthcare Centre, in Redhill, Surrey, where both were resident. RR was convicted of AT's manslaughter on the grounds of diminished responsibility and jailed for life, the only sentence permitted by the Crime (Sentences) Act 1997.

3.3 AT, who was 56 at the time of her death, had been resident at Shrewsbury Court since 1 May 2001. Her placement was arranged and funded by West Kent Health Authority. RR, who was 71 at the time of the homicide, had lived at Shrewsbury Court since 22 June 2004. His placement was jointly funded by what was then known as the South London and Maudsley NHS Trust (SLaM) and by Croydon Primary Care Trust (Croydon PCT).

3.4 This Inquiry was commissioned in March 2006 by South West London SHA (now part of NHS London) with the support and co-operation of K&M SHA (now part of NHS South East Coast).

Terms of reference

3.5 The terms of reference for this Inquiry required us to review the care and treatment of RR and AT; to establish the chronology of events; to consider the responsibilities of the various agencies, organisations, and individuals involved; to consider the services provided by Whitepost/Shrewsbury Court; to review the role played by the regulating and inspecting bodies; and to make recommendations to the SHA in a written report.

3.6 We held our first interview in August 2006 and have seen 41 witnesses, including AT's two sons and RR. Three witnesses were seen twice. All gave evidence voluntarily. We reviewed a vast amount of documentation including all available case notes and clinical records. We could not see everybody that we wanted to either because they could

not be contacted or because they declined the invitation to meet us. A small amount of the documentation was also incomplete. However, we think it unlikely that this has significantly affected the course or the conclusions of this Inquiry.

The Structure of this Report

3.7 We begin by summarising the chronology of events as we have found them. In order for the reader more easily to follow the individual stories of RR and AT, we summarise separately the relevant history for each of them before RR joined AT at Shrewsbury Court and their stories merged. The final part of the chronology section covers the short period, immediately before the homicide, when both lived at Shrewsbury Court.

3.8 We then discuss, at some length, Shrewsbury Court and the quality of care provided there. An understanding of the deficiencies in that establishment is of central importance to an understanding of what we consider went wrong in this case.

3.9 In the following sections of the Report, we consider the management of the care of RR during the period from 2002 onwards. We do so in two parts: his care and management before his transfer to Shrewsbury Court and that during his time at Shrewsbury Court.

3.10 This is followed by a section on the care and management of AT from the time the decision was made to transfer her to Shrewsbury Court. This section includes consideration of the management of her relationship with RR and accordingly includes material relevant also to the care and management of RR whilst he was at Shrewsbury Court.

3.11 We then consider the role played by the regulatory authorities, most importantly the National Care Standards Commission (NCSC) and the Healthcare Commission (HC). This discussion arises out of the conclusions we have reached about standards at Shrewsbury Court and seeks, amongst other things, to deal with the question of why those deficiencies were not identified and/or addressed before this homicide occurred.

3.12 We conclude by summarising our recommendations.

Chronology of events relating to RR before his arrival at Shrewsbury Court

3.13 RR was born on 4 March 1933. Of central importance to this Inquiry is the fact that he has, throughout his life, repeatedly been violent towards women, particularly women with whom he was in an intimate relationship. His violence towards women has usually been associated with command hallucinations – that is to say, the hearing of voices giving orders - and suspected infidelity by his partner, usually prompted by the voices. RR said he first heard voices in his mid-teens and that they had recurred throughout his adult life. They have played an important part in the various episodes of violence in which he has been involved over the years, including the homicide which gave rise to this Inquiry. As a result of his mental health problems, RR has had a lengthy involvement with mental health services as well as numerous criminal convictions for offences including causing grievous bodily harm, malicious wounding and robbery.

3.14 RR was married in 1952 and divorced in 1975. He has three children, but is not in contact with them. His work history includes employment with the RAF before being discharged on medical grounds.

3.15 RR's history of violence towards women begins with his involvement, whilst he was still at school, in a gang rape. In 1960 he attacked his wife and was convicted of causing grievous bodily harm. In 1963 he was diagnosed with a paranoid schizophrenic illness and had the first of numerous spells as a psychiatric in-patient. Between 1973 and 1990 RR was admitted to Sutton Hospital with mental health problems on about 20 occasions. In 1975 he was convicted of the malicious wounding of his mistress, and there appear to have been many other instances of violence towards women. In October 1990 RR was examined by CONS1 from the Department of Forensic Psychiatry at St George's Hospital in London. He produced a detailed and important report on RR, which recorded that RR had told him that he had assaulted with intent to kill seven out of his last ten girlfriends. CONS1 described him as *"severely mentally disordered"* and *"sexually highly deviant"*, being solely and exclusively sadistic or masochistic (mainly the former) in his sexual relationships and interests. He found no evidence of schizophrenia, but concluded that RR *"displayed a severe personality disorder characterised by psychopathic and sexually sadistic traits together with symptoms of a paranoid state…. (RR) is a severe and continuing danger to any woman with whom he becomes sexually involved and in my view can go on to kill a victim in the future… He should not have sexual relationships with women"*.

3.16 In a further report in 1993 CONS1 modified his views on RR somewhat. He still stated, however, that RR was *"potentially very dangerous but only in …the context of sexual relationships"*. He continued: *"It would be very easy for him to move into the community and then to be presumed, perhaps in a year or two's time, to be not dangerous simply because he has lived satisfactorily in the community. It would be necessary to remind the treating team at regular case conferences that he can be very dangerous in the context of sexual relationships. Hence, monitoring should not be only of his mental state but also of his relationships with others, specifically women…"*

3.17 In 2001 RR was admitted to Bethlem Royal Hospital after his violent conduct caused the nursing home where he was resident to refuse to continue to accommodate him. RR was then convicted of an offence of robbery and an order was made under Section 37 of the Mental Health Act 1983. He was accommodated on Chelsham Ward (a mixed sex ward) under the care of CONS2, a consultant in old age psychiatry. Reports prepared for the court in connection with the robbery recommended that he be placed in single-sex accommodation.

3.18 Attempts to find a placement for RR proved difficult. An application to Shrewsbury Court, a mixed unit, was rejected by W1, the registered manager of Shrewsbury Court, because of his history of violence towards women. In early 2003 he was transferred to Witley 3 ward, also at the Bethlem, under the care of CONS3, a consultant in forensic psychiatry.

3.19 RR's physical health was deteriorating. He suffered, amongst other things, from severe obesity, hiatus hernia, congestive cardiac failure, arthritis of the hips and knees, and chronic obstructive pulmonary disease. He could still, however, walk around and take care of his personal needs.

3.20 In April 2003 RR appealed against his Section and despite opposition from CONS3, the Hospital Managers lifted the Section 37 Order. RR thereafter remained at Witley 3 as a voluntary patient. Attempts to find him a placement continued and Shrewsbury Court was asked to reconsider its earlier rejection. In September 2003, W1 reversed his earlier decision and agreed to admit RR, who was transferred to Shrewsbury Court on 22 June 2004.

Chronology of events relating to AT before RR's arrival at Shrewsbury Court

3.21 AT was born on 29 November 1948. She married twice and had two sons, Son1 and Son2.

3.22 Her first contact with mental health services was at the age of 17 when she was seen by a psychiatrist and admitted to hospital as an informal patient. She had a number of diagnoses over the years, including schizophrenia, bi-polar affective disorder and manic-depressive disorder.

3.23 AT first came into contact with the Dartford Community Mental Health Team (Dartford CMHT) in May 1988, and she remained involved with mental health services in Dartford until her death in 2004. In 1999, she was assessed as needing residential care and, following a number of placements, she was in May 2001 transferred to Shrewsbury Court as an informal patient.

3.24 A pre-transfer conference held in April 2001 recorded her as:

- being at risk of suicide based on past history of self-harming and impulsive behaviour under stress
- being at risk of self-neglect due to inadequate independent living skills
- being at risk of financial, sexual, and emotional exploitation, and
- requiring 24-hour nursing care to minimise risk.

3.25 Notwithstanding this assessment, risk assessments carried out at Shrewsbury Court identified AT as at a low or very low risk of financial, sexual or emotional exploitation. The discrepancy between this assessment and the earlier, pre-transfer, assessments appears never to have been noted.

3.26 AT's time at Shrewsbury Court seems to have been largely uneventful. She formed a close and apparently sexual relationship with another resident, J. He died in May 2004, shortly before RR's arrival.

3.27 Dartford CMHT duly followed up AT's placement at Shrewsbury Court, with representatives of the CMHT attending a number of Care Programme Approach (CPA) meetings there. In late 2002, Dartford CMHT closed their file on AT on the grounds that she was settled and not likely to move in the foreseeable future. However, those funding

her placement did subsequently review it further, either in late 2002 or early 2003. Although the documentation is incomplete, it seems to have been concluded that AT's condition had improved to the extent that she no longer needed 24-hour-a-day nursing care, and that a less structured - and less expensive - placement might be more appropriate. That conclusion was not, however, followed up until April 2004, when Dartford CMHT was re-involved and a new social worker, J1, appointed to co-ordinate AT's care.

3.28 No CPA meeting was held for AT between 18 June 2002 and 2 August 2004.

Events following RR's arrival at Shrewsbury Court

3.29 CONS4, the Consultant Psychiatrist working at Shrewsbury Court, had agreed to be RR's Responsible Medical Officer (RMO). The brief care plan which he prepared for RR recorded, amongst other things, that there was a *"high risk of harm to others, low risk to self"* and specified that there should be increased observations *"if there is an incident"*, as well as a search for weapons once a week. RR's Named Nurse, W2, who was qualified as an RMN (Registered Nurse, Mental Health), prepared a nursing care plan, which noted that RR had a history of violence towards others and stated that RR's relationships with women should be *"monitored"*.

3.30 Within a few weeks of RR's arrival, it seems that AT had gravitated towards RR. The evidence we heard indicates that they were spending a considerable amount of time together, including nights in each other's rooms. The relationship was first commented upon in the nursing notes on 18 July 2004. There were concerns recorded during the following months about the amount of money that AT was giving to RR.

3.31 On 30 July 2004 AT was seen by the clinical psychologist employed at Shrewsbury Court, W3. He noted *"Inappropriate relationships with some male clients"*.

3.32 On 2 August 2004 there was a CPA meeting for AT, the first for over two years. One of the main objectives of the meeting had been to consider whether Shrewsbury Court remained the appropriate placement for AT, but the evidence is that AT became upset at this suggestion and was then reassured by CONS4 (who was also AT's RMO and who attended this meeting in that capacity) that she would not be moved from Shrewsbury

Court against her wishes. There appears to have been no mention at this meeting of AT's relationship with RR, although it was noted that AT was financially and sexually vulnerable. The evidence indicates that AT's care co-ordinator was never told of this relationship, let alone of the dangers that RR was considered to pose to women with whom he was in a relationship.

3.33 RR meanwhile seemed happy with his placement at Shrewsbury Court. There were, however, a number of instances when he became involved in violent altercations with other male patients.

3.34 There was no formal follow-up of his placement by SLaM during his five months at Shrewsbury Court, and no CPA meeting took place during this period. Such a meeting had been planned for 8 December 2004 but was postponed.

3.35 On 7 October 2004 RR was reviewed by CONS4. There is no indication in CONS4's notes of this review that he was aware of RR's relationship with AT, nor indeed that he actually met with and interviewed RR on this occasion.

3.36 On 12 October 2004 AT was reported to be distressed after having been threatened by *"her boyfriend"* RR. The nursing notes record that CONS4 advised *"counselling and observation for AT and to watch them"*. CONS4, however, had no recollection, and there is no other record, of any involvement at this time.

3.37 On 29 October 2004 AT reported that RR had threatened to kill her and was alleging that she was *"an adulteress"*. RR told nursing staff that AT was being unfaithful to him and that he felt like *"strangling her"*, but had restrained himself. The clinical and nursing notes record that W3 saw RR on 29 October 2004, but no other notes of such an attendance have been found and W3 has no recollection of it, although he accepts it must have occurred.

3.38 On 30 October 2004 RR and AT were each seen by DR1. She was a staff grade doctor with limited psychiatric experience, who worked one session a week at Shrewsbury Court. She recorded that RR told her that he wanted to kill someone, but that he appeared calm. After discussions with nursing staff, she concluded that RR's threats were *"verbal only"*. Her evidence was that CONS4 was informed about this episode, but there is no documentary record of that contact.

3.39 On 31 October 2004 RR was admitted to East Surrey Hospital with a chest infection. Whilst there, he asked to see a social worker and told her that he had been unhappy at Shrewsbury Court after an affair with a fellow patient. He wanted to contact his care co-ordinator, Q1, because, so it was recorded, *"he would like to be moved as he has vowed to kill both himself and the girlfriend"*. There is no evidence that an account of this discussion found its way either to Q1, or to Shrewsbury Court.

3.40 On 9 December 2004 RR was due to receive his regular depot injection. It is uncertain whether this was ever administered – the documentation at Shrewsbury Court indicates not.

3.41 On the morning of 12 December 2004 RR told his Named Nurse, W2, that he had been hearing voices. The nurse responded by immediately administering RR's morning medication. This was, however, medication for cardiac problems. AT was then discovered in her room at about 8am having been killed by knife cuts to the throat, almost certainly inflicted after RR's conversation with W2. RR was arrested and admitted killing AT.

3.42 Psychiatric reports were subsequently obtained which concluded that RR suffered from paranoid schizophrenia and a personality disorder with significant paranoid, dissocial, and sado-masochistic traits. This had impaired his responsibility for his acts at the time of the killing. He was convicted of manslaughter and has been in prison since.

Whitepost Healthcare Group and Shrewsbury Court

3.43 Shrewsbury Court is part of the Whitepost Health Centre in Redhill, Surrey. It has been an independent hospital since April 2002. The Registered Owner is DR2, who works, full-time, as a general practitioner (GP) in Harrow.

3.44 We have concluded that the quality of the service at Shrewsbury Court before December 2004 was seriously below the standards expected of an independent hospital. This homicide would not, in our view, have happened if the service had been of the standard which patients and placing authorities were entitled to expect.

3.45 Shrewsbury Court was the subject of a detailed inspection by the HC in January 2005, after AT's death. The report of that inspection provides a good indication of the nature and extent of the deficiencies there in the period up to December 2004, and it corroborates many of the conclusions we have reached about the problems at Shrewsbury Court.

3.46 In summary, we find that, although Shrewsbury Court became an independent hospital in April 2002, it did not lose the culture of a residential nursing home. Its management team did not have sufficient experience or expertise to manage a mental health hospital - DR2 did not have a background in mental health and this may have been reflected in the appointments he made to the post of Registered Manager, or Acting Manager. There was inadequate medical input, at consultant level and below. The nursing staff, many of whom were not RMNs and had no proper training in mental health, were not provided with adequate support or training. Many lacked knowledge of basic matters essential in a mental health hospital, such as how to carry out a risk assessment or what was necessary for the proper implementation of the CPA.

3.47 W1 was the Registered Manager until early 2004. He was a trained and experienced nurse with expertise in learning disabilities, but not in mental health. He was qualified as an RMN but had worked, before coming to Whitepost, almost entirely in learning disability. He was responsible for admissions throughout the relevant period (he continued to work for Whitepost as its "marketing manager" when he gave up the post of Registered Manager) and it was he who met with RR before he was accepted as a patient at Shrewsbury Court. He was a well-liked and well-respected manager, but his limited experience of working in mental health meant, we think, he was not in a position fully to recognise what was lacking at Shrewsbury Court.

3.48 W1 lacked the expertise to establish a consistent admissions policy. Inadequate consideration was given to the type of patient group that the establishment was aiming to attract and/or could sensibly hope to manage. The result was that Shrewsbury Court ended up with an unusually wide mix of patients, both in terms of age, and in terms of the types of problems they presented. This wide patient mix significantly exacerbated the management problems for clinical and nursing staff. External regulators expressed concerns about this issue in 2003 and subsequently, but these concerns were not properly addressed.

3.49 When W1 resigned as Registered Manager in March 2004, it seems it did not prove possible to recruit a replacement, W4 who had been deputy manager, became "Acting Manager". He was also trained as a nurse, but in learning disabilities, not mental health. We have concluded that he was out of his depth as Acting Manager, having been promoted above his level of competence. Even more than W1, he lacked the experience or expertise to recognise what was lacking at Shrewsbury Court, and there is evidence of a significant deterioration in standards after his appointment.

3.50 Furthermore, the medical input at Shrewsbury Court was, as at December 2004, inadequate. CONS4 was the only consultant psychiatrist there. He also had an NHS post working nine or 10 sessions each week, with on-call responsibilities as well. The contractual arrangements between him and Whitepost were the subject of a conflict of evidence, but the following is clear. At all material times he had responsibility for all of the detained patients at Shrewsbury Court (of whom there were up to 14). He sought to discharge that responsibility by working one session a week at Shrewsbury Court and by providing additional input as required. He told us that this additional input usually amounted to about 1½ hours a week. He was supported there only by DR1, a staff grade doctor, working full-time for the local NHS Trust. She worked only one session a week at Shrewsbury Court. She had limited psychiatric expertise and her role was essentially to deal with physical health issues, and to "hold the fort" in psychiatric matters if CONS4 was unable to attend immediately. There was also a clinical psychologist, W3, who worked two sessions a week (increased to three sessions in June 2004), but whose role was limited to dealing with patients referred to him by CONS4.

3.51 Up to September 2004 the medical needs of the informal patients at Shrewsbury Court were met by the NHS through the local GP and the local CMHT. The consultant psychiatrist with the local CMHT was CONS4, so he was in fact also the consultant for those informal patients at Shrewsbury Court, including AT, who had been referred to the CMHT.

3.52 In September 2004, following criticisms made by the HC of the fact that informal patients at Shrewsbury Court had no RMO there, CONS4 agreed to become RMO for <u>all</u> of the patients there, detained or informal, a total of about 46 patients. He continued, however, to work just one session each week at Shrewsbury Court, supplemented by additional attendances when he considered this necessary. He estimated that the

additional time he spent at Whitepost following this change in September 2004 increased to about two hours each week.

3.53 It was impossible for CONS4 adequately to perform the role of RMO for more than 40 patients in a single session plus about two extra hours a week. It is inevitable that the quality of care provided to patients suffered as a result of the inadequacies in the amount of consultant input being provided. There is a telling contrast with the position at the time of writing this Report. CONS4, until his recent resignation, undertook two sessions a week, and another consultant psychiatrist, CONS5, undertook a further two sessions. DR1 attends for a further session every week, making a total of four consultant sessions and one staff grade session weekly. On-call responsibilities are divided between CONS5 and CONS4, so there is now always an RMO on call for emergencies. W3 now works five sessions at Shrewsbury Court, two more than before the homicide. This medical cover is provided for the present complement of about 21 patients. In effect, therefore, there are now four consultant sessions, plus DR1's input, for 21 patients - whereas before December 2004 there was one session, plus DR1's input, for all of the patients at Shrewsbury Court, about 46 in number.

3.54 Clinical governance at Shrewsbury Court was inadequate. There was little or no clinical audit. There was no clear structure for staff appraisals and little indication that managers had the ability properly to appraise and develop staff and the process and procedures they used.

3.55 Many of the nurses at Shrewsbury Court were not RMNs, being qualified in learning disability alone. As a result, shifts at this mental health hospital were often led by a nurse without training in mental health, and it was entirely possible for the Named Nurse of a patient not to be trained in mental health. We found the training programmes at Shrewsbury Court were inadequate: by way of example, AT's Named Nurse at the time of the homicide did not even know what the CPA was, and had no effective training in risk assessment. The remuneration package for nursing staff was not generous, and it is likely that the quality of the nursing staff reflected this.

3.56 We were very concerned about the way in which risk assessments were carried out at Shrewsbury Court. The task seems to have been delegated to nurses who had no, or no adequate, training. It was not perceived to be a multi-disciplinary exercise, and there

was no forum where a patient's risk assessment would normally be discussed, reviewed, or updated. Implementation of the CPA was, at best, patchy.

3.57 We also had serious concerns about deficiencies in medication processes and record keeping. Nurses often administered medicines for which there was no doctor's signature, and records were often illegible.

3.58 We found little evidence that staff were up-to-date with policies and procedures relevant to their work, even where these policies existed.

3.59 During the period up to December 2004, DR2, the Registered Owner, responded well, on paper, to such criticisms as were made by the regulatory authorities of standards at Shrewsbury Court. But our impression is that these responses, whilst reading well, were not reflected in what actually happened at Shrewsbury Court on a day-to-day basis. Furthermore, our impression is that, in the absence of criticism from third parties such as the HC inspectors, or the MHA Commissioners, there was little or no attempt pro-actively to identify problems and improve standards. In effect, the approach seems to have been that, if an area was not identified as requiring attention by the regulators, then all was well. DR2's evidence to us strongly suggested that he took the view that, as long as the HC was not threatening to remove Shrewsbury Court's registration, the standards of care were at least adequate. As a result, if deficiencies were not identified by inspectors, they were very rarely uncovered internally. Such improvements as did occur were accordingly driven by the regulators, and not by Shrewsbury Court's management or any assessment by them of what their patients needed.

3.60 It is important to emphasise that this Report has focused on the position at Shrewsbury Court in the period up to December 2004. Notwithstanding this focus, it is clear to us that, following the HC's detailed inspection in January 2005, major changes were made, including the appointment of a new Registered Manager, W8. There have as a result been significant improvements in standards - as reflected in the more recent reports from the HC.

The care and management of RR before his admission to Shrewsbury Court

3.61 The day-to-day care provided to RR during this period was of a high standard. The risks that he posed were managed well. Whilst he was on Chelsham Ward, a mixed unit,

appropriate use of one-to-one observations, as and when necessary, effectively eliminated the risk of RR forming a relationship in which his partner might be at risk.

3.62 We do, however, have concerns about the following issues.

i. The process by which Shrewsbury Court came to be selected as the preferred, ultimately the only, option for RR.
ii. The information supplied to Shrewsbury Court when inviting it to accept RR as a patient.
iii. The extent to which there was a lack of continuity in the management of RR's care; and
iv. The decision made by the Hospital Managers to discharge RR from the Section 37 Order.

3.63 Shrewsbury Court was a hospital of which RR's treating team at SLaM had little first hand knowledge. We were told that when it was first identified, in 2002, as an appropriate placement for RR, reliance was placed upon the fact that one or two difficult patients had previously been transferred there and, so it was thought, been managed successfully, but the evidence about the quality of care provided to these patients seems to us to have been slight. CONS3 knew nothing of Shrewsbury Court at all. We consider that insufficient enquiries were made to enable those treating RR to satisfy themselves that Shrewsbury Court was the appropriate placement for him. It is right to say that RR's social worker, Q2, did ask others who had a more direct knowledge than he did of Shrewsbury Court about the establishment, and it seems that nothing adverse was said to him about it. But no one considered the reports of the regulatory authorities which had highlighted the problems there. The establishment was not visited by anyone involved in RR's care, prior to it becoming, in 2002, the preferred placement option for him. It was eventually visited in August 2003 by Q3, who was by then RR's social worker; but she appears to have been insufficiently familiar with RR's condition properly to assess its suitability (she erroneously reported, for example, that he was <u>not</u> now thought to be a risk to women); and such concerns as she had were not followed up.

3.64 There seems, at least on the face of the documentation, to have been a failure fully or systematically to investigate alternative placements and/or to obtain complete and accurate information about possible alternatives. It appears, for example, that the treating team at SLaM was unaware that St Andrew's, Northampton (which was actually

considered as a possibility for RR) offered a low security single service for older men with a forensic history. And by late 2003, one of the placement panels involved in providing funding for RR's placement was told, in terms, that there was no other possible option for RR apart from Shrewsbury Court.

3.65 We were also told that the treating team in 2002 took the view that it was unrealistic to propose a placement at St Andrew's on the grounds of cost. In doing so, it was effectively taking upon itself a decision about the use of resources which should, we think, have been made by the placement panels responsible for providing funding.

3.66 Having identified Shrewsbury Court as the appropriate placement, (and having been surprised by its initial rejection, in August 2002, of RR as a patient), the treating team at SLaM tried to persuade Shrewsbury Court to reconsider that decision. In the course of doing so, representations were made about RR, which we consider stressed, perhaps to an unwise extent, an optimistic view about the risks which he posed, and which did not highlight concerning aspects of RR's recent behaviour - which included an episode when he again reported hearing voices directing him to commit acts of violence.

3.67 The evidence we heard indicated that these representations played a significant part in W1's decision to change his mind about admitting RR to Shrewsbury Court. The deficiencies in Shrewsbury Court's admissions procedures and, in particular, the minimal involvement of CONS4 in the assessment process resulted in the admission of a patient, RR, who CONS4 himself later conceded should not have been admitted.

3.68 One important lesson which needs to be drawn from this tragedy is that it is not possible for those purchasing services from the independent sector to assume that, just because an independent hospital is carrying on business, it is necessarily meeting appropriate standards. It must be the responsibility of those commissioning services to take positive steps to satisfy themselves that any establishment at which a placement is contemplated is, and remains, "up-to-standard".

3.69 On the issue of the continuity of RR's care, we were struck by the fact that between 1998 and 2004, RR's care passed between five different consultants in five different services. In the process, he moved from general adult psychiatry to old age psychiatry, to forensic psychiatry and finally to private general adult psychiatry - in other words between three specialities (or four, if private adult psychiatry is considered a

specialist entity). This unusually complicated trajectory cannot have assisted in ensuring good continuity, although we reiterate that his day-to-day care, up to the time of his transfer to Shrewsbury Court, was of a high quality.

3.70 The decision by the Hospital Managers to discharge RR from the Section 37 Order was surprising and, in our view, a mistake. There are training issues to be addressed here, although some steps have already been taken in this regard. We also believe consideration should be given to the broader question of whether it is right that Hospital Managers should have the power to discharge a patient admitted under a court order, against the recommendations of the RMO.

RR's care at Shrewsbury Court

3.71 In contrast to the high quality day-to-day care which RR received before his transfer, the care he received at Shrewsbury Court was of a poor standard. Systemic deficiencies there meant that crucial mistakes were made.

3.72 The problems began right at the outset, with the pre-discharge meeting at SLaM being attended only by W2, a nurse who had never before attended such a meeting alone and without W1. An important opportunity to gather valuable information about the practicalities of nursing RR was lost.

3.73 These problems were compounded by inadequate consultant input into RR's care. RR's case was reviewed by CONS4 on only four occasions during his admission, two of which were in the first eight days. In the remaining 23 weeks and four days, CONS4 reviewed RR's case only twice, the last occasion being a month before the homicide. This averages out at approximately once every 12 weeks. Furthermore, reviewing a case does not necessarily entail interviewing the patient, and there is only one occasion during RR's admission (22 June 2004) on which either the nursing or medical notes record that CONS4 actually interviewed RR. It is doubtful that CONS4 actually examined RR on at least one of his four reviews, the last, the evidence indicating that he merely reviewed the nursing notes. CONS4's instructions to nursing staff about how to monitor RR's relationships with women and what this meant in practice, were brief, imprecise and inadequate, perhaps because of the extraordinary work-load, which he had taken on at Shrewsbury Court. He also failed clearly to instruct nursing staff about the "trigger" factors to be watched for, and more importantly, the action to be taken if these were noted.

3.74 We have concluded that there were seven occasions during RR's time at Shrewsbury Court when steps should have been taken which could have averted this tragedy.

- In July 2004, when the relationship between RR and AT was first noticed, steps should have been taken to ensure it did not develop.
- On 12 October 2004 AT reported that RR had threatened her and the notes said the two of them were spending time together, unobserved, in each other's bedrooms. This should have been perceived as a wholly unacceptable state of affairs, given RR's history of violence towards women with whom he was having a relationship.
- On 29 October 2004 RR threatened to kill AT because of what he considered to be her infidelity. Given RR's history, it is difficult to envisage a clearer warning flag. However, CONS4's involvement at this stage seems to have been non-existent.
- At East Surrey Hospital in the first few days of November 2004 RR again said he wanted to kill AT, and he asked to see his social worker so he could be moved from Shrewsbury Court. This information was not communicated to Shrewsbury Court. The notes from East Surrey Hospital record that a psychiatric assessment was to be arranged, but there is no record of this happening.
- On 11 November 2004 CONS4 reviewed RR's case, probably on the basis of the nursing notes and without meeting him. He did not perceive recent events as requiring any action other than a review of the risk assessment (a task to be carried out by a nurse) and a review of RR's condition in six weeks time.
- On 18 November 2004 W2 reviewed RR's risk assessment. He categorised RR's risk of violence to others as high, or very high, but no further action was taken.
- On the morning of 12 December 2004 and before the homicide, RR told W2, that he was hearing voices. The only action taken was to administer RR's cardiac medication.

3.75 There was also a failure by RR's treating team at SLaM to follow up RR's placement at Shrewsbury Court in order to satisfy themselves that it was appropriate. It was never intended that there should be any clinical follow-up by the placing team, the intended follow-up being limited to "placement follow-up" by a Placements Nurse. This did not happen as the Placements Nurse left SLaM during the relevant period and a replacement

was not found in time. We were in any event surprised that the intended follow-up was to be carried out by someone who had had no previous contact with RR.

AT's care at Shrewsbury Court

3.76 We can see no reason to criticise the initial decision to send AT to Shrewsbury Court, although the process and reasoning behind the selection was not entirely clear.

3.77 The quality of her care at Shrewsbury Court was poor. We considered that the principal shortcomings were as follows.

- The risk assessments carried out on AT at Shrewsbury Court were, from the outset, ill-informed and inappropriate.
- There was a failure properly to implement the CPA. Regular multi-disciplinary meetings were not held; and even when they did occur, there is little documentary evidence of proper preparation at Shrewsbury Court or of appropriate follow-up afterwards.
- There is no evidence of any attempt by staff at Shrewsbury Court to consider whether she continued to need a placement where she was receiving 24-hour nursing care and whether it was, accordingly, appropriate for AT to remain resident there.
- The response of staff at Shrewsbury Court to AT's relationship with RR in the four or five months before the homicide was wholly inadequate. There was no sufficient attempt made to explain to her the risks that a relationship with RR carried and no proper attempt was made to protect AT from the dangers inherent in that relationship. Given what was known about RR, allowing him and AT to spend long periods of time, including nights, alone together in each other's bedrooms without any supervision was quite extraordinary.

3.78 There were also deficiencies in other aspects of care, including an absence of active attempts at rehabilitation and occasional deficiencies in the administration of her medication.

3.79 A separate issue concerns whether AT should have remained at Shrewsbury Court at all and the extent to which her placement there was appropriately followed up by the placing authority. The inappropriateness of the risk assessments being carried out on AT

at Shrewsbury Court, and their inconsistency with the assessments pre-transfer, was not picked up at such CPA meetings as did occur. Other indications of possible grounds for concern about Shrewsbury Court, including in particular the reports from the HC, were not identified.

3.80 There was a surprisingly long delay between the time when the view was first formed by those funding AT's placement that she might no longer need 24-hour-a-day nursing support (which was in late 2002 or possibly early 2003), and the time when further consideration was given to this issue (April 2004). We have not been able to determine the reasons for this delay.

Regulatory control

3.81 In view of the serious shortcomings which existed at Shrewsbury Court, it has been necessary to consider the roles of the NCSC and the HC, and to a lesser extent the MHA Commission, and to address the question of why those shortcomings remained unresolved.

3.82 The MHA Commission's role is confined to considering the implementation of the Mental Health Act 1983. As neither RR nor AT were detained patients at the material times, it was not directly concerned with either of them. Some of the general observations made in its reports about Shrewsbury Court are, however, of relevance to the issue of whether there should have been a wider appreciation of the shortcomings at Shrewsbury Court before RR was sent there.

3.83 The HC, formerly CHI and the NCSC, inspected Shrewsbury Court on a number of occasions in 2003 and 2004. Serious concerns were identified on each occasion. Following a short visit in May 2004 the inspectors notified DR2 that the HC might consider enforcement action, if steps were not taken to implement requirements which had previously been made. The last inspection before the homicide was in August 2004. It was noted that Shrewsbury Court was failing to meet the majority of the National Minimum Standards; and at the feedback meeting which followed this inspection serious concerns were expressed about, amongst other things, the fact that there was no RMO there for the informal patients and that CONS4 was supposed to be providing an emergency "on call" service to Shrewsbury Court at times when he was also "on call" for the NHS. Enforcement action was again threatened.

3.84 The inspections prior to the homicide did not come close to identifying all of the shortcomings at Shrewsbury Court, as evidenced by the fact that, when the inspectors came back in January 2005 and conducted a more detailed investigation, numerous other deficiencies were identified.

3.85 Two questions immediately arise. The first is why the inspections conducted before the homicide did not identify the full extent of the deficiencies at Shrewsbury Court. The second is whether the HC ought, in any event, to have adopted a more aggressive approach to try to ensure that Shrewsbury Court did meet the National Minimum Standards.

3.86 The answer to both questions lies, in part, in the limited resources available to the HC at the material times. There is evidence that the relevant division of the HC was seriously under-resourced and its inspectors seriously over-stretched during the period from April 2002 onwards. Inspections at this time took the form of yearly checks of compliance with all applicable standards. The limited time available to inspectors, combined with the range of issues which needed to be considered - from policies and procedures, to environmental issues, to clinical governance - did not, we think, allow for more than a relatively superficial "snap-shot" to be obtained of the establishment being inspected. There was necessarily a heavy reliance on sampling. With the limited time available to inspectors, prompt and effective follow-up of the formal Requirements and Recommendations made in reports (and possible enforcement action) was, for the most part, impractical.

3.87 Another part of the answer is that, according to the evidence of the inspectors who visited Shrewsbury Court, their perception was that, whilst it was a poor quality establishment, it was not the worst which they had seen. We cannot tell whether this was because the full nature and extent of the shortcomings there were not detected, or because there were, at that time, other establishments which were equally poor. There was some variance in the evidence from the HC witnesses about the extent to which Shrewsbury Court was perceived as a cause for concern. However, the significant fact for present purposes is again that it is <u>not</u> possible for those purchasing services from the independent sector to assume that, just because an independent hospital is carrying on business (and has not been the subject of enforcement action by the HC), it is necessarily meeting appropriate standards.

3.88 We were told that the resources available to the HC have increased since 2002/2003. We were also told of changes to the way in which the HC carries out its inspections, with inspections now being "targeted" at establishments, and at areas within an establishment, where it is perceived there may be problems. The HC is now required to inspect establishments once every five years. Whilst it is expected that inspections of mental health hospitals will probably be more frequent than this, the intention is that inspections will now be "targeted" on problem areas or problem establishments, that targeting being based upon an analysis of information gathered by the HC from a variety of sources, including self-assessment declarations by the establishment itself.

3.89 We were initially concerned that a regulatory system which we believe was under-resourced, and which accordingly failed to pick up the full nature and extent of the deficiencies at Shrewsbury Court, has now evolved to a system which it is likely will involve fewer inspections. We are persuaded, however, that the new system of focusing inspections on potential problem areas is a sensible use of limited resources. We consider that there are a number of ways in which the HC can improve upon the "intelligence gathering" which will enable it effectively to target its inspections in this way, and we believe that these can be effectively dove-tailed with the greater responsibilities which we consider must be acknowledged by those commissioning services from the independent sector.

3.90 From the point of view of those purchasing services from the independent sector, we consider that systems should be put in place to ensure that "out-of-area" placements are closely monitored, (such monitoring to include actually visiting the establishment not less than once a year), and to ensure that formal reports are generated by specialist teams upon all "out-of-area" establishments being used, initially at the time of the placement, and not less than once a year thereafter. Those reports should be informed by feedback from the multi-disciplinary team involved with the individual patients concerned, those teams being, we think, best placed to provide a "ground level" perspective of the quality of service being provided. Such reports should enable those purchasing services to assess whether they are getting value for money and to identify establishments where standards are dropping.

3.91 We also believe contractual arrangements with the independent sector could be "tightened up" so that, to the extent that such matters can be quantified, there are contractual obligations to provide a minimum level of service. The inclusion within such

contracts of financial penalties in the event that standards drop below a certain level could be considered as a direct incentive for independent hospitals to maintain standards.

3.92 From the HC perspective, we consider that, if formal reports of the type suggested above were being generated by those purchasing services from the independent sector, they would provide the HC with valuable material to assist with the task of deciding how best to target its resources. Accordingly, a system whereby such reports were regularly provided to the HC would, we think, enable the new system of less frequent, but targeted inspections to work effectively.

3.93 We also consider that the HC should be looking to other sources of "intelligence" about independent hospitals in order to assist with the accurate targeting of resources. Our view is that self-assessment by independent hospitals should, at most, be a supplement to other, more robust, methods of acquiring information about areas of potential concern. Healthcare professionals who deal with hospitals on a daily basis are a potentially valuable source of information. Members of the public need, we think, to be made more aware of the HC's role and encouraged to inform the HC of concerns about the service being supplied at any hospital falling within the HC's jurisdiction.

3.94 The evidence strongly suggested that, perhaps unsurprisingly, problems with effective clinical governance were found by the HC to be more common among smaller, "stand-alone" establishments, than with those which were part of a larger network. The resources available to smaller units tend to be more limited and consideration could be given to ways of encouraging independent hospitals which may only have limited infrastructure for the implementation of clinical governance, to look at partnership working with other providers or joining appropriate networks to access expertise and peer support.

3.95 The Report concludes by making a total of 33 Recommendations.

4. RR

4.1 RR was born on 4 March 1933 in Penmaenmawr, North Wales. RR can recall no history of mental illness on his father's side of the family, but there is such a history on his mother's side. RR's mother had two sisters, and RR believes that one sister murdered the other, and spent the rest of her life in Broadmoor Hospital. RR's mother had severe mental health problems, and had several long admissions to an asylum in Wales. She committed suicide during one of these admissions after learning of her husband's death in the Second World War.

4.2 RR has said he began hearing "voices" in his mid-teens. These voices recurred throughout his adult life, and they have played an important part in many of the episodes when RR has behaved in a violent manner, including the homicide which has given rise to this Inquiry.

4.3 There are references in the medical records seen by this Inquiry to RR having been involved in a gang rape of a girl at school when he was 14. RR has more recently denied this, but the records show he acknowledged his involvement when he was seen in 1990 by CONS1, a Consultant Forensic Psychiatrist in the Department of Forensic Psychiatry at St Georges Hospital, London. (CONS1 subsequently became a professor and we refer to him throughout the remainder of this Report as CONS1). He produced a significant report to which we refer later.

4.4 When he was 17, RR joined the Royal Air Force, where he stayed for about 12 or 13 years before becoming mentally unwell. He had several jobs after leaving the RAF, including work for the Ministry of Defence. He said each of these jobs was terminated because of his poor mental health.

4.5 In 1952 RR married his first wife. They had their first child in 1955, and a second child in 1958. In 1960 RR heard voices telling him his wife was having an affair. He hit her twice over the head with a poker, causing a serious wound. He was charged with causing grievous bodily harm, and received a two-year suspended sentence. He did not apparently

tell anyone about the voices, and he received no psychiatric treatment as a result of this incident.

4.6 RR was then posted to Cyprus with the RAF. He continued to hear voices concerning his wife's fidelity and in 1963 the voices "told" him to shoot his wife because she was having an affair with his commanding officer and they were trying to poison him. He stole a pistol but gave himself up when the theft of the pistol was noticed. He was admitted to hospital where he was diagnosed with a paranoid schizophrenic illness. He had a lengthy period as an in-patient and was eventually discharged from the forces on medical grounds.

4.7 Despite these problems, RR initially stayed with his wife and they had a third child together.

4.8 In 1973 RR was admitted to Belmont Hospital following a recurrence of his mental health problems. Thereafter, he was repeatedly in and out of hospital as a result of persistent paranoid symptoms. There were as many as 20 admissions to Sutton Hospital between 1973 and 1990, 12 of which occurred between 1983 and 1990.

4.9 RR started an affair in about 1973. In 1974 or 1975 the voices returned and told him that his mistress was being unfaithful, as a result of which RR tried to strangle her. A few days later, he stabbed her in the abdomen with a pair of scissors, claiming the voices told him that she was cheating on him and that he should "sort her out". On 30 July 1975 RR was convicted of malicious wounding and sentenced to 18 months in prison, of which he served about 12 months. He spent at least some of that time in the prison hospital. He was diagnosed as suffering from schizophrenia, with a psychopathic personality disorder. As a result of these criminal proceedings, RR's affair came to light and in 1976 RR and his wife were divorced.

4.10 On his release from prison, RR moved into a flat on his own. According to RR, he then heard voices telling him that a neighbour was trying to poison him. He smashed a window, the police were called, and RR was taken to Sutton Hospital where he was admitted for six weeks. He was later transferred to Netherne Hospital. He tried to strangle a female patient there, and he was returned to a locked ward at Sutton Hospital for a lengthy period.

4.11 In 1982 RR was re-admitted to hospital after hearing voices telling him to attack his girlfriend with a pair of scissors. Several in-patient admissions followed in the period up to 1990. A common thread throughout this period was that RR reported hearing voices and, on a number of occasions, he expressed his own concerns that he might hurt someone. He said he had ended at least one relationship with a woman because he was afraid he would end up harming her.

4.12 In 1990 whilst an in-patient undergoing assessment, RR formed a relationship with another woman, but he soon started to hear voices telling him to attack her with a hammer. He then tried to strangle her after hearing voices instructing him to do so. He was again admitted to Sutton Hospital.

4.13 On 15 October 1990 a detailed report on RR was prepared by CONS1. This is an important document, and it is worth quoting CONS1's conclusions at length. He wrote:

"OPINION
[RR] is clearly severely mentally disordered and in the following terms in my view.

1. He is sexually highly deviant. Specifically he is solely and exclusively sadistic and masochistic (mainly the former) in his sexual relationships and interests (all of which are heterosexual in nature). His first "learning" of sex in reality was through rape and, even if it did not in itself reflect sadistic fantasies he had already experienced, it has become entirely the mainstream of his sexual interest. He is able to function sexually only through severe violence or thoughts of severe violence and he is made more aroused by resistance and by fear in the victim. He is angered by any taunting of him about his sexual inadequacies. All of the episodes of serious violence he has exhibited have been in the context directly of sexual contact (although the recent attack may have been "just after" intercourse, there were major thoughts of impotence in his mind). As I have indicated, he is also masochistic, but this is less important by far than his sadistic interests. At the time of his attacks on women, he is completely cut off from their feelings. He has thoughts of strangling and sometimes of stabbing. He has assaulted with intent to kill (on his own description) 7 out of his last 10 girlfriends and, although he snaps out of it and feels remorse afterwards, there is no resistance ex ante to thoughts of violence and homicide (I think largely because they are sexually driven and in the absence of a capacity for empathy) and he is indeed somewhat amazed himself that he has never killed anyone or been charged with attempted murder. His impotence in the absence of

sadistic reality or fantasy has been constant throughout his life and increases his propensity for violence against women. Although [RR] has managed to avoid actual violence with women at the beginning of relationships in recent years, this aspect has always emerged eventually.

2. [RR] displays broader personality difficulties which have been present since at least his adolescence. Specifically, he has a sense of isolation from others in conjunction with a need to separate away from people and in conjunction also with paranoid feelings. He has a psychopathic failure to empathise truly with others.

3. He displays well-circumscribed paranoid delusions which are suggestive of an additional diagnosis of a paranoid state simple (ICD 9). However, much of the content of this reflects and exaggerates his personality disorder and sexual preoccupations.

I found no evidence to support a diagnosis of schizophrenia.

In summary, diagnostically I believe that he displayed a severe personality disorder characterised by psychopathic and sexually sadistic traits together with symptoms of a paranoid state simple.

RECOMMENDATIONS

[RR] is a severe and continuing danger to any woman with whom he becomes sexually involved and, in my view, he may go on to kill a victim in the future. Put somewhat bluntly and illiberally, if he is to avoid the risk of serious harm or death of a victim, he must not have sexual relationships with women. [Emphasis added] *As regards the risk to others, in my view he is not likely to be a severe risk to people other than women with whom he is sexually involved, although he has attacked others and might exhibit more severe violence if he was particularly distressed. At present, I believe the major risk is that of suicide. It is possible that he might leave the ward also in order to attack his last victim but I do not believe that he needs a higher level of containment to avoid this …. He is clearly being managed safely in his current situation, that is on an open ward, but solely in my view because he is in night attire. In my opinion, he should not ever be in the position in the foreseeable future to be able to leave the ward since this would present a major risk to himself and perhaps to others. In my view, consideration should be given as to whether he ought to go to a locked ward in order to improve his quality of life, since he cannot remain in night attire forever. Also, his current situation is*

increasing his frustration. I do not believe that he needs medium security currently and he could be contained in the chronic CSU in Sutton.

My own view would be in favour of continuing with neuroleptics, but probably his symptoms of psychosis represent an untreatable illness which is perhaps more responsive to changes in his situation than to changes in medication. As regards Cyproterone Acetate, this does not diminish his thoughts of harming others and it may be the case that he has attacked whilst he has been on it. Indeed, if he is adequately secured by practical measures, I wonder whether the drug adds much benefit to his regime. Ultimately I believe his personality disorder and sexual deviation are entirely untreatable and all one can attempt to do is to minimise the risk through various management strategies. In my view, [RR] will always represent a very serious risk to that specified group of potential victims which I have identified. He needs either to be contained in hospital, and with avoidance of sexual relationships or, if he were to leave hospital, he would have to have extremely close monitoring and in the context of knowing he is not in a sexual relationship. This latter condition would be a very difficult one to satisfy. [Emphasis added]

He does not warrant a special hospital (indeed I have indicated that he does not currently warrant medium security) so long as 'dangerous situations' are avoided. However, he presents a long term problem and indeed, a long term monitoring problem. … As regards the legal basis of his being in hospital, I understand that he is currently an informal patient and that seems entirely appropriate currently. However, in the event that he makes any attempt to leave the ward, in my view, he should be detained under Section 5 of the Mental Health Act and then immediately placed on a Section 3 Treatment Order. This is justified on the grounds of his own safety as well as the protection of others. He could be detained on the grounds of either/both 'mental illness' and/or 'psychopathic disorder'."

4.14 RR thereafter remained in hospital for a lengthy period. In 1991 he was allowed some unescorted leave, but he was still considered to represent a danger, particularly in the context of a sexual relationship. There is a record that he twice absconded for short periods, returning of his own free will on both occasions.

4.15 By September 1992 consideration was being given to the possibility of moving RR to some form of hostel, and CONS1 was asked for a further opinion. On 6 January 1993 CONS1 wrote to C1, a consultant psychiatrist at the Sutton Hospital. He said:

"You asked me to consider the advisability of him being discharged from hospital in March into a highly staffed (24-hour) hostel specifically functioning as a psychiatric rehabilitation facility.

As I understand his progress since I last saw him, [RR] has ceased to experience auditory pseudo-hallucinations and there has been little concern about either his risk of self-harm or harm to others. I understand that he no longer expresses paranoid delusions about members of the staff as he had done when I saw him on Jasper Ward in 1990. …

When I interviewed him, [RR] confirmed that he had not had auditory pseudo-hallucinations for 18 months and also said that he no longer thought that people were trying to harm him. I am inclined to believe this description of change in his mental state. As regards his assertion to me that he will have nothing more to do with women because they represent a risk of offending to him and therefore a risk of going to prison, I am less confident. The episode when he went to [his girlfriend's] flat after absconding from the hospital involved the two of them sleeping together. He said that he could not get an erection, but he did masturbate her to orgasm. He denied any aggressive fantasies coincidental with this activity. However, at the very least, it demonstrates a continuing interest in sexual activity, albeit that he was impotent as a result of either inherent problems or medication …

As regards the most recent attack on the woman that he was having a relationship with prior to his admission, … (which involved attempted strangulation), he described the importance of the auditory pseudo-hallucinations in determining the attack. It may be that this was a valid factor, but I remain concerned that his underlying sexuality is of major relevance. As regards his diagnosis, substantially I am unchanged in my view from that which I expressed in 1990. I accept the point that you and the independent psychiatrist (who provided a report for his last Tribunal) expressed that there may be some reason to doubt whether he can be classified as having "psychopathic disorder". It may be that I was somewhat swayed by his profound sexual abnormality in coming to that conclusion. Another factor of relevance is my presumption that his personality has always been somewhat abnormal and, indeed, he describes abnormalities in his own thinking

going back to his middle childhood. I think that the psychiatric diagnosis "psychopathic personality disorder" or "sociopathic disorder" may be difficult to sustain. However, I believe that the profound abnormality of his sexuality and the other personality abnormalities which it probably reflects are sufficient for the legal category "psychopathic disorder" in terms of Section 1 of the Mental Health Act 1983.

As regards the diagnosis of mental illness, I still hold to the view that in 1990 he had a paranoid psychosis (although not chronic schizophrenia in my view). I think it likely that the symptoms he experienced then (pseudo-hallucinations and paranoid delusions) have resolved as a result of the combination of continuing medication and a more settled and structured life in hospital than he achieved under pressures of the community. I believe that he would relapse into an overtly paranoid psychotic state similar to the previous mental state if he were to stop taking the medication or perhaps if he was under more pressure and in a less structured environment. On those grounds, in my opinion, he remains detainable under the category "Mental Illness" in terms of Section 1 of the Mental Health Act. As regards his dangerousness, my view remains that he is potentially very dangerous, but only in very limited circumstances. That is, I believe that it is only in the context of sexual relationships that he becomes dangerous. [Emphasis added]. This, in my view, almost certainly relates to his sexual abnormality, albeit that the likelihood of serious violence may be increased in the additional context of symptoms of a paranoid illness. Hence, I believe it would be safe to move him into a 24-hour highly staffed hostel, so long as he was monitored extremely closely and so long as there was continued recognition of the potential for dangerousness should he form a sexual relationship of any sort. It would be very easy for him to move into the community and then to be presumed, perhaps in a year or two's time, to be not dangerous simply because he has lived satisfactorily in the community. It would be necessary to remind the treating team at regular case conferences that he can be very dangerous in the context of sexual relationships. Hence, monitoring should not be only of his mental state but also of his relationships with others, specifically women. [Emphasis added]

I think there would be some benefit in a Guardianship Order. Although he is willing to go to the hostel and continues to accept medication, I believe that there would be some symbolic and real point in such an order. Specifically, it would make it clear to [RR] that, should he change his attitude to living in the hostel or, for example, should he decide he wants to spend nights away at a new girlfriend's house, this would be taken very seriously and steps taken to restrict him. Also, should he become ambivalent about medication,

there would at least be a requirement that he attend hospital for an injection. Again, an advantage would be that he would be required to attend hospital for assessment of his mental state and monitoring of his sexual behaviour, as best it can be done through his own description.

In summary, therefore, I would recommend cautiously that he might move to the hostel you propose."

4.16 In February 1993 a Guardianship Order was made under Section 7 of the Mental Health Act 1983 in preparation for RR's discharge from Sutton Hospital. In March 1993 RR was discharged to a hostel known as Hexagon, in Wallington, where he appears to have been relatively stable. The Guardianship Order was periodically renewed.

4.17 By the end of 1997 RR's physical health was deteriorating and he was having difficulties managing the stairs at Hexagon. He was then transferred to the Jubilee Nursing Home in Purley, a placement which seems generally to have gone well.

4.18 In November 2001 there was an episode when RR became irritated by other residents and smashed some windows. He said he would have hit one of the other residents with a chair if he had not been stopped. As a result, RR was admitted to Chelsham Ward at the Bethlem Royal Hospital. Chelsham Ward is an acute assessment ward for older people with mental illness and for patients with dementia. It deals with patients with organic diseases and those with functional disorders such as depression and schizophrenia. It is a mixed unit and the sexes are not segregated, but all bedrooms have ensuite bathrooms, giving patients a good degree of privacy.

4.19 RR's condition was thought to have settled quickly on Chelsham Ward, but the Jubilee Nursing Home would not have him back. A formal assessment of his needs was carried out by Sutton Community Services. This recorded that RR was considered dangerous to others when in a psychotic state, with the high-risk group being females with whom he had a close relationship. It also said that he should be continuously supervised and that his mental state should be monitored.

4.20 On 13 December 2001, after about a month in Chelsham Ward, RR was discharged to Alpha House in Thornton Heath. Alpha House was a residential care home for people with mental health problems. This was considered an appropriate placement for RR

because, whilst many of the residents were elderly, not all were cognitively impaired, so there was an expectation that RR would be able to find fellow residents with whom he could converse.

4.21 However, RR had only been at Alpha House for slightly over a month when, on 24 January 2002, he was involved in a further violent incident. Having run out of cigarettes and, so he said, *"desperate for a smoke",* he went out to look for cigarette ends. Unable to find any, he saw a woman who he thought had cigarettes and he decided to rob her. He had a pair of scissors with him (he was subsequently unable to give a clear reason why), and when he found a quiet place, he went up to the woman, showed her the scissors and demanded the bag. When she shouted, he hit her on the chin and snatched the bag. Police officers quickly located him, and he was arrested.

4.22 Alpha House refused to have RR back because of his violent behaviour and on 25 January 2002 RR was re-admitted to Chelsham Ward under the care of CONS2, a consultant in old age psychiatry. CONS2 gave evidence to the Inquiry, although he was disadvantaged in doing so because the notes of his ward rounds could not be located. When RR was accepted onto Chelsham Ward, he was placed on one-to-one observations.

4.23 In February 2002, neuro-psychometric tests were carried out by C2, consultant neuropsychologist, which revealed a slight decline in RR's general intellectual functioning, which it was thought might be suggestive of early dementia.

4.24 Criminal charges were brought against RR at Croydon Crown Court. RR pleaded guilty, and a series of reports were produced to assist with sentencing. There were reports by CONS2 and by CONS6, also a consultant in old age psychiatry. CONS7, a consultant forensic psychiatrist who was working with the community forensic team in the Croydon area, prepared a further report.

4.25 CONS2's report, dated 11 March 2002, stated:

"<u>Impression</u>
[RR] is suffering from:
1. personality disorder with paranoid, psychopathic and sadomasochistic traits
2. paraphilia (disorder of sexual preference) - mostly sadistic

3. chronic paranoid illness - currently in remission with treatment - but which currently manifests itself as short-lived paranoid episodes, sometimes with auditory pseudo-hallucinations
4. signs of mild cognitive deficits: possibly as part of a progressive neuro-degenerative illness, with prominent frontal lobe release signs

Risks
In my opinion, he presents an ongoing risk to women and not just in sexual relationships. If his poor impulse control is not managed, then the object of his anger and impulsivity may extend to other people and situations." [Emphasis added]

4.26 CONS6 was instructed by RR's solicitors. In a report dated 19 March 2002 CONS6 referred to the neuro-psychological assessment which he said was consistent with a dementia, the most likely diagnosis being Alzheimer's disease. CONS6's view was that RR fulfilled the criteria for a schizophrenic illness, though it was in remission at that time. He suggested that an order be made under Section 37 of the Mental Health Act 1983 and that RR should be admitted to Chelsham House. He also said:

"With respect to the question of restrictions under Section 41 of the Mental Health Act 1983, my opinion is that these would not be necessary in this case, given his high level of co-operation with care in Chelsham House and his compliance with the pharmacological and social elements of his assessment and care."

4.27 CONS7's report, dated 15 March 2002, supported the recommendation for an order under Section 37 of the Mental Health Act 1983 and she agreed with CONS2 that RR presented an ongoing risk to women, particularly in the context of sexual relationships. She also referred to the evidence of his cognitive decline and said that if this continued *"it is likely that [RR] will continue to display symptoms of impulsivity and aggression possibly with associated violence towards others."* She noted that RR was currently presenting as well in terms of his psychotic illness, and continued:

"I currently view his risk to others associated with psychosis as low, albeit this risk would be increased in the context of relapse, non-compliance with medication or disengagement with services. With regards to the personality aspects of his presentation and, more specifically, the psychosexual component of risk, I was not convinced by [RR] thoughts

that he does not intend to pursue a sexual relationship in the future. Thus, with regards to his future placement and risk management, I would recommend the following:

1. That he continue to undergo assessment and treatment of both his mental illness and his cognitive impairment at Chelsham House and that he remain subject to Section 37 of the Mental Health Act 1983.

2. Careful consideration will need to be given to his future placement. Firstly, I would suggest that a facility such as a supported nursing home in the community for the elderly be sought with staff who have expertise in the management of severe and enduring mental illness in addition to organic disorders. In light of his ongoing risk to women, I suggest that a single sex facility be sought. Clearly, it is crucial that staff are aware of [RR's] forensic history and that his relationships are monitored in addition to ongoing treatment of his mental illness." [Emphasis added]

4.28 In accordance with these recommendations, an Order was made under Section 37 of the Mental Health Act 1983. This was for an initial period of six months. RR returned to Chelsham Ward.

4.29 CONS2 noted in his report that RR had serious physical health problems, recording that he had *"severe obesity, hiatus hernia, congestive cardiac failure, arthritis of hips and knees, chronic obstructive pulmonary disease secondary to smoking. He has breathlessness on exertion with poor exercise tolerance."* RR's physical health became an important element in assessments subsequently made of the risk he posed to others.

4.30 We heard evidence from the Ward Manager of Chelsham Ward, BRH1. She described how RR's condition appeared to have deteriorated since his last stay on the ward, but she also said:

"He became more threatening and intimidating towards other patients and staff, using … his size and stature, because he was a big man, to intimidate people. It was almost like he wanted to rule the other patients, he wanted to be … running the ward rather than just being a patient who was receiving care."

4.31 RR's notes also indicate that he behaved in a sexually inappropriate way towards staff and elderly women patients on the ward, touching a female member of staff

inappropriately, and making attempts to "groom" female patients. There were two female patients on the ward who were described as *"disinhibited",* with whom RR spent a lot of time, suggesting that when they were discharged, they should meet up. Importantly, however, staff on Chelsham Ward were well aware of the dangers of RR forming any kind of relationship with other patients, and all interaction between RR and female patients had to take place in open areas where he could be observed. As CONS2 put it to us:

"With him, definitely no relationship was acceptable to us."

4.32 For much of his time on Chelsham Ward, particularly at the beginning, RR was kept on one-to-one observations - that is to say, with a nurse whose only task was to maintain observations on RR such that, even at night-time, there was always someone with him. Even when RR was not on one-to-one observations, the layout of the ward enabled the nurses to ensure that there was no inappropriate behaviour. BRH1 made it clear in her evidence that, if RR had developed a relationship with a woman, she would have taken steps to get RR off the unit.

4.33 In April 2002 RR signed a consent form indicating that he did not wish to be resuscitated in the event that he had a cardiac arrest.

4.34 By May 2002 RR was becoming unhappy on Chelsham Ward. He made a request to be transferred to a residential care home for older people in the Thornton Heath area, a home which he had apparently found in the Yellow Pages. On 21 May 2002 there was a ward round. DR3, CONS2's Senior House Officer (SHO) on that ward round, made a note which concluded "*Plan: Send assessments to Whitepost"*. This was, so far as it is possible now to tell, the first mention of a possible move to Whitepost/Shrewsbury Court.

4.35 It soon became the principal option under consideration for RR and on 3 July 2002 DR3 formally asked Shrewsbury Court to assess RR's suitability for admission. The request was accompanied by various reports, including one from Q2, an Approved Social Worker with the Wallington CMHT who was, at this time, RR's social worker. Q2's report referred to a recent interview with RR, at which RR had seemed enthusiastic about a move to Shrewsbury Court. After referring to RR's recent history, Q2 stated:
"There was an initial plan for RR to be referred to Thornton Lodge, a mental health care home for the elderly, but it has since been deemed that he cannot live in an informal and

minimally supervised community setting because of the high level of risk of violence that he poses to others and which is not likely to change in the foreseeable future. It is felt that a facility such as Whitepost ... would be more suitable to meet [RR's] needs."

4.36 It is noteworthy that RR's behaviour at this time was causing some concern. On 25 July 2002 it was noted that he was making inappropriate comments of a sexual nature to staff, and on 30 July 2002 the ward round notes refer to his remarks amounting to sexual harassment. On 1 August 2002 there is a note that RR pushed a female patient to the ground, and throughout August 2002 there are further notes of various minor concerns about his behaviour.

4.37 On 9 August 2002 W1 visited RR on Chelsham Ward as part of Shrewsbury Court's assessment procedures. W1 was then the Registered Manager at Shrewsbury Court and one of his responsibilities included assessing patients for possible admission there. W1 refused this initial application for RR to move to Shrewsbury Court. He was concerned about RR's history of violence towards women and about how that risk could be managed. The formal refusal was communicated in a letter dated 14 August 2002.

4.38 CONS2 and BRH1 both said in their evidence to this Inquiry that they were surprised by this decision, firstly, because Shrewsbury Court had previously taken another patient from Chelsham Ward, who they felt was as dangerous as RR and who they thought had been successfully managed at Shrewsbury Court; and secondly, because RR was at that time being managed on a mixed-sex ward without significant difficulties.

4.39 It is apparent that there was some pressure to move RR from Chelsham Ward because consideration was also being given to the possibility of moving him to a forensic ward, Witley 3, at the Bethlem Royal Hospital. That ward provided what was described to us as an open forensic rehabilitation service. The consultant psychiatrist there was CONS3. He had a particular interest in elderly forensic patients and had attended the Maudsley Grand Round, at which RR's case had been presented. He considered RR's case to be of interest, and he felt that he and Witley 3 had something to offer. Croydon PCT had a contract for the use of three beds at Witley 3 for Croydon patients, and this provided a possible route for RR to secure a place there. The possibility of RR being transferred from Chelsham Ward to Witley 3 was not actively pursued whilst it was hoped that Shrewsbury Court would be prepared to accept him, but after W1 refused to accept RR, CONS2 asked CONS3 if he would be prepared to accept RR as a patient at Witley 3.

4.40 CONS2 also asked Shrewsbury Court to reconsider its decision. On 2 September 2002 he and CONS7 co-signed a letter on behalf of SLaM asking W1 to reconsider the decision not to take RR. The letter stated:

"Thank you for your letter of the 14th August regarding [RR]. In it you state that [RR] cannot be offered a place [at Shrewsbury Court] because of the perceived high risk of sexual incidents.

We are of the opinion that, due to his physical health and his currently well controlled mental health, he does not pose a high risk to women. On Chelsham we monitor who he is having contact with, but otherwise do not make any other restrictions. ... Provided [RR's] relationships with women are monitored at Whitepost, we believe his risk of sexually offending/incidents could be managed effectively."

4.41 CONS7 had only seen RR once, for the purpose of the report which she had prepared earlier that year. CONS2 approached her in August 2002, and told her of the difficulties in finding a placement for RR and that Shrewsbury Court had rejected him. He asked her if she would be willing to co-sign a letter asking Shrewsbury Court to reconsider. CONS2 drafted the letter, and CONS7 amended it adding the final sentence of the passage set out above. CONS7 explained that she did not re-assess RR before signing the letter, but that she signed on the basis that she was told by CONS2 that RR had been on Chelsham Ward for about six months without any major concerns, and that he was not presenting a serious management problem. She also told us that she was aware that there had been difficulties in finding a single-sex facility for RR.

4.42 It is interesting to contrast this letter of 2 September 2002 with a letter about RR written the following day by DR4, CONS2's Senior Registrar. On 3 September 2002 she wrote:

"[RR] has no insight into the extent of his difficulty, he has poor impulse control and in my opinion presents an ongoing risk to women. He continues to minimise his previous assault behaviour and sees no need to be in a supported environment. He also reacts poorly to stress with threats of self-harm."

4.43 The letter was written in the context of the renewal of the Section 37 order to which RR was, at this time, still subject. It was, therefore, addressing slightly different issues to those covered by the letter written by CONS2 and CONS7, but there is a significant difference in emphasis between these two letters.

4.44 There is also reference in the records we have seen to CONS7 agreeing with CONS2 to speak to the manager at Shrewsbury Court to try to persuade him to reconsider the decision not to take RR. In particular, there is a letter dated 7 October 2002 from CONS7 to CONS2 saying that:

"I remain of the view that [RR] could be successfully managed at Whitepost and I will make every effort to emphasise this to the manager of Whitepost. In the event that they do not accept [RR], I would be happy to reconsider referral to Witley 3 Ward …"

4.45 It is not clear what actually happened. CONS7 gave evidence to the Inquiry. She had no recollection of speaking to the manager or anyone else at Shrewsbury Court about RR. She was, at this time, about to go on maternity leave, and it is possible that this is a matter which remained outstanding when she took that leave.

4.46 W1 responded to the request to reconsider his decision in a letter dated 10 October 2002. He stated that, having considered RR's case with the consultant psychiatrist at Shrewsbury Court and the rest of the team, the consensus was that they could not provide the level of care and supervision required, bearing in mind it was a mixed-sex unit. But W1's letter went on to say:

"However, if [RR's] improvement is maintained and he demonstrates his ability to live in a mixed sex unit, I will be happy to reassess him in 3-6 months time."

4.47 On 15 October 2002 CONS2 wrote to W1 saying:

"[RR] has been on our mixed sex ward since January this year and has not been a problem, even when there were two instances of disinhibited female patients on the unit. We will now refer [RR] for a possible admission to Witley 3 ward .... However, this is a single sex unit and I hope that this will not prejudice [RR's] chances of being reconsidered for Whitepost in 3-6 months time."

4.48 RR then appealed against the continuation of the Section 37 order to which he was still subject. RR wanted to be discharged from the order so that he could live more independently. His attempt to have the order discharged was strongly opposed. DR5, an SHO to CONS2, wrote the medical report for the Managers Meeting which concluded as follows:

"Impression
It is the opinion of the team that [RR] should stay on his Section 37. This is mostly with regard to the fact that he presents an ongoing risk to other people, especially women, and it is our opinion that this is not just in sexual relationships. He has poor impulse control, as demonstrated by his past history, as well as certain incidents while an in-patient at Chelsham House. He has been assessed by consultant forensic psychiatrists, who are also of the above opinion. If his impulse control is not managed, then the object of his anger and impulsivity may extend to other people and situations. The past history of violent behaviour and the recent violence give cause for concerns, especially given that the likely progressive nature of his cognitive impairment, which may lead to increased disinhibitions. If [RR] is discharged from Section, he will pose an increased danger to women. Although we may be able to treat his behaviour, we will be more able to manage it, for example, by finding suitable accommodation."

4.49 The stance was supported by his social worker, who was now Q3. She prepared a report dated 4 November 2002 stating that RR's past history indicated that there would be a high level of risk to himself and others if he were discharged into the community. She said that RR required a high level of supervised support in a specialist setting, and that he needed to be detained in hospital until a suitable long term placement could be identified.

4.50 On 5 November 2002 the Hospital Managers at the Bethlem Royal Hospital refused RR's appeal and the order under Section 37 remained in force.

4.51 The attempts to get RR transferred to Witley 3 were pursued. There are also references in the notes to other possible placements for RR. Mention was made of an establishment known as Woodleigh Homes, but the cost was said to be high (exceeding £1,500 per week) and in December 2002 it was discovered that this home did not take patients over the age of 65. There were also discussions again about Thornton Lodge, which came to nothing – no doubt because, as had been noted by Q2 in July 2002 when

Thornton Lodge had previously been considered, RR could not be placed *"in an informal and minimally supervised community setting because of the high level of risk of violence that he poses to others"*.

4.52 There are also references in the notes to concerns about RR's behaviour. On 9 November 2002 he refused his cardiac medication, although no psychotic symptoms were noted. On 11 November 2002 RR reported that he wanted to *"smash up"* the ward but had managed to resist, and he denied any psychotic phenomena when feeling like this. On 12 November 2002 however RR did smash a hi-fi unit on the ward. It was recorded that he was *"unapproachable"* at the time, but when he was later reviewed by the duty doctor, he denied any auditory hallucinations or thoughts of self-harm or violence. A short while later, he smashed a clock on the ward, again apparently without warning. When questioned, he said that he had had a *"strange feeling",* but refused to talk about it further.

4.53 The possible admission to Witley 3, and its funding, were discussed at a discharge planning meeting for RR on 19 November 2002. There was also discussion of two alternative placements - St Andrew's Hospital in Northampton, and Woodleigh Community Hospital in Croydon (Woodleigh Homes). Reference was made to the high cost of these alternatives. CONS3 attended this meeting and said he thought that Witley 3 could provide a useful service for RR. There were, however, concerns about whether the ward was suitable for RR in the light of his physical disabilities. The ward was not on the ground floor, and it was thought that RR might not be able to manage the stairs due to his cardiac problems, particularly in the event of an emergency. There were also concerns about the extent to which someone with RR's physical problems could be appropriately nursed on a rehabilitation ward for psychiatric patients. The nursing team leader at Witley 3, BRH2, assessed RR and initially advised:

"[RR] requires a high level of nursing care for his physical problems to be effectively addressed. Witley 3 is not suitable for him, and jeopardises his safety. It seems therefore that, if not Whitepost, then other suitable nursing home placements should be found. It was demonstrated in the time on Chelsham that he could be safely managed on a mixed sex ward, and I feel therefore that Whitepost should consider him on this basis."

4.54 Ultimately CONS3 managed to persuade his nursing staff that RR could be accepted onto Witley 3, and in December 2002 it was agreed that RR would be transferred there. It

was not anticipated that he would stay on that ward for much longer than six months. His social worker, Q3, noted that it was still going to be necessary to find a long term placement for RR; and on a ward round on 10 December 2002 CONS2 advised her to consider St Andrew's old age forensic unit in the event that things did not work out at Witley 3.

4.55 On 20 February 2003 RR was transferred to Witley 3 under the care of CONS3. He settled well. As six months had passed since Shrewsbury Court's rejection of RR, attempts were made to have RR's suitability for a placement there reassessed. It appears, however, that there were difficulties in obtaining a response from Shrewsbury Court and the matter was not pursued at that time.

4.56 On 27 March 2003 Q3 visited RR. He told her he was very happy at Witley 3. He was apparently allowed to leave the ward for about 90 minutes a day. She discussed with him the possibility of going to Shrewsbury Court or to St Andrew's. She noted that RR was *"adamant that he would not go back to any residential nursing environment"* and that he would *"create havoc"* if he were forced to do so. He reiterated his wish to be placed in supported housing, and said he was going to appeal against the continuation of the Section 37 Order to which he was still subject.

4.57 RR did pursue that further appeal which was heard by the Hospital Managers on 15 April 2003. A medical report for the hearing was prepared by DR3 (SHO to CONS3). It concluded as follows:

"<u>Opinion and Recommendations</u>
[RR] has a significant history of violence using weapons in the context of relationships. He has a longstanding paranoid illness which, although currently relatively stable with treatment, does continue to manifest occasionally. His most recent offence in January 2002 is not in keeping with his previous nature of offending, thereby possibly suggesting a different underlying cause associated with increasing impulsivity. There is a possibility that he has developed early vascular dementia, as MRI results show ischaemic brain disease. Its associated cognitive deficits and increased impulsivity remain important aspects of his ability to control his actions. This is further complicated by his abnormal personality and paraphilia.

Although [RR] states that he wishes to stay at Witley 3 and agrees to continue with medication, he continues to pose a risk to himself and others due to his impulsivity and possible further deterioration in cognitive function.

We feel that he is currently appropriately detained. His illness is of a nature that warrants further treatment in the interests of his own health, safety, and protection of others."

4.58 Q3 also prepared a report for this meeting, dated 8 April 2003 supporting the continuation of the Section 37 order. The report concluded:

"[RR] has demonstrated no direct psychotic behaviour since his admission to hospital in January 2002, although he has displayed some aggressive behaviour. Indications are that, in the right environment, [RR] presents fewer risks than he did some 18 months ago.

[RR] is insistent that he will not settle in a nursing/residential home. He has stated that he 'will create havoc' if forced to do so and this would impact on other vulnerable people who are placed there. This means that homes such as Whitepost might have to be discounted as possible placements. Quite clearly, any such placement would have to be informed of [RR's] threats in order for them to prepare for any violent outbursts and to protect other residents. Whether any care home would be prepared to admit someone under these circumstances is debatable."

4.59 There was also a nursing report prepared for the Managers by BRH3, an RMN at Witley 3. This included the following:

"[RR] does not present a physical or psychological danger to others. Whilst in Witley 3, he has not displayed any verbal or physical aggression or violent behaviour. [RR] might be a risk in the community, dependant on his financial status. ... [RR] has been fully compliant with all his treatment whilst on Witley 3. He has not refused treatment since being admitted here. It is my belief that he will continue his treatment if taken off Section, as he has some insight into his mental condition."

4.60 The Hospital Managers allowed RR's appeal, and lifted the Section 37 Order. CONS3 could not recall whether he had actually presented RR's case to the Managers, but

he did recall that, during the hearing, he had been called away to an emergency, and so only learned of their decision later.

4.61 The Managers stated that they had formed the view that RR was not suffering from a mental illness or other mental disorder of a *"nature or degree"* which made it appropriate for him to be detained in hospital for medical treatment, and they gave their reasons as follows:

"Managers were told that the patient, who suffers from a schizophrenic illness, shows no apparent positive symptoms at present, is compliant with medication, and engages in ward therapies and states categorically that he will remain as an informal patient."

They also stated that they did not consider it necessary for the health or safety of the patient or the protection of other persons that he should receive treatment that could not be provided unless he was detained under Section 37, their reasons being:

"The patient continues to require [treatment] which he accepts and Managers consider that, although he continues to require the care of this structured unit, it can be provided without detention."

4.62 We discuss later in this Report the merits of this decision by the Hospital Managers. In the event, RR did choose to remain at Witley 3, notwithstanding the lifting of the Section 37 Order. CONS3 told us, however, that the lifting of the Order changed the way in which staff were able to work with RR, and that, in particular, RR became less willing to talk about his sexual perversions.

4.63 CONS3 also felt that the lifting of the Order undermined his plan - which he described to us as a privately stated plan - to keep RR at Witley 3 in the long term, probably until RR died. Witley 3 was, in some ways, an unusual ward. It provided a forensic rehabilitation service, but also had patients who stayed for many years, so it would not have been out of the ordinary for RR to have stayed there for a few years. RR was, in 2002, 69 years of age. He was in very poor physical health. He had already agreed that he should not be resuscitated in the event that that he suffered a cardiac or respiratory arrest. There was a perception that he might die at any time.

4.64 Attempts continued to try and find RR a suitable placement. On 1 May 2003 there was a CPA meeting attended by, amongst others, CONS3, BRH2, DR3, Q3 and BRH3. It was recorded that the current risk posed by RR was thought to be low due to his psychosis being in remission, his compliance with his medication, and the fact that he lived in a controlled and supervised environment where he was monitored by the clinical team, and where his ability to offend and/or to gain access to victims was limited by physical health problems. It was agreed that he needed 24-hour nursing care, and it was decided that Q3 should again contact Woodleigh Homes to see if they might be prepared to take him. It is unclear why this option was raised again when it had been ascertained in December 2002 that this home did not take patients over the age of 65. Woodleigh Homes confirmed their refusal by a letter dated 16 July 2002.

4.65 On 21 May 2003 RR was admitted to Mayday Hospital for a period of treatment for his chronic obstructive pulmonary disease.

4.66 In June 2003 RR began to try to find himself accommodation, an option now open to him in the light of the lifting of the Section 37 Order. He telephoned one possible residential home and went as far as to place advertisements seeking private accommodation.

4.67 Following Woodleigh Homes' confirmation of their refusal to take RR, Q3 made contact with Shrewsbury Court on 30 July 2003 and spoke to W1. He agreed to carry out a further assessment of RR's suitability, and she faxed up-to-date information on RR to him that afternoon. She made a visit there on 11 August 2003. Her note of that visit reads:

"Went to Shrewsbury Court this afternoon to assess the suitability as a possible placement for [RR]. Met with W1 who gave me comprehensive information about Whitepost and showed me round the building. … W1 explained that it is still classed as a 'hospital' rather than 'nursing home' and this has been causing some funding/benefits problems. He confirmed that he will be assessing [RR] on 18th August and told me that, if he is accepted, he could be offered a bed in October/November. ... My main concern is that the residents I met had severe mental health problems and I am unsure how [RR] would interact with people that he could not converse with (his own mental health is now quite stable). However, I acknowledge that I only met a minority of residents, with the more able being out of the building today. W1 and myself agreed, that if the assessment is satisfactory, [RR] should spend an afternoon at Shrewsbury Court and stay for a meal,

when all residents would be present and he could assess for himself how he would settle with this client group."

4.68 W1 then met RR on 18 August 2003 and prepared a Needs Assessment. He referred in this document to his initial refusal to accept RR and also to letters supporting the application which he had received from CONS7 and so he recorded, "CONS8". W1 said in his evidence that he was sure he had the right name, but it seems likely that this was an error, and was a reference to the letters written by CONS7 and CONS2. There is a CONS8, a consultant psychiatrist and clinical director for the adult mental health services in Croydon, and he gave evidence to the Inquiry. His evidence was that he covered CONS7's position when she went on maternity leave, but there is no evidence to suggest he had any involvement at all in the attempts to persuade Shrewsbury Court to take RR.

4.69 W1 also referred to reports which he had been given, but these were not identified in the Needs Assessment. He said he had been informed by nurses involved in RR's care at Witley 3 that there had been no recent reports of assaults or incidents; and that since RR's move to Witley 3, he had been *"doing fine"* and had the full support of the team there for the placement at Shrewsbury Court. He also noted that RR had visited several times and appeared happy with the idea of moving there - which was obviously a contrast to the attitude RR had previously expressed to Q3, to which she had referred in her report of 8 April 2003.

4.70 W1 agreed to take RR for a trial period of 3 months. The formal letter offering the place was dated 5 September 2003. It specified a weekly cost of £950 *"to include all nursing, medical, occupational therapy and physiotherapy provisions and full accommodation."* The letter said there were a limited number of places at Shrewsbury Court and that there was considerable pressure to admit clients, so an early response to the offer was sought.

4.71 On 23 August 2003 RR told a staff nurse at Witley 3 that he had agreed to carry drugs for a third party. He said he had done so in order to pay back a debt which he had incurred buying cannabis and ecstasy. This appears to have been an isolated occurrence, but it did cause those involved with RR's care to have concerns about the extent to which he was vulnerable to exploitation. There is no evidence, documentary or otherwise, that details of this episode were passed on to Shrewsbury Court at this time.

4.72 On 18 September 2003 there was a CPA meeting concerning RR. Q3 noted that his physical health appeared to be deteriorating in a number of different ways. There was discussion of his involvement in carrying drugs, but the conclusion appears to have been that this was a one-off incident which was unlikely to be repeated. The move to Shrewsbury Court was discussed, and RR confirmed that he was now happy to make the move. Bearing in mind that Shrewsbury Court was offering only a trial period, consideration was given to what would happen if the placement broke down. Q3 wrote to CONS2 informing him that Shrewsbury Court was willing to take RR, but asking for confirmation that CONS2 would be prepared to re-admit him if the placement failed. CONS2 did provide this confirmation.

4.73 Q3 also set about securing funding for RR's placement. On 23 September 2003 she prepared a Community Care Services Comprehensive Assessment. This included the following:

"[RR]'s deteriorating physical health requires 24-hour monitoring, as he is prone to angina and breathlessness. He also has to take a large amount of medication, which again requires supervision and monitoring. [RR] is at risk of becoming seriously mentally and physically unwell if he does not take his medication. [RR] has been diagnosed as having early onset dementia and, although this is thought to be mild at present, there are still associated risks, such as lack of insight into his capabilities. [RR] is also felt to be vulnerable to manipulation from others. He was recently coerced into obtaining drugs for another patient on Witley 3, and was lucky that he did not have fatal consequences as a result of taking ecstasy. [RR] is unable to shop and cook for himself, and would be at risk of malnutrition if not supervised. He is also unable to manage his finances, and his gambling puts him at risk of having serious financial problems. This in turn would result in a risk to others, as the last time that [RR] was in this predicament, he attempted to harm and rob an elderly lady. [RR] is likely to neglect his personal hygiene routine if unsupervised. [RR] therefore requires 24-hour care in a specific care home that will be able to provide for all his physical and mental health needs, whilst being aware of his forensic history."

She assessed his need as critical in all areas.

4.74 This was followed up with a "Community Care Comprehensive Care Plan" which included the following "Statement of Need":

- *"[RR] needs a suitable environment, where he feels safe, respected, with easy access to local facilities and a lift to his bedroom.*
- *[RR] needs his mental state carefully monitored to prevent any threatening behaviour.*
- *[RR] needs assistance and supervision with his medication.*
- *[RR] needs monitoring of his physical health.*
- *[RR] needs supervision with his daily living skills, such as keeping his room clean and tidy.*
- *[RR] needs prompting with his personal hygiene.*
- *[RR] needs assistance with budgeting his finances.*
- *[RR] needs to retain his independence and be encouraged to interact with other residents.*
- *[RR] needs to be able to travel outside of his care home, and have an escort when feasible.*
- *[RR] needs monitoring to prevent manipulative behaviour from/to him."*

4.75 Surprisingly, there was no reference in either of these documents to the desirability of RR being in a single sex environment, nor to any perception that RR might pose a danger to any woman with whom he might form a relationship. No suggestions were made about possible options for RR other than Shrewsbury Court.

4.76 On 25 September 2003 RR went on an escorted visit to Shrewsbury Court accompanied by DR3 (CONS3's SHO) and C3 (an occupational therapist). RR was reported to have said that it was much better than he expected. CONS3 told us that DR3 had gone on this visit, not to assess the suitability of Shrewsbury Court for RR, but rather because he considered it would be useful for her to see such a unit as part of her training. The occupational therapist's role was to consider any issues relating to the layout of Shrewsbury Court having regard to RR's physical health problems.

4.77 The reference in W1's letter of 5 September 2003 to the pressure on beds at Shrewsbury Court was not just marketing talk. Demand for beds there at that time did exceed availability, and a "first come, first served" policy was applied. Funding for RR's placement was to be shared equally between Croydon PCT and the London Borough of Sutton, so it was necessary for the placement to be approved by both bodies. In the event, this took time and the immediate opportunity to move RR to Shrewsbury Court was lost.

4.78 In early October 2002 Q3 contacted W11, the chair of the placement panel for Croydon PCT, regarding the anticipated 50% contribution from Croydon PCT. W11 was then the Assistant Borough Director working for the integrated adult mental health service in Croydon, managing health and social care services for adults of working age in Croydon. He gave evidence to the Inquiry.

4.79 The proposed placement at Shrewsbury Court was also put to the placement panel responsible for making placement recommendations to the Executive Head of Community Care in the London Borough of Sutton. This panel was chaired by W12, Borough Director; and it first came to consider the application on 13 October 2003. The minutes of this meeting stated:

"Not clear from assessment why Whitepost is being proposed. Need NHS continuing care assessment and decision from Croydon PCT regarding their funding responsibility. Can a manager take responsibility for studying the Croydon NHS continuing care criteria and liaising with Croydon PCT regarding assessment and decision etc. Also other possible placements need exploring."

4.80 It is noteworthy that in her evidence to the Inquiry W12 drew attention to the fact that various parts of Q3' assessment of 23 September 2003 had been highlighted by her in the course of this placement panel meeting. The passages in question included the statement *"[RR] is not thought to now be a risk to women."*

4.81 In December 2003 RR reported what were described as *"musical auditory hallucinations"* - specifically hearing bagpipes. It was concluded that this was a result of a depot injection not having been given properly. His symptoms resolved after he received his next depot injection. It was also noted that this episode showed that RR might not tell staff about psychotic symptoms until <u>after</u> those symptoms had passed. He was strongly urged to discuss any such problems with the psychiatric team during the acute phase.

4.82 On 26 January 2004 RR signed a further "Do not resuscitate" form (which he subsequently renewed on 4 May 2004). He said that he was not interested in being resuscitated and that he *"just wanted to go"*. He also reported feeling in fairly good health and thought that the medication he was taking seemed to be working.

4.83 On 12 February 2004 Croydon PCT formally agreed that it would meet 50% of RR's costs at Shrewsbury Court, and on 26 February 2004 Q3 sent an email to W12, following up on the comments made at the last placement panel meeting. She stated:

"As you are probably aware, I am reluctant to go back to panel for [RR]. I initially applied for funding at Sutton's panel for [RR] on 13th October 2003. This was on the basis that Croydon PCT would agree to 50/50 joint funding and this was recommended by the panel. Since that time I have sent no less than five emails to C20 and made several telephone calls to keep her up-to-date with this case and to remind her of the importance of securing the agreement between Sutton and Croydon for this gentleman's placement. I have spent months attempting to secure Croydon's agreement to the 50% funding, and at no point was I informed that there would be a problem with Sutton's 50%. Whilst I am aware that there are other cases of high importance, I feel there is little to be gained by attending another panel meeting. <u>There ARE no contingency plans or alternatives for [RR].</u> He has a serious (some 40 years of sexual offences against women) forensic history (admittance to hospital on Section 37 Nov 2002); a long history of mental illness and now suffers from life-threatening ill health (heart and breathing difficulties). He has been at the Bethlem Royal Hospital for over two years and has been ready for discharge since August 2003. I feel I have done everything possible to ensure he has a placement to meet his needs. <u>To be frank, Whitepost is the ONLY establishment that have agreed to offer [RR] an assessment and subsequent offer of a bed</u>. ... I apologise, if I appear to be difficult - but I would not be doing my job if I did not make a strong case for my client to receive the funding he needs." [Emphasis added]

4.84 Following this strongly worded communication, the Sutton placement panel meeting finally approved the placement at Shrewsbury Court on 1 March 2004.

4.85 Unfortunately, Shrewsbury Court's "first come, first served" policy meant that a bed was no longer available, and there was further delay before RR's transfer. During this period, Q3 moved on and her position as RR's social worker/care co-ordinator was taken over by Q1.

4.86 On 6 May 2004 Shrewsbury Court set out the terms and conditions of the offer being made to RR. These terms included a provision that if RR needed one-to-one

observations, the costs would be covered for the first seven days, but after that the costs would be met by the placing authorities.

4.87 CONS3 ascertained that CONS4, a consultant psychiatrist at Shrewsbury Court, would become the RMO for RR and on 19 May 2004 he wrote to him saying:

"Further to our recent phone call, my understanding is that, if [RR] were to come to Whitepost under a section of the Mental Health Act, you would care for him from the outset as his RMO. If he comes to you informally, you advise me that he should be referred to you at the Redhill & Reigate Community Mental Health Team. I confess to not quite understanding the reasons for the difference but this aside I would now like to formally refer him to your care.

You will see from the accompanying pack that he has already been on a long term section of the Mental Health Act though has been treated without significant problem as an informal patient on Witley 3 ward. We would have considerable difficulties organising after-care arrangements locally at such distance. This being the case, I would ask that consideration be made for caring for [RR] from the outset with the undertaking that if he were to require admission then SLaM (Croydon sector) would undertake this."

There are no notes of the telephone discussion referred to in this letter. There is also no indication of what was contained within the pack of documentation sent by CONS3 with this letter.

4.88 On 9 June 2004 CONS4 wrote to CONS3, referring to a telephone conversation on that date, and confirming his formal agreement to becoming RR's RMO. In his statement to the police following the homicide, CONS4 said this agreement had followed discussions during which he was told that the risk assessment had *"gone down"* in the previous two years; and had gone down in particular since the original referral request had been made in 2002.

4.89 On 24 May 2004 RR was seen on the ward round by DR6, CONS3's SHO. The clinical notes record RR's reaction to his recent visit to Shrewsbury Court. The notes read:

"Some disappointment about his proposed placement … because 'there was a horrible urine smell'. … Furthermore, on the day he visited, the 'younger' residents (in their 40s)

went to the pub, leaving him with the older clients who sat without saying anything. Nevertheless willing to attempt trial of stay at this home."

4.90 On 8 June 2004 a report recording RR's history was sent by DR6 to CONS4. It outlined RR's personal, forensic, psychiatric and medical history, and it concluded:

"Summary
[RR] is a 71-year old man who has been an informal patient since April 2003. He has a significant history of violence using weapons in the context of relationships. His most recent offence in January 2002 is not in keeping with the previous nature of his offending, thereby possibly suggesting a different underlying cause associated with increased impulsivity. There is a possibility that he has developed early vascular dementia as his MRI results show ischaemic brain disease and he has cognitive deficits. This is further complicated by his abnormal personality and history of paraphilia. His long-standing paranoid illness is well controlled with medication. His mental state is clinically stable. The multi-disciplinary team at Witley 3 ward agree that it is appropriate for him to be discharged to the community. In view of his chronic poor physical health, he has been granted "do not resuscitate status" with his valid consent and at his request. This is regularly reviewed."

This was a rather briefer report than the subsequent Discharge Summary, and it can be surmised that it was prepared for the purpose of providing CONS4 with additional information, to enable him to decide whether he was prepared to act as RR's RMO.

4.91 On 21 June 2004 a Section 117 meeting was held at the Bethlem Royal hospital. Present at this meeting were CONS3 and his SHO, DR6; BRH2 (the Acting Ward Manager at Witley 3); Q1; and an RMN from Shrewsbury Court, W2. CONS4 was invited but was unable to attend.

4.92 W2 gave evidence to the Inquiry. His English is idiosyncratic, and was often not easy to follow. He said that, the day before this meeting, he had been given a large file of papers by W4, the Acting Manager at Shrewsbury Court, and been told that DR2, the owner of Shrewsbury Court, had asked that he attend RR's discharge meeting the following day. He said that he was given no further information. He also said that he had attended discharge meetings before, but only with W1, so this was the first meeting he had attended on his own. His evidence was:

"I just sat and listened to what [CONS3] was saying, and he made sure I had a copy of his file, sealed in an envelope. I brought it to [W4] to be given to CONS4."

He also said that he talked to some of the nursing staff at Witley 3 about RR and how to manage him. His evidence was as follows:

"We all sat down and during the handover we talked about it. ... They told us that, if he refuses his medication, you have to give him time and explain to him why. If you want him to respect you, you have to respect him too. You have to explain to him in a calm way why this should be done, why he should take this."

4.93 When asked if there was anything said about his relationships with women, W2 replied that he was told that staff at Shrewsbury Court should:

"inform the female clients about the consequences and he has done it before, [so] they were aware of it."

He said he had read the *"case note"* from the discharge meeting and had learned of RR's history regarding relationships with women. He said he understood that RR's relationships with women were to be monitored. When asked what that meant in practice, he said:

"Because of his past case history, when they go to the smoking room a member of staff shadows them to the smoking room, offers them cigarettes to smoke and talks to them, interacts with them so they are not suspicious you are watching them."

4.94 There are no notes on any file held at Shrewsbury Court recording what W2 was told at this meeting.

4.95 CONS3's notes of this meeting include the following:

"We briefed the visitors about [RR's] background history and I went through some of the salient points to his risk assessment and risk management. We spoke about his diagnosis being one of paranoid schizophrenia currently in remission on depot medication. Aside from that, he has dissocial personality disorder that historically has amounted to a psychopathic disorder. He has a history of problem alcohol use, and even during his

admission to hospital has used cannabis and ecstasy, both causing changes to his mental state. He has cognitive impairment probably of vascular origin with some evidence of frontal release symptoms. This has caused irritability and impulsiveness in the past. It is hard to predict how this will affect his future behaviour. His risk of serious offending is low providing he continues to receive treatment in a contained environment - I understand Whitepost is an independent hospital in the community. He remains compliant with medication, at low risk of absconding and Whitepost has separation of the sexes. Although he is physically unwell and short of breath on minimal exertion, I would not underestimate his capacity to seek out the attentions of women and it would be in the close emotionally charged relationships that I would be concerned about risk to others. A higher risk of less serious offending consisting of irritability, behavioural disturbance and damage to property may exist if his schizophrenia relapses and relapse indicators of this consist of change of behaviour, covertly carrying weaponry (scissors), command hallucinations and musical hallucinations. He is not very able to enunciate these symptoms when experiencing them in the early stages and might simply ask for more depot or his depot early. His compliance is generally good.

He is keen on the move to Shrewsbury Court. He is amazed (we are flabbergasted) that it would appear that he is given 20 cigarettes a day at this new unit. I have asked [W2] to consider the health implications and have advised [RR] that his smoking is a serious problem to his health.

... The crisis plan will consist of a phone call to myself and CONS4 and, within the first 3 months, readmission through CONS2 dependent on the nature of the problem. Thereafter CONS4 would organise an admission to local services through Epsom."

4.96 On 23 June 2004 a comprehensive Discharge Summary was prepared and signed by DR6. It contained a full history, including a detailed summary of RR's time at Witley 3. It also contained a summary of the more recent investigations. It referred specifically to the report of CONS7, from April 2002, as follows:

"CONS7, consultant forensic psychiatrist, assessed [RR] in April 2002. She was of the opinion that he represented an ongoing risk to women, especially in the context of sexual relationships. CONS7 also felt that any of his future relationships with women should be monitored closely. Other aspects of his risk were felt to pertain to his pre-morbid antisocial personality features, his mental illness and his cognitive decline. It was

thought that, should his cognitive function deteriorate further, he was likely to become impulsive, aggressive and possibly violent. It was also felt that, although his psychotic symptoms were relatively stable, should he relapse, become non-compliant with his medication, or disengage from mental health services, this risk would be likely to increase. The recommendation for a future placement was a 24-hour supervised nursing home in a single sex accommodation."

4.97 The report contained a description of RR's poor physical state and concluded as follows:

"Risk Assessment
In terms of his risk to others, his violent behaviour has previously been in the context of a psychotic relapse, typically with command hallucinations or jealousy of a partner (which may have been delusional). His violence has also been linked to his paraphilia, which is characterised by sadistic fantasies, and his disturbed personality. His most recent offence was not in keeping with the previous nature of his offending. That acquisitive act suggests a different underlying cause associated with increase in impulsivity. There is a possibility that he has developed early vascular dementia with frontal lobe impairment (as suggested by his MRI brain and psychometric testing). His aggressive behaviour has mainly been directed at women, both those he is in an intimate relationship with and more recently members of the public. He has used weapons against others in the past (e.g. scissors) and attacked inanimate objects (e.g. smashing windows).

His risk of violent offending is related to the presence of psychotic symptoms. Relapse indicators include musical auditory hallucinations, command hallucinations or voices taunting him. He has had persecutory delusions that others want to harm him. On at least two occasions, he has believed that black members of staff in particular were against him. One episode was in Sutton Hospital when he thought a black nurse was plotting with his wife against him. The other was at Alpha House prior to his current admission, when he thought 3 black members of staff were talking about him 'in their own language'. Relapse has reportedly been related to 'instability in his life, emotional involvement with females and excessive drinking of alcohol'. Our experience on Witley 3 ward has also highlighted the potential risk of inadequate treatment with psychotropic medication (due to faulty administration of the depot rather than non-compliance on [RR's] part) and illicit drug use.

He also has a history of self-harm and suicide attempts, such as by overdosing or hanging. Associated factors in these episodes have included the loss of an intimate relationship and low mood. His poor physical state is also a major risk to his health. His period of working as a drug mule for a fellow patient may represent a vulnerability to exploitation by others.

Currently his risks to others are low for several reasons. The primary reason is that his severe physical health problems limit his movements. His compliance and response to medication, abstinence from substance misuse, and 24-hour support from trained staff are also protective. Nevertheless in view of his past history it is important that all his relationships, particularly with females, are closely monitored. His risks of self-harm are low, as there is no evidence of low mood or discontent.

Diagnosis

- *Paranoid schizophrenia.*
- *Paraphilia of a sadistic nature*
- *Probable vascular dementia with frontal release signs*
- *Personality disorder: antisocial disorder historically amounting to legal classification of Psychopathic Disorder.*
- *Previous alcohol misuse and illicit drug use."*

4.98 On 22 June 2004 RR was transferred to Shrewsbury Court. W2 told us that RR arrived unaccompanied in a taxi.

5. AT

5.1 AT was born on 29 November 1948. Her first contact with mental health services was at the age of 17 when she was seen by a psychiatrist and admitted to hospital as an informal patient. When she was 24, she was re-admitted to hospital and began to have depot injections. She had a number of diagnoses over the years, including schizophrenia, bi-polar affective disorder and manic-depressive disorder.

5.2 AT married for the first time in 1970. Her first son, Son1, was born in 1971; her second son, Son2, the following year. The marriage broke down and ended in divorce in 1983. In about 1985 AT began another long term relationship, but this partner died in 1987.

5.3 The medical records show a number of suicide attempts involving overdosing on medication. These have been described as impulsive, not premeditated acts.

5.4 AT first came into contact with the Dartford CMHT in May 1988, and she remained involved to a greater or lesser extent with mental health services in Dartford until her death in 2004.

5.5 AT married V1 on 19 October 1991. He died in about 1998 and his death had an adverse effect on AT's mental health. It was concluded that AT could no longer continue to live without assistance, and a high level package of care was implemented with a support worker visiting AT on a daily basis. AT then took a further overdose, resulting in an emergency admission to hospital. After a period as an in-patient, she was transferred to a rehabilitation unit for an assessment of her independent living skills. In January 1999 it was concluded that AT required residential care.

5.6 A residential placement was arranged for AT in September 1999 with an organisation known as Advance Housing. The placement soon ran into difficulties. In May 2000 AT took another overdose which resulted in her being admitted to hospital. Advance Housing thereupon concluded AT could not remain in residence, because its staff would be unable to provide her with the required level of care.

5.7 When she left hospital, AT was accordingly transferred to a rehabilitation unit at Martins Drive. Her behaviour was considered by staff there to be very immature at times, particularly when she was not allowed to do what she wanted. She was unable to cope with managing her own money, making unnecessary purchases which left her unable to afford essentials. Whilst considered generally compliant with her medication, it was noted that she would, on occasions, abuse her PRN medication (medication to be taken as and when required). She needed prompting to attend to her personal hygiene, and she did not like cooking, preferring cold food and snacks. It was concluded by staff that, if left unsupervised, she would not eat a balanced diet. Her sleep pattern was assessed as poor - she often chose to stay up late, drinking coffee and smoking, and then to get up late the following morning. The assessment was that AT needed firm boundaries to be imposed.

5.8 Son1 and Son2 told us that AT had told them she had been raped whilst at this rehabilitation unit, and that she had reported this to the local police. No references to such an incident can be found in her medical records. It is, of course, possible she decided not to tell her doctors about it.

5.9 The Martins Drive Rehabilitation Unit took the view that a full assessment of AT's care needs was required. The task was handed to a social worker with the Dartford CMHT, C4. She carried out a detailed assessment of AT's needs on 8 November 2000. On 16 November 2000 a CPA Meeting was held at which it was agreed that C4 should explore the possibility of a placement for AT at Shrewsbury Court, the part of the Whitepost establishment which provided care to patients with mental health problems. Shrewsbury Court was still a nursing home at this time, albeit one registered to take patients detained under the Mental Health Act 1983. The service provided to AT and RR at Shrewsbury Court is of fundamental importance to the issues discussed in this Report and its history and the services it provided are discussed in detail later in this Report.

5.10 The notes of this CPA meeting contain the first reference in the documentation we have seen relating to AT's placement at Shrewsbury Court, some 30 miles from Dartford. It is unclear who first suggested it. When we discussed this with C4 and J2, her team manager at Dartford CMHT, they both said that social workers were not, in 2000, often involved in finding nursing home placements, and that they would generally rely upon staff at the health authority - often the consultants – to suggest placements, because they had, at that time, better knowledge of the options. C4 thought, therefore, that the

suggestion of Shrewsbury Court had come from somebody else, but was unable to recall who this might have been. Our attempt to locate and interview AT's consultant at this time, CONS9, were unsuccessful, and there is no contemporaneous documentation showing why Shrewsbury Court was selected for AT.

5.11 Son1 and Son2 told us that Shrewsbury Court had been presented to them as, in effect, the only alternative for AT other than staying where she was. They said that, although not satisfied it was the right place for their mother, they agreed to the placement because it appeared to be better for her than staying where she was. It was not possible to find out whether this recollection is correct, because none of the witnesses to the Inquiry could recall the reasons why Shrewsbury Court was selected. There is nothing in the contemporaneous documentation to suggest there were any particular difficulties in finding a placement for AT, or that Shrewsbury Court was the only option which could be located.

5.12 A Joint Assessment of Need, dated 28 November 2000, prepared by C4 and CONS9 (although signed by his SHO, DR7) stated:

"Nursing reports following the period of assessment have concluded that [AT] requires 24-hour nursing care. She would not be able to cope alone in terms of inability to manage her finances, poor personal hygiene and independent living skills, abuse of medication and need for constant support. Her immature behaviour and enduring mental health problems make her a very vulnerable person who is open to emotional, financial and sexual abuse and a person in need of firm boundaries in order to maintain her in any given setting.

RISK ANALYSIS ...

1. Past history of frequent admissions ("revolving door syndrome") often following suicide attempts, usually by overdosing. Abuse of prescribed medication and over-the-counter remedies with intent to further abuse if left unsupervised.

2. Mental health and behavioural problems, which have led to impulsive behaviour and possible risks to [AT] in terms of her ability [to] cope with internal/external stresses.

3. Risk of self-neglect due to her inadequate independent living skills, lack of motivation and inability to self-care.

4. Financial, sexual and emotional abuse due to immature personality. [AT] seeks constant approval and meaningful relationships, thereby not always being aware of others' ulterior motives. ...

ASSESSMENT

[AT] presents as having severe and enduring mental health problems, with a number of complex needs, which require 24-hour nursing input. Her inability to cope independently with a high package of care has resulted in a number of hospital admissions and a placement in residential accommodation. Unfortunately, the placement did not offer the level of care [AT] required and subsequently broke down with [AT] being re-admitted to hospital. She can, therefore, be seen as having an unstable accommodation pattern with a lack of daily living skills required for her to live independently or in a residential setting.

[AT]'s behaviour is very challenging at times and she is unaware of the serious risk this places her in. Her immature behaviour requires firm boundaries to ensure [AT] does not harm herself or others. She therefore requires 24-hour care and supervision by mental health professionals in order to:

i. Monitor her mental health and medication and to ensure that [AT] remains stable and minimise the risk of abuse of medication and overdoses.

ii. Professional input regarding her behaviour and treatment including firm boundaries in order to maintain [AT]'s health and safety.

iii. Constant therapeutic input from professional staff as part of a continuing intensive programme of rehabilitation. [AT] requires a high level of support and motivation in order to continue to monitor her needs and assist her in using existing skills and building on these.

... [It] is clear that the multi-disciplinary team feel that 24-hour nursing care is required in order to maintain [AT]'s mental health. Given the high level of input required for [AT]'s ongoing needs in the future, she should be considered for NHS funding for continuing care."

5.13 Based on the information available to us about AT, both before and after this assessment, we consider that this was an accurate and well-informed assessment of AT's condition and needs.

5.14 On 14 December 2000 AT was transferred to Wallbrook Ward at Stonehouse Hospital for continuous assessment. Son1 and Son2 told us they had concerns about their mother's treatment whilst at Stonehouse. They had concerns about her medication; and they felt that there was a lack of direction and that her condition was deteriorating. They instructed a firm of solicitors in Dartford to advise them and they then commissioned an independent psychiatrist's report on AT's condition from a DR8, a consultant psychiatrist. Their recollection was that it was only after they had taken this course that the possibility of a transfer to Shrewsbury Court was raised and that they were told in terms by CONS9 that this was the only option.

5.15 The chronology of events here was not easy for us to ascertain. We have been unable to find contemporaneous records supporting the picture of a downward drift in AT's state. Son1 and Son2 could not provide us with a copy of DR8's report. It is clear from the documentation seen by us that Shrewsbury Court was identified as a possible placement for AT before the transfer to Wallbrook Ward, so it cannot be the case that Shrewsbury Court became a possibility only after the concerns raised by Son1 and Son2 about AT's state whilst she was on that ward. But there is a record of a telephone call from Son2 to C4 on 6 March 2001 raising various concerns and enquiring about his mother's placement. The notes made by C4 also record that AT was expressing concerns about moving from the Dartford area to Shrewsbury Court, although it appears that these concerns were later allayed by a meeting with W1, the Registered Manager of Shrewsbury Court, who visited her about this time in order to assess her suitability for a placement.

5.16 On 13 February 2001 W1 made a formal offer of a placement for AT at Shrewsbury Court at a cost of £1,003 per week. On 15 March 2001 CONS9 wrote to Son2 about the proposal, and gave him W1's contact details so that Son2 could talk to him about the proposed placement.

5.17 On 27 March 2001 West Kent Health Authority agreed to fund AT's placement at Shrewsbury Court. Son1 and Son2 believed a charity was helping to pay for the placement, but this was not in fact the case - all funding was provided by the West Kent Health Authority. The Health Authority said it expected three-monthly reviews of the placement and made it clear that, if AT's condition were to deteriorate, it was anticipated that CONS9 would re-admit her within two working days.

5.18 On 26 April 2001 a pre-discharge conference was held in anticipation of her move. A formal risk assessment was carried out before this meeting. It was signed by CONS9, and it recorded, amongst other things, the following:

"Risk of suicide based on past history of self-harming & impulsive behaviour especially under stress

Risk of self-neglect due to inadequate independent living skills

Risk of financial, sexual & emotional exploitation. ...

Requires 24-hour nursing care to minimise risk under continuing care."

It also said the risk assessment must be reviewed in three months time.

5.19 The pre-discharge conference was attended by CONS9 and his SHO, DR7, W1, C4 and a staff nurse. AT's sons were not present - their recollection was that the letter inviting them only arrived after the meeting. The plan was that AT's care was to be formally transferred to a local psychiatrist after six months at Shrewsbury Court. AT was to be registered with a local GP.

5.20 On 1 May 2001 AT moved to Shrewsbury Court as an informal patient. Funding for her continuing care was granted on the basis that there would be three-monthly reviews of the placement.

5.21 A risk assessment on AT was carried out within days of her arrival on 4 May 2001. This was on a standard form, entitled "Risk Assessment Score Sheet". The person completing this form had to provide an assessment between 0 and 4 of various possible risks. We comment later on the general quality of the risk assessments carried out at Shrewsbury Court, but this risk assessment assessed AT's vulnerability to exploitation, whether sexual or financial, at "0-2", that is to say, between "Very Low" (where evidence of a likely occurrence was minimal/limited) and "Medium/Moderate" (where there was a chance of an occurrence if not actively acted upon.) No attempt was made to distinguish between the upper and lower ends of this category even though, according to the form,

the time scale for review varied depending on the assessment, being six-monthly if the risk was assessed at 0 and three-monthly if assessed at 1 or 2.

5.22 This assessment was startling, bearing in mind that AT had only been at Shrewsbury Court for four days. The assessment of those involved in AT's care for the years prior to transfer had been that *"her immature behaviour and enduring mental health problems make her a very vulnerable person who is open to emotional, financial and sexual abuse"*.

5.23 C4 and DR7 visited AT at Shrewsbury Court on 18 May 2001. In the notes maintained at Shrewsbury Court, C4 was incorrectly described as AT's "CPN" (Community Psychiatric Nurse). It was recorded, amongst other things, that consideration was to be given to transferring X from Shrewsbury Court to Fern Cottage, a rehabilitation unit at the Whitepost Health Care Centre. The notes record that AT was unhappy at the move from Dartford, but agreed to give Shrewsbury Court a bit longer, to see if she settled there. The plan recorded was to visit again in one month's time - although the next note in the contact sheet maintained by Kent Social Services refers to a meeting on 16 August 2001.

5.24 A nursing note on 24 May 2001 recorded:

"During discussion [AT] expressed low mood, poor sleep pattern and complained of being depressed. Said she [would] prefer her anti-depressant to be increased. Also complaint (sic) of hearing voices belittling her. Observation to be maintained".

There was, however, no apparent attempt made by the nursing staff to form an objective assessment of her mood. No attempt was made to communicate this information to medical staff. As we comment below, this limited response was entirely typical of the approach adopted by nursing staff at Shrewsbury Court.

5.25 A CPA meeting was planned for AT in July 2001 - a nursing report was prepared in anticipation of a CPA meeting on 12 July 2001 – but there is no indication that such a meeting took place, and it was probably postponed until 16 August 2001. The nursing report did, however, present a reassuring picture and indicated that AT was settling in well at Shrewsbury Court. It referred to the regular contact maintained by AT's sons since her arrival there.

5.26 The nursing notes record that on 10 August 2001 AT was struck by another patient, but that there were no visible signs of injuries. There is no record of any of the nursing staff spending time discussing this incident with AT; nor is there any documented reference to any accident or incident form being completed.

5.27 The Dartford team made a further follow-up visit to review AT's placement at Shrewsbury Court and to attend a CPA meeting on 16 August 2001. This was attended by AT, CONS9, DR7, C5 (AT's CPN), C4 and an unidentified member of the ward staff at Shrewsbury Court. C4 then prepared a detailed report on the visit. This recorded that AT had settled well at Shrewsbury Court, and that her mental health had been stable, although she had had experienced bouts of depression which had led to an increase in her medication. It was also noted that AT needed help managing her finances and that she had great difficulty in keeping to a budget, having over-spent her allowance by some £200 during the three months or so that she had been at Shrewsbury Court. C4 again recorded that AT was *"vulnerable and open to financial, emotional and sexual abuse"* and again stated *"this requires ongoing monitoring."* She also noted that AT had begun a relationship with another patient at Shrewsbury Court with which AT was very happy.

5.28 In the "Recommendations" section of the review report, it was recorded:

"... Staff have reported an improvement in [AT]'s mental health, but the team felt that [AT] continued to require 24-hour nursing care at this moment of time in maintaining her current mental health. [AT]'s behaviour appeared less extreme and the reinforcement of firm boundaries and motivation by staff have improved [AT]'s self care and led to an increase in her independent living skills. Although nursing care was provided at Wallbrook Ward, Stonehouse, it was felt by the team that this facility cannot meet the needs of [AT] and that it would in fact be a step backwards in terms of planning for her future.

The team felt that [AT] has settled very well at Whitepost after a relatively short period of time and has progressed well, becoming less demanding of staff and her peer group. In planning for her future care, however, it was hoped that [AT] will begin the rehabilitation programme at the Centre with a view to increasing her independent living skills and improving her social care skills, whilst maintaining stable mental health. It is

felt that her previous needs assessment and care plan are still appropriate, as discussed in the Joint Assessment of Need, whilst acknowledging that she has made progress. The multi-disciplinary team therefore recommended that [AT] still requires 24-hour nursing care and that [AT] would benefit from moving on to the Rehabilitation Unit to increase her independent living skills, with a view to reviewing her care in 3 months time."

5.29 On 18 August 2001, it was recorded in the nursing notes that AT had been discovered having sex with another patient, J, in her room, in the early hours of the morning. It appears an Incident Form was completed but, so far as we can tell, no action was taken to prohibit or prevent any recurrence. The attitude of staff at Shrewsbury Court towards the existence of sexual relationships between patients appears to have been relaxed.

5.30 A further risk assessment on AT was carried out on 5 October 2001, five months after that of 4 May 2001. The risk assessment again involved the completion of the standard "Risk Assessment Score Sheet". The person assessing AT on 5 October 2001 again recorded her vulnerability to exploitation, whether sexual or financial, as being "0-2", that is to say, between Very Low and Medium/Moderate. Once again, no attempt was made to distinguish between the upper and lower ends of this category.

5.31 A further risk assessment was carried out on 5 January 2002 by W4, who was at that time one of the nursing staff at Shrewsbury Court. He gave evidence to the Inquiry. As described later in this Report, he was, later in 2002, promoted to a position described as Clinical Nurse Specialist (a position immediately below that of the Deputy Manager in the hierarchy at Shrewsbury Court). He subsequently became Acting Deputy Manager, and then, in 2004, Acting Manager.

5.32 W4's risk assessment of 5 January 2002 used the standard form described above, but on this occasion, and for the first time, areas of concern were flagged. He assessed AT as presenting a high risk (rated 5 on a scale of 1 to 5) of depression and anxiety; and a high fire/arson risk (rated at 4 on a scale of 0 to 4). It is not possible to tell from the nursing notes why these areas were now identified as causes for concern. W4 also assessed the risk of "Vulnerability of exploitation e.g. sexual, financial" as 0 - i.e. "Very Low". It is unclear on what basis W4 reached this view in the face of the assessments

made previously and set out in the Joint Assessment of Need dated 28 November 2000 prepared by C4 and AT's consultant psychiatrist, CONS9, and in C4's report on the visit of 16 August 2001.

5.33 In January 2002 Kent County Council asked CONS9 to re-assess a number of his patients, including AT. It is not clear now what the reasons for this request were, although a three-monthly review had been referred to in C4's report of 16 August 2001, and this had not, so far as we can tell, been carried out. C4 visited AT on 17 January 2002 and noted that she seemed to be keeping well, and was settled. She had been visited by her sons and, as mentioned earlier, had formed a close relationship with a fellow patient, J. There were, however, concerns about AT's finances, as she had begun to get into debt again. C4 had not previously been informed of this problem by Shrewsbury Court, and in a letter to W1 dated 31 January 2002, she expressed her concern about this. She also referred to the fact that there had been a change of AT's keyworker at Shrewsbury Court and said that she wanted to be informed who the new keyworker was.

5.34 At about the end of February 2002 CONS9 moved on from his employment in Kent. In a letter dated 29 February 2002 he noted that AT seemed quite happy at Shrewsbury Court, but that after his departure someone else would have to give further consideration to the placement. He suggested that whoever it was should liaise with C4.

5.35 There is a reference in the nursing notes on 11 April 2002 to AT attending a course entitled "Life Skills Training" at Fern Cottage. This is, eleven months after admission, the first reference to any form of rehabilitation-type work being done with X. There is no indication within the documentation available to us as to why AT attended this course and it appears to have been a "one off" event. There is no evidence of any formal assessment being done to determine her suitability for this intervention, nor any evidence of whether it was a course from which she benefited.

5.36 In May 2002 Son2 contacted Kent Social Services and expressed further concerns about the management of AT's finances. C4 accordingly arranged a meeting on 16 May 2002 at Shrewsbury Court. Son2 was unable to attend, but he raised a number of concerns about Shrewsbury Court and AT's placement there with C4 before she visited. In his witness statement to the police following the death of his mother, he said that he had had

a number of concerns about Shrewsbury Court, including the lack of activities organised for AT, as well as a general lack of cleanliness and a smell of urine. He also commented in that statement, and his evidence to us, that, when he made planned visits to his mother, she seemed *"bubbly and happy to see me"*, but when he made unplanned visits she would appear *"very sleepy, as if drugged"* - the implication being that her medication was generally kept at a level which placed ease of management over her well-being.

5.37 Son1 and Son2 also told us of their increasing concerns about Shrewsbury Court, including concerns about AT's lack of freedom to go out on her own; about occasional thefts of her belongings; and about reports from their mother of episodes of violence. They told us of difficulties getting to speak to anyone in authority at Shrewsbury Court, despite numerous telephone calls.

5.38 At the meeting on 16 May 2002, there was a discussion of AT's finances and her placement generally. It was agreed that a lady identified as "Gill" would take over the appointeeship of AT's finances. AT was recorded as seeming settled. W1 reported that there were no management issues regarding her care and that AT was getting psychiatric support from the local community psychiatrist, CONS4. C4 reviewed the nursing notes and recorded that there was an up-to-date care plan in place. There was a discussion of the role of Social Services, as AT had not progressed as quickly as had been hoped, and it was decided to arrange a CPA meeting to review her care needs. C4 noted that she would be writing a report *"with a view to losing [AT]'s case as she continued to require nursing care and will do so for the foreseeable future."*

5.39 AT's time at Shrewsbury Court seems to have been largely uneventful in terms of her mental health. She attended Shaw's Corner Out-Patient Clinic for psychiatric reviews on a number of occasions, including 14 May 2002 and 19 November 2002. The nursing notes at Shrewsbury Court record that on the latter occasion her medication was changed, and her next appointment was to be on 11 February 2003, but we cannot trace any record of subsequent attendances.

5.40 A CPA meeting took place on 18 June 2002. Apart from a passing reference in the nursing notes, the records retained by Shrewsbury Court contain no reference to this meeting. A further risk assessment was carried out on AT on 16 June 2002. This was

prepared by a nurse, W5, and it was more or less identical to that written by W4 in January 2002. It was prepared using the standard form described above, and the areas of concern flagged were identical to those flagged by W4, namely that AT presented a high risk (5 on a scale of 1 to 5) of depression and anxiety; and presented a high fire/arson risk (4 on a scale of 0 to 4). Lack of staff supervision and non-compliance with medication were again identified as trigger factors. Her vulnerability to exploitation was again assessed as 0.

5.41 The CPA meeting is well documented by C4 in the notes maintained by Kent Social Services. The meeting was attended by C4; CONS4 in his capacity as AT's RMO; W4, the ward manager; AT's keyworker, called "C18"; an occupational therapist; and AT herself. It does not appear that either of AT's sons were invited.

5.42 C4's notes record, amongst other things:

"[AT] stated she is feeling well and settled living at Whitepost and feels she continues to require nursing support .... [AT] also stated she had gone out with another resident and had given her £25 of her money. I consider her to be vulnerable to exploitation from others. General discussion surrounding [AT]'s needs highlighting the continuing need for nursing input in her case and it was concluded that her needs would not change for the foreseeable future. The RMO agreed to write a letter in support of this and W4 to write a detailed nursing report outlining [AT]'s needs. I discussed my role therefore taking into account that [AT] would not be moving anywhere within the year and there was no role for me at present. It was therefore agreed that I should close [AT]'s case but that, when her needs change, an assessment would be undertaken jointly by a CPN and Social Worker."

Evidence from Dartford CMHT's computer records showed that their file on AT was closed on 12 December 2002.

5.43 On 26 June 2002 it was recorded in the nursing notes that

"[AT] [was] upset that staff are planning to break the relationship with [J]. Support given. Settled and slept long period."

There is no evidence that AT's fear that staff were planning to break up her relationship with J was justified. There is no reference in any of AT's medical records to such a plan, and it seems to us unlikely that one had ever been formulated. There are indeed numerous references later in the nursing notes to AT spending most of her time in the company of J.

5.44 W5 carried out a further risk assessment on 16 September 2002, which was, for all practical purposes, identical to that which she had carried out on 16 June 2002. It flagged up the same risks and maintained the assessment that there was the lowest possible vulnerability to exploitation by others. It does not appear, therefore, that any note was taken of C4's comments concerning the risk of exploitation by others.

5.45 On 19 September 2002, the nursing notes record that

"[AT] approached staff and complaint (sic) of hearing voices and these voices kept telling her that she will be transferred out of this place and [J] would be kill (sic). She was reassured. Settled."

5.46 There is then reference within the nursing notes on 26 September 2002 to AT attending, for the first time, a counselling session – possibly in response to the episode a week earlier. It has not been possible to find any notes made during this counselling session - which may have been no more than a one-to-one session with one of the nurses - but the nursing notes refer to her feeling depressed and hearing voices. There is no record of any action being taken in response to these statements, other than a note that she was *"supported psychologically"*. A few days later, however, on 1 October 2002, she was seen by CONS4 and, according to the nursing notes, her "as required" medication was increased. It has not been possible to locate any clinical notes relating to this attendance - this may be because CONS4 saw AT in his capacity as the consultant attached to the local CMHT, based at Shaw's Corner, and because the relevant notes were not, therefore, kept at Shrewsbury Court. As noted above, it has not proved possible for this Inquiry to obtain such of AT's clinical notes as may have been kept at Shaw's Corner.

5.47 On 8 October 2002 two penknives were confiscated from AT's bedroom. There is no note of any discussion with AT about this, and no record of how or why she had obtained them. The discovery did not result in any alteration being made to AT's risk assessment, nor in any changes in her management. There was, however, mention from time to time in the evidence given to the Inquiry of the fact that AT had a fascination with knives.

5.48 Following a review on 24 October 2002, W4, who was at this time AT's Named Nurse, recorded in the nursing notes:

"Mental problems (i.e.) anxiety discussed."

There was, however, nothing documented recording what was going to be done to address AT's anxiety or the possible causes for this. No Nursing Care Plan was drawn up to try to address this issue.

5.49 On 30 October 2002 there is a record within the nursing notes of an incident when AT was hit by a fellow patient. There is, however, no record of any Incident Form being completed. It is noteworthy that just three days after this incident W4, in his capacity as AT's Named Nurse, made an entry in the nursing notes entitled "Weekly Report" which recorded that AT remained *"anxious and unsettled."* He noted, however, that there was *"no challenging behaviour";* and he made no reference to the assault.

5.50 On 7 December 2002 AT was reported to have expressed her love for another patient who she said she now preferred to J, the patient with whom she had previously had a relationship. It was recorded:
"She was counselled and encouraged to stay neutral and not engage in love affairs which can cause problems. ... Necessary advice was given. She should be closely observed please and have one-to-one sessions with her about it."

A member of staff spent time later that day discussing this issue with AT. She was described as in an anxious state, but it was also said that, after the discussion, she *"calmed down"*.

5.51 Although the Dartford CMHT had decided, earlier in 2002, to close the file on AT for the time being, West Kent Health Authority, as the funding authority, continued to monitor AT's placement at Shrewsbury Court. A letter from the "Rehabilitation Continuing Care Team" at West Kent NHS and Social Care Trust, dated 19 September 2002, refers to a forthcoming visit to AT at Shrewsbury Court by C6 and K1, to be undertaken in order to review her placement there and to ensure that it adequately met AT's needs. C6 was an occupational therapist with the Trust, based at Priory House in Maidstone; and K1 was the "Continuing Care Project Manager".

5.52 No notes of this visit were available to us, but it certainly took place. K1 sent an email to J2 at the Dartford CMHT, dated 2 March 2004, in which he referred to an assessment which he and C6 had carried out about a year earlier, indicating that they had visited AT in late 2002 or early 2003. The email recorded that he and C6had formed the view that AT could be moved from the *"expensive placement"* at Shrewsbury Court to a more local one. He said he thought AT was, in effect, using Shrewsbury Court as *"hotel accommodation"* and that it would be worthwhile investigating if there was another more suitable placement. Although this visit by K1 would have taken place some time in late 2002 or early 2003, and although he thought, even then, that AT could and should be moved from Shrewsbury Court, there was apparently no attempt to follow up these conclusions until this email in March 2004.

5.53 On 5 December 2002, there was a further risk assessment at Shrewsbury Court, this time carried out by another nurse, W20. It was similar to the previous assessment, and it again assessed the risk that AT was vulnerable to exploitation by others at "0". It did, however, flag up two new features, namely a risk, assessed at 2 out of 4, that AT might be violent; and a risk, also assessed at 2 out of 4, of sexually inappropriate behaviour. Relevant in this regard is the fact that on 7 December 2002 it was noted that AT was expressing her love towards a fellow patient, GB, and saying she preferred him to another patient with whom she had been close. The records note that she was warned not to engage in love affairs, because they could cause problems. It may be that this behaviour was the reason her risk assessment had been adjusted on 5 December 2002.

5.54 W20 carried out further risk assessments on 5 March 2003 and 6 June 2003. These were both identical to that which had been carried out on 5 December 2002. Both continued the assessment that AT was at zero risk of sexual or financial exploitation.

5.55 The overall picture seems to have been a relatively stable one. There are only occasional indications to be found in the notes provided by Shrewsbury Court in relation to AT that all was not consistently well. On 25 April 2003, for example, it was noted:

"[AT] still paranoid and suspicious. Thinking that people are talking about her and planning to kill her. She was reassured. Had meals and medications. To be observed closely please."

The reference to AT *"still"* being paranoid and suspicious suggests that this had been a problem over a period of time, but this is not evident from the nursing notes over the preceding months.

5.56 A later nursing note, dated 7 July 2003, recorded:

"For the past couple of months, [AT] has been very paranoid. She will sit outside the office and listen to what is being discussed at handover or general conversation between staff and then she will start accusing staff of talking about her and trying to stop her medication; [and] that people is [sic] writing letters about her trying to split her and N up. This is becoming worse."

We have been unable to find any follow-up to this observation. There is no reference elsewhere in AT's records to such behaviour. There is no reference to this apparent deterioration in her condition having been discussed with the medical staff or with the psychologist. There is indeed no indication in the notes that any action at all was taken in response. The reference to *"N"* is unclear, although there was an earlier reference to AT having requested that one of the nursing staff, C7, should become her Named Nurse, so it is possible that this is a reference to him.

5.57 On 20 August 2003 a note was made at Shrewsbury Court on a document entitled "Care Plan Evaluation Page" which stated:

"The new care plan is clearly followed. Remarkable improvement in all aspects of her life, socially, mentally, emotionally and psychologically."

The improvement noted did not, however, result in any consideration being given to the question of whether AT continued to need the 24 hour nursing care which she was receiving at Shrewsbury Court.

5.58 On 8 December 2003 AT's room was searched. There is no explanation discernable in any of the records as to why this happened. Staff found 24 Paracetamol tablets, which AT said she had bought when she was *"down"*. She said that she had no intention of overdosing. An entry was made in the nursing notes by W1, the Registered Manager, to the effect that regular checks of AT's room needed to be made; but there is nothing in the subsequent nursing notes indicating that any further searches were carried out at any time prior to the homicide.

5.59 Son2 said in his statement to the police after the homicide that, in about November 2003, his mother had told him that she was having an intimate relationship with a male member of staff at Shrewsbury Court. He also said she told him not do anything and, despite his anger and concern about this information, he did as she wished. His mother did not tell him the name of the individual concerned, and it has not been possible for us to reach any firm conclusion about the truth of this report. However, a degree of corroboration for this allegation emerged when we interviewed RR. RR volunteered, without prompting, that AT had been having a sexual relationship with a nurse at Shrewsbury Court, whom he was able to identify. He said AT had told him that this was the case, and he also said that he occasionally saw the nurse in question coming out of AT's room, which he considered confirmation of what AT told him. His evidence was not conclusive. It is, for example, entirely possible that AT had chosen, for her own reasons, to invent a relationship, or perhaps substantially to embellish upon a relationship, and to report that invention both to her sons and later to RR.

5.60 Son1 and Son2 told us that they visited their mother on a regular basis. In their respective statements to the police following the homicide, they referred to visiting her at least two or three times a year, sometimes more, and also to having monthly telephone calls. Their evidence to us was that they began to have serious concerns about the placement. They described, for example, an increase in restrictions on AT's movements in and out of Shrewsbury Court and how AT reported various incidents of people fighting and of her belongings going missing. They also told us that when they raised their

concerns with various members of staff at Shrewsbury Court, they found considerable difficulty in getting anyone who would actually take action in response. They recounted how telephoning Shrewsbury Court was often unsatisfactory with return calls being promised, but not received; with telephone conversations with members of staff whose English was not sufficiently good to understand the point being made; and with many calls being directed to W1 who then promised action without ever delivering. They commented that Shrewsbury Court and its staff seemed to be reactive, not proactive, in attending to problems. They also complained in their evidence to us that CPA meetings were cancelled, and they were emphatic that they had not once attended a CPA meeting for AT during her time at Shrewsbury Court.

5.61 A number of their complaints were eventually documented when Son2 made a telephone call on 1 June 2004 in anticipation of a CPA meeting scheduled to take place on 3 June 2004. The note taken of his complaints, which were to be considered at the forthcoming meeting (which he was himself unable to attend), reads as follows:

"Please inspect [AT's] room. Son1 found it dirty would not take his 18-month old daughter into the room.

Carpet is filthy. Room smelt. When challenged, staff said mother lets someone in room who is incontinent & her friend. Lino needed. Bed very old.

Son2 would prefer her to be somewhere else. Family-run residential home. 24-hour care still needed. Needs cooking to be carried out for her. Cleaning to be carried out for her and care

Son feels she has gone backwards, lost confidence. Staff rarely take her out. Relationship broke down with partner ….

Son said when he saw a programme recently on TV about residential places, one which was criticised on the program was better than Whitepost."

5.62 There were remarkably few CPA meetings for AT. As noted above, AT's file at Dartford Social Services was closed on 12 December 2002, because it had been concluded that AT was going to stay at Shrewsbury Court for the foreseeable future, and because Social Services did not, at that time, remain involved with persons in long term residential

care. There was, therefore, no follow-up from Dartford Social Services (as opposed to the Continuing Care Team from the Health Authority) from December 2002 onwards.

5.63 It is possible, however, that staff at Shrewsbury Court may nevertheless have thought that Dartford CMHT was still responsible for arranging CPA meetings. Contained within the papers provided to this Inquiry by West Kent NHS and Social Care Trust is a document recording that, in September 2003, C6 sought to follow-up AT's current position, initially by contacting Dartford CHMT and asking for details of AT's last CPA review. After reviewing their files, Dartford CMHT responded saying that AT had been discharged from their team and that AT's care was now co-ordinated via Shrewsbury Court. C6 then made contact with Shrewsbury Court asking again for the latest CPA review. The response from Shrewsbury Court was that C4 of the Dartford CMHT was AT's care co-ordinator. In the light of these conflicting responses, it was decided, on 9 September 2003, that someone from the Dartford team should now be allocated to co-ordinate AT's care. It does not seem that prompt action was taken, but on 2 March 2004 K1 sent the email referred to above to J2, asking her to review AT's placement. On about 6 April 2004 the Dartford CMHT assigned J1 to be AT's new care co-ordinator.

5.64 J1 gave evidence to the Inquiry, accompanied by J2, her Team Manager at Dartford. J2 recalled that there had been a Trust decision that the cases of all people in continuing care placements should be reopened, to determine whether their placements remained appropriate to their needs. J1's recollection was similar. She said her role was to meet AT, to review what progress she had made and to assess her needs.

5.65 J1 first visited AT at Shrewsbury Court on 15 April 2004. She went with K1 and C8 who is described as being the Community Support Scheme House Manager from 322, High Street, Sheerness (which we understand was supported residential accommodation). The three met W4, who was now Acting Manager of Shrewsbury Court following W1's resignation.

5.66 K1's notes of this visit begin by referring to the fact that AT had had no input from West Kent Services since he and C6 had seen her back in 2002. He recorded that AT had made considerable progress in her ability to look after herself and he again expressed the view that she did not need the level of care and support that she was getting at

Shrewsbury Court. He referred, however, to her relationship with J, recognising that this posed an obstacle to any attempt to move AT on from Shrewsbury Court. He recorded:

"Since our last visit [AT] has struck up a friendship with another resident called [J], … [W4] informed us that they sometimes share a bed at night, so the relationship appears to be a strong one. [AT] assumed that one of the reasons for our visit was to move her; again she became agitated, saying she won't move without [J]. [AT] ... did say that when [J] died one of her sons had said that he would move her to a hospital near him, the staff knew nothing of this and felt it was just [AT]'s thoughts. [W4] l did say that [AT] needed qualified nurses around her to deal with her anxiety states, but as we discussed this further, he did say that the health care assistants could deal well with them if they know her, and we could not see any real reason for qualified nurses having to be with her.

Following the meeting, myself [J1] and C8 discussed the meeting and felt that [AT] didn't need the services of Whitepost now, and that the Community Support Scheme could accommodate her. They have a number of people very similar to [AT]. The moral problem was [J] and how we would deal with the separation, also unknown reaction from the sons

Action

To discuss with C9 if she would take RMO responsibility for CPA and any possible move that may take place. (DB)

Arrange a full CPA review (J1)

[J1] to seek the name of the care co-ordinator for [J] (via Whitepost) to see what his needs were, if they were looking to place him elsewhere, and, if appropriate, would they consider funding him so that he and [AT] could go together."

5.67 J1 did not agree that K1's note was a completely accurate reflection of the decisions made on this occasion. Her evidence, which was supported by her notes of this visit, (notes which incidentally only came to light after she had given her evidence to us), was that following this initial visit, she took the view that there was a <u>possibility</u> that AT could move on in the future. She emphasised that she would not have reached a decision to move AT on after meeting her just once, particularly when AT had been in the same place for a number of years and was quite happy there. Her comments were sensible, and

it seems to us very doubtful that any firm decisions about AT's future would have been made at the first visit to her for over a year, whatever the financial advantages might have been in moving her to supported accommodation in Medway.

5.68 J1 told us that AT was very concerned that the purpose of the visit was to move her from Shrewsbury Court. Her notes record:

"When we were introduced to [AT], she became very distressed ... and started crying 'you are not moving me from here away from [J] I love it here.'" After we calmed [AT] down, we explained we had to come and see her and the fact that we should have been holding CPA meetings for her to see how she is getting on. It was very difficult to carry out even a brief assessment and [AT] asked to leave the room."

5.69 It seems to us likely that there was, in 2004, some tension between the views of K1 and those of J1. A subsequent note in the files provided by Kent Social Services, dated 6 May 2004, refers to a telephone conversation with K1 on this date, in which he stated in terms that AT no longer needed the specialist environment of Shrewsbury Court, and that AT had been assessed by the Community Support Team in Medway as suitable for placement in supported accommodation there. The documents produced to the Inquiry by West Kent Health Authority did not include this assessment, although it was presumably carried out on 15 April 2004. In any event, the outcome of this visit in April was that a CPA meeting to discuss AT's case was provisionally arranged for 3 June 2004.

5.70 On 24 May 2004 J died. AT was given this news by W4, but there is no record of her reaction. The only comment in the notes is that she was *"reassured"*.

5.71 The death of J removed one of the possible barriers to a decision to move AT away from Shrewsbury Court, and enabled further consideration to be given to that possibility. However, the CPA meeting arranged for 3 June 2004 had to be cancelled because, it seems, neither J1 nor K1 were able to attend.

5.72 It is not clear to what extent the possibility of AT moving from Shrewsbury Court was discussed with her family. When Son1 and Son2 gave evidence to the Inquiry, they did

not recall any such discussion. In his statement to the police, however, Son2 referred to his recollection of a discussion with his mother about a possible move from Shrewsbury Court. There is also a note of a discussion which either Son2 or Son1 had with J1 on 1 June 2004, in which it is recorded that *"AT's son"* was *"keen"* for her to move from Shrewsbury Court, and that he had expressed the view that it would be better if she was placed in a smaller, more homely, place. There is a note to a similar effect on 10 June 2004, when J1 made a note that Son2 would like to see AT moved from Shrewsbury Court. It seems likely, therefore, that there had been some discussions with them about the possible move, as one might have expected.

5.73 On 31 May 2004, a further risk assessment on AT was undertaken at Shrewsbury Court. On this occasion, the assessment was carried out by a different nurse, W6. He assessed AT's vulnerability to financial exploitation as very high - at 4, the highest score possible. There was, however, no indication that she was considered vulnerable to sexual exploitation, but it was thought that there was some risk, assessed at 1 on a scale of 0 to 4, that she might be capable of sexually exploiting others. All other aspects of AT's assessment were assessed at 0, including those where it had previously been perceived that there was at least some risk.

5.74 The assessment that AT's vulnerability to financial exploitation was very high was correct, and the alteration in this assessment no doubt reflected increasing concerns at Shrewsbury Court about the ways in which she managed her money, a matter about which her sons had expressed concerns to staff at Shrewsbury Court over the years.

5.75 As noted above, on 1 June 2004, when responding to the invitation to the CPA meeting on 3 June 2004, Son2 took the opportunity also of raising a series of complaints about AT's placement at Shrewsbury Court. He spelt out his doubts about whether Shrewsbury Court was the right place for his mother.

5.76 The nursing information prepared by W6 in advance of the CPA meeting planned for 3 June 2004 included the following comments about AT:

"Reason for Admission:

She needs 24-hour nursing care and psycho-social support with self care. ...

How does the person explain their need for mental health services? Do they have insight into their illness?

She is known to have immature personality, exhibiting this on staff and relatives sometimes. She has a need for supervision and self care, and in the use of money. [AT] has some insight into her illness, and is sometimes apologetic.

What support systems are in place in the community to help the person maintain their mental well-being?

Her two sons, Son1 and Son2, are very supportive of [AT]. They visit infrequently, but are in touch.

In your opinion if the person is released from Section would they agree to comply with the Community Programme?

[AT] is still financially vulnerable, and unable to care for herself properly, if not supervised."

This assessment was, therefore, at odds with that of K1, with W6 feeling that AT continued to need 24-hour a day nursing care.

5.77 In summary, the position before RR's arrival at Shrewsbury Court was that AT's position as a resident there was under active review following the visit made by K1 and J1 in April 2004. K1 appears to have had a different view about whether it was appropriate to make a decision about moving AT from J1. AT's stance, certainly whilst J was still alive, was that she was anxious to remain at Shrewsbury Court. The family's stance appears to have been that Shrewsbury Court was not doing a very good job, and that AT would be better placed elsewhere.

6. Events following RR's arrival at Shrewsbury Court

6.1 On his arrival at Shrewsbury Court on 22 June 2004, RR was seen by CONS4. The clinical notes of this meeting contain a lengthy summary of RR's previous medical history, no doubt derived in large measure from records provided by CONS3's team at Witley 3. CONS4 noted that RR did not appear to have abnormal beliefs or perceptions. He noted no psychotic symptoms. A short four-point Care Plan was set out which read, in its entirety, as follows:

1. *Regular medication*
2. *High risk of harm to others; low risk to self*
3. *Increase observations if there is an incident*
4. *Search for weapons once a week.*

6.2 RR was placed on 15-minute observations for the first day that he was at Shrewsbury Court. These were reduced by CONS4 the following day to general observations. This was a surprisingly early reduction, bearing in mind RR's history, the importance of getting to know him, and the fact that this was the first time for over a year that RR had been on a mixed unit.

6.3 In his statement to the police after the homicide, CONS4 said that when RR came to the unit, he told all staff that RR was a *"high risk to others and a low risk to himself."* We asked CONS4 about this, and he amplified this short statement as follows:

"At the beginning when he first came, I said that there was quite a high risk to women. ... I thought that we should monitor the exploitation and also if he did make any kind of threat, particularly if he had a victim in mind, the risks were quite high."

When we asked whether he had given any instructions to nursing staff as to what they should do if a problem appeared to be developing, he replied:
"Normally, they would contact myself and also increase the observations."

6.4 If these were the instructions given to nursing staff, they were not documented, either by CONS4 or by the nursing staff.

6.5 A document headed "Multi-Disciplinary CPA" was prepared by W2 on 23 June 2004. It was in the form of a nursing care plan and it included the following:

*"**Needs identified**:*

3. Relationship with women should be monitored.

***Action to be taken**:*

Informing future partners about risks of being hurt physically.

Comments

Has a previous history of violence towards women.

***Needs identified**:*

4. Non-compliance with medication and therapeutic regime.

***Action to be taken**:*

Should be encourage and supervise to take his medication. [sic]

Comments

Can be relapse in mental state."

There was little or no information in this or any other document about RR's previous history; about trigger or warning factors for nursing staff to be alert for; or about how to manage the risks which RR posed.

6.6 W2 prepared another document entitled "Admission Review". It is undated, but it is clearly an early assessment of how RR was settling, and it indicated that he was getting on well. Under the heading "Risk Behaviour", it stated:

1. *" Low risk of re-offending currently*

2. *The risk of harm to others has reduced mainly because of his severe physical mobility [sic].*

3. *The risk of psychotic relapse and behavioural disturbance is related to compliance with medication and illicit drug use.*

4. *Low risk of suicide or self harm currently."*

6.7 On 30 June 2003, there is an entry in the nursing notes recording that RR was given a depot injection of Risperidone 50mg. RR was at this stage on regular three-weekly depot injections of Clopixol (Zuclopenthixol Decanoate). He had received his depot injection at Witley 3 on 21 June 2004, the day before transfer. His next depot injection was, therefore, not due until 11 July 2004. It is wholly unclear why he was apparently given a different depot injection 9 days after the last injection. There is no record of Risperidone being prescribed for RR. It appears, therefore, either that this entry in the nursing notes was an error (perhaps relating to a different patient), or that RR was, for unexplained and undocumented reasons, given medication which had not been prescribed for him.

6.8 On 16 July 2004 Q1 telephoned Shrewsbury Court and spoke to W4 about RR's progress. W4 said RR was happy and had no complaints. A review meeting was arranged for 29 July 2004.

6.9 On 16 July 2004 W3, the clinical psychologist, saw RR. The notes of this meeting are brief, but mention that areas of concern included the need to monitor RR's relationships with women. W3 noted that he intended to review RR again in October 2004.

6.10 On 22 July 2004 Q1 went to see RR. She also met W2, RR's Named Nurse. Q1 noted that RR was happy at Shrewsbury Court, although there were minor problems about sorting out his pension payments. She also recorded that RR was seeing the consultant psychiatrist once a week. If this is what staff at Shrewsbury Court told her, it did not reflect what happened, or even what was likely to happen. As explained later in this Report, CONS4 did not regularly see any of the patients at Shrewsbury Court once a week.

In the event, he saw RR no more than three or four times during the entirety of the time that RR was at Shrewsbury Court, and possibly only once or twice.

6.11 Although the arrangements for RR's placement at Shrewsbury Court had been made by social workers from the London Borough of Sutton, the placement was jointly funded by Croydon PCT. On 14 July 2004 Croydon PCT asked SLaM to monitor RR's placement on their behalf. This monitoring was intended to ensure that the placement was and remained appropriate and cost-effective. It was not, so it seems, intended that there should be any "clinical" follow-up by those who had previously had clinical responsibility for RR's care.

6.12 The follow-up which was planned would normally have been handled by a Placements Nurse employed by SLaM. That post was, however, vacant when RR was transferred to Shrewsbury Court. A locum, M1, was subsequently employed to cover the position and, on 14 July 2004, she was asked to monitor RR's placement. M1 contacted Shrewsbury Court on 2 August 2004 to request a copy of RR's care plan, and this was faxed to her on the same day. M1 also tried to get records from Witley 3, and she spoke to RR's social worker, Q1, who told her that the four-week review had been held the previous week and that the next one was due on 22 September 2004.

6.13 Unfortunately, M1 moved on from her position as placements nurse before she could visit Shrewsbury Court. RR's case was not re-allocated until her replacement was appointed in October 2004. The funding authorities were not, therefore, represented at the three-monthly review at Shrewsbury Court in September 2004, and there was no follow-up of RR's placement by anyone acting on behalf of either the funding authorities, Croydon PCT or SLaM, during the time that RR was at Shrewsbury Court.

6.14 A close relationship soon developed between RR and AT. It is not clear when exactly this began. Some witnesses, including RR, told us that AT gravitated towards RR almost as soon as he arrived. RR said they were spending nights in each other's bedrooms within a matter of weeks of his arrival. Other witnesses suggested that the relationship began about a month after his arrival. The first reference to the relationship in the documentation is in AT's nursing notes, dated 18 July 2004, in an entry made by W7, a

nurse, qualified as a Registered General Nurse (RGN), who later became AT's Named Nurse. Her note read simply:

"Becoming very close to [RR]. We should keep an eye on her."

6.15 It is noteworthy, however, that the relationship, and the risks which it entailed as far as AT was concerned, did not feature in the documentation prepared for a CPA meeting relating to AT which took place on 2 August 2004. (This meeting had originally been scheduled for 3 June 2004. It had then been rescheduled for 12 July 2004, but this date was also cancelled because CONS4 was unable to attend.)

6.16 On 20 July 2004 J1 received a telephone call from AT's Named Nurse who reported that AT was very worried about the forthcoming meeting and the possibility of leaving Shrewsbury Court. J1 noted:

"[AT] has improved a great deal since living at Shrewsbury Court. However, she needs to move on and live in a smaller home and settle. She will still have support and be able to move on. …

I got impression they [Shrewsbury Court] do not want her to leave, but she does need to move on."

6.17 On 29 July 2004 a Case Management Review for RR was held at Shrewsbury Court, attended by RR, Q1 and W2. It was recorded that he felt happy at Shrewsbury Court. There was discussion of his physical infirmities and the fact that he became breathless on minimal exertion and used a wheelchair outside. His mental health was said to be stable. There was reference also to an altercation which had occurred between RR and another male patient. It is surprising, and of concern, that there is no reference in the nursing notes, or elsewhere, to any such incident at this time.

6.18 On 30 July 2004 AT was seen by the psychologist, W3. When asked what the reasons were for this, W3 told us that he understood that the HC had identified

shortcomings at Shrewsbury Court which had led to *"anxieties"* amongst the management team. As a result, W3 had been asked to assess and thereafter produce a therapeutic treatment plan for each patient.

6.19 W3 recorded on 30 July 2004, under the heading "Specific Areas of Concern for this patient":

"Skills development: money, boundaries - emotional, physical. Inappropriate relationships with some male clients. Childlike in emotional domain. Attachment to 'father type'."

No individual male patients were named in this note, and W3 told us he did not, at this stage, know the identity of the patients with whom the *"inappropriate relationships"* were. He told us also that there was no *"concrete evidence"* at this stage that AT was developing an inappropriate relationship with RR although we observe that that relationship had, by this time, already been commented upon in the nursing notes. We can think of no reason why nursing staff, if asked by W3, would not have identified the male patients concerned in these relationships, and we think it likely that, if asked, they would have mentioned RR.

6.20 In any event, under the heading "Treatment Plan Aims", W3 wrote:

"Continuing care and support, attention to above - develop confidence in skills and relationships".

W3 did not record any further or more explicit suggestions as to how nursing staff could manage these *"inappropriate"* relationships with men. We are, in any event, concerned that the nursing notes do not record that the meeting between AT and W3 had occurred, let alone its outcome. There is no documentary evidence to suggest W3 provided direct feedback to nursing staff following his meeting with AT, although his evidence to us was that nursing staff were supposed to consult his Treatment Plans when they formulated care plans for their patients.

6.21 There were further concerns around this time over AT's management of her finances. A Care Plan Evaluation dated 31 July 04, which was prepared in anticipation of the forthcoming CPA meeting, refers to her need for support in planning her finances.

6.22 A CPA meeting for AT finally took place on 2 August 2004, the first CPA meeting which AT had had in two years. It was attended by AT, CONS4, attending in his capacity as AT's RMO, W6 (who was AT's Named Nurse), with K1, C8 and J1 attending on behalf of West Kent Health Authority and the Dartford CMHT.

6.23 A manuscript document entitled "Enhanced Care Programme Approach", contained within the documentation supplied to us by Shrewsbury Court, records part of the discussions on this occasion. It describes AT as financially vulnerable, and also, for the first time, as someone who was sexually vulnerable. Under the heading "Relationships", it was recorded:

"Sons' visits infrequent. Misses [J] (death).

Love life from one client and then another is erratic and disturbing to [AT].

Action Plan: Social worker in touch with one son. Observe client for exploitative relationships and counsel asap"

Under the heading "Accommodation", it was recorded:

"Independent home explored. [AT] rejected suggestions of independent living. Was indignant at suggestions of transfer to another home.

Action Plan: Continue as present."

6.24 The thinking of the representatives from West Kent Health Authority who attended this meeting - in particular, K1 - was that it was now appropriate for AT to move on from Shrewsbury Court. J1's notes read as follows:

"[AT] has not had a CPA for approximately 2 years. It has been suggested that [AT] probably does not need to continue at Whitepost and should move into a small 24-hour

care home. Obviously [AT] does not want to move and becomes very upset and anxious with the thought of leaving Whitepost.

It was left up to me to try and explain the reason why we had called for a CPA. Where [AT] is living at the moment is a very expensive care [placement] and it is felt that it is not necessary and she has improved in her mental health since she has been at Whitepost to a degree that it is deemed she no longer requires the intensive care they provide. It is my responsibility to identify whether she does not require the care at Whitepost and could easily live happily in a smaller home in the community. CONS4 reassured [AT] that they had no plans for her to leave. This obviously put me in a difficult position, as [AT] was delighted he had said this. Therefore, the only thing I could say was 'AT, we were looking at possibly moving you in the future to a small place you can call home'.

I am very confused that it is not my decision to begin with. However, to assess whether [AT] should stay or move on is part of my position as a care co-ordinator, but I really feel I should have backing from the people who feel that she should move on even before I was involved."

6.25 When J1 gave evidence to us, she did not have the benefit of these contemporaneous notes - they only became available after she gave her evidence. But the account she gave us of this meeting on 2 August 2004 accorded closely with the notes set out above, so she had, even in 2007, a good recollection of what had been discussed on this occasion. She was clear in her recollection that when, in the course of the meeting, the idea of a move from Shrewsbury Court was raised, AT became upset and CONS4 thereupon provided AT with firm reassurance that she would not be moved from Shrewsbury Court if she did not want to leave. J1 particularly recalled this because she was concerned that, by giving this assurance to AT, CONS4 effectively pre-empted any meaningful discussion of the issue. Her evidence was that she felt that CONS4 had put her in a difficult and potentially embarrassing situation, and her recollection in this regard was later confirmed by the contemporaneous note set out above.

6.26 CONS4 told us that he had no recollection of this meeting. He was surprised to learn that he had attended a CPA meeting for AT at all, because, so he told us, he had not had any dealings with her. He thought that, although AT may have been under his care at Shaw's Corner, she would probably have been dealt with by a staff grade doctor there. He

was, however, unable to explain why it was he who had attended this CPA meeting, saying it did not make much sense to him.

6.27 On 6 August 2004 a Case Management Review was held for RR. It was noted that RR had been involved in a violent incident with another male resident. The notes of this review contain no reference to RR's relationship with AT, nor any indication that consideration had been given to the implications of that relationship and the steps which should be taken by nursing staff to manage it.

6.28 The violent incident discussed at this review had been sufficiently serious for the police to become involved. Concern was expressed by the police in an email to the local CMHT that Shrewsbury Court had not followed the appropriate Vulnerable Adult Procedures.

6.29 On 31 August 2004 Q1 noted that AT had been shopping for RR. It is clear that the relationship between AT and RR was continuing to develop, and it was in or about September 2004 that AT first told her sons she had a new boyfriend at Shrewsbury Court. She gave them the impression it was a sexual relationship, an impression which was reinforced when Son2 visited AT in October/November 2004 and met RR.

6.30 Staff at Shrewsbury Court did not appear to appreciate that AT's developing relationship with RR might be dangerous for her. However, concerns did develop about the way RR seemed to be exploiting AT financially. Concern on this issue was expressed by members of staff as well as by Son1 and Son2. It was clearly a difficult situation to manage, because AT was a voluntary patient and there was no legal basis upon which she could be prevented from spending her money as she chose. Attempts were made by staff to limit her spending and her access to her money and on 10 August 2004 AT was persuaded to sign an agreement prepared by W9, the social worker based at Shrewsbury Court. The aim of this agreement was to try to limit her spending and thereby limit the extent to which others could exploit her. The agreement provided, amongst other things, for AT to prepare a list of her planned expenditure and to collect only the money necessary for that expenditure. The agreement subsequently gave rise to a degree of conflict between AT and staff at Shrewsbury Court. There is, for example, a note made on 2 September 2004 by W10, one of the senior nurses there:

"[AT] has been shouting and screaming parts of the morning about money; I reminded her of the agreement she signed … regarding money".

6.31 W6 (who had, for a while, been AT's Named Nurse) told the police, following the homicide, that he and other members of staff had tried to help AT budget, but that she had resisted such efforts, increasingly so when her friendship with RR developed. W6 said:

"If we tried to stop her from spending her money, she would become childlike in that she would say that it was her right to have access to her money and she would threaten to report staff to the Healthcare Commission, if we didn't give it to her."

6.32 On 10 September 2004 RR requested a session with the psychologist, W3. W3's notes of this attendance do not suggest that there was any particular trigger for RR's request. W3 noted that RR expressed regret for the assaults he had committed and that he appeared to show awareness of the implications, both for the victims and himself. W3 noted that RR was *"very happy"* with his placement and was enjoying the company. The only concern he expressed was that he did not have his own key to his room.

6.33 On 17 September 2004 AT's nursing notes record that staff remained concerned about AT giving money to other patients. The other patients were not named, but it is probable that this related to money which she was giving to RR or spending on him. These concerns were reflected in a revised risk assessment on AT, dated 20 September 2004. This recorded, for the first time, that she was thought to be at a high risk of exploitation, both sexually and financially.

6.34 On 22 September 2004, a further Case Management Review was held for RR which was again attended by Q1 and RR's Named Nurse, W2. It was noted that RR had settled in well and that his only concern was his lack of money. The recent altercation with another male patient was mentioned, but his mental health was said to be stable. It was decided that his placement should be treated as permanent. A CPA meeting was arranged for 8

December 2004. Once again, no reference was made to RR's relationship with AT, let alone to how this should be managed.

6.35 On 3 October 2004 RR became involved in a fight with another patient, VB. RR said later that he was concerned about female patients being *"beaten"* by male patients and he did not think there were enough male staff to cope. He claimed that on this occasion he had been defending a female patient who had been punched by VB. (The female patient was not AT.) An "Adult Protection Inter-agency Planning Meeting" was arranged for 8 October 2004 to discuss this and other episodes of violence which had occurred at Shrewsbury Court in recent weeks.

6.36 On 7 October 2004 RR's condition was reviewed by CONS4. This was CONS4's first involvement with RR since 29 June 2004. It is not clear from the notes made whether CONS4 actually met with RR, or whether this review was based simply upon a consideration of the nursing notes. There is no record in CONS4's own notes of any examination or of any information actually supplied by RR. However, CONS4 told us he believed he did meet RR on this occasion. In any event, CONS4 recorded that RR was *"well"* and exhibiting no psychotic symptoms or aggressive behaviour – although he did refer to the report that RR had punched another patient. Importantly, there is no indication in CONS4's notes that consideration was given on this occasion to RR's relationship with AT. When asked if he was aware of the relationship at this time, CONS4 told us that he believed that it was only later that he first became aware of the relationship. If that is correct, it is remarkable that CONS4, as RR's RMO, had not learned of such an important matter, and did not find out about it during this review, particularly if, as CONS4 believes, he did actually talk to RR on this occasion.

6.37 A risk assessment on RR was completed at about this time. In response to the standard form question *"Is there evidence of any other potential disinhibiting factor (e.g. a social background promoting violence or other unacceptable behaviours)?"*, the *"No"* box was ticked, and it was noted:

"In the past. But from the previous notes, [RR] has been successfully rehabilitated."

In response to a "tick-box" questionnaire asking about the risks of various unacceptable behaviours, it was indicated that it was considered that there was no risk of any of the following:

- Non-compliance with medication,
- Violence to staff,
- Violence to other patients,
- Challenging behaviours.

The Risk Management Plan recorded:

"No major risks identified, but considering his past history [RR] needs continuous monitoring towards other vulnerable female patients."

6.38 On 8 October 2004 the Adult Protection Inter-Agency Planning Meeting took place to discuss four incidents of violence that occurred at Shrewsbury Court between 24 September 2004 and 3 October 2004. The purpose of the meeting was to gather information about these incidents and to plan the way ahead, the intention being to proceed either to a Vulnerable Adult Case Conference or a Senior Management Strategy Meeting. The meeting was chaired by C10, a Senior Approved Social Worker. It was attended by, amongst others, C11, the Vulnerable Adults Officer from the local police force, W4, in his capacity as the Acting Manager of Shrewsbury Court, and Q1, in her capacity as Care Manager for RR. It appears that CONS4 was unable to attend and he sent his apologies.

6.39 The minutes show concern was expressed about the difference in age between two of the patients involved in one of the incidents, and about the management difficulties that such a range of ages posed to staff at Shrewsbury Court. There was a consensus that Shrewsbury Court was a *"real mixture of ages, physical and mental health needs"*. In response, W4 said that efforts were under way to seek extra separate accommodation for the over 65s and the more vulnerable patients. Concern was also expressed about staff levels at Shrewsbury Court which were thought to be too low. It was decided that C10 should try to arrange for senior managers from her Trust to meet representatives of Whitepost to discuss risk management policies in order to try to avoid future problems.

6.40 The minutes of the meeting recorded also that the violent incident involving RR was the first in which he had been involved since his arrival. It seems, therefore, that the meeting was not told about the earlier incident involving RR, which had occurred on or before 6 August 2004. It was, however, noted that he had a history of violence against women. The minutes recorded:

"[RR] is considered to be a low risk. [He] has poor physical health including angina, airway disease, arthritis and dementia.

Recommendations ...

2. *RR's medication needs reviewing.*

3. *RR's placement needs reviewing in view of his physical state."*

6.41 There is no indication in the documentation relating to RR that there was ever a review of his medication following this meeting, let alone a review of his placement. CONS4 told us he had not been asked to review RR's medication and did not recall any discussion about a possible review of RR's placement.

6.42 The meeting of 8 October 2004 made a number of general recommendations. These included.

"The medication of all clients needs to be urgently reviewed. Action: CONS4."

6.43 Although we have seen the notes of just two patients at Shrewsbury, there is no indication of any such review. CONS4 told us he could only recall reviewing the medication of VB, the other patient involved in the altercation with RR. He did not believe he had been asked to carry out a more general review.

6.44 It is a matter of considerable concern that important recommendations made at this meeting on 8 October 2004 do not appear to have been actioned at Shrewsbury Court.

6.45 On 12 October 2004 AT's nursing notes refer to her being threatened by RR.

"[AT] was reported to be distressed by staff member because she was threatened by a fellow resident (RR) who is her boyfriend. Issue was brought to attention of CONS4 because she is more close to this patient and at times they lie in each other's rooms. CONS4 advised counselling and education for AT and to watch them ..."

6.46 There is no equivalent entry in RR's notes, where it is merely recorded that he had spent most of the day with AT. No record was made by CONS4 of his involvement on this occasion or of any advice which he gave. He could not remember any such discussion. He told us he did not think he had ever known that AT and RR were spending time together in each other's bedrooms, and he said his advice would not, in any event, have been *"counselling and education"*. The note was a complete mystery to him.

6.47 On 20 October 2004 AT's nursing notes recorded that she was very agitated because she wanted £300 to buy clothes. There was concern that, if RR were given a large sum of money, she might spend it inappropriately. The situation was resolved by adopting the sensible expedient of arranging for a member of staff to go with her into town, informally to supervise her shopping.

6.48 On 22 October 2004, the following was recorded in AT's nursing notes:

"Continuous observations maintained between her and male friend."

It is unclear what precisely this was intended to convey. There is no previous record of AT and RR being under *"continuous observations"*, so the reference to observations being *"maintained"* is odd. There is no indication in the Clinical Notes that a decision had been made to place either AT or RR under continuous observations. One would normally expect that a decision to place a patient under such observations would have been made by the clinical staff and would have been documented, with an explanation of the reasons for the decision. There is also no subsequent reference to *"continuous observations"* in AT's nursing notes. It is relevant to record in this connection that, as we discussed later, we have concerns about whether nursing staff had a full understanding of the distinction between the various levels of observation which might be adopted from time to time.

6.49 On 24 October 2004 there is a nursing note recording that AT was concerned that RR might be moved away from Shrewsbury Court. The note continues:

"When asked why she feels that way, she said she thinks some people don't like their friendship."

It is impossible to say whether this concern was a result of, or related to, the *"continuous observations"* referred to above.

6.50 The Medication Administration Records Sheets (MARS) record that RR was given his 3 weekly depot injection of Clopixol on 27 October 2004. This is not, however, mentioned in the nursing notes for that date.

6.51 There was an incident involving RR and AT at the end of October 2004 which is of considerable importance. There is some inconsistency in the clinical notes concerning the precise dates upon which events occurred, but an entry in AT's nursing notes timed at 10 a.m. on 29 October 2004 reads:

"[AT] reported that [RR] has threatened to kill her. We went together to Fash (RMN) and she repeated the same statement. Was reassured and Fash promised to talk with [RR]."

6.52 A later note on the same day records:

> *"[AT] appeared very depressed over the above issue. Complaint that [RR] is spreading rumours about her which are not true. Around 4 p.m. she ... started shouting. About the same time [RR] happened to be passing. [RR] said that [AT] is an adulteress. This really upsets [AT] the more. She was removed from the scene by C7. At the time of writing this report, she appears calm and relaxed and is sitting on the floor in the corridor."*

6.53 In RR's nursing notes, there is an entry, also dated 29 October 2004, which reads:

"[RR] called me aside to confide that he has found [AT] unfaithful with another client here in the unit. He felt like strangling her on two separate occasions, but restrained himself because he doesn't want to go … to [Broadmoor]. He says that he has called it quits with [AT]. He was calm as he spoke. W3 was consulted to intervene officially and asked to detail CONS4 for further action. W3 says he talked with [RR] and promised to call CONS4."

6.54 There is, in the documentation available to us, no note made by W3 of any attendance upon RR at or around this time, although W3 did produce his diary to us which contained RR's name on this date, indicating that a meeting had taken place. W3 told us he had no recollection of any such attendance or of any meeting with RR at which there had been any discussion of RR expressing threats towards AT. Although it was recorded in the nursing notes that W3 had said that he would call CONS4 about this incident, CONS4 had no recollection whatsoever of any such discussion.

6.55 This is very odd. It is clearly recorded that W3 saw RR at this time, and W3 told us that he accepted that it must have taken place. There should have been a note of it. If there was, it has been mislaid or mis-filed, which is, in the circumstances of this case, most unfortunate and surprising bearing in mind that all records relating to RR would have been examined with great care only six weeks later. We should record that RR's evidence to us was that he had told the *"psychologist"* at Shrewsbury Court that he "*was hearing voices telling me to harm AT*". He said that he had asked the psychologist if he could be moved away from Shrewsbury Court, but was told there was nowhere to send him. RR's evidence was, however, that this discussion had taken place *"three or four days"* before the homicide, and there is no other evidence at all to support the suggestion that there was any meeting between W3 and RR so shortly before the homicide.

6.56 On 30 October 2004, a Saturday, RR was still complaining to nursing staff that he felt AT was being unfaithful to him. He was reassured, but it was noted that he continued to be upset and was "*verbalising that he feels like killing someone*". The nursing staff called for medical assistance from DR1. DR1 was a staff-grade doctor employed by the local NHS Trust. She had limited psychiatric training. She was not a member of the multi-disciplinary team, but was employed to check on the wards on Fridays after her NHS work

and to respond to call-outs from Whitepost to provide, as she put it, *"short-term cover for CONS4 … and to hold the fort for a short period until he came to the unit."* She had not been trained in the assessment of risk and dangerousness, and her assessment of RR on this occasion was, she said, the only time that she had been asked to assess someone's dangerousness at Whitepost. It is to be inferred from her involvement at this time that CONS4 was, for some reason, unavailable.

6.57 DR1's note of this attendance reads:

"Asked to see. Last two days [RR] has been upset. [AT] was apparently having a close relationship with [RR]; now become closer to another client. Has told several staff that 'he felt like hitting somebody, killing somebody, doing myself in'.

Seen by W3, the psychologist, yesterday. [RR] was commenced on discreet observations. According to W3 although [RR] verbally threatened [RR] did not appear to be psychotic, depressed or agitated.

Today the nurse in charge phoned me to report that she was concerned as [RR] continued to verbalise about "killing somebody" and wanted to see a doctor.

[RR] seen. He said that he is very upset about what is going on with him and [AT], that he wanted to kill somebody, go away from here. "Wanted to go to a lock-up"

Not agitated. Calm. Good eye contact. Rapport.

Mind - Subjective - "Bad"

Objective - upset, no evidence of clinical depression. Slight anxiety. Not irritable. No formal thought disorder or florid psychotic symptoms. ... Verbal threats to hurt somebody or himself. No definite plans/intents.

He requested chlorpromazine but refused because of possible detrimental effect on heart ...

Agreed to increase Zopiclone to 15mgs nocte. Add Lorazepam 2mgs PRN ... until Tuesday.

Opinion

Discussed with staff who believe most of threats verbal only. There have been no attempts to hurt anyone or himself. Apparent calm. Today observed talking to [AT] in friendly manner ... Staff feel happy to leave [RR] on the ward.

Plan

Because of the past history continue discreet observations.

If any difference in behaviour call police.

It will not be therapeutic to cancel leave out of premises, as it will increase anxiety, as well as there are no grounds. Not sectionable, not worse mentally.

Short term: low-medium risk of aggressive behaviour.

Long term: moderate risk of harm to himself and others.

Also warned [AT], the other client, about the risks. Requested to keep distance and space."

6.58 This intervention is reflected also in AT's nursing notes, where it is recorded that AT was interviewed by DR1.

"She admits to telling [RR] lies re relationship with the other client, but says he is not a threat to her. She has been advised to try not to go to his room until this Monday and she agreed. She is calm and settled."

6.59 On the same day, there is a note to the effect that X appeared to have settled a dispute with RR and that they seemed to be spending time together on and off. There is no suggestion that AT was advised at any stage that she ought to end the relationship with RR.

6.60 CONS4 told us that, in the rare cases when it was necessary for DR1 to deal with emergencies at Shrewsbury Court in place of him, she would usually discuss the attendance with him afterwards. DR1 said the same, and when we asked her if she had reported this attendance to CONS4, she said *"Of course I did"*. It would, indeed, be

extraordinary if she had not discussed such a serious matter with him, when it was something that fell so far outside of her normal role at Shrewsbury Court. Very oddly, however, CONS4 had no recollection of such a discussion with DR1 about this episode. There is no clinical note made by CONS4 concerning this episode, let alone recording any discussion about it with DR1 or any of the other staff at Shrewsbury Court. However, DR1's record of her attendance on RR is clearly set out in the clinical records and appears on the same page as that on which CONS4 himself later made notes about RR dated 11 November 2004. CONS4's evidence was that he was indeed aware of what had occurred, but there is no evidence to suggest that he had any direct involvement at the time, or that he provided any input in the days immediately following this episode.

6.61 One reason for this may be that, on 31 October 2004, RR was admitted to East Surrey Hospital with a chest infection. That admission was reported to RR's social worker, Q1, on 1 November 20004, but by a nurse at East Surrey Hospital, not by anyone from Shrewsbury Court. Q1 telephoned Shrewsbury Court and spoke to RR's Named Nurse, W2 to find out what was going on. In the course of this conversation, a rather different account was given of the episode which had just occurred and which is described above. Q1 recorded that she was told:

"[RR] went shopping with £150 of his girlfriend's money and ended up spending it on new clothes for himself, the girlfriend then complained. [RR] therefore accused the girlfriend of having an affair and threatened to kill her. CONS4 was called and PRN medication prescribed. [RR] refused to say what had happened to the girlfriend's money although he has new clothes. He then complained of having chest pains, so an ambulance was called last night. He is in A & E for observation and will be admitted this afternoon for a thorough medical check-up."

6.62 It is very surprising that this information about the background to RR's threats to kill AT does not appear in any of the notes at Shrewsbury Court. The reference made to CONS4 having been called was almost certainly either a mistake or a misunderstanding. As recorded above, there is no evidence that CONS4 had any involvement in this episode.

6.63 The Inquiry was provided, by Surrey and Sussex Healthcare NHS Trust, with the notes retained by East Surrey Hospital in relation to RR's admission at the beginning of

November 2004. The majority of those notes relate to RR's physical condition, but there is a record on 1 November 2004 that RR had told nursing staff there that he wanted to speak to his social worker. He gave the nurses Q1's name and contact number. East Surrey Hospital contacted Q1, but she could not see RR because she was on leave most of the following week. RR then asked to speak to the Social Care Team at the hospital, and he was seen by ESH1later on 1 November 2004. ESH1's note reads:

"Spoke with patient on the ward as he had been asking staff to speak with social care worker. Told me that he had been unhappy at Whitepost after an affair with fellow patient - 15 years younger. Ask me to contact his CM [care manager] in Sutton, as he would like to be moved as he has vowed to kill both himself and the girlfriend. Spoke to ward staff who will organise psychiatric assessment."

6.64 There is no evidence in the clinical notes provided by Surrey and Sussex Healthcare NHS Trust that any psychiatric assessment was carried out. RR may not have been in hospital long enough for such an assessment to be arranged. More significantly, however, there is no reference in the Discharge Notification of the concerns that RR had expressed to ESH1on 1 November 2004. There is no indication in any of the documentation provided by Shrewsbury Court that East Surrey Hospital passed on the information referred to above.

6.65 We do not know whether this is because documents have gone missing at East Surrey Hospital and Shrewsbury Court, or because this important information was not passed on to Shrewsbury Court. It seems to us, however, that the likelihood is that no attempt was made by staff at East Surrey Hospital to pass this information to Shrewsbury Court. If there had been, we think it likely that there would have been some reference to this in the Discharge Notification, as well as a record in the notes at East Surrey Hospital that the information had been passed to Shrewsbury Court and/or to Q1. It might have been that East Surrey Hospital staff assumed that such information would be elicited by the clinical staff at Shrewsbury Court - particularly bearing in mind that RR was under the care there of a consultant psychiatrist – but if this was the assumption, it was an incorrect one.

6.66 The other significant note made during RR's time at East Surrey Hospital is dated 2 November 2004. It reads:

"Conscious and orientated - needs to sort out his psychiatric medicines because when discussed with pharmacist found out that it hasn't been giving [sic] for a month. Queried with Nursing Home and spoke to the nurse in charge (Staff Nurse W14). Told that he was refusing Procyclidine for a while. I think we need to confirm the drugs with a GP."

6.67 It would have been a matter of considerable concern if RR had not been taking his psychiatric medication. We could not, however, find any reference in RR's medical or nursing notes that suggested he had been refusing his psychiatric medication during October, as apparently reported to East Surrey Hospital on 2 November 2004. There are notes recording that he refused medication for physical health problems from time to time, but there are also entries in RR's nursing notes stating, in terms, that he was taking his psychiatric medication. The note referred to above is accordingly difficult to understand.

6.68 On 3 November 2004 RR returned to Shrewsbury Court from East Surrey Hospital. On 5 November 2004, AT's nursing notes record that her mood on that date was "*okay as she is with [RR] all this evening*". The difficulties of the episode immediately before his admission to hospital seem, therefore, to have passed, at least so far as AT was concerned.

6.69 On 8 November 2004 Q1 spoke to W4 at Shrewsbury Court about RR, following up the conversation she had had with W2 on 1 November 2004. W4 said RR was in good health. Surprisingly, W4 is also recorded as having said that he was not aware of RR having made any threats. He was aware that AT was buying presents for RR, but he said that his understanding was that she wanted to give him the money, and the situation was difficult to control, because it was her money. Q1 also spoke to RR, who said he was feeling fine and had no wish to meet her. Whatever the concerns RR had had during the time that he was in East Surrey Hospital, his wish to communicate those concerns to Q1 had passed by 8 November 2004.

6.70 There continued to be concern at Shrewsbury Court about AT's vulnerability to financial exploitation, and there are a number of entries in AT's nursing notes which record that she wanted money to go shopping for RR. The concerns were such that, on 9 November 2004, W4 telephoned RR's social worker, J1, expressing concern that AT was spending money on *"a new friend she had found"*. He estimated she was spending at least £100 each week on this new male friend. W4 said he found the situation difficult to deal with, because AT had the right to do as she pleased with her money. J1 arranged an appointment to discuss the problem further.

6.71 AT's vulnerability to financial exploitation remained a cause for concern to AT's family and to staff at Shrewsbury Court (in particular, to W7 who was made AT's Named Nurse in about November 2004). When Son1 visited his mother in late 2004, W7 discussed this problem with him and they spoke to AT about it. AT, however, became defensive. As a result of his concerns, Son1 asked Shrewsbury Court to send AT's accounts to him. He also asked that RR should be required to provide receipts for all the purchases which he said he was making on AT's behalf. On 29 November 2004 Son1 wrote to Shrewsbury Court reiterating his concerns and suggesting that AT's allowance be reduced to about £50 a week, on the basis that if she needed more, a request could be made to the Named Nurse.

6.72 On 11 November 2004 CONS4 reviewed RR's case. This was an important review, bearing in mind the developing relationship between RR and AT and, more significantly, the recent incident when RR had threatened to kill AT. The notes made by CONS4 on this occasion include the following:

"Close relationship with [AT]. Going shopping with [AT]. Brought back packets of cigarettes. He seems to be spending [AT]'s money.

Mental state: No psychotic symptoms;

Not depressed or elated. ...

Behaviour: Co-operative with staff

No aggressive behaviour

One episode of threatening behaviour - talking about killing someone when he was under stress ...

Medication: No problem.

Changed from Zopiclone to PRN.

Risk: Risk - past history of aggressive behaviour, particularly towards women. Recent threatening behaviour. Assault on another client. No risk of self harm.

Care plan 1) Review of risk assessment - high risk if threatening and he has a victim

2) Review of medication, Zopiclone to PRN.

3) Assess possibility of exploitation/abuse.

4) Review in four to six weeks."

6.73 This review is referred to in the nursing notes on this date. Significantly, it is, however, stated there:

"At the time of the review, [RR] was out shopping with £100 of [AT]'s money."

It appears therefore that the review, and the mental state items recorded by CONS4 in his note of 11 November 2004, were nursing observations which he was summarising, and were <u>not</u> the result of a face-to-face examination of RR by CONS4. When this was put to CONS4, he said that he was uncertain whether he had actually seen RR on this occasion. Interestingly, CONS4 referred to this review in his statement to the police following the homicide, and said that, although he had spoken to RR on this occasion about the relationship with AT, he did not know it was a sexual relationship. It may be that, by the time he made this statement to the police, CONS4 had forgotten that this review had been conducted in the absence of RR, or it may conceivably be that the nursing notes are inaccurate or misleading in suggesting that RR was not present for the review.

6.74 CONS4's statement to the police said also that he had told AT that it was inappropriate to have a relationship with another patient *"as you do not know what they have done"*, but that AT had responded by saying that she *"knew all about him and that she loved him"*. When giving evidence to us, CONS4 said:

"I did speak to [AT] about the relationship and warned her that it was inappropriate for her to form this relationship. I did not say why and give the past history. She responded

that she was in love with him and she knew all about him. So we just decided at that stage to monitor whether she was being exploited or not."

He told us that the exploitation, about which he was concerned and to which he referred here, was financial exploitation by RR, and he agreed that his major concern was RR's financial exploitation of AT rather than any physical risk.

6.75 There is, however, nothing in the contemporaneous clinical notes relating to AT which records any such advice, let alone AT's response. If such a warning were given by CONS4 to AT, it is very surprising that he did not document it.

6.76 CONS4 told us, as he had told the police, that he did not know whether the relationship between RR and AT was a sexual one. It does not appear that he enquired into this issue. Had he done so, he would surely have ascertained from the nursing staff, if not from RR and AT themselves, that they were, on occasion, spending nights together in each other's rooms and he would no doubt have recorded that information. His omission to make this enquiry, particularly if he did in fact meet with RR on this occasion, is surprising.

6.77 RR's nursing notes record on 11 November 2004:

"CONS4 has suggested that, if there should ever be an aggressive outburst of threats, then one-to-one observations should commence; especially if there is a victim in mind. Staff to talk with [RR] after any outburst when he has calmed down. Exploitation to be observed, assessed and noted. This to be done over the next two weeks. This includes spending of [AT]'s money."

6.78 On the same day AT's nursing notes record:

"[AT] was due for review, but refused to attend when CONS4 wanted to speak with her, saying that CONS4 is going to pick on her. A discussion took place with CONS4, W9 and Dr [DR1] and myself. Dr [DR1], CONS4 and W9 has decided that it would be a wise idea to have both [RR] and [AT] together and sit down and have a discussion. I suggested that

[AT]'s son be present for a meeting where her finances can be discussed, as this has caused some problems before when [AT] has used up her money."

It may have been a coincidence that CONS4 reviewed RR's case on the same day as AT's, but it may, perhaps, be that CONS4's consideration of RR's case was prompted by the concerns expressed about his possible financial exploitation of AT.

6.79 It is difficult to conceive of the reasons why X was worried that CONS4 might pick on her, save only that in the recent weeks there had been much emphasis on her finances, with attempts being made by a number of different people to stop her spending her money on other patients, specifically RR. It is possible that AT was worried that CONS4 was going to add his voice to those trying to stop her (as she saw it) spending her money as she wished. In view of the evidence given to the Inquiry by CONS4, and in view of what is to be found (and what is not to be found) in the clinical notes, it seems to us unlikely that AT was concerned that attempts might be made to stop her relationship with RR.

6.80 On 14 November 2004 RR's nursing notes record that RR was not communicating with staff, but was spending all his time with AT. A similar note was made on 15 November 2004. On 16 November 2004 it was recorded that RR was *"still keeping AT under his spell"*.

6.81 On 17 November 2004 J1 (who had, for some days, been trying to obtain a copy of AT's Care Plan in advance of the CPA meeting planned for 7 December 2004) was faxed a copy of a document entitled "Enhanced Care Programme Approach". AT's new Named Nurse, W7, had prepared the document and under the heading "Relationships", it said:

"Her son visits her occasionally. She has good relationships with staff members and other clients as well. But she prefers to develop relationships with men.

Action Plan (to be implemented by all staff members and especially the Named Nurse): She needs observation and also counselling in relationships. Family to be encouraged to continue visiting."

Under the heading "Finances", it was recorded that AT was *"financially vulnerable and can be easily exploited by others."* The Action Plan was *"to teach her how to spend money and not to be exploited"*. Under the heading "Planning to prevent crises developing", it said: *"She needs counselling on budgeting. She needs education and*

counselling with her relationships with men." There was no mention in this document of any concern about the possible dangers to AT of continuing a relationship with a man known to have a history of violence towards women. J1 was never told that AT, the person whose care she was responsible for co-ordinating, was probably in a sexual relationship with a man who was known to pose serious dangers to women with whom he had such relationships.

6.82 RR's three-weekly depot injection of Clopixol was due on 17 November 2004, this being three weeks after the last record on the MARS recording sheet of the depot injection being administered. RR's nursing notes for 18 November 2004 stated: *"[RR] is to have injection this afternoon."* There is, however, no subsequent reference in the nursing notes to the depot injection actually being administered. The MARS recording sheet for 18 November 2004 was not to be found amongst the notes retained at Shrewsbury Court, but it was subsequently located in the notes provided to the Inquiry by East Surrey Hospital. It records that the depot injection was administered to RR on 18 November 2004. We do not know how or why this record ended up at East Surrey, but it is indicative of the poor standard of administration at Shrewsbury Court. In any event, the next depot injection was due on 9 December 2004.

6.83 At about the same time, preparations were being made at Shrewsbury Court for a CPA meeting for RR scheduled to take place on 9 December 2004. A document was prepared by RR's Named Nurse, W2, which noted, amongst other things, that RR posed a *"very active risk physically to fellow clients"*. He identified a fellow patient and expressed the view the two should not be allowed to engage directly with each other without supervision. The same document also identified the need to monitor RR's relationships with women, with the "Action to Be Taken" being described as *"informing future partners about the risk of being hurt physically"*. The document also referred to a problem of non-compliance with medication, with the "Action to Be Taken" section stating *"Should be encouraged and supervised to take his medications."* W2 commented that a failure by RR to take his medication might result in a relapse in his mental state.

6.84 On 18 November 2004 W2 completed one of the standard "Risk Assessment Score Sheets" for RR. Amongst others, the following were identified as risks which were perceived as being in the bracket 3-4 (i.e. as serious risks):

- Risk of violence towards other residents and/or staff
- Risk of drinking or drug taking e.g. substance abuse
- Risk of self-neglect
- Problems with not taking prescribed medication.

The risk of exploitation (that is to say, the risk that RR might exploit others) was assessed as being in the bracket 0-2, as was the risk of sexually inappropriate behaviour. The Risk Management Plan, prepared by W2, included the following:

"1. To compliance with medications and therapeutical regime [sic].

2. Relationship with women should be monitored ...

4. Very active physically with fellow clients - an expression of concern from others."

6.85 On 24 November 2004 RR collapsed with breathing problems and needed to be re-admitted to East Surrey Hospital. He returned to Shrewsbury Court on 2 December 2004.

6.86 On 30 November 2004 Q1 attended a further Adult Protection Senior Strategy meeting held under Surrey Multi-Agency Adult Protection Procedures. This was a follow-up to the earlier meeting on 8 October 2004. It was attended by W4 and W10 from Shrewsbury Court, and by care managers and social workers representing the interests of the individual patients who had been involved in the various incidents which had led to the original meeting. CONS4 was again apparently unable to attend.

6.85 The minutes of the meeting referred back to the recommendations made on 8 October 2004. With regard to the recommendation that the medication of all clients at Shrewsbury Court be urgently reviewed, it was recorded that CONS4 had done this on 12 October 2004. As noted above, however, when we asked CONS4 about this, he said that he had <u>not</u> been asked to review all medication or even to review RR's medication, and there is no reference in RR's (or indeed AT's) clinical records to suggest that CONS4 did review his medication following the meeting on 8 October 2004. It is difficult, therefore,

to understand why it was reported to the meeting on 30 November 2004 that this had occurred.

6.86 With regard to staffing levels, the meeting was told by W4 that he had spoken to DR2, who had said he was happy with staffing levels and, furthermore, that the HC was also satisfied with the staff:patient ratio. However, W4 told the meeting that DR2 was willing to co-operate if the meeting thought extra staff were needed. The minutes record that concern was expressed at the number of incidents involving patients at Shrewsbury Court, and it was suggested that the needs of patients, rather than numerical ratios, should be the determining factor in deciding staffing levels.

6.87 With regard to the problem which had been perceived with the patient mix at Shrewsbury Court, W4 reported that a decision was awaited from DR2 about the purchase of a separate property which could be used to accommodate the older and more disabled patients. The minutes noted:

"It was felt that some of the patients were inappropriately placed in the present establishment and that interim measures around managing risk were needed until separate facilities were available."

6.88 The minutes also noted that the addition of more staff might reduce the risks to the more vulnerable patients, but in response W4 had said that the "Named Nurse" method was currently *"proving successful"*.

6.89 One of the recommendations ultimately made by the meeting was as follows:

> *"Market Strategy - admission policy to be reviewed and suitability of placements assessed with regard to perception that 'there is no where else available'."*

6.90 A follow-up meeting was arranged for 17 January 2005 to be held at Shrewsbury Court. It was noted that DR2 and a representative of the HC, HCC1, were to be invited.

6.91 On 5 December 2004, a note was made in RR's nursing notes as follows:

> *"RR poses no management problem. Still living the life of Romeo & Juliet with [AT]."*

6.92 On 6 December 2004 W7 telephoned J1 to tell her that the CPA meeting planned for 9 December 2004 would have to be cancelled, because CONS4 could not be there. The meeting was re-arranged for 21 December 2004.

6.93 As mentioned above, RR's next depot injection was due to be administered on 9 December 2004. We were, however, unable to ascertain whether the December depot injection was actually given.

6.94 When interviewed by the police on 12 December 2004, following the homicide, RR said that he had had his depot injection two days previously. We formed the view that RR has been a relatively reliable historian, and it is fair to say that he had no reason to tell the police that the injection had been given, if it had been overlooked. Furthermore, in a chronology of events produced following the homicide in connection with an independent review commissioned by Croydon PCT, it was recorded that a depot injection had indeed been given on 10 December 2004. It is not, however, clear upon what evidence this conclusion was reached. We examined the MARS recording sheets for the period 8-10 December 2004, and found no reference at all to RR being given his depot injection. Neither is there any entry in RR's nursing notes suggesting that RR was given a depot injection at or about this time - although, as commented elsewhere in this Report, the standard of note keeping and recording by nursing staff at Shrewsbury Court was not such that the absence of a reference to the administration of the depot injection in the nursing notes can be regarded as a reliable indication that the injection was not given.

6.95 Regrettably, therefore, we have not been able to reach any definitive conclusion on the question of whether RR was given the depot injection due in the days before the homicide. But, in the absence of any record of its administration, we think it more likely than not that it was <u>not</u> given.

6.96 An entry in RR's nursing notes, timed at 7pm on 10 December 2004, records that RR had *"refused meds"*, but it seems that this was a reference only to his normal daily medication - that is to say, Zopiclone 7.5mgs (a sedative), multi-vitamins, and Paracetamol. If this is right, it is unlikely that there was a connection between this specific refusal and the psychotic episode that led to the homicide. At 5.40pm the following day, it was noted that RR was compliant with his medication.

6.97 The evidence obtained by the police as to what occurred on the day of the homicide is as follows. At about 1am, AT was seen knocking on RR's door. The pair were thereafter seen talking together. Later, sometime between 2am and 3am, AT was seen to go back to her bedroom. The evidence of W2 was that RR then remained in his bedroom. However, at or about 7am, RR told W2 that he had been hearing voices. An entry in RR's nursing notes timed at 7.11am reads:

> *"Refused his nocte [night-time] medications. Complained of hearing the voices this morning. Mane [morning] medications given immediately."*

6.98 RR was taken to the smoking room. The morning medications referred to here were, according to the MARS recording sheets, Salbutamol Inhaler, Budesonide 200 mcg, Amlodopine Besilate 5 mg, Frusemide 40 mg, Aspirin 75 mg, Isosorbide Mononit SR 60 mg and one drug, the name of which is difficult to decipher, but which appears to be Diltiazem (for angina). These are all physical health-related drugs, and would have had no immediate effect on RR's mental state. It is difficult, therefore, to comprehend the logic of the administration of these drugs as a response to the alarming information that RR had been hearing voices that morning.

6.99 At 7.30am, AT was seen in her room. There were, at this time, no obvious signs of blood and it seems likely that the attack on AT had not yet occurred. At 7.45am, the changeover from the night-shift to the day-shift took place. C7 was on the day-shift, and he recalls that W2 told him that AT was quiet and withdrawn, and that she had gone to bed early (which C7 says was unusual).

6.100 At 8.10am, W13 (a care assistant at Shrewsbury Court) started work. At about 8.20am, she went to AT's room. The door was closed. She knocked and used her staff key to open the door. She saw that AT was lying across the bed in a strange position. She was under the duvet. W13 then noticed spots of red on the floor. She called W10, one of the senior nurses. They removed the duvet and found that the sheets, quilt and pillow were covered in blood. W10 told W13 to call the police. She did not check for signs of life, but she did not see any breathing or chest movements. She later told the police *"To be honest, I just got out of there as quick as possible*."

6.101 Only one other staff nurse, C7, was on duty that morning. He went to AT's room, and although he did not touch her, he said that he could not detect any sign of life. The police and ambulance crews arrived and took over. Ambulance staff *did* detect signs of life and, at about 8.55am, an ambulance took her to East Surrey Hospital. She was, however, pronounced dead on arrival.

6.102 Shortly afterwards, RR was seen sitting on a chair in a corridor. He said to one of the cleaners *"I've killed AT"*. When asked why, he said *"AT asked me to"*.

6.103 Police at Shrewsbury Court were told about the relationship between RR and AT and went to find him. RR appeared calm. His left hand was heavily stained with dried blood. When asked if he knew why the police were there, RR replied *"I think I've killed her. It's these blazing voices"*. He then repeatedly said *"The voices. The voices"*. He was asked about the weapon he had used and he produced a Swiss Army knife from his jacket pocket which was heavily stained with dried blood.

6.104 At 8.56am, RR was arrested on suspicion of attempted murder. He was cautioned and asked if he understood. He said *"It's the voices. They have been with me for a long time"*.

6.105 RR was interviewed by the police later that day and made full admissions. He was emotional during these interviews, saying that he had loved AT and breaking into tears on a number of occasions. He said he wanted to be locked away forever. He repeatedly blamed the *"voices"*, which he said had told him that she had been unfaithful and that he should *"sort her out"*. He said the knife he used to kill AT had been bought and given to

him by her. He described her as *"having a thing"* about knives, a statement corroborated by AT's son, Son2, in his statement to the police. When asked about the voices, he described how they would come on if he did not get his injection of Clopixol on a regular basis. He said that the last injection had been given just two days previously, which he said was late. He referred to the medication which he had been given by W2 that morning, when he had reported that he had been hearing voices. He made it clear that this medication had been given to him before the homicide. He described how, after the attack, he had washed his hands with soap and water and rinsed the knife after the attack. He described how AT used to leave her bedroom door on the latch so that he could get in, and said that he and AT had sometimes swapped room keys.

6.106 RR also described an earlier occasion when he had heard voices telling him that AT had been unfaithful with another patient at Shrewsbury Court, whom he named. He said *"I knocked him about a bit to try and get him to make a confession but he wouldn't."* His account of the fight was surprisingly detailed. He said that it had taken place shortly before he had gone into hospital with breathing difficulties. He said he had hit the other patient because the voices told him this patient was having an affair with AT. RR told the police that the incident had not been reported to staff, either by himself or by the other patient. If the fight did occur, it is certainly correct that there is no mention of it in any contemporaneous documentation at Shrewsbury Court.

6.107 RR also said in his police interview that he had told a psychologist at Shrewsbury Court that he was going to hurt AT, and that he also told a Staff Nurse, W14, that he was going to hurt AT and kill the patient, with whom, so the voices told him, she was having an affair. He described their responses as *"pooh-poohing"* him. W3, the psychologist at Shrewsbury Court, was adamant, however, that no such statements had ever been made to him. We were unable to locate and interview W14.

6.108 RR also told the police that another patient at Shrewsbury Court had given him *quat* (a plant which contains an amphetamine-like stimulant and which is chewed to obtain euphoric effects), an account which he confirmed when he gave evidence to us. He told us that one of the effects of using *quat* was to bring the voices back more often.

6.109 RR might, of course, be regarded as an unreliable historian, particularly in this interview on 12 December 2004 bearing in mind his emotional state. However, we should

note that, in at least some respects, the account which he provided to the police, self-serving though it might have seemed at the time, has proved accurate. For example, RR referred to his admission to East Surrey Hospital, and told the police that he had contacted the social worker there and said that he was worried he was going to kill somebody if he was let out. He told the police that the social worker to whom he had spoken had said that she would get in touch with Q1, but she was unable to see him immediately. It was only after our interview with RR, when the notes from East Surrey Hospital were provided to us, that it became apparent that RR's account of these events was accurate.

RR's Evidence to the Inquiry

6.110 Our interview with RR took place nearly two years after the homicide. It is, however, of note that many aspects of his account were remarkably consistent with the interview which he gave to the two psychiatrists who examined him at the police station on 12 December 2004 after his arrest, a DR9 and a DR10.

6.111 RR gave his view of the care he had received over the years. He said that, whilst he was at Witley 3, the voices had stopped, but he wanted to leave that ward because he thought he was not receiving enough money in benefits, compared, so he thought, to other patients who were living in hostels and receiving larger sums in consequence. He was disappointed his transfer to Shrewsbury Court had not resulted in his being given any more money.

6.112 He said that there was *"no comparison"* between Witley 3 and Shrewsbury Court and that the staff at Shrewsbury Court were *"rubbish"*. Specifically, he volunteered that staff there *"did not give you your proper tablets on time"*. He described the pattern of life at Shrewsbury Court as follows:

> *"Just sitting about and smoking. Going to the smoke room, and then back to my room. To the smoke room and back to my room. It was boring. There wasn't much activity going on. Half the nurses didn't understand you because they came from Pakistan, and if you were trying to tell them in English, they would say 'Pardon? Can you write it down?' They wouldn't understand you. When my medication was*

late, they would say it was in the pharmacy and that it would come up the next day, but it didn't. It used to come up two days later. It was a lousy outfit."

6.113 He told us that he had kept the Swiss Army knife, which AT had given him and with which he eventually killed her, in the pocket of his trousers "for months".

6.114 Of W2, his Named Nurse at Shrewsbury Court, RR said:

"I used to talk to him, especially when the voices came back. I used to tell him that the voices were back and that I was frightened I might harm AT. He pooh-poohed it, and said I didn't really mean it, and what-have-you."

6.115 RR said that he saw CONS4 just twice during his stay, and he also recalled seeing the psychologist, W3 twice – although the evidence suggests that there were at least three occasions upon which he was seen by W3. RR said that, on the second of the two meetings with the psychologist which he recalled, he had mentioned hearing voices telling him to harm AT. He said that W3 had also *"pooh-poohed it"*. As recorded above, W3 strongly rejected the suggestion that RR had ever told him this; and was adamant that he would not have responded in this way had RR expressed such thoughts to him. We comment in this regard that although W3 told us that he had no memory of seeing RR in October 2004, and said that RR had never expressed to him any homicidal ideation towards AT, he did accept that he must have seen RR at this time in late October. This meeting did, accordingly, occur shortly after the time when, as recorded elsewhere in the notes, RR had made threats to kill AT - indeed the meeting would almost certainly have been arranged <u>because</u> RR had made those threats. Whilst RR might not have repeated those threats to W3, we consider it unlikely that a meeting could have taken place at this time without W3 being aware of the fact that the threats had been made. We also comment, however, that whilst RR's account of seeing W3 just after he had reported that he wanted to kill AT is consistent, chronologically, with the entries in the nursing notes at Shrewsbury Court at the end of October 2004, RR's belief was that this meeting was just a few days before the homicide, and there is no support for this elsewhere in the evidence before us.

6.116 RR told us that he and AT had visited each other's rooms *"practically every night"* from mid-July 2004. He was sure the staff knew, because they saw him in AT's room at night. He said sometimes they had sex and sometimes he would sleep there. He said that he was surprised they were allowed to have this relationship, and that this was different from nursing homes he had been in before.

6.117 RR told that us the voices came back after about four or five months at Shrewsbury Court – which is consistent with contemporaneous records and the episode at the end of October 2004:

"They would start off by calling me names, insulting me and telling me that AT did not love me any more and that she had a new boyfriend…They were just like demons in my head. Sometimes, they would praise me. I would be out of this world when they praised me. But when they insulted me, I would not…. They were very similar (to voices he had heard in the past). *They always told me that the women in my life were … not being true to me and they hated me."*

6.118 He said the voices would come at different times, generally for short periods of ten minutes or so at the start. He said that some days they were stronger than others:

"I told them to eff off and they eff-offed, but then they came back. I thought I had them, by telling them to go away. But later on…., when I was in the East Surrey Hospital with the chest infection, they were back. They said: 'AT is having a whale of a time now that you are away from her. Sort her out, sort her out! … So I asked to see the social worker and I told her."

6.119 It was RR's evidence that the voices very quickly started telling him he should kill AT. He said that he reported this to the 'assistant head nurse' at Shrewsbury Court, and that the nurse said: *"What will your daughter say?"* to which he had replied *"I didn't give a damn about my daughter, but I wanted to leave there before I did some damage."*

6.120 He also described asking to see the social worker at the East Surrey Hospital:

"I said that I was hearing voices and that I was suffering from schizophrenia. I was hearing voices telling me to harm my girl-friend back at the nursing home and could she do something to stop me going back there."

As has been noted above, RR's account was, in this respect, confirmed when the records from the East Surrey Hospital were obtained.

6.121 RR went on to describe his behaviour to AT over the following weeks:

"I would not trust her. I would keep an eye on her. When she was missing at meals, I would go round and check on her. She just sat on the bed. I would say: 'Oh, you're in here then,' and she would say 'yes'. I would say: 'Who's just left?' and she would say 'nobody'. And then about two days before the actual incident, the voices were really bad. They were saying: 'Go on – check on her, check on her! She's just had it away with….X. She's just had it away with X! Go and check on her! Go and check on her!' I would be up and down, up and down, checking, checking, checking, but X would not be there. Then, on the final day, I checked there. I was worn out. The voice said: 'There she is, the dirty rotten bitch! Attack, attack, attack!' I got out my knife, which AT had given me, to carve our name on trees, and I took the knife and cut her throat."

6.122 The voices were *"stronger and more commanding"* than he had experienced on previous occasions. They had been telling him to kill AT for ten days before he actually did so:

"I used to tell them to eff off, you know, and they went away, but after two days of solid checking and checking on her, I was worn out. I had not had sleep or anything. I kept checking on her every half an hour – I would go to her room to see who was with her. There would be nobody there, and I would come back, and then check again and check again. Then the voice said: 'There she is, the filthy cow, she's been at it with so-and-so! Attack, attack, attack!"

6.123 RR told us there were no times during November 2004 when he was free of the voices - *"They were always there in the background."* He said they changed after the homicide:

"They called me a murderer and said I deserved everything I got, and that they should never have done away with hanging. I should have been hanged for what I did to AT."

RR's Care and Treatment - Subsequent developments

6.124 Following his arrest on 12 December 2004, RR was remanded in custody. We have not had access to his Inmate Medical Record, which would have detailed his medical history whilst in prison. Whilst on remand, his depot injection of Clopixol was increased from 400 mg every three weeks to 400 mg every two weeks. RR was transferred from HMP Belmarsh to the Shaftesbury Clinic, a medium secure forensic psychiatric hospital on 19 July 2005. We have not had details of the assessment which led to this transfer, but the shortage of medium secure beds makes it likely that RR had been waiting in prison for transfer to a psychiatric hospital.

6.125 Details of RR's treatment at the Shaftesbury Clinic are given by CONS10, a consultant forensic psychiatrist, in his report to the court dated 7 December 2005. According to this, when interviewed on 30 August 2005, RR said that he had been hearing voices telling him to *"join"* his partner. He had heard the voices *"two days before his depot medication was due"*. He stated that he did not hear the voices after the depot injection and the noise of *'bagpipes'* had also been reduced after his depot medication. At the end of September, RR complained of being woken by bagpipes, but these had disappeared after his medication was given. On 7 November 2005, he was reported to be hearing *"tunes"*. CONS10 concluded that RR suffered from paranoid schizophrenia and a psychopathic disorder, within the meaning of the Mental Health Act 1983, which comprised *"a personality disorder with significant paranoid, dissocial and sado-masochistic traits."* CONS10 considered that RR suffered from an abnormality of mind within the terms of Section 2 of the Homicide Act 1957 and that this impaired his responsibility for his acts at the time of the killing. He recommended that the matter be disposed of by a hospital treatment order under Section 37 of the Mental Health Act 1983 and was of the view that the addition of a restriction order under Section 41 of the Act was *"strongly indicated"*.

6.126 A psychiatric report was prepared on behalf of the Crown by CONS11, consultant forensic psychiatrist, dated 21 December 2005. He reached the same conclusions as CONS10. The fact that the court did not choose to adopt the suggested disposal was not an indication that it did not accept that RR was ill. Rather, the case fell within Section 2 of the Crime Sentences Act, which provides that a person convicted of a serious offence shall be given a life sentence, if he or she has previously committed a serious offence.

6.127 As explained below, it is clear from the medical records that RR had a major relapse of his psychotic illness in the autumn of 2004, probably beginning in October. After his remand to Belmarsh, his depot dosage was increased to Clopixol 400 mg fortnightly, but this did not control the symptoms adequately and these continued through much of 2005.

7. Whitepost Health Centre

History

7.1 Shrewsbury Court is a private, or independent, hospital. It is part of the Whitepost Health Centre, Whitepost Hill, Redhill. The Centre is split into three separate establishments. Shrewsbury Court looks after patients with mental health problems including informal and compulsorily detained patients. The Elms provides care for elderly people with Alzheimer's disease. Lavender Place provides care for deaf people with mental health problems. This Report is concerned with the care given to RR and AT at Shrewsbury Court, but when it is necessary to refer to the over-arching organisation of which Shrewsbury Court formed part, we refer to it as "Whitepost".

7.2 Whitepost is owned and run by The Whitepost Healthcare Group. The Registered Owner is DR2. His wife and children are also involved in the business.

7.3 DR2 currently works full-time as a General Practitioner in the Harrow area. He has worked as a general practitioner in the London area since 1972. He became interested in opening a private care home for the elderly, and he acquired Whitepost in 1986. The premises had been used as a general hospital, but that hospital had closed in the late 1970s, leaving the premises redundant. Initially, DR2 operated Whitepost as a residential nursing home for the elderly, but he then decided to develop the business by offering more specialist care, and he made a decision in about 1989/1990 to diversify into mental health care.

7.4 Shrewsbury Court started its mental health care programme in a serious way in 1993, when a local hospital which had been providing a semi-secure facility for the mentally ill was closed down. The patients there needed to be relocated, and DR2 felt that Shrewsbury Court could provide a service for the elderly patients who had been at that hospital. Shrewsbury Court became, in effect, a private nursing home. The medical needs of most of its residents were attended to by the local general practitioner, although a few were under the care of the local CMHT.

7.5 In 1998 DR2 decided to apply to the local Health Authority to register Shrewsbury Court as a specialist mental health nursing home, so as to allow it to extend its operations by providing care for patients detained under the Mental Health Act 1983. DR2 contacted CONS4, a consultant psychiatrist working for the Surrey Oaklands NHS Trust as part of the Redhill & Reigate CMHT, to assist him in this regard. The CMHT was conveniently based just down the road from Shrewsbury Court at a location known as Shaw's Corner.

7.6 Following an exchange of correspondence in late 1998, DR2 retained CONS4 to act as the consultant psychiatrist for those patients at Shrewsbury Court who were detained under the provisions of the Mental Health Act 1983. There was a significant conflict in the evidence given to us about the nature and extent of CONS4's duties, and this is an issue which is discussed further below.

7.7 The application for registration of Shrewsbury Court as a specialist mental health nursing home was successful, being approved by the local health authority in about 1999.

7.8 DR2 told us that the plan was that CONS4 would have responsibility mainly, but not exclusively, for the detained patients. DR2 explained that by this he meant that, if there were a problem with an informal patient, the first step would be to involve the local general practitioner. The GP would then, if necessary, refer that person to CONS4, in his capacity as the local NHS psychiatrist (as opposed to in his capacity as an employee of Whitepost). It was possible that CONS4 might end up seeing that patient at Shrewsbury Court, rather than at Shaw's Corner. But the formal position would remain that CONS4, as the RMO at Shrewsbury Court, had responsibility in that capacity only for the patients compulsorily detained there. He would also see some informal patients, but only in his capacity as the local NHS psychiatrist, following a referral from a GP.

7.9 On 1 April 2002, as a result of the coming into full force of provisions of the Care Standards Act 2000, any establishment which was providing care for patients detained under the Mental Health Act 1983 became categorised as an independent hospital. Establishments such as Shrewsbury Court, which had been registered under the Registered Homes Act as mental health nursing homes, were required to register as independent hospitals if they wished to continue to provide care for detained patients.

7.10 Shrewsbury Court was carrying on business as an independent mental health hospital at the time of RR's placement at Shrewsbury Court and at the time of AT's death. As such, it was subject to the regulatory regime applicable to hospitals.

Shrewsbury Court

7.11 The residential area of Shrewsbury Court was notionally divided into three "wings". The Lingfield Wing was the designated female accommodation (although it also accommodated some of the male patients with dementia). The Salisbury and Zeta Wings provided the male accommodation. There was a single corridor connecting the male and female areas, and there was a door between those sections, but at the time of AT's death there were no physical restrictions on movement. There was what was described to us as a free flow between the male and female patient areas.

7.12 There was a smoking room in the female wing used by male and female patients. The main lounge and dining area were in the male section and these were used by male and female patients.

7.13 At the time of the homicide, Shrewsbury Court was more or less full to capacity, with 45 patients. AT lived at number 14 Lingfield Wing. She had her own key to her room, although she appears to have mislaid it from time to time. Her room, like all other rooms, was single accommodation. RR lived at number 27 Zeta Wing.

8 The quality of services provided at Shrewsbury Court in the period prior to December 2004

Introduction

8.1 The evidence given to the Inquiry showed that the quality of service being delivered at Shrewsbury Court in the period prior to AT's death was seriously below the standards to be expected of an independent hospital. Had the service there been of the standard which the patients and placing authorities were entitled to expect, this homicide would not, in our view, have occurred.

8.2 We set out later in this Report the specific deficiencies in the service being provided at Shrewsbury Court which resulted in opportunities to prevent this homicide being missed. In this section, however, we set out a more general description of the shortcomings which existed, so as to provide the context for, and an explanation of, the errors which we consider were made in the care provided to AT and RR. The existence of these shortcomings is also relevant to the discussion which follows of:

- the decision made by SLaM to transfer RR to Shrewsbury Court

- the significance of the failure by SLaM to follow up RR's placement in the months which followed the transfer; and

- the question of whether AT ought to have remained at Shrewsbury Court.

8.3 It is not practical to rehearse each and every shortcoming about which we heard evidence. However, as a result of this homicide, Shrewsbury Court was, in January 2005, the subject of an unusually detailed and far reaching investigation by the HC which went far beyond that normally carried out by the HC. It took place over a period of four days and involved a total of six inspectors, with some specialist assistance (whereas a typical regulatory inspection of a unit such as Shrewsbury Court would normally occupy two inspectors for just two days). The findings made confirm that Shrewsbury Court fell short of the standards to be expected of an independent hospital in very many important ways. In his evidence to this Inquiry, DR2 said that he accepted the HC's findings of January 2005. We indicated to DR2 that if, after further consideration, he had reservations about any of the findings which had been made, he should communicate those reservations to

us, but that in the absence of such a communication, we would proceed on the basis that he continued to accept that each of the criticisms made of Shrewsbury Court by the HC following the January 2005 inspection were well-founded. DR2's response was to say that, having decided at the time of the HC report to accept its findings, he did not consider it right or proper to challenge those findings some two years later. In our view, therefore, the HC report dated 18 April 2005 provides an invaluable starting point for anyone wishing to appreciate the extent of the shortcomings at Shrewsbury Court in the period immediately prior to the homicide.

8.4 Our conclusions about the deficiencies in the services provided by Shrewsbury Court are not, however, based solely upon the findings made by the HC in January 2005. Although the evidence we heard was necessarily focused upon the care given to just two patients, AT and RR, that evidence disclosed serious systemic problems.

The Management Team at Shrewsbury Court

8.5 In order to have a proper understanding of the way in which Shrewsbury Court operated in the period prior to December 2004, and of how the various shortcomings which are outlined in this Report came to exist, it is necessary first to describe some of the key figures in the management of Whitepost, their backgrounds, qualifications and experience.

DR2

8.6 DR2 was (and remains at the time of writing) the Registered Owner of Shrewsbury Court for the purposes of the Care Standards Act 2000. In a chart which he provided to us showing the structure of "the Shrewsbury Court Health Care Group", he is described as the "Medical Director", but he told us that he did not have, and had never had, any clinical role at Shrewsbury Court.

8.7 DR2 obtained his medical qualifications in Pakistan, where he worked in missionary hospitals as a general duty doctor. He said he had set up a hospital there, serving about 10,000 people. He then came to England where he first worked as a lecturer at

Manchester University, progressing to work in casualty, orthopaedics, and obstetrics and gynaecology. In 1972, he started work as a general practitioner in London. Between 1983 and 1986, he worked in partnership running a care home in the Croydon area. In 1986, he purchased Whitepost, although he continued to be a full-time general practitioner.

8.8 DR2 did not, at the time he acquired Whitepost, have a background in mental health care - he has subsequently acquired a diploma from London University in developmental health for the care of the mentally ill in the community and in hospital. He did have considerable experience in working with people with dementia, but his lack of experience or expertise in the management of a specialist mental health nursing home meant that he needed to select an experienced and well qualified team to manage Shrewsbury Court.

W15

8.9 W15 was the business manager of Shrewsbury Court at all material times until about mid 2005. She declined to give evidence to the Inquiry. In the management chart referred to above, she is placed immediately below DR2, and immediately above the [Acting] Registered Manager of Shrewsbury Court.

8.10 We did not find it easy to determine the nature and extent of her role at Shrewsbury Court. In a letter to the Inquiry, she stated that her role was a *"supportive administrative role for the proprietors and the clinical staff"*, but witnesses suggested to us that she had a greater involvement. W8, for example, who became the Registered Manager of Shrewsbury Court in 2005, described his perception of her role as follows:

> *"She was an accountant, but she managed the nurses. If the nursing staff had any problems, they always went down to ask W15, so she was seen as the lead player. The management team consisted of W15 and DR2, so any real decisions made were made by the two of them … She very much had control over everything that went on. She had control over how much food was brought into the kitchen, how many hours the housekeepers worked, what was spent in relation to clinical equipment,*

stuff like that. ... She was part of the senior management team who made decisions of how the hospital would run."

8.11 The impression we had, after hearing the evidence from W8 and other witnesses to the Inquiry, including W1, the Registered Manager up to early 2004, W16, a training officer at Shrewsbury Court, and W21, an RMN employed at Shrewsbury Court with responsibilities for quality assurance, was that W15 was a forceful personality, who had, for much of her time at Shrewsbury Court, the ear of DR2, and who exercised considerable influence. According to DR2, she even had some involvement in the formulation of the admissions criteria being used at Shrewsbury Court. If this was indeed the case, that was, we think, a most unusual role for an accountant.

8.12 It is clear that her role included keeping a tight control over spending. This is obviously an important task in any commercial organisation, but there is always the danger that a drive to keep expenditure under control may impact upon clinical standards. If the Registered Manager, the person with primary responsibility for maintaining clinical standards, was alert to this danger and prepared to fight his corner, this would not have been a problem. But if there was a Manager who lacked the necessary experience or expertise to appreciate what was necessary and/or the personality to fight his corner as and when necessary, then there would be a real danger that expenditure necessary to address deficiencies at Shrewsbury Court would be held back. We consider that this may have been an important factor here, at least during the time in 2004 that Shrewsbury Court lacked a proper Registered Manager and had a deputy, W4, standing in as Acting Manager.

W1

8.13 W1 was the Registered Manager of Shrewsbury Court between about 1998/9 and early 2004.

8.14 W1 initially qualified as a Registered Nurse, Learning Disability ("RNLD" – an abbreviation used throughout this Report to describe nurses trained in learning disability, although some of the nurses who were trained in learning disability acquired that qualification when the nomenclature was different). He later acquired a qualification as

an RMN. However, he returned to learning disability nursing as soon as he completed the RMN training, and so never worked as a staff nurse in mental health. He was appointed as a Nursing Officer in about 1975, and stayed in management within the NHS until 1997 when he retired. After his retirement, he heard of a position as deputy manager at Shrewsbury Court, working with the then Registered Manager, W17. After about nine months, W1 agreed to take over the management of the unit and to develop it into a psychiatric unit.

8.15 W1 remained as the Registered Manager until he resigned in March 2004. He told us he was feeling *"burnt out"* and that he had wanted to resign before, but that he had been persuaded by DR2 to stay on. When he resigned, he was asked by DR2 to continue to work for Shrewsbury Court part-time, as its Marketing Manager - or Marketing Consultant, as he preferred to describe it. He worked in this capacity for about one day a week until June 2005, when he finally ceased working for Shrewsbury Court altogether.

8.16 As Registered Manager, and later as Shrewsbury Court's Marketing Consultant, an important part of W1's work included the assessment of patients for admission to Shrewsbury Court.

8.17 W1 was well respected and well liked at Shrewsbury Court. W16 described W1 as *"extremely good ... he tried his very hardest to work with what he had [as nursing staff]."* He appears to have been a "hands-on" manager, who made himself available to staff for support and guidance, whether he was on duty or not. The nurses from Shrewsbury Court who gave evidence to us spoke highly of W1 and suggested that the standard of patient care and nursing management had declined when W1 resigned from his position as Registered Manager. W2, an RMN, told us that the nursing leadership had been *"good"* when W1 was manager but that when he moved on *"everything broke down"*. Likewise C7, an RNLD, told us that when W1 was in charge *"the place was running perfectly. ... Everybody was interested, everybody all working enthusiastically. Once he resigned, it all went down"*.

8.18 Our view is that this evidence may over-state the extent to which things were running smoothly during the period before W1 resigned. As Registered Manager, it was W1's responsibility to ensure that the standards required of Shrewsbury Court, as an independent hospital, were met. As the HC reports in the period from 2002-2004 show, it fell a long way short of meeting those standards. W1's evidence to us showed that he was

himself aware of significant deficiencies. By way of example, he described training at Shrewsbury Court as being a *"major issue"*, his evidence being that budgetary constraints were the problem, and that DR2 was not willing to pay for the training which W1 considered necessary – a contention, we should record, which DR2 disputed.

8.19 It is also noteworthy that W1 told us that nurses trained as RNLDs and those trained as RMNs were, for practical purposes, treated as the same. He said that, although the unit would never be left without a qualified nurse in charge, that nurse could be either an RMN or an RNLD. Whilst W1 seems to have regarded this as acceptable, our view is that it is not appropriate at a hospital providing care to the mentally ill for there ever to be occasions when the nursing staff do not have the guidance of a nurse with training in the care of the mentally ill. W1's evidence to us suggested that he did not fully appreciate the significance of the distinction between the two types of qualification.

8.20 W1 told us that he knew there was a problem with staffing levels, and that this was something which he had raised on a number of occasions with DR2 and W15. He described how he had secured some concessions, but that DR2's stance had been simply to state that staffing levels/ratios had been agreed with East Surrey Health Authority. W1's evidence was that he had told DR2 that the <u>type</u> of patients at Shrewsbury Court required higher staff:patient ratios than had apparently been agreed with the Health Authority, but that DR2 had responded that the unit was not making enough money to pay for extra staff – a suggestion which DR2 rejected. W1 also told us that he had tried hard to secure greater numbers of RMNs, but that his efforts had proved largely unsuccessful. As recorded elsewhere in this Report, it is our view that the terms and conditions on offer to nursing staff were not generous, and we think it likely that this was at least a contributory factor here.

8.21 Our view is that, if W1 had had greater experience of working with the mentally ill, he would have been better placed to meet the arguments advanced by DR2, and less willing to continue working as Registered Manager with what he thought were inadequate staffing levels. His failure to take a firmer stand on these issues was unfortunate but, we think, understandable, bearing in mind that he lacked the experience in caring for the mentally ill to be able to tell DR2 that such steps were essential.

8.22 The Registered Manager engaged by DR2 after the homicide, W8, did manage to improve staff:patient ratios and to recruit RMNs, but the context in which W8 came to Shrewsbury Court was a very different one to that in which W1 worked. In the aftermath of this homicide, and with the investigations and the conclusions reached by the HC, it is likely that DR2 was very much more amenable to proposals to improve services at Shrewsbury Court - even if those proposals came with significant cost implications - than he would have been in the period immediately before the homicide. Our view, however, is that it is likely also that W8's greater experience of working with the mentally ill gave him the experience to insist that changes should be made in order to ensure that a proper service was provided at Shrewsbury Court.

8.23 W1 was a conscientious and committed individual who would have been an able and effective manager when Shrewsbury Court was a nursing home. However, we think he probably lacked the necessary skills and experience to act as the Registered Manager of an independent hospital providing care for the mentally ill, at least without the assistance of others with substantial experience in the provision of care to the mentally ill. The more complex and challenging the patients admitted to Shrewsbury Court, the less appropriate it was for the unit to be managed by someone without significant experience in providing care for the mentally ill. We take the view that W1, whilst recognising deficiencies in the service being provided at Shrewsbury Court, did not have a full appreciation of the extent to which the service being provided there fell short of that which was appropriate at a mental health hospital.

W4

8.24 W4 began work at Shrewsbury Court in February 1999, when he was employed as a Staff Nurse. He was qualified as an RNLD, not as an RMN.

8.25 W4 was appointed in March 2002 as the Clinical Nurse Specialist at Shrewsbury Court. The job title might suggest a position for a nurse who had undergone some particular additional training, or acquired some particular expertise within a specialised field. But at Shrewsbury Court, the position was, in effect, a junior management role which involved, according to W4, tasks such as the general supervision of nursing staff, and monitoring and controlling the administration of medication. A copy of the formal job description was provided to us by DR2. It states that the post-holder will be responsible,

amongst other things, *"on a 24-hour basis for ensuring efficient and effective management of the unit within the resource constraints in order to achieve an agreed standard of care to residents*". In the period with which we are concerned, the post of Clinical Nurse Specialist was in effect, the third tier of management, below the Registered Manager and the Deputy Manager.

8.26 In February 2003 W4 was promoted again to Acting Deputy Manager, immediately below W1, the Registered Manager. The appointment was made for a trial period of three months. Importantly, in a letter to DR2 dated 11 February 2003, W4 wrote:

"I would like also, for the record, to highlight my concerns as discussed with you on the 3rd February 2003 with regard to:

1) The training and development needs of all staff on Shrewsbury Court

2) My [RNLD] qualification (i.e.: that I also do not hold the RMN qualification)

3) *My lack of experience in dealing with Mental Health Act Commission/Care Standards Commission."*

8.27 This letter showed that W4 had serious reservations about his ability to carry out the role of Acting Deputy Manager. He was, in our view, right to have such reservations. Before moving to Shrewsbury Court, he had had little experience of working with people with mental health problems, apart from a period of one year, in 1997/8, when he worked as a Staff Nurse on a unit for patients with a dual diagnosis of learning disabilities and mental health problems. He had had no formal training, and little experience, in management.

8.28 Notwithstanding these concerns, W4 started work as Acting Deputy Manager. Following the completion of the trial period, DR2 wished to confirm W4 as Deputy Manager. Mindful of the requirement placed upon the NCSC by the Care Standards Act to ensure that individuals are suitable for the role of Registered Manager, DR2 wrote to the NCSC on 1 May 2003 about the proposed appointment of W4. The letter stated:

"We write to ask your advice on the appointment of W4 as Deputy Manager to W1, Manager of Shrewsbury Court.

W4 has been working with us as a trained member of staff since February 1999 and, during the course of his work with us, we have seen his professional growth and maturity enhance to such an extent that we are confident of his ability to be a very good Deputy to W1. [W4] has been acting as Deputy Manager to W1 for the last three months ... as we have already advised you.

As you know, the resource of suitably qualified RMNs with management experience in this part of the country is very scarce and we are now faced with a situation where, with the commitments that W1 has, to run this unit, a reliable, hard-working, trustworthy, experienced and qualified person is essential. All these qualities are present in W4 and I enclose copies of his various certificates, while recommending his appointment as Deputy Manager for Shrewsbury Court."

8.29 There appears to have been a considerable delay in responding to this letter. On 15 January 2004 DR2 wrote again to the NCSC enclosing a copy of W4's curriculum vitae, apparently in response to a request by the NCSC. On 22 January 2004 HCC2 of the NCSC wrote to DR2:

"Having read W4's CV, there would appear to be no reason why you should not go ahead and appoint him as the deputy manager. However, as W4 is trained as an [RNLD] rather than an RMN, his knowledge base is obviously different. This is not a problem in itself as W4 has a lengthy experience in mental health. However, as W4 is providing clinical supervision to RMNs, EN(M)s and nursing students, it is important to consider the difference in training. I would therefore recommend that W4 undertake some further training, specifically in mental health nursing or interventions e.g. developments in mental health nursing."

HCC2 told us that this letter was written after discussions with the Regional Manager at the HC. He pointed out that the HC was not required to approve appointments to the position of a Deputy Manager. When commenting upon W4's lack of relevant qualifications, HCC2 told us that there were, at this time, a number of hospitals at which even the Registered Manager did not have clinical or managerial qualifications.

8.30 DR2's evidence to us was that he regarded the fact that HCC2 did not veto the appointment as a positive approval of the appointment, and as reassurance that HCC2

considered that W4 was the "man for the job". This was, we think, a serious misunderstanding of the role of the NCSC/HC. Responsibility for selecting an appropriate candidate always lay with DR2 as the Registered Owner. That responsibility could not properly be delegated to the NCSC. Furthermore, distant though he was from the process, it is noteworthy that HCC2 felt it necessary to recommend that W4 undertake further training specifically in mental health nursing or interventions.

8.31 W4 was formally confirmed as Deputy Manager of Shrewsbury Court with effect from 1 February 2004. The appointment letter said W4 had been asked to speak to the Training Department of Surrey Oaklands NHS Trust to explore the possibility of him joining their RMNs on appropriate training. When W4 gave evidence to us, he could not recall precise details of the course proposed by DR2. He said:

"I can't recall if it was an NVQ4 which is the management certificate, or whether or not we discussed me doing the conversion course to RMN, which I wasn't very happy about because I had a young family and I didn't want to be away for 18 months or however long it is."

8.32 He also said, however, that he felt appropriately skilled to take on the role of Deputy Manager, referring to his experience as a staff nurse and as a Clinical Nurse Specialist. He said he regarded the move to Deputy Manager as a natural step for him to take, saying *"I knew all the staff and clients very well, got on well with the GPs, RMOs and everyone, and I just presumed that everything would work."*

8.33 In the event, W4 did not undertake any additional training. He could not recall the reasons why he had not done so. When we asked DR2 whether W4 had undergone the training, his initial response was *"As far as I am aware he did not. We had an in-house training officer and his training needs were assessed by her."* He later told us, however, that he did speak to W4 *"at every opportunity"* to ask him to liaise with the training officer, W16, about his training needs. There is, however, no indication that DR2 actually checked that W4 had undertaken the training recommended by HCC2 or that he, DR2, ever told W4 that it was essential that he undertook this additional training.

8.34 Very shortly thereafter, following W1's resignation in March 2004 as Registered Manager of Shrewsbury Court, DR2 appointed W4 as the Acting Manager. He did not seek advice from the HC or HCC2 about this appointment, although there was probably no other option, in the short term, other than to appoint W4 to fill the post as a "stop-gap" - one could not expect a replacement manager to be identified and employed immediately. W4 told us that he did not initially have a Deputy Manager, although he did have help from the Clinical Nurse Specialist, W10. Accordingly, whereas previously there had been a Manager, a Deputy Manager and a Clinical Nurse Specialist, there was now just an Acting Manager and the Clinical Nurse Specialist.

8.35 When we asked W4 about this reduction in the management team, he said that, around this time, DR2 took more of an active role in running Shrewsbury Court. DR2, however, in his evidence to us, stated categorically that he did not play any active part in the day-to-day management of Shrewsbury Court. DR2 also told us that W14, an RMN who had joined the permanent staff in April 2004, was appointed acting Deputy Manager to W4 on 25 August 2004, and this was confirmed by documentation he produced to us. W4 told us he had no recollection of W14 being appointed to this post prior to the homicide.

8.36 It seems that DR2 was prepared to allow this temporary, and less than satisfactory, state of affairs to continue for a considerable number of months. In the HC report which followed the inspection of Shrewsbury Court in January 2005, the HC inspectors commented upon the need to recruit a manager with appropriate qualifications and experience. The report noted:
"There is currently not a Registered Manager in post. There has been no manager in post since the end of March 2004. The inspector was informed that attempts were being made to recruit a manager through advertising and a recruitment agency. However, on reviewing this information, based on the evidence provided to the inspector, no action had been taken in respect of pro-active recruitment since 17 May 2004 when the recruitment agency informed the registered provider that they had been unable to recruit to the position."

8.37 Our view is that W4 was out of his depth as Acting Manager. Whilst his inexperience was masked when he was Deputy Manager to W1, when W1 left his post as

Registered Manager in March 2004, W4 was left with responsibilities which he lacked the experience or qualifications properly to discharge.

8.38 A number of witnesses to the Inquiry also expressed this view. W3, the clinical psychologist, told us that he did not feel W4 had the skills to be manager. W8 said of W4:

"I felt sometimes he was really out of his depth and he didn't understand what was going on, W4 even admitted that to me. He said he felt some of it was completely over his head. … I don't think W4 enjoyed the management side of it. I think he did it to help DR2."

Others put it more bluntly. CONS4 said of W4: *"There was a nurse acting up as manager who clearly had not been trained in management of nursing homes or hospitals."*

8.39 W4's inexperience in the field of mental health was evident in some of the answers that he gave in the course of his interview with us. He demonstrated what can best be described as a naïve view of the needs of the client group at Shrewsbury Court. When asked, for example, if he was concerned about the lack of RMNs, he replied:

"I didn't see that as a problem to be honest with you, because we had the psychiatrist in, but we did have a couple of RMNs anyway. It wasn't an ideal set up, but it worked unfortunately apart from that incident"

This was, in our view, a startling attitude for the manager of a mental health hospital.

8.40 When asked about the limited number of hours that CONS4 was spending at Shrewsbury Court (one session per week supplemented only by call-outs when considered necessary), W4 said:

"In my view, it was sufficient, because what CONS4 would offer would be an emergency service, an out-of-hours service. If ever there was a problem, he was always contactable by phone. I had many times to phone him at home and he would come in if required or

give advice over the phone. Yes, it would have been nice for him to be seven days a week, but in my opinion he offered a good service".

It is difficult to see how anyone with experience in managing a mental health hospital could have felt that one session per week from CONS4 was adequate, given the number of patients and the range of complex problems that they presented.

8.41 A further example of W4's inexperience in management is that, when asked about where the responsibility for arranging CPA meetings lay, W4 told us that this was the Named Nurse's responsibility. However, he seemed to have no proper appreciation of the need for steps to be taken by the management (in other words, by himself, as Acting Manager) to put systems in place to monitor this and to ensure that CPA meetings were indeed being arranged as and when appropriate.

8.42 W4 also told us that patients were *"free to roam from one area to the next and go into each other's bedrooms"*. He does not appear to have been concerned about this unusual arrangement - he did not, for example, instruct nursing staff that patients should be prevented from spending time in each other's bedrooms overnight. More worryingly still, he appears to have had no concerns about this situation, even though he should have known about the specific danger which RR posed to women with whom he was having a close or intimate relationship.

8.43 Given these serious shortcomings, it is surprising that no concerns were expressed about W4's performance, first as Deputy Manager and then as Acting Manager, prior to December 2004. DR2 did not carry out any kind of review or appraisal of W4's performance until 10 February 2005 - after the homicide, and after the detailed inspection by the HC in January 2005. His failure to do so was most surprising given W4's obvious inexperience, the concerns which W4 himself had about his ability to fulfil the role even of Deputy Manager, and the fact that W4 had not undertaken the training in mental health which HCC2 had suggested would have been appropriate. The review in February 2005 was undoubtedly part of DR2's response to the concerns raised following, and as a result of, the homicide, but by then it was too late.

8.44 The review in February 2005 was carried out by DR2 himself. It attempted to address some of the issues raised by the HC. There was, for example, reference by DR2 to a new agreement with W4 that he should create a *"comprehensive audit log book"*. DR2 stipulated that

"[W4] will articulate/carry out the full programme of audits as defined in the Audit sheet and present the same at monthly Clinical Governance meetings."

It was also laid down, in a document entitled "Objective Summary Sheet", that W4 was to be responsible, amongst other things, for:

(i) Maintaining safe staffing levels;

(ii) Ensuring that staff were adhering to policies relating to the administration of drugs; and

(iii) Attending all risk assessments, care planning meetings, CPA meetings and Discharge Meetings in order, so it was said, *"to fill in the communication gaps between various professional persons involved for good care of service-users"*

8.45 These objectives were laudable, but this review failed to address the real problem, which was that W4 lacked the experience and training to perform the role which he was employed to perform. There is no indication from his personnel file, or work history, that he had ever received any training that would give him the skills to meet these objectives. Without, for example, having had any training in carrying out risk assessments, his attendance at all risk assessments and CPA meetings was not going significantly to improve the quality of those assessments. We do not understand what was meant by the phrase *"to fill in the communication gaps between various professional persons involved for good care of service-users"*.

8.46 It is, however, clear that the events of December 2004, and the subsequent detailed investigation by the HC, had resulted in DR2 having some appreciation of how far short of appropriate was the service being provided at Shrewsbury Court. It is regrettable that it took an event such as this homicide to bring DR2 to that appreciation.

8.47 After this Performance Review, DR2 took a more pro-active stance vis-à-vis W4. He raised a number of concerns about W4's performance. There is, for example, a letter from DR2 to W4, dated 14 March 2005, in which it was noted that a number of patients had not had CPA meetings, and which pointed out that this was W4's responsibility. As Acting Manager, W4 ought indeed to have had formal responsibility for ensuring that the performance of staff was regularly audited. As part of this process, he ought to have ensured that regular CPA meetings were being carried out for all patients. There is no evidence that W4 carried out any formal audits of staff performance during his time as Deputy Manager, or Acting Manager. But, bearing in mind W4's inexperience in management and his lack of training in mental health nursing, this was, we think, not wholly surprising.

8.48 Our view is that DR2's choice of W4 for the post of Acting Manager was a serious misjudgment, which left Shrewsbury Court with a well-intentioned, but under-qualified Manager, ill-equipped to address the formidable challenges to be met at Shrewsbury Court. An independent mental health hospital ended up being managed by a nurse who was qualified in learning disability not mental health, and who lacked formal training or experience in management. This was, we think, a major contributory factor towards the problems at Shrewsbury Court which we describe in this Report.

8.49 DR2 must bear the primary responsibility. Not only did he appoint W4 to a role beyond his competence, he also failed to carry out any performance review for W4 at any time before the homicide. W4 was appointed to a position which was beyond his expertise. The fact that he failed to perform adequately was almost an inevitability, but his inadequacies should not have gone undetected throughout the period before the homicide.

8.50 DR2 can point to the fact that in January 2004 HCC2 said that there appeared to be no reason why he should not be appointed. This is a matter to which we return later in this Report when discussing the role of the regulatory authorities here, but we do not consider that this endorsement (or more accurately, the absence of veto by HCC2) significantly reduces DR2's responsibility for the appointment of an inexperienced and under-qualified Manager. In the first place, it was DR2's obligation to select an appropriately qualified and experienced Deputy Manager. He was not entitled to pass that responsibility to the NCSC. Secondly, DR2 did not take steps to ensure that W4 received

the additional training recommended by HCC2. Thirdly, HCC2 was asked only to consider W4's appointment as Deputy Manager. DR2 did not obtain the HC's views on the appointment of W4 as Acting Manager in March 2004.

8.51 Our view is that DR2 must have had some knowledge of the problems with W4's performance. As will be seen from the section of this Report which deals with findings made by the HC in 2004, Shrewsbury Court was failing to meet the majority of the National Minimum Standards. There was what must have been, for DR2, a very uncomfortable discussion on 28 August 2004 (described in greater detail below), following an unannounced HC inspection on that date. HCC2 of the HC drew attention, on this occasion, to a number of practices which he made clear could not be allowed to continue, or else the HC would have to take action. DR2's evidence to the Inquiry was that his management team had, since before April 2002, been working towards meeting the higher standards that came with the re-categorisation as an independent hospital. The fact that, by August 2004, Shrewsbury Court was still failing to meet the majority of those standards and was facing the threat of action by the HC, if certain matters were not immediately addressed, should have been the clearest possible indication to DR2 that his management team was failing in this task.

8.52 A letter written by DR2 to W3, dated 14 June 2004, is significant in this regard. He wrote:

"As you know, the inspectors of Shrewsbury Court during their last visit were so disappointed with the overall client care that they have threatened to put on an enforcement order, if radical steps are not taken to make improvements. I therefore have no choice but to get personally involved, as a threat to Shrewsbury Court is a threat to our commercial survival and a threat to my personal survival".

8.53 The letter indicates that, although DR2's evidence to the Inquiry was that he did not at any time play any active part in the day-to-day management of Shrewsbury Court, he did, in the latter part of 2004, have a direct personal involvement in management issues and, in particular, in an attempt to address deficiencies identified by the HC.

8.54 After making various requests of W3, DR2 continued in the same letter:

"A follow-up visit has been arranged towards the end of July, but I suspect that the gravity of concerns of the inspectors were such that I expect an unannounced visit any day. It is therefore crucial that a rapid progress is made in completing our records in a format that is precise, clear and discernable. … Your participation in my efforts to reverse the culture of decline in Shrewsbury Court will be enormously appreciated."

8.55 DR2's letter suggests a sense of urgency in addressing this "culture of decline", but he does not appear thereafter to have taken any particular steps positively to address the problems to which he was referring in this letter. Indeed, according to the HC report from January 2005, no active steps were taken after 17 May 2004 to try to recruit a new Registered Manager (this being the date when the recruitment agency retained told DR2 that they had been unable to find a suitable candidate for this position).

W10

8.56 When W4 was promoted to Deputy Manager, his position as Clinical Nurse Specialist was taken over by W10. W10 is an RNLD, trained in learning disability, not mental illness. She is an experienced nurse, having worked for over 36 years, mostly in the field of learning disability. She started work at Shrewsbury Court as a part-time Staff Nurse in 1997, and became full-time in 2002. She stopped working at Shrewsbury Court in 2005. W10 did not have any specialist qualifications in mental health nursing.

The Culture at Shrewsbury Court

8.57 At the material times up to 1 April 2002, Shrewsbury Court was a specialist mental health nursing home. Although it then became a hospital, the evidence which we heard strongly suggested that it continued to have the culture of an "old-style" nursing home, and indeed that there was a failure fully to appreciate the implications of the transition to the new status as a hospital.

8.58 The style of care being provided at Shrewsbury Court was well described by W8, who became its Registered Manager in 2005. He told us about his impressions when he first took up that position. He said:

"When I first arrived it was very much the feel of a nursing home. Even though it was registered with the Healthcare Commission and was an independent hospital, it didn't have that feel to it. It was very much institutionalised. … Some of the programmes of how they treated people felt very archaic. I felt as though I was walking back into the 1980s instead of the 2000s, and there was no clinical team-working there. They had an RMO and a clinical psychologist, but they didn't discuss patient care. … The RMO met with the nursing staff and they discussed patients, but the psychologist would also be seeing patients, but he wouldn't be feeding into the whole Care Programme Approach and what was meant to be happening. ...

The first thing I noticed when I first looked around was that it felt that the nurses weren't actually nursing, but they were standing around like bodyguards. There were people at different corners, but they weren't engaging patients, they were just observing patients. The first time I said, 'Why do we not take a few of these patients out in the form of rehabilitation?' they looked at me as if to say, what do you want to do that for? It was very archaic. ..."

8.59 The same impression was described by HCC2 of the HC, who visited Shrewsbury Court on two occasions during 2004. He said:

"The quality of care was poor. The way in which it was managed was poor, although I think the manager's heart was in the right place. It is just the structures were not in place and it was, essentially, running as a nursing home and it should have been acting as a hospital."

His observations on the nursing style and nurse-patient interaction were as follows:

"It was custodial type. There was not a focus on rehabilitation. It was a very medical model and lots of people sitting round doing nothing and not much communication going on. … It rather reminded me of an industrial therapy unit they used to have in the big institutions."

8.60 DR2 told us he was fully aware of the implications of the change in status in April 2002 and that the management of Shrewsbury Court had made a positive decision, before April 2002, that Shrewsbury Court would become an independent mental health hospital, and would accordingly aim to meet the more onerous standards required of a hospital. He told us that it had been appreciated that this would mean, amongst other things, the need to create and implement entirely new policies and procedures. He said that no less than 80 new policies and procedures had had to be devised, and he described how the task of preparing these policies and procedures had been divided up amongst eight people. He said that meetings were held every two or four weeks to discuss compliance with the new requirements.

8.61 We doubt whether, in fact, there was ever such a systematic attempt to effect the changes which were necessary as a result of the transition in April 2002. There are a number of reasons for this.

8.62 Firstly, the evidence of CONS4 was that he had only found out that Shrewsbury Court was an independent hospital in September 2004. He said he had become aware of this when someone on the nursing staff mentioned that the HC inspectors had said it was a hospital. He then spoke to DR2 who confirmed the position. CONS4 also said he did not know about the criticisms which had been made in the HC reports between 2002 and 2004. He said that he was aware only of the reports of the MHA Commissioners and the *"nursing home regulators*". It is hard to understand how CONS4, the only consultant psychiatrist working at Shrewsbury Court, could not have known about its status as an independent hospital, if the organisation had, since before April 2002, been making the preparations which DR2 described to us.

8.63 When we put this to DR2, he said that CONS4 *"should have been fully aware of the implications of the changes in the legislation*". It is, in our view, significant that DR2 did

not tell us CONS4 did know about the transition, and that he, DR2, knew that to be the case because he had discussed the implications of that transition with CONS4.

8.64 Similarly, when we asked W1, the Registered Manager at Shrewsbury Court until early 2004, when he found out that Shrewsbury Court had become an independent hospital, he replied:

"That only came to the fore after W21 came. ... It was only when W21 came and he informed DR2 that he felt the standards we were using were not the right standards."

W21 started work at Whitepost on 3 April 2002. W1 said that there had been no noticeable changes at Shrewsbury Court at the time of the transition in April 2002. W3, the clinical psychologist at Shrewsbury Court also told us that he and *"other members of the clinical staff"* were not made aware that Shrewsbury Court was registered as an independent hospital until after the homicide in December 2004.

8.65 Secondly, as will be seen from what follows in this Report, the regulatory bodies responsible for monitoring independent hospitals' compliance with the requisite standards, the NCSC and latterly the HC, visited Shrewsbury Court on a number of occasions between April 2002 and January 2005. They consistently found that Shrewsbury Court was falling short of many of the applicable standards, and was failing properly to fulfil the various requirements made of it with regard to, amongst other things, the creation and implementation of the requisite policies and procedures. We cannot reconcile DR2's description to us of a concerted effort being made to comply with the requirements imposed upon Shrewsbury Court as a result of its re-designation as a hospital, with the findings made, during this period, by the NCSC and the HC.

8.66 It is also noteworthy in this context that Shrewsbury Court's own minutes of a feedback meeting which occurred after an HC visit August 2004, records that DR2 responded to an important point raised by the inspectors (regarding the fact that informal patients at Shrewsbury Court did not have an RMO there) by saying that Shrewsbury Court was not a hospital. The minutes read:

"Medical cover

Detained [patients] have RMO cover, informal [patients] don't have cover? [DR2] - yes.

[Inspector] - not acceptable for patients in [mental health] Hospital. All patients should have RMO cover to provide a decent quality of treatment and care, if no RMO why are they in hospital.

[DR2] - not hospital. [Emphasis added]

[Inspector] - Yes, under Care Standards Regulations, you are a hospital. Registered as Independent Hospital. Hospital taking patients liable to be detained under Mental Health Act. If you choose not to call yourselves a hospital, up to you, but leads people to think you are a nursing home, which you are not."

This exchange makes it difficult to accept that DR2 and the management of Shrewsbury Court properly understood the implications of the changes which had occurred in April 2002.

8.67 We asked DR2 what steps had been taken to notify the organisations which had placed patients at Shrewsbury Court about the re-categorisation of Shrewsbury Court as an independent hospital. DR2's somewhat surprising reply was that there had been no systematic notification to those who were purchasing services from Shrewsbury Court of the change in status. He said that he had expected those responsible for placements to know that Shrewsbury Court had become a hospital. He pointed out that Shrewsbury Court's brochures and mail shots made it clear that it was providing care for detained patients, from which, he said, it would have been apparent that it must be a hospital, because it could not otherwise have taken such patients.

8.68 Our view is that it was Shrewsbury Court's responsibility to inform those purchasing its services, and the families of residents, that its status had changed. It is, in any event, surprising that the management did not seek to publicise the change, if, as DR2 asserted, a deliberate decision had been made to make that change. If time and money had been expended in an attempt to raise standards, one would have thought that DR2 would have wanted to publicise that fact. It is doubtful that the omission to inform service-users of the re-classification made any difference to the course of events here, but it is relevant to note that not all of those involved in the placement of RR at Shrewsbury Court in 2004 were aware that it was an independent hospital. For example, W12, who was the chair of

the placement panel at SLaM, told us she did not know Shrewsbury Court was an independent hospital when her placement panel approved the decision to send RR there. She said that, if that fact had been appreciated, it might have made a difference to the way the placement was funded.

8.69 However, the fact that there was no attempt to notify those purchasing services from Shrewsbury Court of the change in status does reinforce the doubts which we have as to whether, as DR2 asserted, there was in fact a proper appreciation by the management of Shrewsbury Court of the implications of the change in status which occurred in April 2002. We think it likely that this lack of understanding contributed to the failings at Shrewsbury Court which allowed this homicide to occur.

The Medical Staff at Shrewsbury Court

CONS4

8.70 CONS4 was the consultant psychiatrist at Shrewsbury Court at all material times. He resigned from his position there in April 2008. He gave evidence to the Inquiry on two separate occasions.

8.71 He qualified as a consultant psychiatrist in 1995. His first post as a consultant psychiatrist was in the Redhill & Reigate area, working for what was then the East Surrey Priority Care NHS Trust. As part of this service, he also managed up to 12 in-patient beds at the East Surrey Hospital. He was assisted by an SHO (a training grade post which rotated every three months) and by a staff grade doctor (a junior doctor no longer in training). He has remained covering the same area ever since. He presently works for the Surrey Oaklands NHS Trust, working with the Redhill & Reigate CMHT. This is conveniently based at Shaw's Corner, a few hundred metres from Shrewsbury Court.

8.72 In 1998, he was asked by DR2 to assist with setting up a service for patients who were detained under the Mental Health Act 1983. CONS4 described Shrewsbury Court at this stage as a mental health nursing home taking patients who needed 24-hour nursing

care. When asked whether there was any particular focus to the patient base, CONS4 told us that there was no particular diagnostic category, although all patients were adults.

8.73 CONS4 was clear that the role which he was initially employed to fulfil at Shrewsbury Court was only to provide care for those patients there who were being detained under the Mental Health Act 1983. When he first gave evidence to us, he was vague about the contractual arrangements, saying that there was no proper contract, and that it had been agreed that he would be the *"visiting consultant"* and provide consultant care. He said his role had not extended into the management or organisation of the establishment, to which he was, in effect, a visiting outsider.

8.74 We were, however, subsequently shown correspondence passing between DR2 and CONS4. In 1998, DR2 wrote asking for CONS4's assistance and advice with the registration of Shrewsbury Court as a registered mental nursing home capable of providing care for patients detained under the Mental Health Act 1983. CONS4 wrote back confirming his willingness to act as the consultant psychiatrist and Section 12 doctor (that is, a doctor authorised to make a medical recommendation to detain patients) at Shrewsbury Court. On 25 August 1998, he wrote further to DR2 as follows:

"I have, at your request, prepared a proposal for remuneration for my work with the Whitepost Health Care Centre and I have considered the following facts before coming to my conclusion:

a) As the responsible medical officer (RMO) under the Mental Health Act, I would have 24 hour/7 days a week clinical responsibility for the patients.

b) I would have to be 'on call' and available 7 days a week.

c) The patients themselves, although not acutely ill, are usually the most difficult and most disturbed psychiatric patients.

d) As the majority of the patients, if not all, will be detained under the Mental Health Act, they will require a considerable amount of administrative work.

e) The level of support in terms of the medical staff is likely to be limited.

f) I will also be intimately involved in drawing up of operational policies, development of services, clinical audit and ensuring that the quality of care is high.

g) In the private sector, the average level of recompense to a consultant psychiatrist is £50 per day per patient.

Taking all these factors into account, I suggest payments of £25 per day per patient. This is likely to be, at most, only 10 percent of the total income."

8.75 This proposal was accepted by DR2 by letter dated 26 August 1998. DR2 told us that, as far as he was concerned, the duties which CONS4 would perform were as set out in CONS4's own letter of 25 August 1998.

8.76 CONS4's evidence about this correspondence has caused us considerable concern. As noted above, he initially told us that his role was merely that of a *"visiting consultant"*, having no greater involvement in affairs at Shrewsbury Court than any other consultant who happened to have a private patient as an in-patient in a private hospital. After DR2 provided us with the exchange of correspondence referred to above, we re-interviewed CONS4. CONS4 accepted that the exchange of correspondence had taken place, but would not accept that it meant that his duties encompassed all of those matters identified in his own letter of 25 August 1998. He maintained that that letter only concerned what he was to be paid, and he said the list of tasks were part of his *"pitch"* to DR2 - a *"pitch"* designed to persuade DR2 that the level of remuneration should be that proposed by CONS4. He told us the letter should not be regarded as defining his duties. He accepted, however, that he had never told DR2 either that he was not going to perform these duties or that the letter overstated the level of commitment which CONS4 intended to give to Shrewsbury Court.

8.77 We found it impossible to understand how CONS4 could, on the one hand, say that the list of duties set out in his letter of 25 August 1998 was intended to persuade DR2 to pay remuneration at the level proposed by CONS4, but then say, when the proposal was accepted, that he did not have an obligation to carry out those duties. Our view is CONS4 must have intended, at least when writing the letter of 25 August 1998, to provide the services which he listed. The alternative hypothesis would be that CONS4 had never intended to provide the full range of services spelt out in this letter, and that he wrote it for the sole purpose of persuading DR2 to pay him more money. That would be tantamount to deceit.

8.78 DR2 told us that he always understood that CONS4 had agreed to provide all of the services specified in that letter. Bearing in mind that CONS4 does not say that he ever disabused DR2 of the impression that he, CONS4, would be providing those services, DR2's position in this regard seems entirely reasonable. We conclude that CONS4 did agree to provide all of the services identified in his letter of 25 August 1998. CONS4's evidence about this whole topic was unsatisfactory, particularly since, before this correspondence came to our attention, he had maintained that his role was no more than that of a *"visiting consultant"*. Following discussion of this correspondence in his second interview with us, CONS4 did concede that he had had a rather greater involvement in the affairs of Shrewsbury Court. He accepted, for example, that he had attended project meetings to discuss the reports from the MHA Commissioners and to discuss the response to be made to those reports. He accepted that he had had some input, from a clinical perspective, into the formulation of a few policies and procedures.

8.79 CONS4 described to us his work at Shrewsbury Court during the period up to mid-2004. When he began work there, there were no detained patients. Numbers slowly built up and eventually he was looking after 12 to 14 detained patients. He adopted the practice of spending a session at Shrewsbury Court on Tuesdays, during which he would conduct a ward round of those patients under his care. He told us that the ward rounds also involved a nurse from the ward and, for the first year, an occupational therapist, although, so he said, she then left, being replaced only by someone described as an *'activities nurse'*. There was no junior doctor, apart from DR1, whose limited input we describe below, and the social worker did not, according to CONS4, generally attend ward rounds. Some assistance was provided to CONS4 by a clinical psychologist who worked part time at Shrewsbury Court, but his input did not extend to attending ward rounds. CONS4 told us he would also visit his patients on an *ad hoc* basis if he was advised of particular problems. He estimated that the additional visits probably added up to an extra hour-and-a-half each week in addition to the four-hour weekly session on Tuesdays.

8.80 CONS4 told us that initially, whilst the number of detained patients at Shrewsbury Court was relatively small, he was able to see each of them every week. As the number increased, however, the regularity with which he saw them decreased. He said that when numbers reached 14, he was able only to see them, on average, once every third week.

8.81 Throughout the time that CONS4 was working at Shrewsbury Court, he continued to work for the NHS. His NHS work involved him being on call - usually one day in eight. His position was, accordingly, that he was not only on call, 24-hours-a-day, seven-days-a-week, in his capacity as the RMO for the detained patients at Shrewsbury Court, but he was also, from time to time, on-call for the NHS. CONS4 told us he had agreed with his NHS medical director that he could walk out of NHS sessions (i.e. daytime sessions) to go to emergencies at Shrewsbury Court. He could not, however, explain what he would have done if there had been simultaneous night time emergencies at both places - he appeared to rely on the low probability of this occurring. In August 2004, the HC expressed the view that this was improper, and the feedback notes for the unannounced HC inspection of 24 August 2004 show that the inspectors threatened to contact the GMC if they found CONS4 covering private and NHS facilities at the same time. CONS4 told us that his NHS managers were probably not aware that he was being paid by two different organisations for being on call to each at the same time, but he did not consider his position to be an unusual or inappropriate one, and he said that DR1 would have covered him had he been unable to attend an emergency at Shrewsbury Court due to his NHS commitments. We comment that whilst DR1 might have been able to cover for CONS4 at times which did not interfere with her own NHS commitments, this was not the arrangement specified by CONS4 in his letter of 25 August 1998. We comment elsewhere upon DR1's limited training and experience in psychiatry. It is difficult to see how CONS4 could have perceived her to be an adequate stand-in for a consultant psychiatrist.

8.82 Be this as it may, the position before September 2004 was that CONS4 was employed by Whitepost to be responsible only for the detained patients at Shrewsbury Court. His contract did not prescribe the number of hours or sessions he was obliged to provide, but merely required him to perform the role of RMO for each of the detained patients at Shrewsbury Court. His remuneration for this was (as had been agreed in August 1998), £25 per day per patient. Based on eight patients at £25 per day per patient, CONS4 was, therefore, contemplating remuneration of £72,800 per annum at the time of his "pitch" in 1998. Records of what CONS4 was actually paid for his work at Shrewsbury Court between 1999 and 2004 were given to us by DR2. His remuneration was substantial. It suffices, for present purposes, to say that during this same period, CONS4 was working maximum part-time within the NHS (that is to say ten four-hour sessions, up to the introduction of the new NHS consultant contract of September 2003, after which it would have been nine four-hour sessions). Even though he was working only one four-hour session at Shrewsbury Court (plus an extra one or two hours a week) CONS4's income from

Whitepost actually exceeded his NHS salary. We comment that it would, in these circumstances, have been reasonable for DR2 to have expected considerable input from CONS4 into his new venture.

8.83 We have already referred to the HC visit to Shrewsbury Court on 24 August 2004 and their concerns about CONS4's on call arrangements. The inspectors also expressed concern about the fact that informal patients at Shrewsbury Court did not have an RMO - CONS4 being the RMO only for the detained patients, with the other patients accessing the services of a consultant psychiatrist on the NHS, by securing an out-patient referral to the local consultant psychiatrist (who happened, usually, to be CONS4). In other words, the informal patients were, in effect, often NHS patients of CONS4, but they did not have an RMO at Shrewsbury Court itself. The inspectors insisted that this arrangement could not continue, and that the informal patients had to have an RMO there. Accordingly, in September 2004, DR2 entered into a revised agreement with CONS4, the terms of which were recorded in a letter dated 6 September 2004. DR2 wrote:

"The other matter is to do with your responsibilities as the RMO to those clients who are not detained under the Mental Health Act. As a clinician, I agree with the Inspectors wholeheartedly that a psychiatric evaluation of all those patients who are not detained and are living in an establishment where there are a lot of detained patients be carried out as routine by a psychiatrist. We should therefore be grateful to you if you could kindly take on this additional responsibility in Shrewsbury Court. During our discussions you have very kindly agreed that from today, we will be paying you at the rate of £5.50 per patient per day, whether or not they are detained in Shrewsbury Court."

8.84 CONS4 agreed to take on this responsibility and from September 2004 onwards he had responsibility, as the RMO, for all patients at Shrewsbury Court, informal and detained. According to CONS4, it was at this stage that he was informed, for the first time, that the status of Shrewsbury Court had changed from a registered mental nursing home to hospital.

8.85 CONS4 told us he agreed to take on this role on the understanding that it was a *'transitional stage'* and because he believed many of the informal patients were *'largely stable',* and hence the increase in his workload would not be as significant as it would

have been if the "new" patients had been as challenging as the detained patients for whom he was already the RMO.

8.86 The additional responsibilities falling on CONS4 were not reflected in any significant increase in the time CONS4 spent at Shrewsbury Court. He said that he continued to undertake a single session there each week, supplemented in the same way as described above, although he said that after September 2004 he probably made more frequent additional visits, over and above the single session he was working. There was, however, nothing remotely approaching an increase in time at Shrewsbury Court proportional to the increase in the number of patients for which he was now responsible. He told us that he tried to deal with the extra work-load by seeing five patients per week, instead of four, with the patients now being seen on a six-weekly cycle - in other words once every six weeks from September 2004 onwards. Even if one accepts CONS4's assertion that the informal patients did not need the same degree of attention as the detained patients, the result of the changes in September was that the detained patients were now being seen less frequently, for shorter periods of time. The informal patients were, at best, being seen once every six weeks.

8.87 CONS4 did not, in the event, manage to see all of his new patients - the informal patients - once every six weeks. As explained elsewhere in this Report, there is some uncertainty as to how often CONS4 saw RR. There are four reviews by CONS4 recorded in the clinical records, but there is only one occasion when it is clear from medical and nursing notes that CONS4 actually saw RR. On one of the other occasions, the nursing notes indicate that CONS4 did <u>not</u> see RR – recording that RR was out shopping at the time of the review. So the review on that date was presumably note-based. The other two entries in the medical notes do not record any interview, or any information elicited by CONS4 from RR, so it is uncertain whether CONS4 actually met RR on either or both these occasions. Even if one assumes the most favourable interpretation of the notes, CONS4 probably saw RR just three times between his admission on 22 June 2004 and the homicide.

8.88 Whilst CONS4 attended a CPA meeting for AT on 2 August 2004 (albeit one that he could not recall), there is no note of him reviewing her condition on a ward round at any time after the change in his responsibilities in September 2004.

8.89 The additional responsibilities taken on by CONS4 in the second part of 2004 were not confined to Shrewsbury Court. CONS4 accepted that he had also agreed to become the RMO for both Lavender Place and Fern Cottage. Lavender Place was a seven-bedded unit for deaf people. Fern Cottage was a rehabilitation unit with three beds. Assuming all 35 beds on the main ward were occupied, this means that from 6 September 2004, CONS4 was RMO for up to 45 patients.

It is not essential, for the purposes of this Inquiry, to consider the commercial sense of the agreements between DR2 and CONS4. It is relevant, however, to note the following.

i. From 1998, CONS4 considered that he could adequately discharge the obligations inherent in being the RMO for the detained patients at Shrewsbury Court in one session a week (supplemented only by *ad hoc* attendance to address any specific needs which arose from time to time), even though this meant seeing those patients increasingly infrequently, as the number of patients for whom he was responsible increased.

ii. From September 2004, CONS4 took on the role of RMO for all 35 patients at Shrewsbury Court, together with the patients at Lavender Court and at Fern Cottage, whilst continuing to work a single session each week, supplemented only by *ad hoc* visits.

8.90 We comment that acting as RMO for 40+ patients, would, at least within the NHS, probably constitute a full-time job for more than one consultant psychiatrist, equipped with a multi-disciplinary team. Furthermore, in an NHS hospital, there would have been junior psychiatric staff working with the consultant and junior staff available as cover 24 hours a day. CONS4 told us he was looking after 12 NHS patients in 2004, for which he had two ward rounds per week, and that he was assisted in their care by a junior doctor (an SHO). In contrast, the assistance available to him at Shrewsbury Court was limited to one session of emergency cover each week from DR1, who told us that she considered her role was primarily to deal with physical ailments, rather than psychiatric issues.

8.91 It was impossible for CONS4 to provide care to this many people in a few hours a week without a multi-disciplinary team. It would have been so, even if CONS4 had only

been RMO for 35 or 36 patients. In his second interview with us, CONS4 agreed that caring for so many patients in such a short time was an impossible task, and he accepted that it had not been possible for him to provide a satisfactory standard of care. He agreed that he had so many patients that he *"did not really have time to consider things in detail."* He had hoped that the situation would not last long and had thought that some RMO cover for the patients was better than none.

8.92 We consider that CONS4's decision to take on responsibilities he could not realistically hope to discharge effectively is one of the principal explanations for the errors and misjudgments which were made during the time that RR was at Shrewsbury Court.

8.93 As noted above, although RR was not a detained patient, CONS4 had agreed, in response to a request from CONS3, to become RR's RMO. Initially this was simply to smooth the transfer - CONS4 had not expected RR to become part of his workload at Shrewsbury Court, but had expected that RR would, as an informal patient, be referred to the CMHT at Shaw's Corner where his care would be monitored on an out-patient basis. (We comment that, although RR would have been under CONS4's team at Shaw's Corner, it might well have been a junior who saw him there). In the event, however, after reading the reports on RR which were supplied by CONS3, and having taken on board the details of RR's past, of which he had apparently been previously unaware, CONS4 changed his mind and decided to keep RR on his list. This obviously increased still further the number of patients that CONS4 had to see in his weekly session at Shrewsbury Court even before September 2004. It is unsurprising that the amount of time CONS4 spent with RR was so very limited.

8.94 It is relevant in this context to note comments made by the HC following the inspection of Shrewsbury Court after AT's death. The report included a Requirement that the Registered Provider must develop and implement policies and procedures to ensure that all patients received a comprehensive assessment, a requirement which arose out of a finding that such assessments were not being carried out on all patients at Shrewsbury Court. The report stated:

"Assessment in Case Notes:

Four case notes were reviewed; these were current case notes and did not include any archived files. There was no evidence in any of the notes of a new comprehensive assessment being completed following admission; [emphasis added] *three of the patients were admitted during or before 2003, one was admitted in 2004. One case file contained a mental state assessment tool specifically for non-mental health professionals; Shrewsbury Court staff completed this. One case file contained a completed nursing assessment tool to be used one month after admission. There was no evidence of a consistent method of assessment throughout the files, nor was there any apparent link with the CPA/Care Management process. There was evidence of completed risk assessments."*

8.95 Deficiencies on each of the four sets of case notes reviewed by the HC inspectors suggest that there were widespread problems in this regard. This evidence also suggests that the problem existed before September 2004, and cannot, therefore, be ascribed solely to the extra workload which CONS4 took on at that time.

8.96 Our conclusion is that primary responsibility for the inadequacy of the consultant input at Shrewsbury Court in the months before December 2004 must lie with CONS4 who took on responsibilities which he could not realistically hope to discharge properly. Prior to September 2004, CONS4 was acting as the RMO for 12-14 detained patients in the course of just one session each week. That was, in itself, remarkable, given the lack of a multi-disciplinary team. After September 2004, CONS4 took on responsibility as RMO for up to 45 patients, whilst still working the same single session each week. CONS4's overall remuneration from Whitepost did not increase substantially at this time, but the impression which we have formed is that CONS4 was probably willing to take on these additional responsibilities - responsibilities which he must have known he could not discharge properly - because he was, perhaps naively, unwilling to "rock the boat" with an establishment for which he had worked for the previous four years or so.

8.97 CONS4 told us that, in retrospect, he regretted taking on the extra patient load in September 2004. He said that he had told DR2 at the time that a four-hour weekly slot was

insufficient for the task, but DR2 had disagreed and CONS4 had not pushed the point. He told us:

"I believe that there was a very brief conversation [with DR2] when I did say that I might need more time, but his feeling was that it was sufficient."

(We should record here that DR2 told us that he could not recall having a conversation of this nature with CONS4.) When we asked CONS4 if he had expressed concerns to DR2 or anybody else about the extent to which the additional burden imposed after September 2004 affected his ability to care for his existing patients, the patients who were detained under the Mental Health Act 1983, CONS4 conceded that he had not done so. CONS4 made the point to us that he had been in a difficult situation because he considered that the only alternative to accepting the additional responsibilities asked of him was to withdraw altogether, leaving patients at Shrewsbury Court without any input from a consultant psychiatrist at all. Our view, however, is that CONS4 did have a further alternative, which was simply to refuse DR2's request

8.98 We have also considered DR2's responsibility for the inadequate level of consultant input at Shrewsbury Court. From a purely contractual point of view, it could be said that DR2 had engaged an appropriately qualified consultant psychiatrist to provide a comprehensive service at Shrewsbury Court. It could be said that DR2 relied upon this consultant to provide an appropriate level of service, and to raise with DR2 the need for additional consultant input, if and in so far as that was necessary. In the absence of any request by CONS4 for greater consultant input at Shrewsbury Court, it could be said that DR2 was entitled to assume that a reasonable quality of service was being provided.

8.99 However, that is not the complete picture. DR2 knew that CONS4 was working, and would continue to work, nine or ten sessions each week as an NHS consultant psychiatrist. DR2 must have known, therefore, that CONS4 was not in a position to provide *"24-hour, seven-days-a-week clinical responsibility"* and on-call cover for his patients at Shrewsbury Court seven days a week. When DR2 was asked about this, he simply expressed the view that it was, in effect, CONS4's problem, since CONS4 had contracted to provide 24-hour, seven-days-a-week cover for the detained patients at Shrewsbury Court. That was not, however, a reply which properly addressed the question of how DR2 thought, as a

matter of practice (as opposed to contract law), the needs of patients at Shrewsbury Court were going to be met.

8.100 Whether or not CONS4 had the *"very brief conversation"* with DR2 to which he referred in his evidence, DR2 must also have known that the position in this regard would be exacerbated when, in September 2004, he agreed that CONS4 should become the RMO for all of the patients at Whitepost (that is to say at Shrewsbury Court, The Elms, and Fern Cottage), a total of up to 45 patients. DR2 must, in our view, have known that it would be impossible for CONS4 to carry out this responsibility adequately, whilst still meeting his NHS commitments. When we asked about this, DR2's initial response was again to say, in effect, that CONS4 had undertaken the contractual responsibility, and it was his obligation, therefore, to find a way in which he could properly discharge that responsibility. DR2's position was, therefore, that it was, in effect, up to CONS4 to find a way of reconciling his NHS commitments with the additional responsibilities which he took on in September 2004, impossible though DR2 must have known that would be.

8.101 That may be correct as a matter of pure contract law, but we think it was as nonsensical for DR2 to employ CONS4 to do a job he could not hope to do properly, as it was for CONS4 to accept it. Our view is that responsibility for the fact that the consultant psychiatrist at Shrewsbury Court had wholly insufficient time to provide adequate care to each of the patients under his care (and in particular to AT and RR) must be shared between DR2 and CONS4.

8.102 DR2's representatives later told us that *"during at least one conversation around September 2004, DR2 formed the impression that CONS4 was reducing his NHS commitments"*. CONS4 told us he was unaware of any such conversation, but we comment that if there had been some such discussion, it is surprising that DR2 relied upon an *"impression"* and did not ascertain what precisely CONS4's plans were in this regard before arranging for CONS4 to take on additional responsibilities at Shrewsbury Court.

8.103 The question arises as to why DR2 allowed this state of affairs to occur. The answer is not straightforward. DR2 was paying CONS4 a considerable amount of money for his work at Shrewsbury Court and it certainly cannot be said that DR2 was retaining a consultant psychiatrist at less than the appropriate market rate. But the conclusion that DR2 must have known that he was not getting value for money is inescapable. The reports

from the NCSC and the HC were explicit and it is beyond question that DR2 was fully aware of CONS4's NHS commitments and the consequent impossibility of CONS4 providing 24/7 on call cover for his patients at Shrewsbury Court.

8.104 We can only speculate as to the reasons why DR2 was prepared to allow this situation to continue. It may be that Whitepost was doing well financially and that DR2 did not want to "rock the boat". It may be that DR2 was comfortable working with CONS4 and found it easier to deal with him than someone who might have been a more forceful personality and more willing to insist that money should be spent on raising standards.

8.105 It is appropriate to record in this context, that following the homicide and following the extensive investigations carried out by the HC in January 2005, DR2 *did* take action to improve standards at Shrewsbury Court. W8 was appointed as Registered Manager in 2005, and he told us that DR2 had, by and large, been prepared to incur the expenditure which W8 considered was needed in order to effect the necessary changes at Shrewsbury Court. In particular, DR2 had accepted the need for a significant reduction in patient numbers and for a significant increase in the amount of medical input at Shrewsbury Court. This is to be welcomed.

DR1

8.106 Further medical cover at Shrewsbury Court was provided by DR1 who DR2 described in his evidence as a *"psychiatrist trained doctor"*. DR1 is a staff-grade doctor employed by the local NHS Trust.

8.107 DR1 is originally from Sri Lanka. She trained in the former USSR, following which she returned to Sri Lanka to undertake a five-year internship. The internship was general, covering all aspects of medicine. She worked in general medicine, surgery, paediatrics and gynaecology before moving to work with the emergency treatment unit, where she studied anaesthetics. When she moved to the UK in 1991, she started training in anaesthetics. In 1996, she secured a GP rotation in the Redhill area, and started working as an SHO with a consultant who provided psychiatric care to the elderly. She was then offered a staff grade post with Redhill CMHT. Her work was junior in nature, although after three years she was given her Section 12 approval. She continued working with the

Redhill CMHT for seven years until about 2003, when she moved to work with the continuing needs and assertive outreach team. She continues to work as a staff grade doctor in that team.

8.108 Her formal psychiatric training was accordingly limited, being just eight months in old age psychiatry, (which can be compared with the 6-8 years, with associated examinations, needed to become a consultant). Although she was approved under Section 12(2) of the Mental Health Act 1983, she told us she had, as of 2004, been involved in only a few Mental Health Act assessments, and she had seen her consultant conduct *"around ten"*.

8.109 DR1 started work at Shrewsbury Court in around 2000. She described her work there as that of a *"duty doctor, a kind of deputising service"*, which was on top of her full-time work as a staff grade doctor with the Redhill CMHT. Initially, she was involved in the ward round, but her role evolved to her providing an out-of-hours medical back-up service for which she was paid the equivalent of one staff grade session per week. She told us:

"I didn't want to be the only cover for Whitepost, because there were patients on sections and I didn't think that was appropriate for me to do."

8.110 She was not, therefore, a member of the multi-disciplinary team. She said that she regarded herself as employed to check on the wards on Friday after her full-time work was finished, and also to respond to call-outs from Whitepost so as to provide short-term cover for CONS4 if, for example, he was held up with his work. She said her job was *"to hold the fort for a short period until he came to the unit."* She did not substitute for him as RMO when he was on leave, and she did not think she had the experience to work without RMO cover. She said her main duties were taking blood, writing prescriptions, and dealing with falls. She was *"an extra pair of hands"*. She was rarely called out-of-hours, and such call-outs were usually for physical rather than psychiatric issues. She was *"very rarely"* called out to undertake a psychiatric assessment. She had not been trained in the assessment of risk or dangerousness. She had no forensic training and had never dealt with a sexual psychopath, or with anyone who had a history of stabbing or trying to strangle women. Her assessment of RR on 29 October 2004 was the only time she had been

asked to undertake an assessment of someone's dangerousness at Whitepost. She was not sufficiently experienced to stand in for a consultant on an emergency rota, nor did she see herself as being able to do so or doing so. There appears to have been little contact between CONS4 and DR1. Each was working, in effect, no more than one session a week, and there was generally no overlap between their respective working hours.

8.111 DR2 described DR1 to us as a *"trained psychiatrist"*. We do not, however, think that DR2, or more particularly CONS4, could have considered her to be sufficiently qualified and experienced to provide appropriate cover for CONS4 in an emergency involving a complex or dangerous psychiatric patient. She herself told us that she did not think she was appropriate cover for CONS4 when it came to dealing with detained patients.

8.112 It is relevant, in this regard, to note that, when DR2 wrote to CONS4 on 6 September 2004 and asked him to make sure that 24 hour on-call cover was provided in a manner which would satisfy the HC inspectors, he said:

"You have mentioned DR1's enhanced responsibilities in this regard and would ask you to confirm as soon as possible the details of this arrangement. The compensation for DR1 for the additional duties will of course be a matter that you will have to address."

It appears, therefore, that CONS4's proposed solution to the problem which had been identified by the HC inspectors with regard to on-call cover was that he should contract DR1 for her to provide on-call cover when he was unavailable. It seems that DR2 was content with this. There is no evidence that CONS4 did in fact enter into any new arrangement with DR1 following September 2004, but, for the reasons outlined above, our view is that such an arrangement would have been inappropriate in any event.

8.113 The use made of DR1 as cover for CONS4 illustrates, in our view, the failure of the management at Shrewsbury Court to ensure that there was an appropriate level of medical input. CONS4's input was wholly insufficient for the number of patients for which he had responsibility, particularly after September 2004. The on-call arrangements were wholly unsatisfactory. The extent of the reliance on an inexperienced staff-grade doctor employed by the local NHS Trust, who, in effect, "helped out" at Shrewsbury Court outside her normal NHS working hours, was wholly inappropriate.

8.114 Responsibility for these deficiencies must lie with DR2 and CONS4, but also to an extent with W1 and W4, respectively the Registered Manager and the Acting Manager of Shrewsbury Court in the period up to December 2004. They should have recognised the deficiencies in the level of medical input, but they seem either to have failed to appreciate the severity of the problem or to have been unwilling to take a stand against DR2 on this issue.

W3

8.115 Whitepost also employed the services of a clinical psychologist, W3. W3 qualified as a psychologist relatively late in life, after a career in structural engineering within the oil industry. He had, however, had experience as a part-time counsellor, working with organisations such as the National Children's Home Child Line. He started to work at Shrewsbury Court in late 2000, with his initial contract being for one session per fortnight. He worked only with patients referred to him by the RMO, CONS4. On occasion, he was asked to provide psychological support to members of staff at Whitepost.

8.116 His contract was later increased to two sessions a week, and in June 2004 to three sessions a week, but he still only worked with patients referred to him by CONS4. His position was an odd one. He did not participate in ward rounds, and he only occasionally attended CPA review meetings, even for patients who had been referred to him by CONS4. He told us that he did not generally take part in preparing risk assessments. Before December 2004, therefore, W3's role was a relatively limited one.

8.117 W3's hours have, since the homicide, been increased to five sessions per week. This was a direct response to comments made by the HC in its reports in 2005.

External medical input

8.118 Much of the medical input for physical problems with patients at Shrewsbury Court was provided through the local GP, with whom the informal patients were registered. The GP attended to their physical health, and in the event that those informal patients

required psychiatric input, the position before the changes made in September 2004, was that the GP would refer them to the local NHS consultant psychiatrist, CONS4.

Summary

8.119 The medical input at Shrewsbury Court was remarkably sparse for a mental health hospital. It amounted to the following.

- One session provided by a local consultant psychiatrist, who was also supposed to provide 24-hour on call cover, but whose ability to do so was limited by his NHS commitments.
- One session provided by a relatively inexperienced staff grade doctor who had limited psychiatric training. She was supposed to provide back-up to the on-call cover being provided by the consultant, but her ability to do so was also limited by her NHS commitments, and her inexperience.
- Two sessions a week provided by a relatively inexperienced clinical psychologist.

Our view is that the level of care was astonishingly light for a hospital with about 36 patients, of which 12-14 were detained patients, and where the patient mix was unusually wide, presenting staff with an unusually wide variety of challenging problems.

8.120 An instructive contrast can be drawn between the level of medical input available to Shrewsbury Court at the time of writing this Report and the position in late 2004. CONS4, until his recent resignation, undertook two sessions a week, and another consultant psychiatrist, CONS5, undertook a further two sessions. DR1 attends for a further session each week, making a total of four consultant sessions and one staff grade session each week. On-call arrangements are divided between CONS5 and CONS4, so there is always an RMO on call for emergencies. This medical cover is provided for the present complement of patients, which, at the time of writing, totals just 21, with 15 on the mental health unit and 6 on the deaf unit. There are, therefore, now four consultant sessions, plus DR1's input, for 21 patients, whereas before December 2004 there was one session, plus DR1's input, for all 35 patients. W3 now works five sessions compared with three before the homicide. There could not, in our view, be a clearer indication of the inadequate medical care in late 2004 than this enormous increase in medical care since, notwithstanding the substantial reduction in the number of patients.

8.121 Responsibility for the inadequate level of medical input at Shrewsbury Court must lie with the management, in particular DR2, the Registered Owner, but also, we think, with CONS4. He should have made it clear to DR2 and to the Registered Manager that it was not possible for him effectively to care for the patients there in the limited time which he was able to allocate to those patients.

Shrewsbury Court's Admissions Policy and Patient Mix

8.122 The operation of the admissions policy and the patient mix it produced were, we think, central to Shrewsbury Court's problems. By 2004, it had an unusually wide mix of patients, in terms of age and their problems. In our view, the mix would have presented serious challenges for any organisation.

8.123 DR2 provided the Inquiry with an undated document which set out the admissions criteria being used at the material times before December 2004. It is a brief document which it is worth setting out in full.

"ADMISSION CRITERIA

The criteria for admission for clients under the Mental Health Act 1983.

1. *The clients will only be admitted of a written agreement is made available from the Psychiatrist that the client can be cared for within the community and especially in Shrewsbury Court Nursing Home.*
2. *The client can only be admitted if the Unit Manager of Shrewsbury Court and the RMO of Shrewsbury Court are in agreement of this admission.*
3. *The clients to be admitted under the Mental Health Act ordinarily would have been in hospital for a minimum of two years under the direct care of a consultant psychiatrist.*
4. *The following categories if clients will not be admitted to Shrewsbury Court;*
    a. *clients with recent history of sexual abuse.*
    b. *clients with recent history of alcohol abuse.*
    c. *clients with recent history of drug abuse.*

d. clients with recent history of child abuse.

e. clients with recent history of excessive violence.

f. clients with a recent history of arson.

g. clients whose general appearance is intimidating and threatening.

h. *If after the admission the client appears to pose a risk because of any of the above, the Unit Manager and the RMO will take immediate steps to return the client to the referring agencies, with whom agreement will be made in advance and in writing in this respect."*

8.124 DR2 told us that he prepared these admission criteria with the assistance of W1 and, he believed, the Business Manager, W15.

8.125 W1 described the way the admissions procedures worked when he took over as the Registered Manager. What should have occurred is that he and CONS4 should together have met with prospective patients to make a joint assessment. However, whilst this had happened on a few occasions, it was usually just W1 who assessed patients for admission, although he said that all referrals were passed on to CONS4 and that in some cases CONS4 did speak to the referring consultant.

8.126 W1 described the admission criteria at the time as "*relatively simple*", namely:

"whether that particular client would fit into the client group we had, how that person would influence the client group, and also how capable we were to manage such a client. There were certain written exclusions for admission: drug abuse, sexual assault, child abuse and alcoholism, and that was at the express wish of East Surrey Health Authority then".

When asked if there was any policy about the age of patients coming to Shrewsbury Court, he replied:

"I don't recall at that time, but I know from 2000 it became 65 or something like that, with special dispensation if they were over."

Shrewsbury Court had a number of patients with dementia. When asked how the management of those patients dovetailed with the management of those with different types of mental health problems, W1 acknowledged that that this had given rise to difficulties.

8.127 In contrast to what W1 told us, CONS4's evidence was that his role in assessments for admissions was confined to detained patients and that he had never had any involvement in the assessment or admission of any of the informal patients. With regard to the detained patients, he said:

"The patient would be referred with various documents, previous assessments and so on. Normally [W1] and I would have a discussion about the suitability of the client, then [W1] would normally make the assessment".

He confirmed that he had taken part in a few assessments when he started working for Shrewsbury Court, but said that he had not had enough time and assessments were, accordingly, generally left to W1 alone.

8.128 CONS4 told us he had concerns about the mix of patients and that there were, from time to time, admissions that proved difficult to manage and who had to be *"returned"*. He also said *"for sectioned patients, 70-80% of the assessments were fine"*, implying, therefore, that 20-30% of assessments made had led to inappropriate admissions. He thought it was very likely that the percentage of successful assessments would have increased if he had been actively involved in the assessment process.

8.129 CONS4 also told us he had concerns about the informal admissions and the mixture within that population of psychotic illness, personality disorder and dementia. He said there was *"an odd mix"* and that "*there was a wider mix than you would normally have. … There was a concern that some patients might be too old and maybe too vulnerable".*

8.130 W8, who began work as the Registered Manager in 2005, told us that his understanding of the admissions policy in place before he arrived at Shrewsbury Court was that it was the Manager who made admission decisions, usually without discussion with the clinical team, a situation he described as *"quite bizarre."* The result was, he said, an unusually wide mix of patients, both in terms of age and in terms of the types of problems with which those patients presented. W8 also described how the admissions policy had changed. He said that now the clinical team - the in-house social worker, the psychologist and the RMO - have weekly meetings with the Manager. New referrals are discussed at these meetings, and two of the team then go out to assess the patients, before the

meeting makes a collective decision. This represents, in our view, a compelling contrast with the position before the homicide.

8.131 Concerns about the admissions policies at Shrewsbury Court and the consequential patient mix were also expressed, in the years prior to the homicide, by the MHA Commissioners and by the NCSC/HC. After a visit on 18 February 2003, the MHA Commissioners reported that they were concerned at:

"the range of clientele groups, their ages and physical and health needs ... Commissioners felt that staff were working with very difficult and challenging groups of patients, some of who appeared to have complex behaviour and needs. It was felt that the caring demands of some of these patients had an adverse effect on other patients' care, especially younger rehabilitation patients who complained that their needs were not being addressed."

These concerns were reiterated after the MHA Commissioners' visits on 27 August 2003 and 27 February 2004. Following the 27 August 2003 visit, under the heading "Patient Mix", the Commissioners wrote as follows:

"It was the Commissioners' view that many of the problems, including the issue of aftercare provision, stemmed from an unsatisfactory patient mix. Reference was made to this matter in the visit report following the Commission's visit in February 2003. Commissioners are still of the view that staff are being asked to work with patients with such diverse needs, long term enduring mental health problems, demanding physical problems and the younger patients requiring active regular intervention, that there was a risk that none of these needs could be fully met, and all would to an extent suffer as a result of the demands placed upon care staff by others.

Recommendation - Managers need to determine the functions of the unit and train staff to meet a specific category of clinical need."

The same point was made after the MHA Commissioners' visit on 27 February 2004.

Similar concerns were expressed at the "Adult Protection Inter-Agency Planning Meetings" held on 8 October 2004 and 30 November 2004. These meetings were arranged in

response to a series of incidents at Shrewsbury Court which had raised vulnerable adult concerns. The minutes of the meeting on 30 November 2004 noted that some of the patients were considered to be "*inappropriately placed*" and the following recommendation was made:

"Admission policy to be reviewed and suitability of placements assessed with regard to perception that 'there is nowhere else available'."

8.132 The HC inspection in January 2005 also highlighted serious concerns about the admissions procedures. The inspectors noted that the suitability of prospective patients was not judged against any specific referral criteria, and that the referral form completed by W1 was very brief, with space to record only two or three lines of information about the prospective patient. The Inspectors also noted that W1 had told them that there could be a delay of up to six months after accepting a patient before funding was agreed, but that staff at Shrewsbury Court did not re-assess to ensure that there had been no material change in the patient's condition during that time, relying on the referring authority to notify them of any such change.

8.133 Our view, in summary, is that the evidence shows that the admissions procedures at Shrewsbury Court in the period which is relevant to this Inquiry were poorly thought through. There was little or no attempt to identify any particular category of patient for admission, and the result was a patient mix which was very wide and very challenging for staff. This appears to have been obvious to outsiders - it was the subject of repeated comments over the years by the regulatory authorities. According to CONS4, it was also a matter about which he expressed concerns.

8.134 A substantial proportion of the responsibility for this situation must rest with W1, the man who was responsible for admissions in the years before this homicide. However, it is relevant to note that, although W1 was qualified as an RMN, he had never actually worked as an RMN before he started work at Shrewsbury Court. He had no experience of working with forensic patients. He had no up-to-date formal training in areas such as risk assessment and management. But notwithstanding this, it appears that he was given the responsibility of carrying out, alone, the vast majority of assessments on those referred to Shrewsbury Court for admission. This was an extraordinary position for an independent mental health hospital. The question then, arises as to how this position was reached.

8.135 First and foremost, DR2, as the Registered Owner of Shrewsbury Court, ought not to have appointed a man with so little experience of mental health nursing to have primary, often sole, responsibility for such an important matter as admissions, particularly when Shrewsbury Court became an independent hospital.

8.136 Secondly, CONS4, as the consultant with responsibility for the patients at Shrewsbury Court should, in our view, have formally raised the issue of the need to modify the admissions procedures. He should have drawn attention to the fact that the varied and difficult patient mix was detrimental to the interests of his patients there, and made his task, and the task of the other staff at Shrewsbury Court, unduly difficult.

8.137 Thirdly, it could be said that the regulatory authorities should have been more insistent that the problems which were identified with the patient mix, and the lack of a clear admissions policy, were addressed.

8.138 The question of whether the regulatory authorities should have taken action with regard to the various deficiencies identified from time to time at Shrewsbury Court is discussed later in this Report. As far as DR2, W1 and CONS4 are concerned, attributing responsibility is not straightforward. DR2 could say that he lacked any mental health background and could not be expected to appreciate that the admissions policy was inappropriate and that the patient mix was unduly wide. He could also say that this was, in any event, the responsibility of the Registered Manager or the RMO, and that if there had been concerns, these should have been raised by those with a "hands-on" involvement in the running of Shrewsbury Court or by the regulatory authorities. W1 can legitimately say that he tried to perform the role which he was employed to perform to the best of his ability, and that he cannot be held responsible for the fact that he was under-qualified or lacked the necessary experience for that role. CONS4 can say that his role as an employee of Shrewsbury Court was a limited one, and that (at least until September 2004) he had responsibility only for the detained patients there, and that he was not, accordingly, responsible for the decisions made with regard to the admission of informal patients.

8.139 One difficulty here - a recurring difficulty in explaining and understanding what occurred at Shrewsbury Court - is the extent to which key individuals actually appreciated the extent to which they were under-qualified or lacked the appropriate training/experience for the tasks which they had to carry out. A person may lack the experience to know that he/she is inadequately equipped to perform a particular role.

That said, however, our view is that DR2, W1 and CONS4 must share responsibility for the problems with Shrewsbury Court's admissions policies. DR2 may have lacked experience in the management of an establishment providing care to the mentally ill, but we consider that that inexperience should have caused him to be all the more aware of the importance of employing individuals who did have the right experience. It was, we think, a misjudgment to employ W1 as Registered Manager, when he must have known that W1 had worked almost exclusively with people with learning disabilities, rather than mental health problems. The concerns raised by the regulatory authorities, in particular by the MHA Commissioners, about the patient mix, and the apparent lack of direction with regard to the specific category of clinical need being addressed at Shrewsbury Court, should have alerted DR2 to the fact that the admissions policy/procedures needed to be re-thought.

8.140 The same point can be made about W1. We have no doubt that when he accepted individual patients for admission to Shrewsbury Court, he believed that each would be appropriately placed there. However, when he saw, as he must have done, the comments made by the regulatory authorities with regard to the patient mix, he, as Registered Manager, should have discussed those concerns with DR2 and CONS4.

8.141 It is regrettable that, although CONS4 told us that he was concerned about the patient mix, increasingly so throughout 2004, his concerns did not result in attempts being made to address the problem. That may be a result of CONS4 having failed to communicate his concerns with sufficient urgency; or it may be a result of the management's willingness to allow the status quo to continue unless and until it became essential to make changes. However, CONS4 had responsibility, as RMO, for all of the detained patients at Shrewsbury Court, as well as responsibility, in his capacity as the local consultant psychiatrist for most, if not all of the informal patients. He also had the expertise as a consultant psychiatrist to understand the significance of the wide patient mix, and the difficulties it posed for staff, as well as the potentially detrimental implications for the patients themselves. We think he was well placed, therefore, to identify the problem and to make representations to DR2 and/or W1 about the urgency of the need, from a clinical perspective, to address the problem regardless of the stance adopted by the regulatory authorities.

8.142 CONS4 should, in our view, have informed DR2 and W1 that it was essential that admission decisions had a far greater degree of clinical input, in order to ensure that

inappropriate admissions were not made and to avoid an unduly wide patient mix. CONS4 should have explained that the admission of complex and potentially very challenging patients should not be contemplated without a consultant psychiatrist being involved in the assessment of those patients. He had the expertise and experience to tell DR2 that, whatever W1's other qualities, he did not have the background in mental health to enable him always to make appropriate decisions about admissions to Shrewsbury Court, and that it was essential that assessments for all admissions (not just those of detained patients) had input from a consultant psychiatrist. There may have been cost implications for DR2, but CONS4 had the experience and expertise to tell him that it was essential to get the admissions policy right, and that this could not be left to W1.

8.143 The overall impression we have formed is that there was an unfortunate willingness amongst senior management to allow the status quo to continue unless and until external events made it essential for changes to take place. This impression is not confined to the way in which the management handled admissions to Shrewsbury Court and the way in which it responded to the concerns which were raised, over the years, by the regulatory authorities. The position with regard to admissions policy does, however, provide a clear example of the problem. Whether the lack of response was a result of a collective failure to appreciate the seriousness of the problem, or was a result of an unwillingness to incur expenditure unless and until it was unavoidable, it is impossible now to judge with certainty.

Clinical Governance

8.144 One consequence of the weaknesses which we have outlined above in the management team at Shrewsbury Court was the inadequate attention paid to clinical governance in the years before the homicide.

8.145 Clinical governance in the health services was first defined in the NHS document "A First Class Service" (1998). It was born out of the need for real accountability for the safe delivery of health services. It is about ensuring patient safety, providing the highest quality care, life-long learning and collective responsibilities. It applies equally to the independent sector as to the NHS.

8.146 We asked to be provided with the minutes of all clinical governance meetings at Shrewsbury Court over the relevant period. We were told that most of those minutes could not be found although eventually the minutes from some six meetings between 2000 and 2004 were produced – some described as "clinical governance" meetings, others as meetings of the "Shrewsbury Court Project Team".

8.147 It is striking that these minutes show that, in the period prior to the homicide, CONS4 was not a regular attendee. CONS4's evidence to us was that, when he first started work at Shrewsbury Court, he had attended what he described as *"project meetings"*. He was asked if these were clinical governance meetings, and he said that they were *"really management meetings."* He went on to describe how the meetings became more infrequent, and when we asked him about his attendance, he replied:

"If [the meetings] happened, they were very infrequent. Towards the end, I cannot remember being asked to attend. They may have happened, and I might not even have known the time of them."

W8 confirmed that, when he arrived at Shrewsbury Court, CONS4 was not a regular attendee at such management meetings as were taking place.

8.148 Regardless of CONS4's contractual responsibilities, he should have been asked to attend all clinical governance meetings - it is, in our view, essential for clinical staff to be involved in clinical governance discussions.

8.149 Although the documentary evidence we received about these meetings was patchy, it seems to us that such meetings as were taking place prior to the homicide were more in the nature of management meetings, rather than clinical governance meetings in the sense that that term would be understood in the NHS. They recorded few of the standard agenda items one might expect at a clinical governance meeting, such as clinical audit, education and training, risk management and incident reporting. One would have expected true "clinical governance meetings" to have been the forum for discussion about the visits made by the NCSC (latterly the HC) and the MHA Commissioners, with action plans being agreed and progress being tracked at subsequent meetings. Some discussion about these issues was minuted, but it was not the formalised discussion of these issues and of action plans that one would expect. It appears to us that, in the period prior to the

homicide, there was little or no proper understanding amongst the management of Shrewsbury Court of what clinical governance actually involved.

8.150 Our views in this regard are confirmed by comments made by the HC and the NCSC in their reports on Shrewsbury Court. The report following the January 2005 inspection recorded that there was no documented evidence of an established clinical governance strategy – the inspectors had been told this was *"under development"*. The report stated:

"Clinical Governance.

Minutes of … meetings were reviewed and it was identified by the inspector that the meetings described as Clinical Governance covered issues including bed occupancy, staffing levels and recruitment, staff rotas, appraisal and supervision, and discussion around the formation of audit tools and incident forms. There was no evidence of the use of these meetings to analyse incidents/accidents and to identify learning points from these. These meetings appear to focus on operational management."

8.151 HCC2, the HC inspector who visited Shrewsbury Court shortly before the homicide, described to us his concern at the lack of policies/procedures, structure and clinical governance at Shrewsbury Court, saying

"… it was about structures not being in place, people not doing their jobs, no idea about clinical governance at all - it was just amazing really."

He also commented that problems with clinical governance were not, in his experience, uncommon at this time with small "stand-alone" independent hospitals (as opposed to those independent hospitals which formed part of larger, perhaps nationwide, networks which had greater resources to devote to clinical governance issues). The other witnesses from the HC who gave evidence to us also confirmed that the problem during this period was particularly acute with those smaller independent hospitals which had, as a result of the changes which came into effect on 1 April 2002, only recently become categorised as hospitals, and were, during the period 2002-2004, still addressing the full implications of that re-categorisation.

Responsibility for the lack of clinical governance at Shrewsbury Court during this period must, in our view, lie with the Registered Owner, DR2, and the Registered Manager, W1 and, latterly, the Acting Manager, W4. However, one of the obligations which, so we have concluded, CONS4 agreed to take on when he accepted DR2's offer of employment at Shrewsbury Court, was to be *"intimately involved in the drawing up of operational policies, development of services, clinical audit and ensuring that the quality of care is high."* DR2 said he relied on CONS4 to advise him how to provide a quality service which met all regulatory requirements. Whilst formal responsibility for compliance with these regulatory requirements did not lie with CONS4, we think that it was reasonable for DR2, a man with no particular background in or experience of treating those with mental health problems, to place such reliance upon CONS4 – particularly bearing in mind how much he was paying CONS4.

8.152 CONS4 did not, in our view, provide all of the services which he had said, in his letter to DR2 of 25 August 1998, he would provide. In particular, he did not become *"intimately involved in drawing up of operational policies, development of services, clinical audit and ensuring that the quality of care is high."* The evidence about this is, however, slightly confusing.

8.153 CONS4, as recounted above, was reluctant to accept that his letter was anything more than a "pitch", of no contractual effect, although, on further pressing, he did concede that he had had some involvement in these matters. He said:

"I suppose there would be some clinical involvement in ... operational policies and the development of services and so on. ... I suppose, clinical input into ... some of those policies."

His concession was still remarkably limited, bearing in mind what he had said in his letter of 25 August 1998. In his interviews with us, he could recall only providing some assistance with the emergency tranquilisation policy and with a policy on the provision of emergency medication. He said that his role in this regard was limited to commenting on drafts prepared by others.

8.154 DR2, on the other hand, suggested to us that CONS4 had had an active involvement in clinical governance meetings since before April 2002, those meetings being aimed at deciding how best to manage the transition into an independent hospital.

8.155 So the rather peculiar position was that DR2 was telling us that CONS4 did, in accordance with his contractual obligations, continue to attend clinical governance meetings during the years 2002 to 2004, whilst CONS4, notwithstanding the terms of his letter of 25 August 1998, denied attending such meetings except at the very beginning of his time at Shrewsbury Court.

8.156 Our conclusion is that the position was probably that CONS4 did not regularly attend such meetings as took place, at least after the first year or so of his employment. That was his evidence, and whilst we considered his evidence was, in other respects, less convincing, what he said about these meetings was credible and consistent with other evidence we heard, and the fact that he had, so it seems to us, very limited time indeed available to discharge his clinical role at Shrewsbury Court, let alone any additional "managerial" responsibilities. We do not think, therefore, that CONS4 was, in 2004, providing significant input at Shrewsbury Court in terms of developing services, the drafting of operational policies or clinical audit.

8.157 The next question, therefore, is why did CONS4 not have such an input, when he had, in our view, clearly represented that he would be *"intimately involved in the drawing up of operational policies, development of services, clinical audit and ensuring that the quality of care is high"*. Linked to this are the questions of whether DR2 was aware of the lack of input from CONS4; and if so, why did he not take steps to require CONS4 to do that which he had represented he would do as part of his work for Shrewsbury Court.

8.158 It is impossible for us to provide the answers to these questions with any certainty. We have, however, concluded that the most likely explanation is that whilst CONS4 began work at Shrewsbury Court intending to devote time to issues such as the development of services, the drafting of operational policies and clinical audit, he found he did not have sufficient time each week to provide this contribution. With his NHS commitments and the increasing number of detained patients at Shrewsbury Court for which he had direct responsibility, it seems to us likely that CONS4 was unable to find time to address these broader, managerial, aspects of his work for Shrewsbury Court. It may be that he has also

managed to persuade himself over the years of the truth of the account which he gave to us, in his second interview, about the limited nature and extent of his contractual obligations.

8.159 Why then did DR2 not require CONS4 to do that which CONS4 had represented he would? One difficulty in answering this question is that DR2 maintained throughout his evidence to us that CONS4 did play a significant role in the management of Shrewsbury Court, and did, for example, regularly attend the "clinical governance" meetings. As noted above, in the light of CONS4's own evidence and the documentation we have seen, we think it likely, however, that DR2's recollection about this was erroneous, and that CONS4's input on clinical governance issues was very much more limited. The question accordingly arises as to why did DR2 not address this issue with CONS4.

8.160 There can be little doubt but that DR2 was aware that all was not well. The reports from the NCSC and the HC showed that Shrewsbury Court fell a long way short of the requisite standards. DR2 referred to the *"culture of decline"* in his letter to W3 dated 14 June 2004 and said that the HC had threatened an enforcement order if *"radical steps"* were not taken to make improvements. DR2 must, we believe, have known that CONS4 was not regularly attending the so-called clinical governance meetings. Why then did DR2 not raise these concerns directly with CONS4? DR2 was paying CONS4 a considerable amount of money, and we think that it would have been reasonable for him to consider CONS4 at least partially responsible for the deficiencies which were being identified by the HC.

8.161 It may perhaps be that DR2 was unduly respectful of CONS4's position as a consultant and found it difficult to challenge him about his failure to attend these meetings or to deal more proactively with the matters which had been raised by the HC. But that would be a remarkable supine position, and DR2 did not strike us as a man who would have adopted such a stance.

8.162 It may be that DR2 did not understand how serious the shortcomings were. In his evidence to us, DR2 expressed the belief that the fact that Shrewsbury Court was allowed to keep its registration from the NCSC/HC was, as he saw it, evidence that Shrewsbury Court had met, or had sufficiently met, the standards needed to maintain that registration. In other words, because the NCSC, and latterly the HC, was content to allow

Shrewsbury Court to continue in business (in that its registration was not revoked), then, so DR2 indicated, enough must have done to satisfy the regulatory authorities. We considered that this showed a remarkable lack of understanding of the role of the NCSC and the HC, but it may explain the lack of urgency in, and the ineffective nature of, the attempts made between 2002 and 2004 to address the concerns raised by the regulatory authorities.

8.163 If DR2 did indeed have this view, one corollary would have been that he would have perceived no urgent need to incur substantial costs in addressing the requirements made by the NCSC and the HC unless and until enforcement action was threatened, and that is consistent with other aspects of the evidence we heard. There is the letter of 14 June 2004, from DR2 to W3, in which DR2 referred to threats of enforcement action by the HC inspectors and sought W3's assistance in trying to reverse the *"culture of decline"* at Shrewsbury Court. It seems to us significant that one of the very few documents produced to us recording DR2's concerns about the quality of service at Shrewsbury Court was a direct response to his fear of enforcement action.

8.164 It should be recorded here that DR2's evidence to us also included the following statement:

"I persistently reminded my colleagues, my managers, of their responsibility to address the arising issues from the previous report. I agree readily that we did not sack anybody, we didn't take anyone to task formally, but it was not because of the lack of our resolve. In hindsight, I would have seen that my managers did a much better job than they were doing, or appointed somebody in place of them."

We asked DR2 if he could produce any documentation to corroborate his evidence about these "persistent reminders" to his management team. He indicated that he would do so but, in the event, was unable to do so.

8.165 We cannot say with certainty why DR2 did not take steps to require CONS4 to provide the service which he had represented, back in 1998, he would provide. The most likely explanation seems to be that, in the absence of threats of enforcement action by the regulatory authorities, DR2 thought, mistakenly, that enough had been done by his management team (including CONS4) to ensure a reasonable quality of service, and that

there was, therefore, no need to apply pressure to CONS4 to do more than he was in fact doing. It may matter little. The fact is that inadequate attention was paid to clinical governance during the period up to the homicide in December 2004, and responsibility for that failure lies both with CONS4 who had, we have concluded, a clear contractual obligation to be intimately involved with matters of clinical governance; with DR2 who must by no later than 2002/2003 have been aware that CONS4 was not properly discharging his functions in this regard; as well as with W1, the Registered Manager, and W4, the Acting Manager.

8.166 The fact that CONS4 did not, in the event, do that which he had represented in 1998 he would do had serious consequences. Of all those involved with the running of Shrewsbury Court, CONS4 was best placed to advise as to what was necessary in terms of clinical governance and clinical audit. He worked as an NHS consultant and, as such, he should have had a full understanding of how a clinical governance structure should have been developed. He could have contributed a great deal at Shrewsbury Court. If CONS4 was not, in 2004, providing any significant input at Shrewsbury Court in terms of developing services, the drafting of operational policies and/or clinical audit, the position was that there was probably no-one involved in that process who had appropriate training, or experience of working, in mental health. DR2 had no such experience; W15 (if she was involved) had no clinical background at all; the Acting Manager, W4, was trained in learning disability, as was the next in the hierarchy, W10. The situation was only a little better in the period before W4 became Acting Manager, in that W1, whilst an RMN, had obtained that qualification in the 1960s and had not, since qualifying as an RMN, worked in a mental health unit before his move to Shrewsbury Court. The fact that no-one involved in the management of Shrewsbury Court had any significant background in mental health makes it, we think, unsurprising that there was a failure properly to appreciate what was required of it as an mental health hospital, and unsurprising that the quality of service suffered.

8.167 Perhaps the most important consequence of the collective failure to put in place appropriate clinical governance at Shrewsbury Court was that there was no effective clinical audit programme agreed or implemented.

8.168 The NCSC report for February 2003 commented that comprehensive clinical audit had yet to be put into place and that clinical audits in many areas had not been completed. The NCSC report following the July 2003 inspection recorded that clinical

audit *"does take place"*, but that further development was needed to meet the required standard. This might have appeared encouraging, but the HC, following an inspection in August 2004, wrote:

"Clinical Audit

Clinical audit has not been effectively implemented to date, however the management are making progress with this standard. The inspectors were informed that Shrewsbury Court are hoping to have the processes in place soon."

8.169 The HC report following the January 2005 inspection said:

"Clinical Audit : There was no corporate policy or procedure available that defined how the information gathered … would be utilised within clinical governance.

Note was made that records of incidents are recorded. Audits presented to the inspector included the numbers of incidents per month. There was no analysis/audit of the incidents currently taking place to identify patterns/trends and learning outcomes".

8.170 There appears likewise to have been no clear structure for conducting regular or effective staff appraisals. DR2 told us that there was in place a system of Independent Professional Review. He said that the person conducting the review would identify the subject's training needs and communicate those needs to the training officer, who would then either provide the training herself, or arrange external tutors.

8.171 However, as noted above, the only appraisal of W4's performance was conducted after the homicide. Equally importantly, neither W4 nor W10, whose training had been in learning disability, had the expertise effectively to appraise the nursing staff they were managing. As far as we know, neither was provided with any training as to how to conduct appraisals. There could, in these circumstances, be no effective system of staff appraisals, a fact confirmed by the HC report provided after the visit in August 2004 which recorded:

"There was no evidence provided that staff were undertaking continuing professional development; or that staff were having appraisals to identify their training/educational needs."

8.172 We think it inevitable that these failures contributed significantly to the systemic problems at Shrewsbury Court.

Nursing Staff

8.173 Before the homicide in December 2004 the nursing staff at Shrewsbury Court were working a three shift system. The early shift was in theory staffed by four trained nurses and four health-care assistants, and the late shift by three trained nurses and four health-care assistants. The night-shift was staffed by two trained nurses and two health-care assistants.

8.174 DR2 provided us with staff records which showed that the position on 12 December 2004 was that, in addition to W4 and W10, there were a total of 14 Registered Nurses working at Shrewsbury Court, together with 25 care assistants. Of the 14 nurses, eight were qualified as RMNs, four as RNLDs and two as RGNs.

8.175 Although we perused the notes of just two of the 35 or so patients at Shrewsbury Court, the clear impression we formed, even from this relatively limited evidence, is that the quality of nursing at Shrewsbury Court in the period prior to the homicide was not high.

8.176 The remuneration for nursing staff at Shrewsbury Court was not generous, and the terms and conditions of employment there were poor. According to W8, when he was appointed in 2005, the position was that night duty for nurses did not attract any additional payment, and the only "unsocial hours" payments were for working at weekends and over Christmas. Qualified nurses were getting 25 days annual leave, including bank holidays, and there was no provision for sickness pay. There was no company pension scheme. Support workers were only getting 20 days annual leave, including bank holidays. Such terms were unlikely, we think, to attract good quality nursing staff.

8.177 Concerns were expressed in the evidence to us about the quality of the nursing staff. CONS4 described some as *"poor"*, with *"the good staff being overloaded and having to do most of the work."* When asked how it felt when he conducted a ward round, CONS4 replied that by 2004 *"it was beginning to become a bit uncomfortable",* because the information and input from other team members *"did not seem to be of a reasonable quality."* CONS4 said he had discussed this several times with DR2, and also with W1 and W4, saying that Shrewsbury Court needed to recruit some good staff. He said that DR2's response was that they had been advertising and were actively trying to recruit, but even if this was so, the terms and conditions on offer were not attractive, and it is unsurprising that concerns about the quality of staff persisted.

8.178 We heard other evidence about the quality of nursing care. W3 said:

"How would I describe it? Them and us. A certain fear at times from staff towards the patients, and that in turn would create a distance".

He thought there was a lack of interaction between staff and patients and described to us a specific occasion which he considered indicative of the problem:

"I remember a patient who was sexually disinhibited, and there was a rush to get him into a room for privacy. It was done in an appropriate way, but the language used, there was no understanding of mental illness at times. The language used, for example, was, 'You know you shouldn't be doing that.' Someone who is mentally ill doesn't know these things, so there was a lack of understanding, a lack of empathy, a lack of all the properties of a therapeutic relationship at times."

8.179 One other factor which must have affected the effectiveness of the nursing staff was that many of the nurses employed there were not RMNs but were RNLDs - trained in learning disability; or even RGNs – nurses with training in physical, but not mental health, nursing. The quality of observations recorded in the nursing notes was poor. There was, for example, a tendency to record what the patient had reported about how he/she was feeling but without any comment by the nurse upon whether there was objective evidence supporting that report, and without an attempt being made to form an objective assessment of the patient's mental state. When W3 was asked about the quality of information which he received from nursing staff about those patients who he was seeing,

he told us that he would generally be given information about how patients behaved on the unit - whether, for example, there had been any inappropriate behaviour - but that information about their mental states was rarely forthcoming. A nurse trained as an RMN ought to be able to provide that sort of information, and we think it likely that shortcomings of this nature were largely a consequence of the fact that many of the staff were not RMNs, and had not, accordingly, been trained to make these sorts of observations.

8.180 It is not clear to us what policies were, as a matter of practice, in place at Shrewsbury Court with regard to observations on patients. We note that, in its report of February 2003, the NCSC recorded:

"There is a general observation policy for all patients that makes reference to observation at levels 1 to 5 and there is a separate policy detailing these levels. The observation form including details of the meaning of each level. There is no written information on the length of time a member of staff spends on each period of observation or the breaks."

However, we found very few references, in all of the nursing notes which we have examined, going back to 2000 in the case of AT, to the numerical categorisation of the level of observation being maintained at any given time. If there was, as the NCSC report indicated, a written policy which specified five different levels of observation, there is no evidence at all that nursing staff were regularly applying that policy.

8.181 Both W4 and W10 - who were, in effect, the management team for Shrewsbury Court during the period immediately prior to AT's death - were RNLDs. It was unrealistic to expect them, as nurses trained in learning disabilities, effectively to manage a unit providing care to mental health patients, particularly a unit where there were patients with complex and diverse needs. The management of such a unit involves, amongst other things, giving guidance to the nursing staff and ensuring that the care being provided is of an appropriate quality, and we consider that that role could only sensibly be filled by someone with training in nursing the mentally ill.

8.182 The lack of RMNs meant that there would, on occasion, be no RMN at all on duty. Because neither W4 nor W10 was trained as an RMN, shifts would regularly be led by a

nurse without a training in mental health. Our view is that that was an unacceptable state of affairs in a mental health hospital.

8.183 A further consequence of the lack of RMNs at Shrewsbury Court was that a patient's Named Nurse might have no mental health training. By way of example, the Named Nurse for AT in the period immediately prior to her death was W7. She had been trained as a general nurse in Pakistan, and had gone to Shrewsbury Court for adaptation training. She found working with mental patients interesting and challenging, and she asked DR2 to let her work at Shrewsbury Court and gain more experience in mental health. She obtained her qualification as a RGN in July 2004, and, after a month or so, was appointed as the Named Nurse for four patients. AT was added to her list of allocated patients in October 2004. W7 had had no training in the CPA – she told us that she did not even know what the initials stood for - but at Shrewsbury Court it was the Named Nurse who was supposed to be responsible for arranging CPA meetings. It was wholly unacceptable for the Named Nurse to a patient in a mental health hospital to be a nurse with no specific mental health qualification or training.

8.184 We recognise that there is a national shortage of RMNs. DR2 told us that he appreciated that employing RMNs would have been preferable, but that recruitment had been difficult. We think this may well have been one of the consequences of the unattractive terms and conditions being offered to nursing staff, although we comment that W8, who was appointed as Registered Manager in 2005, told us that had managed to ensure that all qualified staff working at Shrewsbury Court were qualified as RMNs. We do accept, however, that hospitals in the independent sector can have difficulty in attracting qualified nurses unless the remuneration package is sufficiently generous to match the collateral benefits of working for the NHS. It is essential that those responsible for commissioning services from the independent sector are alert to the possibility of potential weaknesses in this area. Some insight into the quality, and qualifications, of nursing staff at a particular establishment can be derived from the reports generated by the regulatory authorities. However, as explained elsewhere in this Report, there are serious limitations upon the extent to which such reports can be relied upon - the HC simply does not have the resources to "drill down" into this level of detail.

8.185 Consideration must therefore be given by those commissioning services to ways in which they can ensure:

- That they are as fully informed about these issues as it is possible to be.
- That any independent hospital being used to provide care to the mentally ill has an obligation to maintain certain standards.
- That systems exist to ensure that any such obligation can be effectively monitored.

Our view is that this is something which can, at least to some extent, be achieved by incorporating within the formal contracts between commissioners and hospitals in the independent sector specific, tangible, standards which can be monitored by or on behalf of the commissioners.

8.186 It is our recommendation therefore that those responsible for commissioning services from the independent sector should consider adopting significantly more detailed contracts with the hospitals with which they contract, with a view to imposing specific contractual obligations with regard to specific aspects of the service being provided, and with consideration also being given to the imposition of proportionate financial penalties in the event of non-compliance.

8.187 The nature and extent of any such contractual obligation would be a matter for commissioners to consider, if necessary on a case-by-case basis, but by way of illustration, a PCT might, in its capacity as the commissioner of services from an independent mental health hospital, consider imposing some or all of the following types of obligation:

- That the RMO who is to take over the care of a patient will attend the discharge meeting; and will thereafter see the patient in question a specified number of times each week or month.
- That all (or, perhaps, a specified percentage of) nursing staff should be qualified as RMNs; and/or that shifts are invariably led by an RMN; and/or that the patient's Named Nurse must be an RMN.
- That staff:patient ratios should never fall below a specified level.
- That all qualified staff employed by the service provider receive validated / accredited training in areas such as risk assessment; CPA/Care Coordination; Clinical Policies and Procedures; Management of Actual or Potential Aggression (MAPA); with regular, mandatory, up-dates or refresher courses.

- That systems are in place to ensure that all staff are aware of all clinical policies and procedures, and that records evidencing compliance with this obligation should be kept and be available for inspection.
- That staff from various specified disciplines will produce written reports for all CPA meetings which take place for the patient in question.
- That there should be appropriate segregation of the sexes.
- That any serious untoward incident which occurs in relation to the patient in question would be reported to the placing authority, together with a copy of the internal Incident Report.
- That the service provider will comply with all local multi-agency procedures in relation to the protection of vulnerable adults.
- Importantly, that the purchasing authority should be entitled to carry out spot checks, without notice, and should have an entitlement to inspect such documentation as might be necessary to confirm compliance with the terms of the contract.

8.188 Consideration could also be given to imposing contractual obligations relating to the continuing training of consultant staff. Within the NHS, consultant psychiatrists are now subject to three processes which aim to make sure that their working practices are of a satisfactory standard. The first is annual job planning, in which the consultant discusses with his director his current activities during the sessions of his week and plans his timetable for the next year, taking into account workloads and personal professional development. The second process is a formal system of appraisal, in which the consultant is required to complete a detailed *pro forma* about his/her performance, submitting written evidence of satisfactory standards having been reached, wherever this is possible. This is then formally discussed with his manager and signed off. Consultants are encouraged to undergo "360 degree appraisal", in which the views of their patients, nursing staff, and administrative staff are actively sought. The third process is that of continuing professional development (or 'CPD'). Consultants are required, as part of their appraisal progress, to show that they have engaged in adequate CPD in the past year. Consultants are encouraged to form 'CPD groups' with their colleagues to provide both peer support and a monitoring function. The purpose of CPD, of course, is to ensure that consultants keep up-to-date with developments in the field (including, inevitably, risk assessment). It is clear that no such structures were in place at Shrewsbury Court. We do not know to what extent this may be an issue at other independent mental health hospitals, but we suggest that consideration could also be given by those

commissioning/purchasing services from the independent sector to imposing contractual obligations designed to ensure that structures designed to achieve the same goals do exist within the independent sector.

8.189 We also consider that express agreement upon some form of financial penalty in the event of non-compliance by a service provider with the types of obligation identified above would provide a direct commercial incentive for the hospital concerned not to "cut any corners".

8.190 It is, of course, to be hoped that the sorts of contractual requirements outlined above, and discussed in other contexts in other parts of this Report, would be superfluous because a properly run independent mental health hospital would regard it as entirely obvious that such requirements should be met. But the most important message to be derived from this Report is that it is vital that those commissioning services from the independent sector do not take anything for granted; and do not assume that an independent hospital is providing an acceptable level of care, just because it continues to be registered by the HC. Furthermore, it is our view that the introduction of such contractual requirements by commissioning authorities could be used as a means of driving up standards in a way which is not dependent upon the over-stretched resources of the regulatory bodies which presently have the primary responsibility for maintaining standards in the independent sector.

Education, Training and Continuing Professional Development

8.191 There was, so far as we could tell, no identified training plan for Shrewsbury Court staff which was specific to mental health. At the times material to this Inquiry, there was a training officer employed, W16. She gave evidence to us. She is an RGN with the additional qualifications of a BSc in Health Studies, a diploma in nursing and a diploma in teaching. Much of her career was spent in intensive care units, followed by a teaching post at the University of Surrey. She started at Whitepost in September 2001 and left in September 2004. Her successor was W18, who was appointed on 1 December 2004, and left on 1 March 2005. We did not interview him but according to DR2, he is qualified both as an RGN and as an RMN.

8.192 According to W16, the main focus of her work was with students undergoing adaptation training at Whitepost. Her job was to decide whether they were competent to practice. She was clear in her evidence that she was not employed to do any mental health training at Shrewsbury Court, for the very good reason that she was not herself mental health trained. She did tell us that Whitepost also engaged C12, who was mental health trained, to do some teaching to Shrewsbury Court staff. DR2 told us that W16, like her predecessors had authority to bring in external tutors to provide training if she deemed that to be necessary.

8.193 W16's evidence to us was that she had no budget for training. She attended meetings to discuss training issues, which she said were initially held about every six weeks, but which then, she said, just petered out. She told us that she did not believe that any such meetings had occurred in her last 18 months at Whitepost.

8.194 Very oddly, DR2 told us he believed W16 was trained in mental health; and that he regarded W16 as responsible for assessing W4's training needs, in his role as Acting Manager. We find it difficult to see how this could have been considered appropriate, given that she did not have mental health training herself - or even learning disability training, as W4 did.

8.195 This evidence indicated to us a lack of clarity about responsibilities for assessing the training needs of staff, for organising training and for providing and paying for it. Although DR2 maintained that, by employing W16 to assess training needs and organise training, he had made appropriate provision for training at Shrewsbury Court, our view is that W16 did not have the qualifications or experience to assess, let alone to meet, the training needs of staff at a mental health hospital. If DR2 was right in telling us that her responsibilities did extend this far, she should never have been considered the appropriate person for the job. Notwithstanding DR2's evidence, however, our view is that W16 did not assume any responsibility for training on mental health issues, and that she would not have led anyone to believe that she would be willing to assume such a responsibility. Her evidence about this issue was credible and we think her role was probably a more limited one than was suggested by DR2. We do not consider that she can be held responsible for the deficiencies in training staff at Shrewsbury Court in mental health issues.

8.196 W1's evidence to the Inquiry was that he considered training at Shrewsbury Court to be a *"major issue"* and that he thought the problem was DR2's unwillingness to fund the training which he, W1, thought necessary. He said:

"The issues would tend to raise their ugly head during the monthly heads of department meeting and everyone vied for a piece of the cake, so everyone would try to shout louder than the next person to get what they wanted, and training to some extent took a back seat."

W1 told us that no formal courses were arranged to train nurses in carrying out risk assessments. When asked how staff would know how to complete the standard "tick box" type of risk assessment form which was in use at Shrewsbury Court at the material times, he replied that this was achieved with some training provided by himself and CONS4. When asked what training he personally had had in risk assessment, he replied: *"It was down to my experience."*

8.197 DR2's evidence to us about these issues was very different. He said:

"We never refused any request coming from any of our managers for any costs that were required to implement change. … Our principle has always been that whatever needs to be done has to be paid for and there are no upper limits with regard to that. What we are saying is there was no specific budget that we assigned for change. Whatever was required in terms of environment, in terms of staffing, in terms of training, was provided."

8.198 It is, however, difficult to reconcile this with the evidence we heard from other witnesses. The body of evidence we heard about budgetary constraints at Shrewsbury Court, in the period before this homicide, was substantial.

8.199 W1's evidence about risk assessment training highlights an important aspect of the problems up to 2004. Primary responsibility for training nursing staff on a crucial aspect of the service being provided - the carrying out of risk assessments on the mentally ill patients - was provided in an *ad hoc* way by W1, who whilst an experienced nurse, and an

RMN, had never worked with the mentally ill as a qualified nurse until he came to Shrewsbury Court. We consider it wholly unsatisfactory that training on risk assessment was provided by somebody whose qualification as an RMN had been acquired in the 1960s and who had not since that time worked in a unit providing care to the mentally ill. This meant that the training, such as it was, was being provided by somebody lacking "hands-on experience", and who was unlikely to be up-to-date with developments in the field over the past 30 or so years.

8.200 W3 described similar difficulties in the organisation and delivery of courses which he felt were essential for staff to equip them with the necessary skills to care for the client group at Shrewsbury Court. He told us he had developed various training programmes because he was concerned about the quality of staff, but that they were never implemented because of cost considerations (providing the training would have meant engaging W3 for a further session) and because of a lack of staff commitment. W3 told us that he had discussed his concerns about training with DR2 on a couple of occasions, but that (in contrast to the present position), there was, prior to the homicide, no formal forum for discussion about such concerns.

8.201 It is relevant in this context to note that, in the NCSC report from February 2003, it was commented that the Registered Manager, W1, had expressed the view that staff were still in the *"process of development"* in terms of training. It is recorded that W1 had said that most training had been in-house and that staff were from a variety of different nationalities and needed help developing a common standard. This looks to us like an acknowledgement by W1 that there were shortcomings in the training. The inspectors noted that no training had yet been held on the National Service Framework for Mental Health. W1 is recorded as having told the inspectors that staff had received training in risk assessment, but the inspectors noted that no documentary evidence was available to substantiate this. They also noted that there was a full-time training co-ordinator, but commented that there was no documentation recording the training which had actually been undertaken by staff.

Staffing Levels

8.202 A number of witnesses to the Inquiry referred to concerns about staffing levels at Shrewsbury Court. Although it is right to record that these concerns were rejected by DR2, and that we did not undertake any detailed investigation into the issue, the frequency with which this issue came up in the evidence does suggest that others did consider this to be a problem.

8.203 W1, the Registered Manager until 2004, told us:

"Staffing levels have always been the main issue - I said it then and I'll say it now - ... in private homes or hospitals, money is the thing that counts. I had an uphill battle - and I'm sure W17 before me had the same thing."

[The reference here to W17 was a reference to W17, the Manager of Shrewsbury Court before W1.] W1 went on to ascribe the problems with recruitment to the pay being offered, as well as to the fact that the number of staff on the ward, proportionate to the number of patients, was not attractive to potential employees either. He said he had had several discussions with both DR2 and W15 about these issues. He said that he understood that the East Surrey Health Authority had agreed the staffing levels, but he felt that the numbers agreed were insufficient to manage the type of patients at Shrewsbury Court. He described the response of DR2 and W15 as being to the effect that it was a matter of money and that the unit was not making enough money.

8.204 When asked if he, as Registered Manager, had the authority to get in additional staff if he felt, on clinical grounds, that this was needed (to provide, for example, for one-to-one observations), W1 replied that he had to get clearance from W15. When asked if obtaining that clearance was a formality, he replied that there was usually something of a debate with W15, and that she might, for example, suggest waiting to the following day, or ask whether W1 had discussed the position with CONS4. He did add, however, that it was relatively rare for extra staff to be sought in this way.

8.205 W4's evidence about this issue was that, if there was a need to have one-to-one observations, the issue would be run past DR2 who would ask social services to pay for the

extra member of staff. When asked about situations where it was deemed necessary to start one-to-one observations at short notice, before it was possible for get clearance from social services, W4 said he would try and find additional staff, and his evidence was that DR2 was always willing to agree to extra staff in these circumstances.

8.206 W1's evidence about the occasional difficulties in getting additional staff in at short notice if and when a particular need, such as a need for one-to-one observations arose, were confirmed, and indeed significantly amplified by some of the nurses who gave evidence to us. W19, an RNLD who regularly worked as a shift leader, told us there were times when he thought they needed extra staff but he had not been allowed to get in additional nurses. He said that, on occasion, it was DR2 himself who questioned whether extra staff were needed. C7, another RNLD, told us that when he requested extra staff, the management would often turn him down. He too said that it was sometimes DR2 himself who turned down the request. W10 told us that permission was needed from those in 'authority' to bring in extra staff - and she said she had to get the go-ahead from DR2.

8.207 DR2 did not accept this. He was adamant that he had no clinical input at all at Shrewsbury Court. In relation to staffing levels, he said:

"We had agreed the staffing levels with the health authority. That was some time ago. Thereafter, there was never a situation where we, or I personally, ever refused a request for staff when it was asked of me, by my managers. The staffing level was enhanced as the number of people, or their needs, became such that they wanted a member of staff. I personally always said to my managers that, whatever staff numbers they wanted, we would provide."

DR2 was told that this was not consistent with what had been said by other witnesses who had given evidence, and he suggested that each such witnesses had reasons for presenting an unfavourable or distorted account of events, saying:

8.208 *"A lot of the people who are the current witnesses unfortunately had to be made redundant for various reasons and whatever."*

8.209 It is not possible for us to determine precisely where the truth lies in these conflicting accounts - and we did not hear any evidence from, for example, W15 - but, as

recorded above, there were several witnesses who, independently, described DR2's involvement, from time to time, in rejecting requests for additional staff.

8.210 It is relevant here to note that the NCSC report for February 2003 noted that Shrewsbury Court met Standard M5 (which relates, amongst other things, to staffing levels) with a staff:patient ratio of 4:1 on the main unit. No doubt this observation, and similar comments in later reports, reassured DR2 that staffing levels at Shrewsbury Court were adequate. However, the inspectors would not be in a position, following their relatively brief visits to Shrewsbury Court, to form any definitive view about staffing levels and whether the needs of individual patients justified a higher staffing ratio. If DR2 did take the NCSC comments as confirmation that staffing levels at Shrewsbury Court were adequate, and that any concerns expressed by the Registered Manager, or other staff, about those levels could, therefore, be disregarded, that was a serious misinterpretation of the role of the NCSC inspectors.

8.211 It is also relevant to note that staffing levels were also raised at the Adult Protection Inter-agency Planning Meeting held on 8 October 2004 after a series of violent incidents at Shrewsbury Court. The recommendations made included the following.

"The level of staffing on the afternoon/evening shift needs review. Presently there are three qualified workers and four health care assistants. In the evening, tea for the patients has to be served and cleared away and medication administered. The patients disperse widely and there is insufficient staff to adequately supervise all the patients indicating the need for additional staff support. Action: [W4]"

8.212 The follow-up meeting on 30 November 2004 was told that W4 had spoken to DR2 who had said he was happy with the present staffing levels and that the HC was also satisfied with the staff:patient ratio. However, DR2, through W4, expressed a willingness to co-operate if the meeting deemed additional staffing necessary. The minutes record that concern was expressed about the number of incidents and it was suggested that the needs of patients, rather than numerical ratios, should be the determining factor in deciding staffing levels.

8.213 These discussions were overtaken by events and the drastic changes effected following the homicide, but the observation that there may have been a focus by the management at Shrewsbury Court upon staff:patient ratios, rather than upon a properly informed assessment of the needs of patients seems to us to have been a pertinent one. It would certainly be a cause for concern if decisions over clinical issues, such as, for example, initiating one-to-one observations were being determined by a non-clinician. Whilst we accept that the financial implications of increasing staffing levels can be a legitimate consideration, patient care and safety (and that of the staff) should have been considered of paramount importance.

8.214 Overall, the evidence which we heard suggested that the nursing staff at Shrewsbury Court were poorly paid, poorly trained and, in a number of respects, poorly led. The absence of appropriate induction and training programmes, the absence of a proper clinical governance framework, and the weaknesses in nursing leadership, compounded the problems which flowed from the difficulties in attracting good quality nursing staff to Shrewsbury Court, when the terms and conditions being offered there were uncompetitive. Our view is that the quality of nursing staff at Shrewsbury Court was a significant factor in the events which led up to this homicide, and we now go on to discuss a number of specific areas of direct relevance to the events prior to AT's death.

Risk Assessments/Care Plans

8.215 The process by which risk assessments at Shrewsbury Court were carried out in the period prior to the homicide has been a major cause of concern for us. DR2 provided us with a document from 1999 entitled "Risk Management Programme" as evidence that there did exist, at all material times, an appropriate written policy with regard to risk assessment. However, whatever written polices were in place, the evidence we have heard, and the documentation which we have seen has led us to conclude that the risk assessment process prior to the homicide was crude, was not appropriately evidence-based, and was undertaken, not as a multi-disciplinary task, but by individual nurses who lacked the appropriate training.

8.216 Risk assessment is an essential part of the CPA and the business of every mental health practitioner. It involves a detailed consideration of historical information, clinical items and current contextual factors. This must be structured and contain data that has been demonstrated by research to be associated with increased risk. A summary of these issues is given in the 2007 document, entitled "Best Practice in Managing Risk".[1]

8.217 This Report is not the place to write at length about the theory and nature of risk assessment. If more information is needed, a comprehensive and readable account of this area is found in W21 Maden's book "Treating violence: a guide to risk management in mental health" (2007: Oxford University Press).

8.218 In order to carry out a risk assessment, a detailed knowledge of the patient's case is necessary. Risk assessment is a time-consuming process which can only be carried out by those who have been trained in the application of whichever risk assessment 'tool' a service has chosen to use. It will involve detailed consideration of background records, consultation with other members of the multi-disciplinary team and examination of the patient. 'Brief' risk assessments may be carried out to establish whether a fuller assessment is needed, particularly in general psychiatry. Risk assessment does not otherwise lend itself to short-cuts.

8.219 We described in the chronology of events how risk assessment at Shrewsbury Court was, to a large extent, a "tick-box" exercise using a form entitled "Risk Assessment Score Sheet". This listed 15 areas of possible risk namely:

- Risk of self-injurious behaviour;
- Violence towards family other residents, staff;
- Violence towards members of the public;
- Use of dangerous weapons;
- Sexually inappropriate behaviour;
- Arson and/or fire;
- Damage to property;
- Risk of drinking or drug taking e.g. substance abuse;
- Problem with absenting e.g. AWOL, wandering;
- Vulnerability of exploitation *[sic]* e.g. sexual financial;

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511

- Risk of exploitation, e.g. sexual financial;
- Risk of self-neglect;
- Problems with not taking prescribed medication;
- Risk to children;
- Risk associated with activities of daily living;
- Risk to physical health.

8.220 The score sheet invited the person completing it to record the scale of possible risk on a scale of 0-4, by ticking one of two boxes next to each item. The first box was labelled 0-2, and the second 3-4. An accompanying set of definitions entitled "Risk Assessment Rating Scale" was appended to the score sheet. This is reproduced below:

Score	Rating	Meaning	Definitions
0	Very low	Little predisposition	Evidence of likely occurrence is minimal/limited. *Action* – Preventative. Review 6/12
1	Low	Some predisposition	Some evidence of likely occurrence if not regularly monitored. *Action* – Monthly monitoring. Preventative. Review of risk 3/12.
2	Medium/Moderate	Fair predisposition	Chance/likelihood of occurrence if not actively acted upon. *Action* – Planned treatment and/or preventative medical/nursing action. Review of risk 3/12
3	High	Possible predisposition	Evidence indicates most likelihood of occurrence

			in the short term. *Action* – Planned. Nursing/medical intervention. Review 1/12.
4	Very high	Definite predisposition	Evidence of occurrence exists now or the probability of it at any time. *Action* – Planned intervention. Review 1/12.

Instructions

Any scores reflecting 3 or 4 points must be actioned immediately and reviewed as stipulated.

8.221 This "Risk Assessment Score Sheet" is not a risk assessment in itself but a scoring sheet for a risk assessment. From the manner in which it was completed by staff at Shrewsbury Court, however, it is evident that it was seen as a risk assessment in itself, which was completed by ticking the boxes. There is no evidence that any true form of risk assessment was ever conducted on AT or RR to be summarised on this score sheet. Staff who completed this type of form told us that they had little instruction and sometimes simply copied the previous form. It seems that the process of "doing a risk assessment" meant ticking boxes on the form and little else.

8.222 The document entitled "Risk Assessment Rating Scale" is an extraordinary document, in terms both of the odd concepts and inherent contradictions that it contains. For instance, the column entitled "Meaning" concerns what is termed "pre-disposition", which is only one element of the risk picture. The pairings between "ratings" and "pre-dispositions" and between "predisposition and "definitions" are difficult to understand. For instance, a "possible predisposition" is equated with a "high" risk and also with "most likelihood of occurrence in the short term". The "definitions" column gives instructions for when the next review should take place. For "very high" risk, it is stated that a further review should take place in one month. However, where risk is present, its monitoring

should be a continuous process. It is difficult to know to what the "review" is meant to relate, other than to an instruction to complete the tick-box score sheet again at a stated interval.

8.223 The evidence we heard showed that, in the period prior to the homicide, the task of completing these so called "risk assessments" was allocated to nursing staff who had little or no training in risk assessment. It appears never to have been a multi-disciplinary process following a full assessment of an individual, including his/her past history. By way of example, as we record later in this Report, AT's previous history and previous risk assessments appear to have been completely overlooked. Trigger factors relevant to RR's condition were not identified appropriately. There were no formal multi-disciplinary meetings to discuss an individual's care and treatment (other than the infrequent CPA meetings, which we discuss below). There was, accordingly, no forum where an individual patient's risk assessment would normally and regularly be discussed, reviewed and updated. There was no system to ensure all staff had appropriate and accurate information or a quality risk assessment document to assist them in the process of assessing a patient's risk and completing this somewhat crude form. Risk "scores" did not appear to relate to what was recorded in the clinical notes or to what had occurred in the course of the CPA process. The completion of this "Risk Assessment Score Sheet" seems to have been an entirely self-standing exercise that was not informed by, and did not complement, other aspects of the care being provided.

8.224 Furthermore, it does not appear to have been anyone's formal responsibility to ensure that individualised risk assessments and management plans were carried out routinely and consistently. Although the standard form documents in use indicated that subsequent assessments were to be carried out at three or six monthly intervals thereafter (depending on the nature and extent of the risks identified), this did not occur, at least as far as AT was concerned.

8.225 It is self-evident that risks will vary with time, context and intervention. It appears, however, from the evidence we heard, that staff at Shrewsbury Court did not treat risk assessment as a fluid process. Whilst that evidence was presented in the context of two specific patients, it disclosed systemic failures which extended beyond those two individuals.

8.226 When we asked W8, who was at the time when we were hearing evidence the Registered Manager of Shrewsbury Court, about the risk assessments being carried out there when he arrived in 2005, he said:
"I don't think there were any real formal risk assessments being done. It was very much a circled box which was done by a nurse and the RMO. I don't think there was any real clinical input. There was no multi-disciplinary team-working where everybody sat down and discussed the risk. They were sometimes doing three CPAs in one day and to me that's not appropriate. That's not enough time to be able to sit down and plan someone's care and do risk assessments and have a professional conversation about this patient's clinical needs."

8.227 W4 acknowledged that the risk assessment form being used in the period prior to the homicide was not a good format. When asked if he felt ticking a few boxes on a list could be justifiably called a risk assessment, his response was *"no, not at all"*. We asked him what sort of care plans would be in place to try to protect somebody like AT, who was assessed as being sexually vulnerable. He replied:

"Without looking at her risk assessment, I doubt that was even addressed on her risk assessment. I would imagine we just had a standard risk assessment which you have probably seen. It is a tick exercise, if they have a drug habit, tick, are they sexually vulnerable, tick, that is as far as it goes. It wasn't a particularly good one."

8.228 He said risk assessment was considered a nursing task, and when we asked if other disciplines were involved in the process, he replied:

"That practice only happened after AT died. The risk assessment process was stepped up and there was more multi-disciplinary involvement within the process, but prior to that it was just a nurse ticking it".

He agreed that ticking a form could not justifiably be called a risk assessment. He said that he knew now that *"there are much better forms out there"*.

8.229 We considered this evidence to be a telling and concerning insight into his weaknesses as Acting Manager of Shrewsbury Court. Even though he formed the view, correctly, that a crucially important process such as risk assessment was being carried out in an inadequate way, he did not take steps to remedy the situation.

8.230 Furthermore, from the limited number of such assessments that we have seen - in the records relating to RR and AT - it appears that the standard form score sheet was often not appropriately completed, with staff often only identifying the relevant "bracket" - i.e. "0-2" or "3-4" - rather than specifying where, within that bracket, the perceived risk lay. An examination of AT's records shows that changes in the assessment (i.e. a decision to tick a different box indicating a different level of risk on a particular question) did not appear to be evidence-based - or at least the evidence was not properly documented. When, for example, there were changes in AT's risk assessment, it was often not possible to tell from her nursing or clinical records what had caused the change in the perception of that aspect of risk.

8.231 The HC report in January 2005 showed that these failures were widespread. The inspectors reviewed a *"selection"* of patient care records and stated:

"These were sparse in content and did not reflect the interventions by staff. There was no assessment in any of the care records reviewed of an assessment of the patient's mental health. Not all entries identified the designation of the signatory. It was not clear from the care records seen if they had been reviewed by staff that work at Shrewsbury Court or at the nearby Elms Care Home."

The report continued:

"Following [AT's homicide], full risk assessments have been completed on all patients. The inspector saw a file containing copies of all risk assessments completed recently. The risk assessment tool used is called CARDS - Clinical Assessment of Risk Decision Support - this form is originally designed as a template for completion on computer. It is currently being completed by hand. This has meant that information recorded in boxes such as the nature and degree of risk and previous interventions and lessons to learn is limited by space. There is no allowance for the need to add information that may be more than the box will allow.

There is not a contingency plan identified in the event of deterioration or periods of increased risk.

There is however a risk management plan, although this has not been completed adequately to cover a contingency plan."

8.232 More worryingly still, it appears that staff gave or received no training or guidance in completing a full risk assessment. When we asked W8 about staff training in risk assessment, he replied:

"They didn't tell me they had received any, and from the way I saw things happen I would say they had very little training in risk assessment."

8.233 We also asked W4 about training in risk assessments. The full exchange is worth recording:

"Q. What training has staff had in carrying out risk assessments?

A. Probably none.

Q. Have you had any?

A. No.

Q. Is any offered to staff who are new starters or is there an ongoing training programme?

B. Well I would say 'no', unless you can prove me wrong, but I don't recall any training given of that nature.

Q. Is anybody trained in the CPA process and the risk assessment as part of that?

C. *Again I think not."*

8.234 W1, the Registered Manager until 2004, said:

"That was indeed a major issue. Training itself was a major issue because training takes a large chunk of anyone's budget. The risk assessment management and that sort of thing was largely down to me and to a lesser degree CONS4 who was consultant".

CONS4, however, denied any involvement in any training programmes arranged at Shrewsbury Court.

8.235 We interviewed a limited number of the nursing staff working at Shrewsbury Court in 2004 for the reasons explained in 3.6. However, their evidence caused us to have grave concerns about whether risk assessments could possibly have been carried out properly at Shrewsbury Court at that time.

8.236 W7, who was AT's Named Nurse for a short period immediately prior to the homicide, told us that she was expected to do a risk assessment for each of the patients for whom she was Named Nurse. When we asked what training she had had in carrying out risk assessments, she replied *"Nothing"*. When asked how she could, therefore, carry out the risk assessments which she was expected to carry out, she said:

"C7 was a nurse and when I was a student he told me a few things although not in detail. I also read in the notes what sort of risk assessment I would need to do. ... I did it on my own."

When we asked her how she would reformulate the action plan within the risk assessment, she replied that she would take this from the previous notes - an understandable answer given that she had no specific knowledge, training or expertise for carrying out a risk assessment and formulating an appropriate action plan.

8.237 When we asked W2, who was RR's Named Nurse, about training in risk assessment, he said that when W1 had been the Registered Manager, he had brought in people *"from outside"* to teach a risk assessment workshop. When asked how the risk assessment process worked, he said:

"... CONS4 will tell us to do a risk assessment of [a particular patient]. You sit down [with] the client and find out the causes and the outcome of the causes, and how it could be solved."

When we asked how the risk of violence was assessed he replied:

"Why is he in that mood, what causes it, the environment, things such as auditory hallucinations - you find out all of that and how you can solve it".

This indicated a very simplistic approach to an important and potentially complex aspect of his work as an RMN. He had a very limited view of what a comprehensive risk assessment entailed or what should be done with the information once the form was completed. There was no suggestion that assessments were carried out as part of a multi-disciplinary process.

We asked W19, one of the RNLDs at Shrewsbury Court, about the risk assessment process. He told us that he had had some risk assessment training which he thought was in-house, possibly lasting one day. In common with the other witnesses from whom we heard evidence, he did not suggest that carrying out a risk assessment was ever perceived as being a multi-disciplinary exercise.

Care Programme Approach

8.238 The CPA was introduced in 1991. It applies to all people with serious mental health problems who are accepted as patients of specialist mental health services. The CPA framework can be used in relation to aftercare which has to be provided in accordance with Section 117 of the Mental Health Act 1983, but the statutory health and social services agencies need specifically to ensure that their Section 117 duties are being fulfilled within any agreed CPA care plan.

8.239 The CPA process has four stages:

1. Systematic assessment of the person's health-care and social care needs.
2. Development of an agreed Care Plan.
3. Identifying a keyworker to be the main point of contact and to monitor the delivery of the care plan.
4. Regular review of the person's progress and care plan with agreed changes to the plan as appropriate.

8.240 DR2 told us that the CPA was adopted at Shrewsbury Court in November 1998. When considering the implementation of the CPA at Shrewsbury Court, we think it useful, once again, to start with the evidence of W8 and his observations when he first arrived at Shrewsbury Court in 2005. He said:

"I felt they didn't get very much training in relation to CPAs. For example, I said to staff when they were care co-ordinators that they had to start writing reports for CPAs, and a lot of them didn't even know how to sit down and start to write a report. So we had to sit down with everybody and train them in relation to the sort of things we were looking for in order for them to put in reports for them to present at CPAs. ... I don't think they really had any training in the whole CPA process and what it meant."

8.241 He confirmed that the Named Nurses, or care co-ordinators, for patients were not necessarily RMNs, but could well have been RNLDs - trained in learning disability, not mental health. This was plainly inappropriate, but it does perhaps make the failure properly to implement the CPA at Shrewsbury Court understandable.

8.242 We asked W8 if he had been able to form a view as to how regularly CPA meetings had being conducted for patients during the period before his arrival. He replied:

"It was very hard to look through patients' files, they were quite confusing. There were no multi-disciplinary notes and it was very hard to find what you were looking for. The CPAs did happen every six months but it really wasn't a CPA, it was just like another clinical team meeting. It was just a consultant and the nurse, sometimes the relatives were there and sometimes the social worker was there, but a lot of the time the care managers didn't come. Their reasons for that was that the invitation came too late or they only had 24 hours notice. I wouldn't say you could call it a CPA."

He added:

"In some of the notes I went through there was some CPA documentation, but it didn't tell you very much. When I checked some of them, they might have had a CPA six months or a year ago, and the CPA documentation would be completely the same, so the care

plan hadn't changed. It looked as if it had just been retyped and a different date put on, so it was hard to say if any real discussion went on."

8.243 W8 confirmed that responsibility for ensuring proper implementation of the CPA had, prior to his arrival at Shrewsbury Court, rested with W4. As recorded above, W4's evidence was that he did not think that staff at Shrewsbury Court were trained in the CPA process.

8.244 Our concerns about the implementation of the CPA were confirmed to some extent by the reports from the regulatory bodies. The MHA Commissioners who visited Shrewsbury Court on 18.2.03 reported that they *"continued"* to have concerns about the policies in place with regard to CPA reviews on detained patients at Shrewsbury Court. The HC report of February 2003 then stated:

"Following comments made by the MHA Commissioners at their last visit, the hospital has reviewed their CPA policy and procedures and are currently piloting the new system. The MHA Commissioners (at an inspection taking place at the same time as this inspection) found … that the CPA forms were missing from some patients' files but were of a good standard in others, and that the Section 117 form was also sometimes missing. CPA review meetings are set for every three months, but according to the Manager they are not consistently held."

8.245 More encouragingly, on a follow-up visit in July 2003 the HC noted that there was a clear written policy and procedures that implemented the requirements of the CPA. However, the implementation of these policies and procedures was not verified by the inspectors, by auditing individual patients' notes or otherwise, because of patient confidentiality issues, which the inspectors considered precluded them from examining individual patient records.

8.246 The MHA Commission's report following a visit on 27 February 2004 noted under the heading "Assessments":

"The standard of care plans seen was variable, in that some care plans were good and included physical as well as mental health needs/problems but other care plans did not reflect the care requirements or problems documented in the daily evaluations."

8.247 The HC report following the visit in August 2004 commented:

"Care Programme Approach

Although a detailed list of those patients' Care Programme Approach is maintained, there was evidence that some patients were not having reviews regularly."

8.248 It would seem that action was taken in response to this finding. According to the minutes of a clinical governance meeting on 23 November 2004, all CPAs were by then "up-to-date". However, the HC report following the January 2005 inspection noted the absence of a single, multi-disciplinary record and specified that all current, recent and relevant patient notes and information should be integrated into such a record. The commentary recorded that four patients' case notes had been reviewed. The inspectors noted that there was no evidence on file that patients had been involved in the care-planning process at all. The inspectors also commented that it was not always clear who had been invited and who had attended CPA meetings, and that whilst the CPA meetings invite/attendance list included the consultant, the patient, a nurse from Shrewsbury Court, and a social worker and/or CPN, there was no evidence of any other professionals, such as a psychologist, being invited to or attending the meetings. It was commented that the content of the CPA 'Needs' and 'Action Plan' tended merely to restate the patient's problems, rather than setting out goals and an action plan to achieve those goals.

8.249 We heard evidence from G1, currently the Regional Director with the MHA Commission covering London and the South East, who visited Shrewsbury Court in 2004, and from G2, who visited Shrewsbury Court in her capacity as an MHA Commissioner on 12 December 2004. They said that one of the detained patients had reported that staff had simply given him CPA documentation to sign, without involving him in the planning exercise at all - which was entirely inappropriate. When we asked if the Commissioners had found <u>any</u> files where they were satisfied that the appropriate CPA procedures had

been gone through, the response was that errors had been picked up on each file sampled - although it was emphasised that the sample was necessarily only a small one.

8.250 It is important to emphasise that the criticisms we make here of the risk assessment process are specific to the period before the homicide in December 2004. In 2005, W8 introduced an improved standard form. Arrangements have been put in place to ensure that staff receive appropriate training on risk assessment. The CPA and risk assessment process is now linked with the local Trust and seems more suitable for the client group at Shrewsbury Court.

Medication

8.251 We heard evidence of poor practice regarding patients' medication at Shrewsbury Court. We have specific and important concerns about the way in which medication for AT, and more particularly for RR, was administered during their time at Shrewsbury Court, but here we discuss more general issues.

8.252 Following their visit on 27 August 2003, the MHA Commissioners reported, as part of their overall conclusions:

"The system for prescribing and administering medication has weaknesses that leave it open to abuse."

The problem with prescribing medication was described as follows:

"It is the Commissioners' understanding that the RMO signs a prescription form (in triplicate). This is sent to the pharmacy which then types the prescription onto a medicine card, which is then returned to the ward. It is this medicine card that the nurses use to administer the medication. After one month, the nurses re-write the prescription, deleting any changes and send this to the doctor for his signature. The card is then sent to the pharmacy and the cycle continues. Apart from the obvious possibility of a transcription error, this system means that nurses are administering medication for which they have no doctor's signature."

The report identified examples of patients receiving medication using a medicine card which indicated neither when the medication was commenced, nor when it had been given to the patient.

8.253 Depot injections should be recorded on a MARS recording sheet signed by a doctor. All qualified nurses should follow the Nursing and Midwifery Council's "Guidelines for the Administration of Medicines" which state *"all medication prescription charts should be signed and dated by the authorised prescriber"*. It is also good practice to record the administration of depot injections in a ward or unit diary as a "double check". One would also expect the daily nursing notes to refer to the administration of a depot injection, with a record of the site of injection (e.g. left buttock). Depot prescriptions should also have a "next due" date to reduce the risk of a depot injection being missed. The nurse giving the injection should be the person who signs the prescription sheet and records it in the nursing notes. It should also be standard practice for the same person to record on the prescription sheet when the next injection is due and to make a note of that date in the ward diary/depot register.

8.254 At the time of the homicide, the MARS recording sheets at Shrewsbury Court were not being signed by a doctor. The minutes of the feedback discussions following the HC's unannounced inspection on 27 August 2004 show that the HC inspectors drew attention to this issue, and made it clear that this could not continue. DR2 provided an assurance that the matter would be attended to. However, if any steps were taken in this regard, they were ineffective. The MARS recording sheets for RR and AT for November and December 2004 (up until the homicide) do not have a doctor's signature.

8.255 Furthermore, nurses' signatures or initials on these MARS recording sheets are often illegible. Some entries on the form are not dated, and some sheets have no start date. There was nowhere on the MARS sheet being used at Shrewsbury Court to record the date when the next injection was due, and it was not accordingly recorded there. DR2 told us that a depot register was in use before the homicide but unfortunately no copy of this document could be found. CONS4 told us that he did not know of such a register, but he confirmed that there was a list of patients on depot.

8.256 It was not standard practice for nurses routinely to record in the nursing notes that a patient had been given a depot injection or when it was next due. We found no record of the site of injections in any of the nursing notes produced to us.

8.257 C7 told us that, when medication cards were full, they were re-printed from the pharmacy, not rewritten by a doctor. When we asked him to confirm that nurses were therefore administering medicines from a drug card that was not signed by a doctor, he said *"that was the norm"*. He confirmed that the local GP would visit Shrewsbury Court once a week and fill out a FW80 (prescription) and that would then be dispensed by a pharmacy in Reigate.

8.258 If the system at Shrewsbury Court did indeed allow nurses to administer medication from a drug sheet which had not been signed by a doctor, that was wholly inappropriate.

8.259 The deficiencies in record keeping make it very difficult to tell, in the case of AT and RR, whether the correct depot injection was always given on the appropriate date. As we explain elsewhere, we have very real concerns that RR's depot injection may have been missed in the days immediately before the homicide.

8.260 The HC also recorded concerns about the management of medication. Following the inspection in January 2005 it said:
"The medicines management policy had been updated in September 2004. It provided written policies on ordering, prescribing, receipt, storage, administration, including rapid tranquillisation, and disposal.

The policy on ordering continued to refer to the 'MARS Sheet' as the drug record for each patient.

The policy on prescribing made no reference to, or provided any procedure for, prescribing but referred to administration and verbal orders. There was a policy on the management of drug errors, but no errors had been reported. An inspection of six patients' notes and MARS Sheet indicated serious errors and omissions related to medicines administration, none of which had been recognised or reported by any member of the nursing or medical staff. Depot injections were managed using a separate form identified as 'Depot Medication'. An examination of four forms showed that staff were

not consistently witnessing the administration of depot injections and the time intervals on the forms did not always tally with the MARS sheet." [underlining added.]

8.261 Concerning evidence on the subject of medication was also given by W10. She said that, on returning to Shrewsbury Court after a seven-week trip abroad, she checked the quantity of injection ampoules of medication being stored, and found that there were too many. Her evidence was that the pharmacy invariably delivered the precise amount required for patients at Shrewsbury Court - no more, no less. So the fact that there were too many ampoules could only mean that some depot injections had not been given. More worryingly still, her examination of the records for the individual patients showed that all injections were recorded as having been given. There are two possible explanations. Either, exceptionally, the pharmacist had delivered too many injection ampoules, and that had been missed by staff at Shrewsbury Court, or staff had signed medication cards indicating that medication had been given when it had not. Either would be concerning. W10's view was that it was likely that the latter explanation was the correct one.

8.262 Our conclusion is that adequate systems to ensure, and properly record, the safe and appropriate administration of medicines, simply did not exist at Shrewsbury Court at the material times prior to December 2004.

Communications / Record Keeping

8.263 We have already commented upon the absence of evidence of multi-disciplinary team working at Shrewsbury Court in relation to risk assessments, and upon the inadequate way in which the CPA was implemented. Multi-disciplinary team working is essential in ensuring effective communication, decision-making, high-quality care and responsiveness to patient need, and we consider that the absence of a proper appreciation of the concept of multi-disciplinary working seriously affected Shrewsbury Court's ability to provide effective care.

8.264 The limited and disjointed nature of the medical input was a major contributory factor. CONS4 had very limited time to discuss individual patients with other members of staff. He was unable, for example, to attend the discharge meeting for RR which took place at Witley 3. He was unable to attend the Vulnerable Adult meetings which took

place in relation to patients for whom he had a responsibility on 8 October 2004 and 30 November 2004.

8.265 CONS4 sometimes referred patients to W3, but as both of them were part-time and as their working hours did not generally overlap, direct communication would have been limited. Similarly, DR1 was working part-time at Shrewsbury Court, and the opportunities for her to meet with CONS4 and discuss patients would have been very limited.

8.266 Clinical notes were not integrated. W3 kept his own files on his patients and his observations and conclusions were not transferred into the main clinical or nursing notes. Although his notes were kept in the same file as the psychiatric and nursing notes, they were in a different section which could, so it seems to us, lead to problems. We have commented above on the missing notes of his attendance on RR of 29 October 2004. W3's expectation, which we consider was probably an optimistic one, was that his notes would nevertheless be consulted when care plans were being formulated.

8.267 The evidence we heard about the quality of the hand-over of information when staff came on duty at the beginning of each shift was inconsistent. W19 said that all staff starting a shift would attend the hand-over meeting – except for one nurse who stayed with patients on the ward. When he was asked how that nurse would be made aware of the information, he responded that the nurse in question would probably attend the hand-over on the next occasion - an arrangement which would mean that the nurse in question would then work a whole night-shift without receiving up-to-date information about the patient group. He also told us that the hand-over period varied, but that the shift overlap was about half an hour. Given that that there were sometimes 35 patients at Shrewsbury Court, the quality of information communicated about each would have been scant, with staff having approximately one minute per patient per hand-over.

8.268 W2 told us that procedures at hand-overs had become more relaxed after W1 left. He said:
"Everything should have been written down in the liaison reports, but sometimes when they hand over to you, nothing is written down."

8.269 W7 told us there was no detailed hand-over of patients. C7 said the team leader would hand over all relevant information. He also said, in contrast to W19's evidence, that the entire new shift would attend the hand-over.

8.270 Whatever the exact situation was concerning hand-overs, the nursing notes relating to RR and AT show that clear, concise and accurate information about patients was not always readily available to nursing staff.

8.271 It is relevant to record here that W4's evidence to us was that when he returned from a period of leave, his practice was not to read all of the patients' files. To obtain up-dated information about his patients, he relied upon information communicated to him at staff hand-overs to up-date him, and upon CONS4 and DR2 to tell him of any specific problems. Bearing in mind the variable quality of the shift handovers, this was poor practice. We have already recorded that W4 told us that he had been unaware of the episode at the end of October 2004 when RR made threats to kill AT. It is most concerning that the Acting Manager did not become aware of this serious episode, particularly when it involved a patient, RR, who was known to be dangerous to women with whom he was in an intimate relationship.

8.272 G1 from the Mental Health Commission also told us of concerns about the adequacy of the documentation maintained at Shrewsbury Court in relation to detained patients. He said that there had been poor recording of the communications between the doctor and the patient such that he, as a Commissioner, could not tell from those records what conversations had taken place between the doctor and the patient about their attitude to the medication, and/or whether the patient was genuinely giving informed consent.

8.273 We discuss the impact of these communication and record-keeping deficiencies on the effectiveness of the care and management of AT and of RR later in this Report.

Policies and Procedures

8.274 A clear and concise set of clinical policies and procedures is essential to ensure that staff provide a consistent quality service, and that there is an audit trail if things go wrong. Policies and procedures need to be reviewed regularly and updated in line with

new evidence or guidelines. Staff must be made aware of these clinical policies and procedures as part of their induction programme. As and when policies are up-dated or new policies are introduced into an organisation, these must be cascaded to all appropriate staff. All clinical policies and procedures should have a review date.

8.275 Responsibility for ensuring that nursing staff are up-to-date in their knowledge of policies and procedures lies with the senior nursing staff - at Shrewsbury Court, with the Registered (or Acting) Manager and/or the Deputy Manager or Clinical Nurse Specialist. However the evidence we heard indicated that many of the policies and procedures which should have been in place prior to the homicide were either deficient or absent. The clearest evidence of this is to be found in the reports of the inspectors of the NCSC and the HC.

8.276 The NCSC report for February 2003 noted that there was no evidence showing that staff had read policies and procedures relevant to their area of work and had signed statements to that effect. It was commented that the hospital had started considering the development of a policy to reflect the National Service Framework, but that this was in its infancy. A formal Requirement was made by the NCSC to the effect that the Registered Person was to ensure that there was a written policy and supporting procedures in place, reflecting the Mental Health National Service Framework. In relation to those Standards relating to the implementation of policies, the inspectors reported that they did not consider that they could properly inspect patient records, because of concerns about patient confidentiality. They said they intended to revisit these Standards as and when guidance on the issue of patient confidentiality had been given to them by the NCSC.

8.277 In the HC report, following the January 2005 inspection, it was noted:

"The inspector was provided with a folder containing the policies and procedures in operation at Shrewsbury Court.

The inspector identified that the policies in place were the National Minimum Standards, re-written as Shrewsbury Court Policies. The polices in place did not provide staff with guidance on procedures to follow to meet the National Minimum Standards. The majority of policies were not signed by the author, were not dated and no review date was incorporated.

Staff signatures

On a review of staff files, the inspector identified that staff had been written to on 3 January 2005 instructing that it is their responsibility to read the relevant policies and procedures, and that they should do so and sign a statement to that effect by 31 January 2005.

The inspector reviewed the folder that was provided and identified that 20 staff had sections of the folder that they had to sign stating which policies they had read. On reviewing this folder, 14 of these staff had not read any of the policies and the remainder of staff had read a very small selection of the policies.

Staff training

There was no evidence at the establishment that policies and procedures were incorporated in induction and training."

8.278 This report also criticised various of the policies and procedures which were in place, including those relating to the management of serious and untoward incidents, nursing observations, nursing handovers, and the CPA.

8.279 Our view, based upon a limited number of interviews with nursing staff at Shrewsbury Court, is that this was not just a failure to ensure that the right paperwork was in place or to demonstrate that staff had read and understood the applicable policies. There was a more fundamental failure to ensure that the staff had actually read those policies at all.

8.280 W8 told us about the policies and procedures in place when he arrived in 2005:

"They were inadequate policies. The policies were written, but they were never reviewed, so they just stayed on the policy file. There was no policy group that looked at policies and said 'this one needs to be reviewed'. I don't think anybody took the lead in that, and that's reflected in that the policies said Shrewsbury Court Nursing Home, and they were registered as an independent hospital in 2002. So in 2004 they were still calling themselves a nursing home."

8.281 Furthermore, the evidence we have seen casts doubt on whether the policies and procedures that were in place were being followed. Again, we must emphasise that the evidence which we have heard was focused on the care and management of two specific patients, and the witnesses we interviewed were the people who had had a direct involvement with these patients. However, the evidence given by the nursing staff showed a degree of confusion over whether there were, in fact, policies on matters such as observation and searches, and if so, what they were. The nursing notes showed no systematic approach to these issues. Observations on AT and/or RR were described in a variety of ways, most of which did not accord with the terminology used in the written policy on observations in existence prior to the homicide.

8.282 When we asked W8 whether the (inadequate) policies which were in existence at the time of this arrival at Shrewsbury Court were actually being followed, he replied:

"That's a hard question. When I came into post, I expected them to follow policies but I couldn't tell you prior to me coming into post. For example, I don't think CPA was done appropriately. Risk assessment wasn't done appropriately. ... I would say the majority of them weren't aware of the policies."

Reactive Management - an over-reliance upon the regulatory bodies to set and monitor standards

8.283 We have referred to the minutes of Adult Protection Planning Meetings held on 8 October 2004 and 30 November 2004 in the context of staffing levels. The notes of the second meeting record that DR2 had told W4 he was happy with the staffing levels, and that the HC was satisfied with the staff:patient ratio, but that he, DR2, was willing to *"co-operate"* – which presumably means employ extra staff - if the meeting decided additional staff were needed. The meeting then suggested that the needs of patients, rather than numerical ratios, should determine staffing levels. We think this observation was pertinent, but we also believe this exchange highlights a number of important points which show what was wrong at Shrewsbury Court.

8.284 Firstly, it shows the weaknesses in the management. Decisions about staffing levels were clinical decisions for the Registered Manager, not for DR2. He was the Registered Owner, but, if, as he maintained, he did not have any clinical involvement, it was inappropriate for him to be expressing views on the adequacy of the staffing levels.

8.285 Secondly, it shows how DR2 relied on the HC to set standards. As noted above, his view seems to have been that, if the HC was allowing Shrewsbury Court to continue in business, the standard of care was adequate. We put it to DR2 that it was clear from the HC reports that Shrewsbury Court was failing to meet the majority of the National Minimum Standards but DR2 reiterated that his understanding had been that because Shrewsbury Court had been allowed to keep its registration, it must have been close enough to meeting the requisite standards.

8.286 We had difficulty accepting that DR2 had such a misconception of the way in which the NCSC and the HC operated and had so fundamentally misunderstood the gravity of the criticisms raised in their reports in the period prior to December 2004. Taking his evidence at face value, however, our view is that this was a serious abnegation of responsibility towards the patients at Shrewsbury Court. The HC inspectors were not in a position to form a definitive view, in the course of a short "spot-check", upon the potentially complex question of whether the particular needs of particular patients justified higher staffing levels. It was the duty of the management to ensure that there were enough staff to meet those patients' needs. They did not discharge that duty by doing the minimum necessary to meet the requirements of the regulatory authority, and to avoid enforcement action being taken by the regulators.

8.287 We also think that the discussions at these two meetings illustrate well how Shrewsbury Court was largely managed in a <u>reactive</u> way. In other words, if and when concerns were expressed by some external body, be that the NCSC/HC, or the MHA Commissioners, or a meeting such as these Adult Protection Planning Meetings, DR2 and the management at Shrewsbury Court responded to those concerns. Action plans would be prepared, assurances provided to the relevant body, and, in some instances, the necessary steps would be taken. But the focus would be on taking the steps necessary to satisfy the external body in question, <u>not</u> on a proactive consideration of what was needed to provide an adequate level of service for the patients at Shrewsbury Court.

8.288 At least two consequences flowed from this. First, if deficiencies were not identified by some external body, the chances of those deficiencies being addressed by the management team were slim. Second, the level of services being provided at Shrewsbury Court was driven, not by an assessment of the needs of the patients, but by what happened to be identified by third parties such as the NCSC/HC.

8.289 Regulation is not intended to be a substitute for proper, pro-active consideration being given by the management of independent hospitals to the needs of their patients. It is self-evident that spot-checks by the HC would not identify all deficiencies in the services being provided. The point is clearly demonstrated when one compares, on the one hand, the findings of the HC inspectors in July 2003 (a typical two-man inspection for two days) and August 2004 (a slightly shorter inspection), with, on the other, the findings of the major investigation carried out in January 2005. The fact that the January 2005 inspection unearthed so much more than the earlier inspections is not, or is not necessarily, a reflection on the quality of the earlier inspections. It is a reflection of the additional resources which were put into the January 2005 visit, which enabled the investigation to be more thorough than a conventional annual inspection. The fact that the January 2005 inspection did disclose so much more of concern shows the extent to which the approach adopted by the management at Shrewsbury Court meant that if a problem was not identified by an external body, it was unlikely to be identified at all. If Shrewsbury Court had had proper systems in place to audit the delivery of services to ensure quality was maintained, it is hard to see how so much that was so wrong could have remained to be discovered by the HC inspectors in January 2005.

The Future of Shrewsbury Court - Grounds for optimism?

8.290 We have commented above upon the contrast between the level of medical input at Shrewsbury Court now, compared to late 2004. Before December 2004, Shrewsbury Court had an Acting Manager, qualified in learning disability with little experience or training which might equip him to run an independent mental health hospital. There was only one consultant session each week, together with single sessions from DR1 and W3 for up to 35 patients. The position changed significantly in the period after the homicide. The appointment of W8 as Registered Manager meant that the establishment was being run by an experienced manger with training in mental health. Consultant psychiatrists

were working a total of four sessions each week at Shrewsbury Court. They were assisted by W3 who was working three sessions each week, and by DR1 working one session. This was for just 21 patients. All qualified nursing staff are, according to W8, now RMNs, so shifts are no longer being headed by a nurse with no training in mental health.

8.291 It is not part of our terms of reference to assess the current standards of care at Shrewsbury Court, and we have not done so, but the information outlined in the preceding paragraph is an indication of tangible improvements made since December 2004. W8 has now moved on from Shrewsbury Court, but he outlined in his evidence some of the steps which had been taken, over and above the recruitment of staff, to address the problem areas which we have discussed above – the adoption of a coherent admissions policy, the establishment of a clinical governance framework with regular clinical governance meetings involving the clinical staff, ensuring multi-disciplinary working and the effective implementation of the CPA. Whilst we have not attempted to "audit" how successful W8 has been, the latest reports from the HC and the MHA Commission make much more encouraging reading.

8.292 We asked W8 if DR2 had been reluctant to employ the additional staff to service the much smaller patient group now resident there. He replied:

"*No. I have to say that DR2s were signed up to it. I said the only way we could move the hospital forward was that we had to think about what we were paying staff to be able to recruit appropriate staff, and they agreed with me, so in relation to getting the extra money that wasn't a problem …. I think he realised the place was a mess but just didn't know what to do to try and pull it all together.*"

8.293 There are, therefore, grounds for hoping that the standard of services at this particular independent mental health hospital will not fall back to the alarmingly low levels of late 2004.

8.294 We recommend, however, that Whitepost Healthcare Group now commissions an independent, top to bottom, governance review at Shrewsbury Court with the objective of consolidating and building upon on the improvements made there since

the homicide and supplementing the Recommendations and Requirements provided to date by the HC.

9. RR's care before his admission to Shrewsbury Court

9.1 In this section of the Report, we consider the quality of the care provided to RR in the period from 2002 up to the time of his move to Shrewsbury Court, and the question of whether anything could or should have been done differently which might have averted this homicide. In considering these issues we acknowledge, of course, that our comments are made with the benefit of hindsight.

The care provided to RR during his time on Chelsham Ward and on Witley 3

9.2 We consider that the day-to-day care provided to RR during this period was entirely satisfactory. During the time that he was on Chelsham Ward, a mixed ward, his in-patient care appears to have been of a high standard, and it is clear that his potential risk, a brief relapse and his difficult behaviours were expertly managed. All appropriate steps were taken to prevent, so far as was possible, RR developing a relationship with any women on that ward.

9.3 Similarly, after his transfer to Witley 3, the management and associated documentation continued to be of a high standard. We comment, however, that it is possible that the success in managing RR on Witley 3 may perhaps have created problems for others in understanding the nature and seriousness of the continuing risk that RR posed. The transfer to an all-male ward, whilst appropriate in terms of placement and risk management, had the inevitable effect of removing the opportunity to continue observing RR's interactions with female patients. The removal of the stress of interactions with women, and hence the removal of the triggers and context for his disruptive behaviour and relapse, may well explain why the problems which had been apparent at Chelsham House stopped when RR reached Witley 3 and why the records show that RR underwent a lengthy quiescent period there before rapidly breaking down at Shrewsbury Court. He was being nursed on a specialist forensic ward with high-quality care. The fact that he was so well contained on a specialist single-sex facility may have been erroneously interpreted by some of those involved in his case as an indication that such an improvement would continue in a less specialised and mixed sex setting.

9.4 We have focused, in particular, upon the following aspects of the management prior to his transfer to Shrewsbury Court: -

- The process that led to the decision that Shrewsbury Court was the appropriate place to which to transfer RR.
- The information given to Shrewsbury Court prior to RR's transfer.
- The continuity of the care provided to RR.
- The decision made by the Managers on 15 April 2002 to lift the Section 37 Order to which RR had been subject since the court hearing on 22 March 2002, and the response to that decision.

The selection of Shrewsbury Court as the appropriate placement for RR

9.5 As noted above, the first reference which we have found to the possibility of RR being transferred to Shrewsbury Court was in the notes of a ward round on 21 May 2002 when a note was made by CONS2's SHO, DR3, which concluded "*Plan: Send assessments to Whitepost*". We discussed this entry with CONS2. He could not remember who had first come up with the suggestion of Whitepost/Shrewsbury Court for RR, but he thought it might have been a joint decision by him and BRH1, the ward manager. He told us that he was happy *"to put my name down as being one of the people who thought of it."*

9.6 His recollection was that Shrewsbury Court had gained a lot of *"credibility"* with him for having taken on and apparently coped with a very difficult patient who had been under the care of one of his colleagues. He described this patient as having dementia and disinhibition and said that he repeatedly tried to have sex with women on the ward. CONS2 said of Shrewsbury Court:

"They had a reputation for providing quality care for people with challenging needs, and the fact that the man they had taken was more likely to try and have sex with other clients than [RR], and that they managed to cope with him, to us made [RR's] placement there a possibility."

9.7 BRH1's evidence to us was that it had not been her who had first recommended Shrewsbury Court for RR. She did, however, know of it. She had trained at Netherne Hospital in Coulsdon, and when this hospital was closed, Shrewsbury Court had taken over the care of a number of its patients. She commented that she thought that Shrewsbury Court was *"one of the only units that would take someone detained under the Mental Health Act"* and said:

"I assumed that [Shrewsbury Court] was a residential home that looked after people who were detained under the Mental Health Act. ... At the time I still believed that Shrewsbury Court had the ability …- to be able to cope with [RR]. They had RMN nurses there. I wouldn't like to say what their staffing establishment is because I don't know, but they had quite a few qualified RMN nurses which would suggest to me that they had the skills and abilities to look after someone with complex mental health needs."

She told us that she had been to Shrewsbury Court once for a CPA meeting in relation to another patient. She told us that it had all seemed *"fairly reasonable"* with a *"fairly robust environment*", and that she had noted staff there interacting well with the patients.

9.8 CONS2 knew of the recommendation that RR needed a single sex environment, and he knew that Shrewsbury Court was a mixed unit. He told us that he did not, therefore, consider Shrewsbury Court an ideal placement for RR, but that he had nevertheless felt that it represented a reasonable compromise between the forensic risks that RR posed and the need to address his extensive physical health problems. In his oral evidence to us, he said:

"... I can't think of any single sex environment which would have taken him. Single sex environments are rare, certainly for men. I can only think of one unit and you would have to be an ex-army veteran for that. ... We had no other facility which we had easy access to which could take [RR]. None of the homes could take him. The forensic wouldn't take him because he was too old and too physically unwell. .... The only forensic unit in the country which would take elderly people was St Andrew's. Again without looking at my notes, I can't remember whether or not St Andrew's was thought

of as an option before, during or after. I suspect we were encouraged, because of the extremely high cost of St Andrew's, to consider other possibilities."

[Although CONS2 was not able, during the course of his interview, to recall whether St Andrews had been considered as an option, the contemporaneous documentation clearly showed that he had indeed given consideration to St Andrews as a possible placement for RR.]

9.9 CONS2 later told the Inquiry that because Shrewsbury Court was able to take patients who were detained under the Mental Health Act, he regarded it as offering a higher degree of security than a nursing home of the type contemplated by CONS7, and that, accordingly, he considered the single sex requirement which had been identified by CONS7 was *"not as important"*.

9.10 In any event, whatever the genesis of the suggestion, Shrewsbury Court soon became the principal option under consideration for RR. A note of a telephone conversation on 11 June 2002 between DR4, a senior registrar in psychiatry who was based with CONS2 and who worked on Chelsham Ward, and RR's social worker, Q2, records that it was agreed that Whitepost/Shrewsbury Court was the appropriate placement for RR. Q2's note of this conversation includes the following:

"Whitepost is not a special hospital but is most appropriate for dealing with the sort of difficulties that [RR] has. Bethlem have used it before with great success but DR4 will consider similar alternatives should C13 have any suggestions."

This is followed on 13 June 2002 by a further note recording a telephone conversation between Q2 and C13. She was a social worker who knew of Shrewsbury Court, and Q2's note includes the following:

"C13 rates Whitepost highly and said it should be suitable for [RR]'s needs. Others, Hexagon, Thornton Lodge probably no longer meet those needs. Lots of places have been tried for [RR]. We need to see [RR] as I have not met him for many years."

During this conversation, C13 identified C14, a senior social worker with Sutton Community Outreach Service, as someone who had a number of clients at Shrewsbury Court and on 14 June 2002, Q2 contacted her about RR's placement. The substance of this discussion was not recorded, but it is reasonable to infer that C14 said nothing adverse about Shrewsbury Court.

9.11 The fact that Shrewsbury Court came in this way to be adopted in the minds of those concerned with RR's care as the most suitable placement available for him is important because it seems to us that the idea that it was a suitable placement passed with RR to CONS3's team at Witley 3. Responsibility for the placement decision rested, of course, with those responsible for RR's care at the time of the transfer to Shrewsbury Court, and it should be noted that it was some 16 months after RR's transfer from Chelsham Ward to Witley 3 before RR moved to Shrewsbury Court. However, our impression is that those involved in RR's care after his transfer to Witley 3 assumed that the suitability of Shrewsbury Court for RR had already been established.

9.12 The evidence we heard indicates that the conclusion that Shrewsbury Court was suitable for RR was reached in reliance, in large measure, upon what might be termed "anecdotal" evidence about its abilities to manage difficult patients. CONS2 told us that he had made *"all enquiries"* about possible placements for RR, using his *"personal network of contacts"*, and he further pointed out that he had presented RR's case at the Maudsley Grand Round. He described Shrewsbury Court to us as having a reputation for *"providing quality care for patients with challenging needs"*. He had, however, never visited Shrewsbury Court, and his evidence to us indicated that his impressions of it were largely based upon the fact that one of his colleagues' more difficult patients had been transferred there and had, apparently, been managed well. He told us that he had heard nothing more about this patient after the transfer to Shrewsbury Court and commented *"No news is good news in these cases."* We comment, however, that the fact that nothing more had been heard in relation to this one patient could not, of itself, be regarded as a positive reason for concluding that Shrewsbury Court provided high quality

care. It would have been different if CONS2 had been aware of, for example, follow-up visits at which favourable impressions of the quality of care provided at Shrewsbury Court had been formed, but this was not, apparently, the case.

9.13 In his evidence to us, CONS2 referred also to the fact that one of his own patients had been transferred to Shrewsbury Court. He told us that this patient had been physically violent and very difficult to manage on Chelsham Ward. The patient had then been transferred to Shrewsbury Court. However, CONS2 also told us that this placement had subsequently broken down and that it had proved necessary to move the patient to St Andrew's in Northampton. In his oral evidence to us, CONS2 said that this other patient, whose name he could not recall, may have moved on to St Andrew's before the decision had been made to try and place RR there. If that was the case, it would, at the very least, have been providing a mixed message about Shrewsbury Court and its ability to cope with difficult patients. Shortly before completion of this Report, however, CONS2 (who has since September 2006 been working in New Zealand and latterly Australia) informed the Inquiry that the patient in question *"was moved to St Andrews well after RR had been referred and rejected by Shrewsbury Court"* and commented that as a result Shrewsbury Court's inability to cope with this patient would not have been apparent to him at the time when Shrewsbury Court was first selected as a possible replacement for RR. If this was the case, it would no doubt have provided CONS2 with some reassurance about Shrewsbury Court's ability to cope with difficult patients.

9.14 CONS2 also made the point that ultimate responsibility for deciding whether Shrewsbury Court was suitable for RR rested with Shrewsbury Court itself commenting *"it was impossible for a clinician outside Shrewsbury Court to assess the suitability of RR as they would not have an extensive knowledge of the environment, staffing and procedures, regardless of any checks that had been carried out."* It is certainly correct that Shrewsbury Court had an obligation to assess RR before agreeing to accept him as a patient, but we do not consider that this diminishes the obligation on those making the placement to seek to satisfy themselves that the proposed placement was a suitable one for the patient in question.

9.15 As the summary outlined above makes clear, there were others involved in the placement decision at Shrewsbury Court who had a more direct knowledge of the

establishment. BRH1's evidence was that she had formed the view that it seemed a reasonable place with a fairly robust environment with reasonable interactions between the nursing staff and patients – albeit that this was based solely upon her attendance at a single CPA meeting there. RR's social worker, Q2, ensured that he made contact with other social workers, C13 and C14, who he knew had knowledge of Shrewsbury Court, to see what their views were. He recorded that C13 rated Shrewsbury Court *"highly"* and that she felt, presumably on the basis of information she was given about RR by Q2, that it would be suitable for RR's needs. We comment, however, that Q2 had not, at this time, seen RR for *"many years"*, and so was not perhaps best placed to form a definitive view about what was suitable for him.

9.16 In the light of this evidence about the way in which Shrewsbury Court came, in 2002, to be regarded as the preferred placement for RR, we have come to the view that there is scope for improvements in the process by which such placements are selected. We consider that a more systematic approach should be adopted, identifying first which are the most suitable possible placements for the patient on clinical grounds; and then ascertaining whether any of those establishments would consider taking the patient and whether funding for the placement could be obtained.

9.17 There was, in our view, a surprising lack of documentation recording the decision making process which led to the recommendation of Shrewsbury Court. We also think that there may have been an over-reliance on "word-of-mouth" recommendations. That is not to criticise a reliance being placed upon the views, however informally expressed, of individuals such as C13 who had first-hand knowledge of Shrewsbury Court. "Word-of-mouth" communications from colleagues whose judgment is trusted is a useful way of obtaining an evaluation of the strengths and weaknesses of an establishment. However, we also think that there were a number of relatively straightforward and inexpensive checks could and should have undertaken to see whether there were any reasons to have any concerns about RR's placement at Shrewsbury Court, which were not undertaken.

The Need for a Systematic Approach?

9.18 There had been a clear assessment of what was needed for RR. CONS7's report dated 15 March 2002 had identified the need for a facility such as a supported nursing home in the community for the elderly, with staff who had expertise in the management of severe and enduring mental illness and organic disorders. She added: *"In the light of his ongoing risk to women, I suggest that a single sex facility be sought."*

9.19 However, there appears, at least from the documentation which we have seen, thereafter to have been no systematic attempt to identify such an establishment. There were very good reasons for CONS7's recommendation of a single sex facility and the first task ought, we think, to have been to identify which establishments, if any, could care for elderly people with a severe and enduring mental illness, and which could also provide a single sex environment. If this task was ever undertaken, the process was not documented - at no stage, so far as we can see, was a list ever prepared of possible placements, so that placements could be compared and a decision made as to which was best suited to RR's needs. Interestingly, CONS2 commented to us, in written observations made after completion of his oral evidence, that *"CONS7's comments regarding seeking a single sex facility are irrelevant as they were made with reference to a nursing home in the community, and in a nursing home licensed and staffed to cope with patients detained under the Mental Health Act … the need for a single sex facility would have been less."*

9.20 Whilst there are a number of references to be found throughout RR's medical records to the various possible placements considered for him from time to time, the documentation we have seen does not contain a document which recorded, in one place, the various placement options considered for RR from time to time, the reasons why those options were rejected, and/or why Shrewsbury Court was ultimately selected in preference to other possibilities. A record of these matters would, we think, have been useful, not only as a record of what occurred and why, but also as a means of encouraging the more systematic approach towards placement decisions which we consider appropriate.

9.21 We therefore recommend to PCTs and to NHS Trusts providing mental health services that care co-ordinators should be required to compile and maintain a formal

record, in a single, easily accessible document, which sets out each of the placement options considered for the patient in question; which documents the approaches made to each and the response(s) received; and which explains the reasons why the option eventually selected was ultimately chosen in preference to other possible options.

9.22 We note, in this context, that there does not appear to exist any central directory of establishments providing care to the mentally ill which sets out the admissions criteria being used by those establishments, so that those involved in a potentially difficult placement can, with relative ease, identify which establishments should at least be considered. There appears to have been some uncertainty amongst those responsible for placing RR about the admissions criteria of various of the establishments which were considered from time to time. By way of example, an establishment called Woodleigh Homes was under consideration until it was discovered in December 2002 that it did not take patients over the age of 65. Even this discovery did not prevent further consideration being given to RR's possible placement there at a CPA meeting in May 2003. Similarly, although Thornton Lodge had been considered, and rejected, as a possible option for RR in July 2002 (on the grounds that it could not provide the level of supervision necessary for RR), it re-emerged as a possible option in discussions at the end of 2002.

9.23 CONS2 told us that he did not know of any single-sex units that might have taken RR, and he said that he had believed the unit at St Andrew's was not single-sex. In fact, however, a facility was opened at St Andrew's in 2002 offering a low security single-sex service for men over the age of 60 who had committed, or were suspected of having committed, serious offences. There may, perhaps, have been reasons why this was not precisely appropriate for RR, but it seems to us that it would have merited consideration. There were also other forensic units in the private sector providing single-sex accommodation, such as "Partnerships in Care", which could, we think, have been approached to take RR. We cannot say whether these units would, in all respects, have been appropriate, or whether they would have been prepared to take RR, but the point, for present purposes, is that we can find no evidence that they were considered either by CONS2 or by any of the colleagues whom he consulted about possible placements for RR.

9.24 CONS2 told us in the course of his evidence that he did not see any way in which hospital patients who had capacity could be prevented from having sexual relations. He suggested that if a patient such as RR became involved in a relationship, then, unless the

patient in question had lacked capacity or was perceived to be "vulnerable", all that the doctors could do would be to warn the woman concerned of the dangers. We do not, however, consider that it is necessarily correct. A hospital could, in our view, legitimately require patients, as a condition of their residence, to conform to internal rules; and these could include a prohibition on sexual relations with other patients. We also comment that, with this point of view, CONS2 would surely have been even more cautious about sending RR to a mixed unit (knowing, as he did, of the dangers that RR would pose to any woman with whom he might enter into an intimate relationship), and all more anxious fully to investigate whether there were single sex alternatives which might at least have been possibilities for RR.

9.25 We acknowledge that it may well have proved very difficult, if not impossible, to find a placement which could have accommodated the particular combination of problems which RR posed. In addition to his forensic history and the mental illness which meant that he was, and would remain, a potential danger to women, he was elderly and had numerous physical health problems which required a high degree of medical care. There was also the possibility of early dementia. A number of witnesses spoke of the problem of finding appropriate placements for elderly male offenders in need of long term forensic care. With an aging population, this is likely to become an increasing problem in the future.

9.26 It is our recommendation, therefore, that consideration be given by SHAs to the question of whether the needs of patients with a significant forensic history, who would normally fall within the care of the forensic services, are adequately met by existing old age psychiatric services; or whether there is a need, locally or regionally, for a unit with the expertise to provide care, to the level of medium security, specifically for older adult males with a forensic history. Similarly, the need for forensic psychiatrists, and for multi-disciplinary forensic teams, specialising in old age should be assessed and appropriate posts created accordingly, as a central initiative if necessary.

9.27 Whatever the position with regard to the availability, locally or nationally, of beds for elderly forensic patients, we are still surprised both by the limited number of options which appear to have been considered for RR and by the lack of accurate information about such options as were in fact considered. It may be that there were other enquiries

made of other establishments which are not documented, but one of the problems in this case was the eventual conclusion, in 2003/4, that there was simply no alternative apart from Shrewsbury Court. We accept that it might have been the case that more extensive enquiries would still not have led to the identification of a more appropriate establishment, willing and able to take RR. However, we are concerned that more extensive enquiries do not appear to have been made, and that those involved in the placement of RR appear, so far as we can tell from the documentation before us, to have confined their consideration of possible placement options to a relatively small number of options, some of which were inappropriate in any event.

9.28 It is therefore our recommendation to the Department of Health and to SHAs that consideration should be given to the creation of a National Directory of organisations (both within the NHS and in the independent sector) which provide services to the mentally ill, with details of those organisations' admission criteria.

9.29 Such a directory would need to be updated regularly. It should be searchable, enabling those seeking placements to enter details of the patient, in order to try and find an appropriate match in the directory. It would be useful, for example, if it was possible to establish which units were capable of taking patients over 65 years of age, who had mental illness (as opposed to dementia) and a history of violence. Such a directory would enable those involved in the placement of difficult patients, such as RR, to learn of the existence of establishments which might be appropriate, but which had not previously come to their notice.

9.30 Readily available information about all available alternatives would also help to avoid time and effort being expended in pursuing unsuitable options. We have already referred to the surprising fact that possible placements at Thornton Lodge and Woodleigh Homes were revisited even after it had been determined that those establishments were not appropriate - Woodleigh Homes, for example, having a policy of not even considering patients over 65. We should also comment upon the consideration given to a possible placement at St Andrew's, Northampton. The possibility of a referral to the elderly service at St Andrew's was brought up on several occasions, but was not taken any further. CONS2 suggested that this was because St Andrew's, at, he estimated, £2,000 per week, was too expensive. He told us that he thought St Andrew's would have been higher up everyone's list of priorities if money had not been a problem - if one could afford it, he said, one

would always choose a *"Bentley instead of a Mini"*. However, no referral to St Andrew's was ever made, so the supposition, which we think is implicit in this evidence, that funding would have been refused, was never put to the test.

9.31 CONS2's views about the prospects of securing funding for such a placement would, no doubt, have been based on past experience. He told us that asking the funding panel to place RR in *"a specialist forensic unit"* such as St Andrew's did not have *"any realistic chance of success given that the forensic psychiatric recommendation [of CONS7] was not for a specialist forensic placement."* It is nevertheless unfortunate that he did not apparently know of the facility which had been opened at St Andrew's in 2002 offering a low security single-sex service for men over the age of 60 who had committed, or were suspected of having committed, serious offences. The balance between cost and safety is a relatively common issue in psychiatric placement, whoever may be required to make the judgment upon it. However, in our view, the role of clinicians should always be to identify and recommend the most appropriate treatment for their patients. If financial constraints mean that it is not possible to fund that treatment, that should, in our view, be a decision for others.

9.32 We therefore recommend to PCTs and to NHS Trusts providing mental health services that it should be emphasised to those involved in making recommendations for placements for psychiatric patients that the primary concern must always be the patient's individual needs, rather than financial considerations.

9.33 We recognise, in making this recommendation, that there is a danger that those involved in placement decisions may, accordingly, seek always to recommend the "Rolls-Royce" solution, with a view to protecting themselves from future criticism in the event that an alternative placement turns out to be inappropriate. We would hope and expect, however, that a professional approach would still result in sensible recommendations being made in those cases where something less than the most expensive solution is the most appropriate. It also may, perhaps, be that one consequence of this recommendation is that the role of placement panels, which decide whether funding should be provided for a recommended placement, will become more onerous. But if it is the case that placement decisions, which are less than ideal on clinical grounds, have to be made for

financial reasons, it is our view that that should be transparent, rather than obscured by any kind of “filtering” by those responsible for making the placement recommendation.

9.34 It is relevant to note in this regard that RR was transferred to Witley 3 before his eventual admission to Shrewsbury Court. He remained there for some 16 months. CONS3 told us that the cost of a bed at Witley 3 at the time was £123,000 per annum. CONS2 commented that the placement at Witley 3 did not need to be approved by a placement panel so that funding issues were, so he said, "irrelevant". However, assuming CONS2’s estimate of the cost of a placement at St Andrew’s to have been accurate at £2,000 per week, the logic of the financial argument may, so it seems to us, have been misconceived. (The response to this may be that Croydon had contracted in advance for the Witley 3 beds, but CONS3 told us that his understanding was that financial adjustments would be made if the beds were not used.) In any event, this further emphasises the importance of placement recommendations being made on clinical grounds, whilst leaving others to determine whether or not those recommendations are financially viable.

9.35 One option which we are surprised was not more actively considered was the option of keeping RR on Witley 3. Witley 3 was described as a forensic rehabilitation service, but it did have patients who had stayed on the ward for many years. RR was, at this time, 69 years of age. He was in very poor physical health and there was a perception that he might die at any time. It was CONS3’s view that the safest place for RR to be kept until his death was on Witley 3, notwithstanding that the ward was considered to be a rehabilitation unit.

9.36 CONS3’s views in this regard were not spelt out to his colleagues or documented in the medical records. He saw a tension between his views and those of the nursing staff on Witley 3. There had, as recounted above, been concerns about RR moving to that ward in the first place because of his physical health problems. Not only did those problems place an unusual burden on the nursing staff there, there was the real possibility that RR might die on the ward, with deleterious consequences for the mental state of other patients on that ward, as well as, perhaps, the morale of staff. BRH2, the nursing team leader, said in her evidence to us that a death on the ward would be a very unusual event. CONS3 explained to us how he had had, therefore, to battle to some extent to get RR onto Witley 3 ward. He said that BRH2 had been against RR coming to the ward, let alone staying there

long term, and that she was worried that Witley 3 might become the only option for RR. BRH2's evidence confirmed this to some extent, although she made it clear that, if the decision had been made to keep RR, she would not have opposed it. CONS3 emphasised, very reasonably, that he was part of a team at Witley 3 and that whilst he could sometimes *"push the agenda"*, he had to take heed of the views of his senior nurses. He was, therefore, reluctant to propose, let alone to insist upon, keeping RR on Witley 3 as a long term option.

9.37 With the benefits of hindsight, we think that it was unfortunate that the option of keeping RR on Witley 3 was not formally put forward as a possibility which merited consideration. However, the suggestion of Shrewsbury Court had been raised, and endorsed, long before CONS3 became involved in RR's care. In the absence of concerns about the quality of care at Shrewsbury Court, we doubt that Witley 3 would have been considered as a preferable long term option to a placement at Shrewsbury Court. Even leaving aside the issues raised by BRH2, Witley 3 was a significantly more expensive option than Shrewsbury Court.

Were adequate enquiries made about Shrewsbury Court?

9.38 The evidence we heard indicated that CONS2 was probably the person who, in 2002, first suggested Shrewsbury Court for RR. As the consultant with responsibility for RR, his views as to the possible placements for RR would obviously have been very important at that time, although it is clear that there was also significant input from Q2, RR's social worker. After RR was transferred to Witley 3, responsibility for the placement decision passed to CONS3's team, and the social worker who replaced Q2, Q3.

9.39 We have commented above on the extent to which, so it seems to us, reliance was placed, in 2002, upon "anecdotal" endorsements of the quality of care at Shrewsbury Court when concluding that it was an appropriate placement for this difficult and potentially dangerous patient. It is our view that Shrewsbury Court should not have become adopted in 2002 as the preferred option for RR without further steps being taken to ensure that it was capable of providing adequately for RR's needs, and equally

importantly, was capable of providing an environment which would be safe both for him and his fellow patients.

9.40 As will be apparent from the section of this Report which deals with the quality of care being provided at Shrewsbury Court in the period up to December 2004, there were very serious shortcomings in that service. Our view is that, if further investigations had been carried out, doubts would have emerged about whether Shrewsbury Court was capable of providing an appropriate level of care for, and was able to cope with, someone as potentially challenging and dangerous as RR. There were, we think, at least indications which could and should have been identified which would have sounded warning bells.

9.41 Firstly and most obviously, there was the material recorded in the reports of the NCSC, the HC and the MHA Commission. Very surprisingly, it does not appear, however, that anyone involved in the placement decision looked at these reports.

9.42 We therefore recommend to PCTs and to NHS Trusts providing mental health services that, when commissioning services from a hospital in the independent sector those involved in the placement decisions should, as a matter of routine, look at least at the latest reports prepared by the HC and the MHA Commissioners on the hospital under consideration, in order to ascertain whether there are any concerns about the establishment which might be material to the placement decision.

9.43 Secondly, the evidence which we heard indicates that some of the fundamental problems with Shrewsbury Court might not have been unduly difficult to discern had a visit been made to that establishment in advance of the decision being made that it was the appropriate place to transfer RR. The patient mix there was something which had been commented upon in the reports from the regulatory authorities, and it is of significance that one of the MHA Commissioners, G2, told us that one of the first things which struck her when she arrived at Shrewsbury Court for her first inspection was the very wide patient mix. This was also something which struck Q3, RR's social worker, when she visited Shrewsbury Court on 11 August 2003. Following this visit she wrote:

"My main concern is that the residents I met had severe mental health problems and I am unsure how [RR] would interact with people that he could not converse with…. However, I acknowledge that I only met a minority of residents, with the more able being out of the building today."

9.44 It is unfortunate that these concerns were not followed up. The decision to place RR at Shrewsbury Court had, however, already been made prior to Q3' involvement, and it may perhaps be that she took the view that she did not want to "second guess" a placement decision which had already been made by those who had been involved with RR for longer than she had, and which had obviously been a difficult and lengthy process. If she did take this view, it would have been a mistake – once she was appointed as RR's social worker, she had a direct responsibility for decisions made and she could not discharge that duty by asserting that she was merely going along with the plan already agreed. Another possibility is that the concerns which she recorded in this note were not so great as to cause her to reconsider the fundamental question of whether Shrewsbury Court was the right place for RR. It may have been a combination of these factors. Regrettably, it was not possible for us to contact Q3 and she did not, accordingly, give evidence to this Inquiry.

9.45 We think it is important, however, to highlight the limitations of Q3' input. She was not a member of the treating team. Indeed, she was not part of a forensic service, but worked for an adult community service in a different borough from the Bethlem Hospital (where Witley 3 is situated). She was working for a different Trust. The social worker at Witley 3 was from Southwark, as were most of the patients. When we asked CONS3 about Q3' role he said:

"She was not familiar with Witley 3 ward and we were not familiar with her".

He said that he had only seen Q3 at two CPA meetings. Yet he told us that he was *"relying on her to place [RR] effectively out-of-area."*

9.46 The position was, therefore, an odd one. Q3 was not a forensic social worker, but was required to arrange a placement for a complicated 'forensic' patient, looked after by a team from another area with which she did not work. We think that there can be little

doubt that her lack of knowledge of forensic issues, her detachment from the Witley 3 team, and her "out-of-area" status were impediments to her providing meaningful assistance in finding an appropriate placement for RR. Her visit to Shrewsbury Court could and should have been an important part of the decision making process for RR's placement, but we think that she was, for these reasons, poorly placed to influence the decision, particularly as it was a placement decided upon some time before her involvement in RR's care.

9.47 We should also say that, from the evidence that we heard about developments at Shrewsbury Court, it seems likely that the quality of care there deteriorated somewhat in the 10 month period between her visit and RR's eventual transfer there. As mentioned above, the departure of W1 as Registered Manager was perceived by a number of witnesses to the Inquiry to have been the precursor to a deterioration in standards there. Nevertheless, as noted above, Q3 did pick up on one of the concerns which had emerged in other quarters – the patient mix – expressing concern about whether RR would be able to interact with patients with the type of severe mental health problems that she met in the course of her visit. Worryingly, however, Q3 failed to raise any other concerns about Shrewsbury Court. Her failure to comment on the fact that it was a mixed unit, and that men and women shared the same facilities, was surprising. Although it is difficult for us to reach any definitive conclusion without having had an opportunity to interview Q3, it appears to us that either her assessment of the suitability of Shrewsbury Court was inadequate, or that she was unaware of the significance of the fact that RR would be free to mix with female patients if he were transferred to Shrewsbury Court.

9.48 There are indications that Q3 did not fully appreciate the significance of the risk issues involved in RR's case. She did not mention, either in her Community Services Comprehensive Assessment of 23 September 2003 or her Community Care Comprehensive Care Plan, the desirability of RR being in a single sex environment. Nor did she suggest that he might pose a danger to any woman with whom he might form a relationship. Her statement in the former document that *"[RR] is not now thought to be a danger to women"* was simply wrong. The statement was not without consequence. As remarked above, that particular phrase was highlighted by W12, Borough Director, at the meeting to consider RR's application to Shrewsbury Court on behalf of the Sutton funding panel. It

seems, therefore, that this statement did play at least a part in influencing that panel's decision.

9.49 A visit by a patient's social worker or care co-ordinator to a hospital at which a placement was being considered would normally be a satisfactory and sufficient step to take before confirming that placement as appropriate. Here, however, that visit was carried out by someone whose involvement in RR's care was peripheral and who seemed to have had an incomplete understanding of the nature and extent of the risks involved in placing RR in a mixed setting. She was not part of a forensic service and she appears to have been somewhat detached from the team providing care to RR on Witley 3. She does not, therefore, appear to have been appropriately qualified to assess whether Shrewsbury Court was a suitable environment in which to place RR. If this is right, we consider that her limitations should have been recognised by the treating team on Witley 3 who should themselves have ensured that someone who was appropriately experienced and informed visited Shrewsbury Court to assess its suitability for RR.

9.50 It is right to record here that following W1's decision to accept RR as a patient at Shrewsbury Court, RR made an accompanied visit there on 25th September 2003. He was accompanied by DR3, CONS3's SHO, and C3, an occupational therapist. However, neither of these women had the role of assessing the overall suitability of Shrewsbury Court as a placement. CONS3 told us that his SHO had been sent in order simply to broaden her experience. The occupational therapist was sent with a view to ascertaining whether there were any potential difficulties with a transfer to Shrewsbury Court from an environmental point of view, bearing in mind RR's physical limitations.

9.51 In our view, a man with RR's history and particular constellation of risks should not have been sent to a placement without its suitability being thoroughly assessed by someone with a full knowledge and understanding of RR's background and of the risks that he posed, and with the experience and expertise to make an informed assessment of the suitability of Shrewsbury Court. This did not happen.

9.52 There are, in our view, a variety of reasons why this was the case. Firstly, the difficulties which had been encountered in finding any placement at all for RR meant that there would have been reluctance to view critically the one option which appeared to be left to him. Secondly, it seems to us that it was assumed that the suitability of Shrewsbury Court as a possible placement for RR had, in effect, been established before the various individuals who were involved in the care of RR in 2003 and 2004 became involved in his care, the view that it was an appropriate placement having been reached during the time that RR was on Chelsham Ward, when CONS2 was his consultant, and Q2 was his social worker. CONS3 told us that he thought that Shrewsbury Court had already been determined to be an appropriate destination for RR, and bearing in mind what we have said above about Q3s' limited involvement, it is, perhaps, unsurprising that she did not choose to revisit what had been a difficult placement process, even after her visit there in August 2003. There may also have been a lack of clarity concerning the role of each agency in finding and assessing this placement.

9.53 We accordingly recommend to PCTs and to NHS Trusts providing mental health services that, in any case in which an out-of-area placement is being considered at an establishment with which those responsible for the patient's care are unfamiliar, it should be mandatory for a visit to be made to that establishment, in order to assess its suitability for a patient, by an individual, or by a team, which has both a proper understanding of the patient's needs; and sufficient experience and expertise to make an informed assessment of the establishment in question.

9.54 Reliance upon "second-hand" reports as to the suitability or otherwise of an establishment should be discouraged. To the extent that reliance is placed upon such reports, full details should be recorded of the nature and extent of the third party's knowledge of the establishment in question and of the information supplied by that third party so that there can be accountability for inappropriate placements if and when they occur in the future.

The information supplied to the placement panels

9.55 We have considered the role of the placement panels which were involved in the decision making process here, and which endorsed the decision to move RR to Shrewsbury Court. Funding for RR's placement was endorsed by two separate placement panels, that for Croydon PCT (chaired by W11), and that for the London Borough of Sutton (chaired by W12, Borough Director). W11 and Q1 gave evidence to the Inquiry. Both confirmed that the role of the placement panel was not confined to a consideration of the financial aspects of the proposed placement, but extended to a consideration of the clinical issues. Both confirmed that there could well be circumstances in which they would query, on clinical grounds, the appropriateness of a proposed placement.

9.56 There are obvious difficulties for a placement panel, however experienced, in "second-guessing" the views which have been reached by those with day-to-day responsibility for the care of a particular patient, particularly when the decision is inevitably going to be based, in large measure, upon the information supplied to that panel by those with that day-to-day responsibility. The point was, however, made to us by W11 that his background, as a social worker who had worked exclusively in mental health, gave him a very good basis from which to make judgments about proposed placements. He described the main point of the placement panel with which he was involved as being to try to bring *"some lateral thinking"* into the process. Both he and W12 made the point that a placement panel has an important role to perform in ensuring that all appropriate questions have been asked by those advancing the recommendation and in ensuring that all appropriate options have been considered before a recommendation is endorsed and funding approved.

9.57 Clearly, in such circumstances, it is of vital importance that the placement panel is provided with appropriate and accurate information about the patient concerned. We have concerns about the quality of the information which was provided in this particular case, particularly that which was considered by W12 and the placement panel which she chaired.

9.58 Included within the information which went to Q1 was the report prepared by Q3 which stated, in terms, that RR *"is not thought to now be a risk to women."* This was the passage in the assessment which was highlighted by Q1 in the course of her consideration

of the placement, so it is clear that it may have played a significant part in her panel's decision to approve this placement. Overall, the documentation presented to the placement panel in support of the application for funding for RR's placement at Shrewsbury Court seems to us to have understated the extent of the danger which he posed to others, particularly to women with whom he had an intimate relationship, and so to have understated the danger of placing him in a mixed unit (contrary to the recommendation made by CONS7 in 2002). Furthermore, although the documentation presented to the placement panel did refer to RR's forensic history, that aspect was not highlighted.

9.59 The task of a placement panel in determining whether or not a recommendation made by those with "day-to-day" knowledge of the patient in question is an appropriate recommendation is inevitably a difficult one, but one which is rendered all the more difficult if incomplete or misleading information is put before the placement panel.

9.60 We accordingly recommend to PCTs and to NHS Trusts providing mental health services that cases brought to a placement panel should be accompanied by a full, up-to-date, chronology, with a view to ensuring that all relevant past behaviour is fully realised and considered by the panel when deciding whether or not to endorse a recommended placement.

9.61 The requirement for a formal up-to-date chronology to be prepared in cases where an out-of-area placement is being considered would also have the benefit that there would then exist a potentially useful document which could be incorporated within the material routinely passed on to the receiving services.

The information supplied to Shrewsbury Court and its decision to accept RR

9.62 The focus in this section of this Report is not upon the information supplied to Shrewsbury Court at the time of the transfer in June 2004, but upon the information which was passed to W1 in 2002, when attempts were being made to persuade Shrewsbury Court to admit RR.

9.63 It is relevant to begin by considering CONS2's report on RR of 11 March 2002. He wrote under the heading "Risks":

"In my opinion, he represents an ongoing risk to women and not just in sexual relationships. If his poor impulse control is not managed, then the object of his anger and impulsivity may extend to other people and situations."

9.64 In a letter written by CONS2 to Shrewsbury Court on 2 September 2002, he stated:

"…you state that [RR] cannot be offered a place [at Shrewsbury Court] because of the perceived high risk of sexual incidents. We are of the opinion that, due to his physical health and his currently well-controlled mental health, he does not pose a high risk to women."

9.65 The following day, however, CONS2's Senior Registrar, DR4, wrote supporting the continuation of the Section 37 Order to which RR was, at this stage, still subject, stating:

"*[RR] has no insight into the extent of his difficulty, he has poor impulse control and in my opinion presents an ongoing risk to women. He continues to minimise his previous assault behaviour and sees no need to be in a supportive environment. He also reacts poorly to stress with threats of self harm."*

9.66 Each of these documents was produced for a separate purpose, but the contrast between the impressions conveyed by each is striking. Furthermore, a close examination of the case notes from Chelsham House for the ten weeks before the letter of 2 September 2002 to Shrewsbury Court does, in our view, suggest that RR's mental health was not wholly settled. In particular:

9.67 A nursing note from RR's file for 17 June 2002 reads: *"He hears again voices telling him to attack someone as he did in the past, and also the voices telling him to put his feet in T.V. so he have electric shock."(sic)*

9.68 A nursing note dated 18 June 2002 reads: *"Assessed by DR3 and DR4. His command voices are telling him to do specific acts."* The medical notes on 18 June 2002 state that the voices had been preceded on 17 June by *"tunes, bagpipes"*. On the same day, a care plan was drawn up, and the section entitled "Patient's Problem" was completed as follows: *"[RR] is hearing voices commanding him to do specific acts (self-harm and harming others)."*

The "nursing concerns" section of the care plan is largely obscured in the available photocopy by a "post-it" note. However, the first concern reads: *"Risk re acting on the hallucinations…"* and records that RR was placed on one-to-one observations for the next two days, following which he was placed on 15-minute observations.

- On 19 June 2002 the nursing entry reads:

  "This a.m. [RR] complained of hearing music in his head and requesting injection…..Discussed with CONS2. Clopixol 10 mg. prescribed in stat dose to be given…"

- On 17 July 2002 RR was noted to be *"making inappropriate remarks to staff of a sexual nature."*

- On 25 July 2002 RR was *"overheard at lunch-time making an inappropriate flirtatious comment to a female student…has made similar comments in past couple of weeks."*

- On 1 August 2002 RR was noted to have pushed a female resident on to the floor. He explained that she had *"slapped him unexpectedly."*

- On 13 August 2002 he was noted to be *"elated at times with occasional inappropriate comments."*

- A note on 15 August records RR as having stated that he *"did not mean to swear at…CONS2 the other day…"*

- CONS2's dictated ward round note for 20 August 2002 reads: *"now a bit high.... and is irritable"*.

- On 23 August RR is noted to have pushed a female patient in an apparent confrontation about an ashtray. Three confrontations with male patients are also noted during August.

- The nursing note for 2 September 2002 states that CONS2 intended to renew RR's Section 37 Order the following day.

9.69 In the light of these entries, we found CONS2's statement in his letter to Shrewsbury Court of 2 September that *"we are of the opinion that, due to his physical health and his currently well-controlled mental health, he does not pose a high risk to women"* somewhat surprising. It was a bold statement to make less than three months after RR had last reported command hallucinations telling him "*to attack someone as he did in the past"* - his past attacks having been on women. His subsequent behaviour had been sexually disinhibited, and he had committed two, albeit relatively minor, assaults on female patients during August. It is clear that his physical health did not prevent him from behaving in this manner and that his mental health was still subject to periodic deterioration. The purpose of CONS2's letter was to persuade Shrewsbury Court to reconsider RR's application for a place there. (We note in this regard that in a letter from DR4 dated 17 September 2002, it was commented - *"Clearly this gentleman has been blocking our beds for a long time"*.)

9.70 CONS2 did not assert in his letter that RR did not pose <u>any</u> risk to women, but merely that he did not pose a *"high"* risk. However, in the context of the events summarised in the preceding paragraphs, we think that this letter to Shrewsbury Court in September did somewhat understate the extent of RR's continuing problems.

9.71 The letter to Shrewsbury Court of 2 September 2002 was also signed by CONS7, the community forensic psychiatrist for Croydon. She amended the letter by adding the sentence: *"Provided [RR's] relationships with women are monitored at Whitepost, we believe his risk of sexually offending/incidents could be managed effectively."* She told us, however, that she had never been to Whitepost, and that she had never spoken to any of the clinicians, nurses or doctors there. She had not seen RR since she prepared her report of 15 March 2002 some six months earlier. She said she had agreed to sign the letter after CONS2 telephoned her and explained that they were having difficulty finding a suitable placement for RR. In the light of what CONS2 told her, she did not review RR's notes before signing the letter. She said:

"I had to be led by CONS2. He was the expert in the elderly services. He should know where his patients are going."

CONS2 commented, in his written observations, that he thought that it was *"nonsensical to state that an expert in psychiatric risk i.e. a forensic psychiatrist, would be deferring to an expert in old age psychiatry on a matter of risk"* but it seems to us, from the contemporaneous documentation, that CONS7 was re-involved at this stage primarily to add greater weight to the request to W1 to reconsider his decision not to accept RR. She was not asked to re-examine RR, and it was only later, on 2 October 2002, that she was asked for her views about alternative placements for RR if W1 continued to refuse to accept him. .

9.72 CONS7 told us that her understanding at this stage was that RR had been on Chelsham Award for some six months without any major concerns and that he was not presenting a management problem. Her recollection was that she was not informed that, during this six-month period, RR had had command hallucinations, over a period of three days, telling him to attack others *"as he did in the past"*. She told us that if she had known this, she would have arranged to review RR before signing the letter to Shrewsbury Court. It was certainly sensible of her to add to the letter the sentence quoted above, but it is our view that it was unwise of her to agree to sign a letter concerning the mental state of a patient she had not reviewed and giving an opinion about the suitability of a hospital of which she had no knowledge.

9.73 The full extent of CONS7's involvement in the attempt to persuade Shrewsbury Court to reconsider its refusal to accept RR is not entirely clear. CONS2 sent her a fax on 2 October 2002 asking *"If [Whitepost reject RR] could you please advise me if you think Witley 3 Ward would be suitable and what could be alternative places in case it is not."* CONS7 wrote back on 7 October 2002:

"I remain of the view that [RR] could be successfully managed at Whitepost and I will make every effort to emphasise this to the manager of Whitepost".

9.74 CONS7 told us that she was *"pretty sure"* that she did not in fact ever contact Shrewsbury Court directly and that she left on maternity leave shortly after writing this letter. This letter does, however, appear to indicate that she was willing, on the strength of CONS2's assurances, to make representations to an independent hospital about a patient whom she had seen just once, some six months previously, in circumstances where she had not even reviewed the notes for the previous six months or found out anything more about Shrewsbury Court.

9.75 The letter from CONS7 and CONS2 dated 2 September 2002 was important. It elicited an undertaking from W1 to re-assess RR for admission to Shrewsbury Court *"if his improvement is maintained"*. It is of note that CONS2 responded to W1's letter on 15 October 2002, stating:

"[RR] has been on our mixed sex ward since January this year and has not been a problem, even when there were two instances of disinhibited females on the unit."

9.76 We think the statement that there had been nothing by way of *"a problem"* was (whilst somewhat imprecise terminology) somewhat surprising, bearing in mind the events summarised above, and in particular the recurrence, in June 2002 of the command hallucinations telling RR to attack others.

9.77 In situations where placement issues are particularly problematic, those responsible for the patient are obviously in a difficult position. There can, in a worst-case

scenario, be only two options available - either to retain the patient in an inappropriate service, or to send the patient to an inappropriate placement. In such circumstances, the pragmatic approach is to accept that second-best will have to do, because it appears that no other possibility exists. That may be a regrettable inevitability in circumstances where resources are finite and suitable placements limited in number. However, we consider that it is important for this situation to be addressed transparently, so that all concerned may know what the true position is and may have a full and proper appreciation of the risks inherent in that situation.

9.78 It goes without saying that the temptation, in a world of limited resources, to tailor clinical recommendations, risk assessments or diagnosis, to current bed availability, must always be resisted.

9.79 Whilst we have no doubt that there was a genuinely held belief that RR's age and extensive physical health problems meant that the risk which he posed to other was substantially reduced, we think that the correspondence with Shrewsbury Court did somewhat understate the management issues which had arisen with RR during his time on Chelsham Ward. It should be said, however, that there is no suggestion that W1 was deprived of the opportunity to consider any documentation which he considered necessary or appropriate to assist him in his assessment of RR's suitability for admission to Shrewsbury Court. The correspondence from CONS2 and from CONS7 did, according to W1, contribute to his decision to revisit the question of whether or not to accept RR, but we comment that it ought not to have played a major, let alone a decisive, part in his eventual decision to change his mind about RR's suitability for admission. CONS2 and CONS7 could reasonably have expected those responsible for deciding whether RR was suitable for admission to Shrewsbury Court to reach their conclusion independently of the views which they themselves had expressed. Their letter did not purport, in any sense, to be a formal, let alone a comprehensive, report on RR in September 2002.

9.80 It is also relevant in this connection to note that, following this correspondence, RR had a second period of relapse at Chelsham House in November 2002. The nursing note of 10 November 2002 records:

"C/o feeling angry and agitated. C/o hearing tunes, particularly bagpipes, which he associates with him committing a violent act."

9.81 On 12 November 2002 he reported that he had an urge to tip over the tables in the dining room. In the early hours of 13 November 2002 he suddenly smashed the hi-fi without warning. Staff were unable to stop his smashing activity, and the emergency team was called for assistance. Several hours later he smashed the wall-clock on the ward for no reason. He claimed afterwards that his depot injection was five days late and that this was why he had deteriorated. He later said that he had felt *"strange"*, and (according to the tribunal decision of 21 November 2002) described the strange feelings to the psychologist as *"a perception of something…trying to come in over the wavelengths'"*.

9.82 This episode was important because it, and the events in June 2002, illustrated that his psychotic symptoms were imperfectly controlled. It also illustrated what we consider to be a significant theme of his care over the years – a susceptibility to relapse if a depot injection was given improperly or late. These events in November 2002 were not, so far as we can tell, explicitly drawn to Shrewsbury Court's attention, even though it was anticipated that W1 would shortly revisit his decision to reject RR – he having indicated he would do so some three to six months after his letter of 10 October 2002.

9.83 A Mental Health Review Tribunal refused RR's application for discharge from the Section 37 Order at the Bethlem Hospital on 21 November 2002. They gave their reasons for refusing to discharge as follows:

"There was clear evidence from the RMO that the patient continues to suffer from a mental illness, namely paranoid schizophrenia which is currently responding to treatment, namely depot medication. It is a chronic illness with repeated relapses and associated with those relapses there has been serious violence…

We accepted the evidence of the RMO that the patient's mental state fluctuated and his behaviour was unpredictable.

The RMO also gave evidence of a brain scan which showed atrophy especially affecting the frontal lobes, although he stated that this was only mildly affecting his cognitive

function, it was significant enough to impair his judgment and the level of his impulse control (frontal lobe syndrome).

In addition to the mental illness, there was evidence of a personality disorder with paranoid, psychopathic and sado-masochistic traits.

There was clear evidence that the patient has repeatedly been a risk to others in the past and immediately prior to the current admission. There has also been a history of self-harm, although the patient is not currently depressed. He does however suffer from a number of physical health problems and needs prompting regarding self-care and taking his medication for his physical illness.

The patient informed us that he would remain as an informal patient if discharged from Section. However, the Tribunal accepted the evidence of the RMO that he could not be relied upon because of his fluctuating mental state and impulsivity."

9.84 In our view, this was an accurate summary of RR's situation and a sensible decision. It was, however, not an assessment which was, so far as we can tell, ever explicitly drawn to the attention of Shrewsbury Court either in 2002 or in 2003 when W1 reconsidered RR's possible admission. Again, however, we make the point that those responsible for assessing RR's suitability for admission to Shrewsbury Court might have been expected to examine this sort of material before making a decision.

9.85 It is, in summary, our conclusion that RR should never have been accepted for admission to Shrewsbury Court. It should have been recognised that it was an establishment which was unsuitable in terms of its patient mix and which lacked the structure, staffing, skills and procedures to deal with patients presenting such complex needs and significant risks as RR. Regrettably, as we have explained in the section of this Report which deals with the admissions policies and the patient mix at Shrewsbury Court, the system in place at Shrewsbury Court for assessing referrals was less than satisfactory. There was little, if any, medical input into the assessment and the procedure relied upon personnel, specifically W1, insufficiently skilled to evaluate complex cases that needed significantly more than nursing care. The admissions procedures, such as they were, were informal and inconsistent.

9.86 In his evidence to the Inquiry, CONS4 accepted that, in retrospect, RR's admission was inappropriate. He said RR *"was an unsuitable patient for our unit - basically, we just did not have the experience"*. We consider this to be an accurate and central observation.

9.87 W1 had reached a similar conclusion when he turned down the application the first time RR was referred in 2002. He told us:

"Initially when I had the report from the consultant there, I turned [RR] down on the grounds that one of the reports stated that he shouldn't be in a mixed sex unit because of his sexual deviance."

9.88 The question inevitably arises as to why W1 changed his mind and why he failed to appreciate that RR continued to be an unsuitable patient for admission to Shrewsbury Court. When we asked about this, W1 told us that three factors had influenced him.

- He said he had been told to reassess RR *"because there were two psychiatrists who were saying [RR] has changed"*. W1 was almost certainly referring to the opinions of CONS2 and CONS7 in their letter to Whitepost of 2 September 2002 and CONS2's letter of 15 October 2002.
- He also said that he had been influenced by the fact that RR was no longer compulsorily detained, saying: *"It probably had a lot of influence, in all honesty."*
- He said that he had probably also been influenced by RR's age and infirmity (although we comment that neither factor seemed to have changed significantly between the two assessments).

9.89 It seems, therefore, that rather than conducting any form of structured assessment of his own, W1 effectively deferred to the opinions of the referring psychiatrists about the appropriateness of a placement at Shrewsbury Court, notwithstanding that those psychiatrists did not have (and that W1 had no reason to believe that they had) any particular knowledge of Shrewsbury Court. There was no psychiatric assessment of RR

from Shrewsbury Court itself. W1's assumption about the significance of RR's informal status was wrong. Whilst this might have been an understandable inference for a lay person to draw, it should not have been something which misled someone with the responsibility to decide on admissions to a mental health hospital.

9.90 We sought to understand the extent of CONS4's involvement in RR's acceptance at Whitepost. Whilst he did not see himself as having a role in assessing voluntary admissions, he said that he occasionally helped out with decisions about voluntary patients. He told us that he had not looked at any paperwork relating to RR, but W1 strongly disagreed with this statement, telling us that CONS4 would have been given a copy of the original referral documentation. CONS4's evidence was that he had had a *"fairly brief"* discussion about RR with W1 after the second referral in 2003. He said:

"All I can say is that there was this conversation with W1 and the other team were pushing us to take him. What eased my concern about him was that he was too physically disabled to do anything wrong. Also he had been on a mixed ward".

9.91 Pressed further, CONS4 told us that the change of mind had been because Whitepost had been told that RR was *"at death's door"* and it had therefore been assumed that he no longer represented a danger to others. Some support for his recollection in this regard came from DR1, who recalled talking to CONS4 about RR and being told, amongst other things, that because RR was now older and physically more frail, he would be easier to manage.

9.92 It is true that RR's mobility was reduced by his physical state. However, it is clear from the fact that he took trips into the community from Witley 3 that he was far from moribund. Even a cursory examination of the paperwork would have revealed as much. It should have been obvious that, if RR were placed on a mixed sex unit where he would be interacting with female patients every day, his physical disabilities alone could not be relied upon to preclude the possibility of his causing serious injury to such a patient.

9.93 Our view is that, whether or not CONS4 did see the original referral documentation, his actual involvement in the decision to accept RR was probably very limited indeed. He certainly did not undertake any sort of formalised review. He did not suggest to us that he had expressed any cautionary note to W1 about the admission of RR, but his limited involvement was no doubt seen by W1 as constituting a form of endorsement of the placement by CONS4. We take the view that it was ill advised of CONS4 to participate at all in the assessment process, without insisting on full participation.

9.94 CONS4 told us that in his NHS practice he would not have accepted the transfer of someone with a history of serious violence from a forensic unit without going to see them first. However, so he said, Shrewsbury Court was different in that *"it was more a nursing home culture, rather than a hospital culture."* He agreed that it was at times, *"a type of care where corners were cut",* and we reiterate our previous observations about the culture at Shrewsbury Court. However, our view is that, with this perception – an accurate perception - of the way in which Shrewsbury Court operated, CONS4 should have been all the more alert to caution W1 against the admission of a patient from a forensic unit with a long history of serious violence. The fact that Shrewsbury Court did not carry out its own psychiatric assessment of a potentially dangerous patient such as RR before accepting him, and the fact the consultant psychiatrist who was to become RR's RMO had no real involvement in the assessment process, was startlingly poor practice.

9.95 We also comment that, notwithstanding the substantial delay between the assessment at which W1 finally deemed RR to be suitable for admission to Shrewsbury Court (which took place on 18 August 2003) and RR's actual transfer (which did not take place until 22 June 2004, over 10 months later) there was no attempt made by W1, or anyone else at Shrewsbury Court, to ascertain whether there had been any material change in RR's condition during that period. W1 told us that he had assumed that SLaM would notify Shrewsbury Court if there were any material change. This was in our view an inappropriately passive attitude and one which should not have been adopted in the admissions arrangements at a mental health hospital.

Considerations for the future

9.96 We do not know if other independent hospitals have similar difficulties to those which existed at Shrewsbury Court in the period up to December 2004. What can be said, however, is that the facts disclosed by this Inquiry illustrate that it is, regrettably, possible for an independent hospital to be carrying on business, with registration from the HC, and yet to be providing a standard of care which falls significantly below an acceptable quality. We discuss elsewhere in this Report the reasons why the full nature and extent of the deficiencies at Shrewsbury Court were not identified by the regulatory authorities before this homicide, and we set out our recommendations as to how steps might be taken to minimise the danger that similar deficiencies in any other such establishment should go undetected. However, it is relevant to note that, following proposed reforms of the regulatory regime, the resources available to the HC in the future are likely to be somewhat reduced, and that the number of inspections which will be made of hospitals in the independent sector is likely to be reduced (the intention being that such inspections as are carried out will be focused upon establishments, or areas within establishments, where it is perceived there may be problems).

9.97 In this context, a major part of the solution to the problem of identifying sub-standard establishments seems to us to lie:

- with the systems which are engaged when those commissioning services from the independent sector take decisions as to where to make placements, and
- with the contractual arrangements which are then put into place between those commissioning services, and the independent hospital in question.

One conclusion to be drawn from the findings of this Inquiry is that it is not possible for those making placement decisions to <u>assume</u> that an establishment that provides healthcare within England and Wales is doing so to an acceptable standard. In particular, it cannot be assumed merely from the fact that the HC has not taken steps to close an establishment down that the establishment in question is providing care of an acceptable standard. It follows, therefore, that those responsible for commissioning services from the independent sector must recognise the need to take steps to satisfy themselves that any establishment at which a placement is contemplated is, and remains, up to standard.

9.98 A more systematic approach needs to be adopted when making placement decisions. When commissioning services from the independent sector, commissioners need to take steps to satisfy themselves that appropriate clinical governance structures are in

place and are being adhered to at the unit under consideration. The first and most straightforward place to look for evidence of this will be the latest HC reports, but these may be increasingly out of date as the HC moves away from annual inspections towards an approach of less frequent, albeit more focused, inspections. It is important, therefore, for commissioners to recognise that the burden must increasingly lie on them to satisfy themselves that the establishments in which they are placing patients do have appropriate clinical governance procedures in place, which are being adhered to, and further that those establishments are able to provide an appropriate standard of care, and are appropriately resourced to do so.

9.99 Word of mouth can and should still be a useful way of gaining an impression of the quality of an establishment, but it is important for all such contacts to be recorded in order that there is always a clear documented explanation as to why an establishment has been selected in preference to others. There should be a record of all such discussions so that the appropriateness of the decision-making process can subsequently be assessed.

9.100 Accordingly, allied to the earlier recommendation that care co-ordinators should be required to compile and maintain a formal record which sets out each of the placement options considered for the patient in question; which documents the approaches made to each and the response(s) received; and which explains the reasons why the option eventually selected was ultimately chosen in preference to other possible options, we further recommend to PCTs and NHS Trusts providing mental health services that, whenever an out-of-area placement is being considered, care co-ordinators should obtain and formally record a standard set of basic information relating to the establishments under consideration and the care which they provide before services are commissioned.

9.101 The nature and extent of the information to be gathered and recorded in this way is a matter for detailed consideration, but it could include some or all of the following.

i. The reasons why the particular unit in question has been selected in preference to others.

ii. Whether the establishment has been visited by the care co-ordinator or anyone else in the treating team, prior to the placement decision; and if not, why not.

iii. Which other establishments, if any, were considered.

iv. When the establishment in question was last inspected by the HC and by the MHA Commissioners, and whether the reports generated disclose any causes for concern.

v. The identity of the RMO who will take over care of the patient and the regularity with which it is anticipated that he will actually see the patient.

vi. The identity of the care co-ordinator and of the CMHT, if any, which will, be responsible for the patient following the transfer.

vii. Information about the proportion of qualified staff at the establishment who are RMNs, RNLDs, RGNs.

viii. The doctor: patient ratio which the establishment generally seeks to maintain.

ix. The nurse: patient ratio which the establishment generally seeks to maintain.

x. What arrangements are made to ensure appropriate segregation of the sexes.

9.102 When looking here at the possible indications available to those involved in the placement of RR at Shrewsbury Court that there might have been grounds for concern about the way in which that establishment operated, we have considered the way in which Shrewsbury Court approached the actual transfer of RR, and the discharge meeting which was held immediately prior to the transfer. There were, we think, a number of aspects of the approach adopted by Shrewsbury Court in this regard which should have struck staff at SLaM as surprising and perhaps concerning.

9.103 In the first place, as noted above, Shrewsbury Court did not undertake its own psychiatric assessment of RR before accepting him – CONS4, the consultant psychiatrist who was to become RR's RMO, had no apparent involvement in the assessment process. Neither did Shrewsbury Court undertake any form of multi-disciplinary assessment prior to the decision to accept RR. Furthermore, CONS4 did not even attend the discharge meeting held on 21 June 2004. That meeting was attended by a nurse, W2, who had never previously attended such a meeting on his own. He lacked the requisite experience and expertise to handle such an important meeting without support; and the impression which

we have formed, having had the benefit of interviewing W2, is that it is very likely that his limitations would have been apparent to those attending that discharge meeting.

9.104 A second possible indication of shortcomings in Shrewsbury Court's admissions procedures was the fact that, notwithstanding a substantial delay between the assessment on 18 August 2003 at which W1 deemed RR suitable to be admitted to Shrewsbury Court and RR's actual transfer on 22 June 2004, over 10 months later, there was no attempt made by anyone at Shrewsbury Court to ascertain whether there had been any material change in RR's condition during that period. W1 told us that his assumption had been that SLaM would notify Shrewsbury Court in the event that there was any material change, but the failure to reassess notwithstanding such a lengthy period of delay prior to the actual transfer is surprising. That failure is obviously a criticism to be made of the procedures in place at Shrewsbury Court (although it should be noted that it is not a failure which could, in any sense, be considered to have contributed to what subsequently occurred, since there is no suggestion of any deterioration in RR's condition over this period). The point for present purposes, however, is that those responsible for the care of RR might, to put it at its most neutral, have been surprised by the relaxed approach adopted by Shrewsbury Court in this regard.

9.105 There were, therefore, some slight indications to those with responsibility for RR's care at Witley 3 that Shrewsbury Court did not have good systems in place, in at least some aspects of its admissions procedures. Those indications would, however, have come very late in the day, when the decision to transfer RR to Shrewsbury Court was probably perceived as a *"fait accompli"*. As a matter of practicality, it is unrealistic to suggest that the decision to transfer RR should have been reconsidered at such a late stage in the light of what were, we think, relatively slight markers of inadequate admissions procedures at Shrewsbury Court.

9.106 We think, however, that these markers should have raised concerns about the adequacy of the service at Shrewsbury Court and that this should have caused, at the very least, attention to be focused on the need to follow-up the placement to ensure that all was well in the weeks and months which followed the transfer.

9.107 It would also have been useful, we think, for those with responsibility for RR's care to have seen the assessment carried out on RR by Shrewsbury Court before the transfer was effected, so that they could be reassured that all the relevant information about RR had been "taken on board" by those who were now to have responsibility for him.

9.108 We recommend, therefore, to NHS Trusts providing mental health services that consideration be given to the adoption of a policy that, when teams are referring a patient out-of-area, or to a unit in the independent sector, they should routinely ask to see the written assessment report carried out on the patient in question by the assessing team at the establishment to which the transfer is contemplated; and should ensure that that assessment is reviewed by or on behalf of the current RMO before the transfer takes place.

Summary

9.109 There were a number of aspects of the process of placing RR at Shrewsbury Court which we have concluded, albeit with the benefit of hindsight, contributed to the making of a placement which was, we think, inappropriate for RR.

- There was, we think, incomplete information about possible alternatives available to those involved in the placement decision at the time when Shrewsbury Court was first identified as the preferred option for RR.

- Evidence in the public domain about shortcomings in the quality of care provided at Shrewsbury Court – in the form of the reports from the regulatory authorities – was not taken into account.

- There was also a failure to ensure that, prior to the placement decision being made, a visit was made to Shrewsbury Court by somebody with appropriate knowledge of RR's particular circumstances, and with the experience and expertise, to assess whether Shrewsbury Court could manage effectively the risks which he posed. Even though there were, in August and September 2003, visits to Shrewsbury Court with a view to assessing its suitability for RR, those visits were not conducted by

individuals with the appropriate experience or expertise to assess its suitability for this particularly difficult and challenging patient.

- There was, we think, probably a reluctance on the part of those who became involved in the decision-making process after Shrewsbury Court had been identified as the preferred option for RR, to revisit what had become, almost by default, a consensus that it was the appropriate placement for RR.

Difficulties in continuity of care

9.110 Difficulties are more likely to arise when the care of a patient is transferred between different organisations, or parts of an organisation, rather than receiving an integrated service from one agency. We have concluded that the unusual complexity of the pathway that RR followed here may well have affected the continuity of his care and coherence of care planning. It is relevant therefore to summarise the details of his trajectory of care.

9.111 RR was originally a resident of the London Borough of Sutton. The responsibility for his social care has remained with Sutton. From mid-2002, the social worker concerned was Q3 of the Wallington CMHT, based at Sutton Hospital. She took over this responsibility from Q2 from the same establishment. This was by then part of an integrated mental health and social care trust, providing services to Kingston, Merton, Richmond, Sutton and Wandsworth – the South West London and St George's Mental Health NHS Trust.

9.112 Responsibility for RR's medical care, by contrast, was, from 1998, transferred between different organisations, and between different components of one large organisation, SLaM.

9.113 RR had been discharged from Sutton Hospital in March 1993 and had been placed on a Guardianship Order under Section 7 of the Mental Health Act 1983 in an intensively-staffed nursing home in Sutton. At this time, his psychiatric care was undertaken by the

Sutton Community Outreach Service, a general adult service belonging to the St Helier NHS Trust, where his consultant was C1.

9.114 In 1998, he was moved to the Jubilee Nursing Home in Purley. After a brief period, C1 transferred RR's care to the care of C15, consultant in the psychiatry of old age, at the Elderly Community Mental Health Team in Purley in the London Borough of Croydon. At that time, its psychiatric services were provided by the then Bethlem & Maudsley NHS Trust. The latter then amalgamated in 2000 with a neighbouring trust to form the South London and Maudsley Trust (SLaM), providing psychiatric services to the London Boroughs of Croydon, Lambeth, Southwark and Lewisham.

9.115 When RR required in-patient admission in November 2001, he was sent to an old age in-patient unit, Chelsham House at the Bethlem Hospital, which is part of SLaM, but is located "out-of-area" in Beckenham in Kent in an area administered by the London Borough of Bromley. He was then discharged to a residential care home in Thornton Heath in the London Borough of Croydon. At this point his RMO changed to CONS2 who, other than having in-patient beds, worked at the Queen's Resource Centre in Croydon, as did CONS6, who later provided a report to Croydon Crown Court for RR's sentencing for robbery. When RR required readmission some five weeks after his discharge to Thornton Heath, he remained under the care of CONS2.

9.116 A forensic opinion was then sought from the Croydon Forensic Service, another component of SLaM. The sole consultant in this service was CONS7 who led a community forensic team. She did not have in-patient beds. Forensic in-patient provision for Croydon at that time was based at two sites. Medium secure in-patient beds were commissioned by Croydon PCT from the South West London NHS Trust and were located at the Shaftesbury Clinic at St George's Hospital in Tooting in the London Borough of Wandsworth. Three forensic rehabilitation beds were purchased from Witley 3 ward at Bethlem Hospital in Kent which was part of SLaM and whose patients were mainly from Southwark. RR was eventually transferred from CONS2's care at Chelsham House at the Bethlem to CONS3's care at Witley 3 ward, also at the Bethlem.

9.117 RR was finally placed at Shrewsbury Court in Redhill. To explain the geography, Redhill is in Reigate and Banstead, a local government district with borough status in the county of Surrey. Surrey borders a number of other administrative areas, including Greater London and Kent. Redhill is some 8 miles from Purley, 11 miles from Croydon and 15 miles from Beckenham.

9.118 Psychiatric care in Redhill was provided by the Surrey Oaklands NHS Trust. In April 2005, after the events with which this Report is concerned, Surrey Oaklands NHS Trust merged with Surrey Hampshire Borders NHS Trust and North West Surrey Partnership NHS Trust to form the Surrey-wide mental health trust, the Surrey and Borders Partnership NHS Trust. CONS4 who provided consultant services to Shrewsbury Court, was and remains primarily an NHS consultant in general adult psychiatry in the Redhill/Reigate/Horley CMHT, originally part of the Surrey Oaklands NHS Trust.

9.119 Between 1998 and 2004, therefore, consultant responsibility for RR moved from a general adult psychiatrist in Sutton; to an old age community psychiatrist in Purley; then to an old age consultant at an in-patient unit in Kent (the community part of whose job was in Croydon); then to a forensic in-patient psychiatrist in Kent (via the intercession of a community forensic psychiatrist in Croydon); and finally to a consultant adult psychiatrist in the private sector in Surrey. RR's care passed, therefore, between five different consultants in five different services in a period of seven years, in the process moving from general adult psychiatry to old age psychiatry, to forensic psychiatry and finally to private general adult psychiatry - in other words between three specialities (or four, if private adult psychiatry is considered a specialist entity). This is, it scarcely needs saying, an unusually complicated trajectory.

9.120 Within this complicated trajectory, there was an absence of clear protocols or pathways for transfer of responsibility between services. Specifically, there were no clear pathways or protocols between general adult psychiatry, old age, forensic in-patient, and community forensic services within SLaM. We believe that this may have affected the case of RR in three ways:

- There was no clear understanding of which service maintained ultimate responsibility for RR's care as he was transferred between services: the originating service (general adult psychiatry), the old age service, the mediating service (Croydon community forensic), the 'rehabilitation' placement (in-patient forensic rehabilitation) and the "out-of-area" private general adult psychiatry placement (Shrewsbury Court), with its unusual relationship with local NHS general adult services.
- There was a failure of services to engage in co-ordinated discharge planning when RR left Witley 3 ward.
- The lack of co-ordination between the services was the major factor in a failure to engage in any form of clinical follow-up.

9.121 It is difficult to avoid the conclusion that the difficulties between services were compounded by the borough structure of SLaM services and the 'cross-boundary' issues which resulted, both between different SLaM services in different boroughs and between psychiatric services and social services. In RR's case, CONS3 had no knowledge of Croydon or Sutton, because his focus was Southwark. He was not in a position personally to know what placements were available in an area in which he did not work. He knew nothing of Shrewsbury Court which was both outside his geographical area and outside his psychiatric speciality. RR had come from the old age psychiatry service. He was on a forensic unit and being placed by a social worker from a general psychiatry unit into a private general psychiatry hospital. These interface issues must inevitably have provided barriers to appropriate transition, despite the best efforts of those involved.

9.122 We did not discover any evidence that CONS2's old age psychiatry service was involved in any of the case conferences or discharge planning for RR. CONS3 did get CONS2's agreement that he would readmit RR to the elderly ward, if the placement at Shrewsbury Court rapidly broke down. Unfortunately, this arrangement did not extend to the elderly team being included in the Shrewsbury Court care-plan or the placement reviews. Again, boundary issues are likely to have been of importance here. RR was being discharged from a forensic service, not an elderly service. He was being discharged into a general adult placement, not an elderly placement, and he was being transferred to an area for which the SLaM elderly team had no responsibility. CONS2 told us that his service would have expected to be involved in follow-up at Shrewsbury Court if they had placed

RR there directly. But they did not. RR came through the Bethlem in-patient forensic service.

9.123 The community forensic service for Croydon does not appear to have been involved in discharge planning or arrangements for future monitoring. CONS3 told us that he felt sure they were invited to case conferences, but CONS7 did not recollect any such invitations and told us that she would not have expected the community forensic team to have been involved in such meetings. The absence of relevant paperwork and CONS7's maternity leave confuse the picture, although we gather that CONS7 did attend CPA meetings for some of the patients placed on Witley 3 when her other commitments permitted her so to do.

9.124 It is clear that there was a difference in expectation between CONS3 and CONS7 on the issue of follow-up in RR's case. CONS3 had a clear expectation that CONS7's team would have a role in monitoring RR's placement at Shrewsbury Court. He told us that he would have expected CONS7 to have some link with RR's placement and he said that he *"would have expected that the forensic team would be involved in subsequent CPA meetings at [Shrewsbury Court]"* - but they were not. CONS7, on the other hand, was of the view that she had not placed RR on Witley 3 – she told us that the extent of her involvement in his placement there was that she was asked whether one of the three beds there which had been commissioned by Croydon PCT could be used to accommodate RR. When we asked her if she would have expected to be consulted when he was discharged, she said:

"Not necessarily because … I took the view that [if] I don't have one of my own forensic patients that I need that bed for, if the elderly service from Croydon want to use it, that's fine once they liaise with and interface with the Witley 3 team, and I would expect that to go as far as discharge planning."

Her recollection was that patients placed in out-of-area establishments, such as Shrewsbury Court, would have been monitored by a placements officer employed by SLaM.

9.125 CONS3 told us:

"One of the big problems in my experience was organising aftercare, because there would always be an argument if they were placed out of … area, who would look after them. This is not unique to Croydon – this is across the entirety of SLaM – and I find it absolutely astonishing that even now we are having the same battles and debates about who should provide aftercare."

9.126 The relationship between the different parts of the forensic service within SLaM seems to us to constitute a problem to the effective management of care. The service was disjointed. In-patient services for one borough were provided in other boroughs, and there was a 'disconnect' between in-patient and community forensic services. There were differences in styles of care between boroughs and even within boroughs. CONS3's evidence was that:

"It is a different style of service even within the same borough, and that is particularly exemplified by the current styles within north and south Southwark. SLaM is a bit like the European Union. Everyone likes their own independence, and while we are part of a bigger picture, old habits die hard and there is still a sense, unfortunately, of rivalry between the different boroughs. There is little link in many regards between Lambeth forensic services and Southwark forensic services for instance…So it is a bit of a mess in that regard."

9.127 There may be a similar disjuncture between community forensic services for Croydon and in-patient services provided elsewhere within SLaM. We understand the advantages of organising health and social services on a borough basis. However, in our view, this is only a sound framework when the services in question can be provided within the borough. We have been told that forensic provision within SLaM has been subject to recent re-adjustment, but we are concerned that cross-borough provision could give rise to a disjointed service if it does not have a central directorate or any other kind of central co-ordination.

9.128 Interface problems were also evident in RR's case in terms of funding and funding follow-up. CONS8, clinical director for the adult mental health service in Croydon, confirmed that the *"lack of a close working relationship"* between two parties was a

potential issue. He told us there were always difficulties in placement when social and health care were the responsibilities of different boroughs:

"You get confusion as to who is doing what, or feelings that people aren't pulling their weight.

The funding delays in RR's case were caused, at least in part, by having different organisations involved. The arrangements for monitoring and reviewing the appropriateness of the placement also came to be determined by these funding arrangements. In the event, neither the old age team, nor the community forensic team, nor the Witley 3 team, nor any other clinical team were involved in any clinical follow-up. CONS8 told us that the follow-up arranged by the funding body was not clinical follow-up, but placement follow-up – in other words, as he put it, *essentially for value for money".* The placement at Shrewsbury Court was to be assessed on this basis after the probationary period of three months. This task was devolved by the funding bodies (the Croydon PCT and Sutton social services) onto the Adult Placement Team, representatives of the Croydon adult psychiatry service. But this was an organisation which had no previous knowledge of RR, had never been involved in his care, and had no special expertise in either old age or forensic psychiatry specialities. Furthermore, the Adult Placement Team, CONS8 told us, comprised at that time a single individual, a locum nurse. As has been explained, above, that individual did not, in the event, visit Shrewsbury Court or take part in either of RR's placement reviews. Unfortunately, before the second placement review, she resigned, leaving the Adult Placement Team without any personnel at the time of RR's second review – when it was decided to make the placement permanent. In other words, the placement reviews were undertaken solely by the representative of Sutton Social Services (Q1), with no participation by any representative of the medical services on behalf of the agency that was responsible for RR's medical care and had jointly funded the placement, Croydon PCT.

9.129 We recommend to SHAs that interfaces between general psychiatry, old age psychiatry services and the forensic psychiatry services in each region should be clearly defined. Clear protocols and pathways for the transfer of care and responsibility between different elements of a psychiatric service should be drawn up by provider organisations.

9.130 It appears to us that a number of people involved in this case seemed to equate old age with an absence of risk. That suggests a need, not only for pathways for movement

between services, but for greater liaison and cross-fertilisation in terms of aspects of each speciality that affect the others' patients, but of which the other services may have little experience. Services may split into separate categories, but the needs of patients do not necessarily conform to the niceties of administrative division. Training for psychiatrists, and indeed all mental health professionals should incorporate greater awareness of such interface issues.

The decision by the Hospital Managers to lift RR's Section 37 Order

9.131 As noted above, RR was transferred to Witley 3 ward at the Bethlem on 20 February 2003. Less than two months later, on 14 April 2003, RR was discharged from the Section 37 order by the Hospital Managers against medical advice. CONS3 told us that he had been *"flabbergasted"* by this decision, which came only four-and-a-half months after a Mental Health Review Tribunal had refused RR's application for discharge. In our view, the Managers' decision to discharge was based on a misunderstanding of the law and was the result of an insufficient understanding of issues of risk in forensic patients.

9.132 The Mental Health Act 1983 does not define specific criteria to be applied by the Hospital Managers when considering the discharge of a patient who is detained. However, Section 23.11 of the revised Code of Practice (1999), published by the Department of Health and the Welsh Office, pursuant to Section 118 of the Mental Health Act 1983, states:

"The essential yardstick in considering a review application is whether the grounds for…continued detention under the Act are satisfied. To ensure that this is done in a systematic and consistent way, the review should consider the following questions, in the order stated:

Is the patient suffering from a mental disorder?

If so, is the disorder of a nature or degree which makes treatment in hospital appropriate?

Is detention in hospital still necessary in the interests of the patient's health or safety, or for the protection of other people?

If the panel is satisfied from the evidence presented to them that the answer to any of these questions is 'no', the patient should be discharged."

9.133 At SLaM, there were formalised criteria for the Managers to address in making their decision. These are set out in their 'decision form' document, in which SLaM had adopted the statutory criteria for Mental Health Review Tribunals in considering appeals against treatment orders, (set out in Sections 72 (1) (b) and 72(2)(a) of the Mental Health Act 1983). These mirror the three criteria upon which the RMO is required to report to the Managers, which are set out at Section 20(4) of the Mental Health Act 1983. In brief, SLaM opted to have its Managers assess the continuation of detention by using the same criteria as are used by the Mental Health Tribunal to consider appeals against detention.

9.134 The role of the Hospital Managers in terms of discharge may need some explanation here. The Hospital Managers are the detaining authority under the Mental Health Act 1983. When a treatment order (such as a Section 37 Order) is coming to the end of its current period, the RMO is obliged under Section 20(3) of the Act to supply the Managers with a report as to whether the patient fulfils the criteria for renewal of the authority for detention. These criteria are set out at Section 20(4) of the Act. The Managers are required to conduct a review as to whether these criteria are satisfied. This is what happened in RR's case in April 2002. In practice, the Hospital Managers do not involve themselves directly. They are permitted to delegate their functions to a sub-committee of the relevant hospital trust, which may be made up of outsiders. In practice, the representatives of the Managers who discharge their functions under the Act are usually lay people from the local community, often retired, who have an interest in mental health issues and who are prepared to undertake training in how to fulfil their functions as 'Managers'.

9.135 The three Managers concerned with RR's appeal, who all gave evidence to us, were highly experienced in conducting Managers' hearings, although their experience was predominantly with patients who were civilly detained, rather than with those committed to hospital by the Courts. C16, who chaired their panel, told us that he had been a Hospital Manager since 1998 and had probably dealt with over a thousand hearings, some involving forensic patients.

9.136 The other panel members on 15 April 2002 were G3 and M2. G3 trained as a social worker specialising in mental health, and had had a post managing all the mental health services for a London borough. She was appointed to the Guy's and Lewisham District Health Authority in 1981, and told us that that led her to become a Mental Health Act Manager in about 1984. She chaired the Mental Health Act Managers' Group for Lewisham and North Southwark District Health Authority for seven years, and then became a board member of the Lewisham and North Southwark Mental Health Trust in 1999. She told us she had sat on countless hearings in her capacity as a Manager. M2 was trained as a nurse and had a degree in nursing from the University of Pennsylvania. She has been a Hospital Manager since 1992 and has, for the last 6 years chaired the Southwark group of Hospital Managers. She estimated that she sat as a Manager on about 100 hearings each year.

9.137 We have considered two separate aspects of this decision to discharge the Section 37 Order. The first is whether the documentation completed by the Managers, justifying their decision, demonstrates an adequate and appropriate understanding of the task which they were performing – an issue which is relevant to their training. The second is whether a decision to discharge could reasonably have been made at that time on the information before the Managers.

9.138 The three Managers completed a very brief decision form, giving their reasons for discharging RR from the Section 37 Order. It is our view that those reasons evidence a lack of clarity in the minds of the Managers as to the criteria to be applied on such an appeal.

The Managers concluded that RR was <u>not</u> *"still suffering from a mental illness (or other mental disorder) of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment"*. Their reasons, set out below in their entirety, were as follows:

"Managers were told that the pt., who suffers from a schizophrenic illness, shows no apparent positive symptoms at present, is compliant with medication, engages in ward therapies, and states categorically that he will remain as an informal patient."

9.139 We comment that of these four reasons, the last three are not relevant to the question of whether RR was *"still suffering from a mental illness … of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment*. It is unclear, therefore, why these factors were listed as reasons for the Managers' decision on this first question. The fact that RR showed *"no apparent positive symptoms"* can certainly be considered as relevant to the issue of the "degree" of RR's mental illness, but does not address the issue of the underlying "nature" of that illness. The Managers' failure to address this issue of the 'nature' of RR's illness is a matter of particular concern, since, for the reasons discussed below, we consider that the 'nature' of RR's mental illness was such as to make it appropriate for him to be detained in hospital for treatment.

The second legal criterion considered by the Managers was: *"is it necessary for the health or safety of the patient or for the protection of other persons that he/she should receive such treatment and it cannot be provided unless the patient is detained under this Section?"* The Managers ringed the 'no' option to this question and gave the following as their reasons:

"The pt. continues to require treatment, which he accepts and Managers consider that, although he continues to require the care of this structured unit, it can be given without detention".

9.140 The first point to make here is that, having concluded that RR was not still suffering from a mental illness (or other mental disorder) of a nature or degree which made it appropriate for him to be detained in hospital for medical treatment, there was no reason for the Managers to consider this secondary question at all – the Section 37 Order could not be continued in the light of their first conclusion. This in itself suggests a lack of clarity about the role which they, the Managers, were performing. However, it is fair to say that, if the Managers were satisfied that RR would accept treatment on a voluntary basis in hospital, whether or not he was the subject of a Section 37 Order, they could base a decision to discharge the order on those grounds. The way in which the Managers set out their reasons, however, suggests to us a worrying lack of clarity in their approach.

9.141 We now consider the issue of whether their decision was a reasonable or appropriate one. We have already commented on the apparent absence, in the written reasons provided by the Managers, of consideration having been given to the 'nature' of RR's mental illness. The Mental Health Act Manual by Jones, a copy of which is usually available to Managers at hearings and a copy of which C16 told us he had previously been given, sets out the relevant case law concerning "nature". This includes the case of *R. v. London and South West Region Mental Health review Tribunal, ex. P. M.* In that case, Latham J. when considering the position of a patient with a history of relapsing, said:

"The correct analysis, in my judgment, is that the nature of the illness of a patient such as the applicant is that it is an illness which will relapse in the absence of medication. The question that then has to be asked is whether the nature of that illness is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment. Whether it is appropriate or not will depend upon an assessment of the probability that he will relapse in the near future if he were free in the community."

9.142 In April 2003, the position was that RR was suffering from schizophrenia, a relapsing illness - he would relapse if he did not take his medication, and indeed, he had twice shown evidence of relapse whilst taking his medication within the past year, even when in the contained environment of a hospital. It was only 10 months since he last experienced command hallucinations telling him to harm others. The nature of his illness was such that the issue for the Managers should have been one of proportionality - whether the risks to the public outweighed the wishes of the patient.

9.143 We were very surprised that, given RR's history, both past and recent, the Managers decided upon discharge, particularly when their evidence to us was that it was most unusual for them to discharge against the advice of the RMO. C16 told us that he had taken part in over a thousand hearings and said *"I think I've only ever discharged one other forensic patient, not more than two forensic patients. That's up to now, not just up to then."* G3 said that for her to discharge any patient was *"very, very rare. I always err on the side of caution."* The third member of the panel, M2, concurred, saying that, in all her time sitting on Managers' hearings, she had probably discharged *"fewer than ten"* patients from any form of order. She could not remember ever having discharged a forensic patient; and G3 told us she had never discharged a forensic patient.

9.144 It is worth here setting out what was before the Managers on this occasion. CONS3 had previously provided a report which stated:

"In my opinion, this patient is suffering from mental illness and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in hospital. Such treatment is likely to alleviate or prevent a deterioration in his condition. I am of the opinion that it is necessary, in the interests of the patient's own health, in the interests of the patient's own safety and with a view to the protection of other persons that this patient should receive treatment and it cannot be provided unless he continues to be detained under the Act, for the following reasons. He has a history of psychotic illness with auditory hallucinations, with serious offending to others. His offending pattern now appears to be more impulsive and may relate to an early vascular dementia. Even in hospital, he has made threats to fight, damaged property and gone 'AWOL' and suspected of theft. He has limited understanding of his offending and needs further hospital treatment."

9.145 The formal medical report for the Managers' hearing was written by CONS3's SHO, DR3. DR3 did not mention CONS1's reports and did not explicitly set out, in the 'opinion' section of her report, the team's concerns about RR's dangerousness to women. CONS3 told us that he had seen and approved DR3's report before the Managers' hearing, although he had not countersigned it, which he agreed would have been good practice. As regards the content of the report, CONS3 told us:

"Re-reading it now, it is very easy to say that it could have been more emotively argued and it was not. Factually, it is accurate. It does discuss the point towards the risk. And I have to say that I would not have thought in any way, shape or form that the Managers would, or were going to, make him informal based on this report. I thought it was absolutely impossible that they would make him informal".

9.146 The social worker's report for the Managers meeting was prepared by Q3. As we have commented above, she was an outside social worker, rather than a member of the

hospital team (because RR was from Croydon, whereas the team social worker on Witley 3 was from Southwark). Her report stated, incorrectly, that:

"[RR] has demonstrated no direct psychotic behaviour since his admission to hospital in January 2002."

The report concluded:

"It is therefore recommended that [RR] remain on detention (Section 37) until his team feel that his mental health is sufficiently stable and all options for accommodation have been fully discussed and considered".

The manner in which Q3 expressed herself here was unfortunate. The need for there to be further discussion of the available options for a patient's future accommodation is <u>not</u> a criterion for renewing an authority for detention.

9.147 There was also a nursing report prepared for the Managers by BRH3, an RMN on Witley 3 ward. It is not mandatory for there to be a nursing report for a Managers' hearings, although the Code of Practice states at Section 23.14:

"In advance of the hearing, the review panel should obtain written reports from the patient's RMO and others who are directly involved in the patient's care, such as the keyworker, Named Nurse, social worker and clinical psychologist."

9.148 BRH3 described himself in his report as the 'primary nurse'. The report was completed on a pro forma which appears to be an internal SLaM creation. The questions on the pro forma were proscriptive in that they limited the areas for comment to a series of pre-defined headings. None dealt with the criteria defined for consideration by the Managers. This was right and proper - nursing staff are not qualified to diagnose illness or prescribe treatment. In this case, however, the nursing report was at odds with the conclusions of the medical report in that it stated: *"[RR] does not present a physical or psychological danger to others".* BRH3 also stated *"It is my belief that he will continue his treatment if taken off Section, as he has some insight into his medical condition."*

9.149 CONS3 told us that he was unaware of this nursing report or of its contents before the Managers hearing. It also seems unlikely that BRH3 was aware of the contents of the medical or social work reports when he prepared his pro forma. In our view, it is poor practice for nurses, or indeed any other clinician, to produce reports contradicting the views of the clinical team without informing them of this first.

9.150 We recommend to Trusts providing mental health services that no reports for Managers' hearings or Mental Health Review Tribunals should be prepared in isolation from other members of the multi-disciplinary team.

9.151 We asked why the Managers had, in this instance, chosen to overrule the views of the consultant forensic psychiatrist. In reply, C16 told us that he had been involved in a previous appeal by RR, which had been rejected, but that on this occasion RR had been represented by a lawyer. C16 said us that RR had seemed to be improved mentally and that he had felt that it was in RR's best interests to stay on Witley 3 as an informal patient. His reasons for this conclusion were essentially pragmatic. RR had no fixed abode and no support from his family. He had been very unwell and he was getting good nursing care on Witley 3. He was a person who would benefit from a very structured environment, and Witley 3 had the great advantage of being an all-male ward. C16 explained that a significant component in his decision to allow the appeal was that RR had said that he was going to stay at Witley 3 voluntarily, but his reasons had also included the fact that RR was responding to medication. He said:

"We had seen that [RR] had had a longish period of treatment with medication in a particularly intensive nursing environment, and that as far as we could see at that time, he had been a 'good boy'. He had done all that was expected of him, apart from a few blips here and there."

9.152 We comment that whilst a year might indeed be termed a *"longish period of treatment"*, we find it difficult to understand how the Managers could have regarded two episodes of relapse, one with command hallucinations to harm others, as well as the other behaviours detailed above, as no more than *"a few blips"*. Using the criterion of being *"a good boy"* suggests a fundamental lack of understanding of issues of risk.

9.153 G3 told us that she had been swayed by the nursing report which had stated, in effect, that there was no reason why RR should be in hospital. In their evidence to us, the Managers commented that the nursing report would generally come from the individual with the highest level of patient contact, and they considered such a report was essential to formulating a well-rounded view of the patient's care and progress. We nevertheless thought it surprising that such an experienced panel chose to place greater reliance upon the nursing report than the views of the consultant psychiatrist with responsibility for RR's management, at least without fully exploring with the consultant why there was such a difference in view between him and the nurse in question. We note, in this regard, that Section 23.17 of the Code of Practice states:

"While the panel must give full weight to the views of all the professionals concerned in the patient's care, its members will not, as a rule, be qualified to form clinical assessments of their own. If there is a divergence of views about whether the patient meets the clinical grounds for continued detention, ….the panel should consider an adjournment to seek further medical or other professional advice."

9.154 CONS3 had been called away to an emergency in the course of the Managers' hearing. The Managers told us that their recollection was that he had given some oral evidence to them before he had to leave, and that, after his departure, his SHO, DR3 remained to represent the medical team. We are, however, concerned that the Managers here then proceeded to discharge a patient against the advice of the RMO without the RMO himself being able to attend the entirety of the hearing and having the opportunity fully to respond to the arguments which the Managers considered justified discharge. Section 23.16 of the Code of Practice specifies that the Managers should ask the RMO to give his views during the hearing. It was unfortunate that, in this instance, CONS3 was called away to an emergency. An adjournment of an appeal of this nature is never satisfactory, but we take the view that it is only in the most exceptional circumstances that Hospital Managers should choose to discharge a patient against the advice of the RMO if they have not had the opportunity to hear from the RMO himself.

9.155 It is, accordingly, our recommendation to NHS Trusts providing mental health services that the guidance given to Hospital Managers, in the course of their training, should include the strongest possible caution against deciding to discharge a detained

patient against the advice of the RMO without having first taken oral evidence from the RMO.

9.156 M2 told us that she had been trained that it was appropriate to look to the least restrictive method of dealing with a person, compatible with the nature and degree of their illness. She said that her thinking may have been along the lines that, if the nature of RR's illness was never going to change, he would never get off the Section at all. Both she and G3 thought that RR would stay on Witley 3 and that the formality of a Section 37 Order was not needed in order to achieve this result.

9.157 The evidence before the Managers was that RR suffered from a relapsing illness, and that he had suffered relapses even when on medication and in hospital. The Managers were aware that he was potentially a risk to women with whom he was in a relationship, and that the result of the discharge would be that RR would be free, if he wished, to leave the hospital and form relationships. The fact that he had said he would remain on the ward voluntarily was a relevant consideration, but whatever RR's intentions might have been as at 14 April 2003, the result of the discharge of the Section 37 Order was that he was free to walk out of the ward and not return.

9.158 In these circumstances, we have concluded that the Managers' decision was a mistake. We are conscious of the benefits of hindsight, but take the view that the information which was available to the Managers at the time was such that their decision to discharge, against the RMO's advice, was misguided.

9.159 It is, accordingly, relevant to consider the training which these Managers had had. C16, the chairman, told us that he had been to a number of training events over the years. He mentioned training in child protection, substance abuse, fire training and cultural diversity. There had, however, been no training module in risk assessment, and no training specific to patients with a forensic background. Significantly, following AT's death, and as part of the response to the issues arising from the homicide, a forensic training module has been introduced for Managers. C16 described this as *"an afternoon lecture with overhead slides"* from a forensic psychiatrist at the Bethlem. He said that,

as a result of having attended this session, he now appreciated that the Managers needed to be "*a lot more careful"* with forensic patients, adding: "*There is usually a much higher risk element, or there has been a history of risky behaviour or violent behaviour, etc., which you can't disregard."*

9.160 M3 from SLaM, who accompanied C16 when he gave evidence, told us that one of the changes made at SLaM following AT's death was that Managers without this forensic training were no longer allowed to sit on Managers' hearings for those detained under Part III of the Mental Health Act 1983 (i.e. admissions through the courts). This is certainly a sensible step to have taken, bearing in mind the error of judgment which we consider occurred here, and, in particular, the Managers' apparent failure fully to appreciate the significance of RR's forensic history. Those shortcomings were, in our view, particularly concerning bearing in mind the considerable experience of the three Managers who were concerned with RR's appeal.

9.161 We have not carried out a detailed investigation into the nature and extent of the training which was, in 2003, provided to Hospital Managers before they sit on appeals of this nature. It is clear that following, and as a result of, this homicide, consideration has been given to the need for enhanced training, to improve Hospital Managers' understanding of the issues which can arise in the case of a forensic patient. We remain concerned, however, that such an experienced panel came to such a surprising judgment, and provided reasons which we consider evidenced a lack of clarity in their understanding of the issues which they had to address.

9.162 We accordingly recommend to NHS Trusts providing mental health services that there should be a comprehensive review of the nature and extent of the training given to Hospital Managers before they sit on appeals of cases admitted under Part III of the Mental Health.

9.163 We also recommend to SLaM that it undertake a review of the nature and extent of the training given to its Hospital Managers before they sit on appeals of cases admitted under Part II and Part III of the Mental Health Act 1983 in order to assess

whether that training is now sufficiently detailed and wide-ranging to provide those Managers with a proper understanding of the legal principles which need to be applied, and, in particular, of the distinction between issues concerning the "nature" of the mental illness and the "degree" of that illness.

9.164 In any event, it appears to us an anomaly that Managers have the power to discharge some patients placed on hospital orders by the courts, when they are prevented from releasing others. RR pleaded guilty to an offence of robbery contrary to Section 8(1) of the Theft Act 1968 - a relatively serious crime. It is difficult to imagine that the sentencing court would have envisaged RR being released from the Section 37 Order, against medical advice, only thirteen months after the making of the order. Patients "sentenced to hospital" by the courts are a special group, and their cases often involve more complex factors than the cases of those placed on civil orders under the Act. We are concerned that Hospital Managers and their delegees may not possess the necessary skills to deal with cases sent to hospital by the courts.

9.165 We understand that the last guidance issued by the Home Office to the judiciary on the subject of restriction orders was in 1990 and that new guidance is planned by the Ministry of Justice for issue in 2008.

9.166 We recommend to the Ministry of Justice that the new guidance to be issued to judges in 2008 should make prominent the fact that Hospital Managers can (and do) discharge Section 37 Orders against medical advice if restriction orders under Section 41 are not made concurrently.

9.167 The Managers' decision to discharge RR did, in our view, have a significant impact on how events subsequently unfolded. If a patient is compulsorily detained, that inevitably has an impact upon the perception of the risk that a person poses and the interaction between the patient and the clinical team. When the Section 37 order was discharged, the treating team lost the power to direct RR into an appropriate placement against his will - the power to determine RR's placement passing from the RMO to the patient. Significantly, it meant that if RR did not want to remain on Witley 3, he did not have to do

so. He was free to look for his own accommodation, and the evidence discloses that he did indeed do this. In a letter to Q3 dated 30 July 2003, CONS3 expressed his concern that RR had taken to advertising himself in a local newsagents as an elderly man requiring accommodation who would help with gardening to offset costs. He commented: *"Whilst this situation would be undesirable and inappropriate, it is indicative of his desire to move on from hospital now that he is an informal patient."*

9.168 It is likely also that the discharge had an effect in "downgrading" the seriousness with which RR's case was taken by other people – amounting, in effect, to a downgrading of perceived risk. W1's evidence, which we found credible, was that the fact that RR had, in the period between the first assessment in August 2002 and the second assessment in August 2003, become an informal patient probably influenced him significantly when he changed his mind and agreed to RR's admission to Shrewsbury Court.

9.169 The fact that, in the event, RR remained on Witley 3 for another 14 months after the discharge of the Section 37 Order was pointed to by the three Managers as a partial justification of their decision. But the length of that period is misleading. RR was offered a placement at Shrewsbury Court on 5 September 2003, less than five months after the Managers' hearing. The remaining time that he spent on Witley 3 was a result of waiting for a vacancy to emerge and delays in the funding process. The evidence is that RR himself was keen to move on from Witley 3 and was actively trying to find accommodation shortly after the discharge from the Section 37 Order.

9.170 Attempts to arrange RR's transfer to Shrewsbury Court would probably have been made even if RR had remained compulsorily detained. A placement at Shrewsbury Court cost £49,400 per annum, compared to £123,000 at Witley 3. The requirements for RR's care concerned the nature, quality and expertise of the facility, rather than its particular designation. However, if RR had remained a compulsorily detained patient, it is at least possible that Shrewsbury Court might have examined the referral more carefully and/or that Witley 3 might have examined the suitability of Shrewsbury Court more carefully.

Could RR have been further detained after his discharge by the Managers ?

9.171 Having concluded that the Managers' decision to discharge RR from the Section 37 Order was a mistake, the question then arises as to whether CONS3 should have immediately taken the robust step of "re-sectioning" RR - a point made by the Managers themselves in the course of their evidence to us.

9.172 CONS3 described himself as "*flabbergasted*" by the outcome of the Managers' meeting, but he explained his decision not to re-section RR after their decision to discharge him as follows:

"There is a difference in my mind between starting a section de novo or continuing one, and there was no material change of circumstance ultimately. The mental illness was certainly not of a degree that you would section him if you saw him in outpatients, and arguably I do not think that if you saw him in outpatients at the time you would say, 'My goodness, such is his psychopathic disorder this man needs to be detained in hospital' because he was in hospital and he was going along with the treatment programme. So, ultimately we said no, he is in hospital. He is staying informally. We will carry on like this."

9.173 We also comment that a second psychiatrist and an approved social worker would have had to agree to a new Order. In the unusual circumstances of this case, such agreement might not have been straightforward to obtain.

9.174 CONS3 went on, very candidly, to say that with the benefit of the experience he now has, and if faced with the same situation today, he would re-section RR. In 2002 he had only been a consultant for about 18 months and was still, as he put it, on *"a learning curve"*.

9.175 We have considerable sympathy for CONS3's position in this respect. In order to re-section a patient, there has to be a material change in their condition. What amounts

to a “material change”, sufficient to justify re-sectioning, is a matter for interpretation, but it is far from certain that a case for such a change could have been made immediately after the Managers’ hearing. The position might well have been different three months later, when RR started advertising for accommodation. With hindsight, it would, perhaps, have been wise for CONS3 to have included, as part of RR’s care-plan, that if RR did attempt to leave the hospital, or if there was some other change in his circumstances, he should immediately be assessed with a view to possible compulsory detention.

10. RR's care at Shrewsbury Court

10.1 Events at Shrewsbury Court after RR's admission have been outlined above, as have various of the deficiencies at Shrewsbury Court. In this section of this Report, we consider how those deficiencies impacted on RR's care, and we comment on what we perceive to have been the key failures – when action could and should have been taken which might have prevented this homicide.

CONS4's acceptance of RMO status in RR's case

10.2 Whilst RR was accepted for admission at Shrewsbury Court in August 2003, he was not actually admitted until June 2004. Shortly before the transfer, on 19 May 2004, CONS3 wrote to CONS4 seeking clarification about RMO care for RR at Shrewsbury Court. Included with this letter were various enclosures, albeit unspecified. CONS4's evidence to us was that he picked out the following from his perusal of these enclosures:

"The long history of violent behaviour, particularly to females; use of knives and scissors; the violence in the context of relationships; diagnosis of schizophrenia, but possibly delusional disorder with paranoid features; paraphilia; and some sign of other dementia."

10.3 CONS4 had never accepted a patient from a regional forensic service at Shrewsbury Court before, but he told us that he recalls thinking *"potentially [RR] was quite a dangerous patient."* Nevertheless, CONS4 agreed to act as RMO to RR without examining him first. It will be recalled that, at this time, CONS4's responsibilities as an employee of Shrewsbury Court extended only to providing care for the detained patients there, so his willingness to act as RMO for RR was a departure from his usual role.

10.4 His decision to accept responsibility as RMO for RR without examining him first was, in our view, an error of judgment. Had he refused this request, on the reasonable grounds that he was already seriously over-stretched, that would have presented a real,

possibly insurmountable obstacle to RR's transfer. The transfer could only have taken place if someone agreed to become RR's RMO, and the only person who could possibly perform that function at Shrewsbury Court was CONS4. If CONS4 had refused the request in CONS3's letter of 19 May 2004, it seems to us very probable that that refusal would have prompted enquiries by CONS3 into the level of consultant input at Shrewsbury Court. Such enquiries would, in turn, have led him to appreciate the inadequacy of that input.

10.5 Had CONS4 chosen to visit RR at Witley 3 or to have RR brought to meet him at Shrewsbury Court, he would probably have appreciated that one of the key assumptions upon which the decision to admit RR had been based – the assumption that he was physically too frail to present a risk to anyone – was misconceived. RR's physical state did vary from time to time – in particular, there were occasions when breathlessness rendered him largely immobile – but whatever the limitations on his mobility may have been, it would, we think, have been apparent on meeting him that he was physically capable of harming a woman living in close proximity – i.e. in the same hospital - particularly if RR was able to form a close relationship with that woman.

10.6 The probabilities are that, with his NHS commitments, CONS4 simply did not have enough time to devote to Shrewsbury Court, or to contemplate meeting and assessing RR, or indeed any other prospective informal patient. The question remains - why did CONS4 agree to take on the responsibility of acting as RR's RMO when he knew RR was a potentially difficult patient and when he must have known that he would have very limited time to devote to RR's care.

10.7 We think that the likelihood is that CONS4 genuinely believed that RR's physical health was such that he would prove to be an undemanding addition to his workload. We also think it is likely that CONS4 was willing to help out an establishment from which he was receiving substantial remuneration for what was, in reality, no more than about 5-6 hours work each week (although he was on call for much of the time, this was not, as a matter of practicality, an onerous obligation).

10.8 Whatever the reasons, however, our view is that CONS4's willingness to take on the role of RR's RMO compounded the problems caused by the inadequacies in Shrewsbury Court's admissions procedures.

The pre-transfer case conference at Witley 3

10.9 In the transition between one psychiatric service and another, the communication of accurate information about a patient's case is crucial. Such information includes details of history, diagnosis, care needs, treatment strategies, risk and prognosis. It is communicated in various ways - in written reports; by the receiving service examining the patient; and at the case conference prior to transfer, at which essential issues can be discussed between the teams from both services and in which the patient and his family or representatives may also be involved.

10.10 In RR's case, detailed written information was provided to Shrewsbury Court by the forensic service at Witley 3 but it is unclear to what extent this was read or digested by its recipients. Shrewsbury Court did not carry out any structured assessment or examination of RR prior to the transfer. There was a further opportunity for Shrewsbury Court to acquire information about RR at the pre-transfer case conference, but our view is that Shrewsbury Court failed properly to engage in this process.

10.11 CONS3 wrote to CONS4 on 14 June 2004, inviting him to a case conference on RR at the Bethlem on 21 June and apologising for the short notice. CONS4 did not attend, perhaps because of the short notice, perhaps because his habit was to devote only Tuesday afternoons to Shrewsbury Court and the case conference was on a Monday morning.

10.12 We acknowledge that it is often difficult for busy consultants to attend meetings at short notice, but CONS4 could have asked for the case conference to be postponed to a date which was more convenient for him. This would certainly have been the wiser course of action, particularly with a patient for whom he had agreed to act as RMO, who

was coming from a forensic service and who CONS4 considered *"potentially … quite a dangerous patient."* His failure to attend this meeting is, perhaps, an illustration of the limited extent to which he was willing or able to attend meetings which could not be accommodated within the single session which he had adopted the practice of working at Shrewsbury Court.

10.13 Had CONS4 attended the meeting, we think it likely that some of the misperceptions about RR would have been exposed and corrected. In the event, the opportunity was missed. Normally, W1 would have attended such a meeting, but on this occasion it was a nurse, W2, who attended on behalf of Shrewsbury Court. W1 told us that the reason for this was that, if he had attended, Whitepost would have had to pay him for an extra session and he understood that it was unwilling to do so. DR2, however, strongly rejected the suggestion that Whitepost would have been unwilling to meet the costs of W1 attending this meeting. It is not now possible to determine the truth of the matter. What can be said, however, is that it was plainly inappropriate for this meeting to be attended by W2 alone. He had never been alone to such a meeting before. He was not given any guidance as to his role, nor as to what information he should be seeking to obtain. He had no forensic training and he had neither the skills nor the experience adequately to represent Shrewsbury Court. Any nursing representative sent to such a meeting should be of sufficient seniority to have a clear grasp of the issues involved, to know which points to focus upon and to explore in discussion, to have the ability to form their own judgment on important elements and to make decisions on behalf of the receiving establishment. Our view is that W2 did not have these necessary qualities.

10.14 It is our recommendation that PCTs and NHS Trusts providing mental health services should, when commissioning services from "out-of-area" hospitals, make it clear to service providers that it is expected, as a matter of routine (and will be required as a matter of contract), that at pre-transfer case conferences, both hospitals will be represented by appropriately senior staff; and that, in all but the most straightforward cases, this means that there should be a multi-disciplinary representation, including the presence of both the transferring and the receiving consultants.

The failure to follow up RR's placement at Shrewsbury Court

10.15 We have commented above on the complicated history of RR's involvement with SLaM and what seemed to be the absence of clear protocols or pathways for the transfer of responsibility between services within SLaM. Boundary and interface issues appear to have been important. CONS2 had agreed to re-admit RR to Chelsham House if the situation rapidly broke down at Shrewsbury Court, but this involvement did not extend to any assessment of whether the placement was breaking down. RR was being transferred from the in-patient forensic service, not the elderly service. He was being discharged into a general adult placement, not an elderly placement, and he was being referred to an area for which the SLaM elderly team had no responsibility. CONS3 had expected the Croydon community forensic team to have some involvement in the follow-up, but CONS7's view was that this was an elderly case.

10.16 It would, however, have been open to CONS4 at any stage to seek a follow-up assessment from any of these three agencies when matters began to go wrong at Shrewsbury Court. He did not do so. CPA meetings would have provided a natural forum to which other agencies could have been invited to review progress. However, none had been held on RR by the time of the homicide.

10.17 What follow-up there was comprised 'placement' follow-up, not clinical follow-up. There were two care-placement meetings about RR on Thursday 29 July 2004 and on Wednesday 22 September 2004. CONS4 did not attend either. His non-attendance could be merely an unfortunate coincidence, but we think it likely to be a further indication of the fact that it was not possible for him to provide adequate care for all of the patients at Shrewsbury Court for whom he had responsibility in the limited time which he was spending there, an issue to which we now turn.

The psychiatric input to the care of RR at Shrewsbury Court

10.18 The evidence presented to us indicates that RR probably received no more than an hour or so of contact with a psychiatrist in the time he was at Shrewsbury Court, a period of nearly six months. Significantly, his condition was not even reviewed by his consultant, CONS4, when, in late October 2004, his mental state deteriorated and he expressed an intention to kill AT. This level of input from staff at Shrewsbury Court was, in our view, wholly inadequate.

10.19 It should go without saying that all patients in psychiatric hospitals should have their cases reviewed by a consultant on a regular basis and be seen regularly by psychiatrists. In a rehabilitation setting, a fortnightly consultant review may be sufficient, whereas an acutely ill patient may need daily review. In most hospitals, there are junior psychiatric staff on the ward every day, who regularly review patients' progress, who assist with the consultant's ward rounds and who are on hand to deal directly with problems as they arise. In some well-provided hospitals, there is an extra tier of junior doctor, intermediate between the consultant and the ward psychiatrist to whom the latter can also turn. In hospitals where there are no junior staff at all, the role of the consultant is necessarily more direct and it behoves the consultant to spend more time on the wards in order to ensure the provision of adequate care.

10.20 There were, in reality, no junior psychiatric staff at Shrewsbury Court. As explained above, DR1's role there was a very limited one. Notwithstanding this, consultant input to RR's care was negligible and for long periods it was non-existent.

10.21 RR was at Shrewsbury Court for 24 weeks and five days. He arrived on Tuesday 22 June 2004 and left on the day of the homicide, Sunday 12 December 2004, when he was taken into police custody. During his time there, he was moved to East Surrey Hospital on two separate occasions for a total of 12 days. The first such period was between 1 and 5 November 2004, when he was moved to East Surrey Hospital: complaining of shortness of breath. The primary diagnosis was "*infective exacerbation of chronic obstructive pulmonary disease*". He returned to Shrewsbury Court on his own by taxi without waiting

for hospital transport. The second such period was between 25 November and 2 December 2004, when he was treated for shortness of breath due to pulmonary oedema. Both periods were during the time that he was evidently relapsing in terms of his psychotic illness.

10.22 During RR's in-patient stay at Shrewsbury Court, there are medical entries in his notes on only five occasions. On 22 June 2004, an entry was made by CONS4 following RR's admission. On 29 June 2004, there was a ward round entry by CONS4. There is a further ward round entry by CONS4 on 7 October 2004. This is followed by a lengthy entry made by DR1 dated 29 October 2004 (but probably recording an attendance on 30 October). Finally, on 11 November 2004 there is a further entry by CONS4.

10.23 So RR's case was reviewed on only five occasions during his time as an in-patient at Shrewsbury Court, two of which were in the first eight days. In the remaining 23 weeks and four days, CONS4 reviewed RR's case only twice, the last occasion being a month before the homicide. This averages out at approximately once every twelve weeks. There was a period of more than three months, between 29 June and 7 October, when CONS4 did not review RR's case at all. Our view is that this was wholly inadequate.

10.24 A second issue concerns how often RR was actually <u>seen</u>, in the sense of being subject to some form of examination or interview by psychiatric staff. It is possible to conduct interim reviews of a patient's progress by considering the reports of others. However, a psychiatrist cannot form his own opinion of a patient without actually interviewing and examining them himself. In someone with a chronic psychiatric condition, such an examination is essential when there is any adverse change in their condition, such as deterioration in mental state, or any reports of concern about their behaviour. But even apparently stable patients need regular interview and examination to check their progress regardless of whether problems have been reported. It is, after all, the characteristic of hospital care that it involves medical treatment as well as nursing care.

10.25 It is clear that RR was interviewed by CONS4 on 22 June 2004, because there is a record of a physical examination. We think it very probable that CONS4 did <u>not</u> see RR on

11 November 2004, because the nursing notes explicitly state that, at the time of the review, RR was out shopping (with AT's money.) As noted above, when we put this to CONS4, he told us he was uncertain whether he had actually seen RR on this occasion – accepting that it was at least possible that he had conducted a review of RR's notes without seeing RR. It seems likely therefore that the mental state items recorded by CONS4 in his note of 11 November 2004 were nursing observations which he summarised.

10.26 We comment that if CONS4 had a practice of writing down mental states based on nursing observations, then there is also nothing in the notes specifically to indicate that he saw RR on 29 June 2004 or 7 October 2004. His notes do not state that he actually saw RR, nor do the nursing notes. The nursing notes mention RR being seen by CONS4 on only one occasion, 23 June 2004.

10.27 RR told us in his interview (and then reconfirmed) that he had seen CONS4 just twice during his time at Shrewsbury Court. He said:

"The first time, he said: 'Do you feel like hurting anybody?' and I said no. 'Are the voices back?' and I said no. He asked if I felt like harming myself, and I said no. That was it. That was the first time.

The second time I saw him was after I had been there three months. He said: 'Your time's up now. It's up to you whether you want to stay or not.'"

10.28 RR appears to be describing one occasion shortly after his arrival at Shrewsbury Court and one at the time of his three-month review. There is no note in the medical notes about any meeting with CONS4 on the second of these occasions, and CONS4 was not recorded as being present in Q1's care management review document. It is possible that CONS4 might have seen RR without it being recorded in the medical or nursing notes, or it is possible, and perhaps more likely, that RR's recollection in this regard is inaccurate.

10.29 Our conclusion is that it is certainly a possibility that RR was examined only twice by psychiatric staff during his admission – once by CONS4 on 22 June 2004 and once by DR1

on 29 October 2004 – and that it is, in any event, highly probable that he was seen no more than four times – on 22 June, 29 June, 7 October and 29 October.

10.30 The first documented record of threats by RR towards AT was on 12 October 2004. It seems probable to us that RR was only seen once between this date and the homicide on 12 December 2004 by any member of the psychiatric medical staff. And this was by DR1, a staff grade doctor with limited psychiatric training who told us that she considered her role as being a form of temporary cover for CONS4, dealing primarily with physical ailments rather than psychiatric issues.

10.31 This level of psychiatric input during this period was, in our view, wholly inadequate bearing in mind the seriousness of the episode at the end of October 2004. We consider it would have been inadequate even if CONS4 did actually see RR on 11 November 2004, instead of merely reviewing his notes. RR did not receive, by a significant margin, the level of psychiatric input which his condition merited.

10.32 It is almost certain that this lack of psychiatric input into RR's case was a consequence of CONS4's excessive work load. We have discussed this issue, and the responsibility for this state of affairs occurring, at length above, but it is worthwhile summarising the position. CONS4 told us that he had agreed, in September 2004, (which was, unfortunately, shortly before the relapse in RR's condition in October 2004) to act as RMO for some 46 in-patients at Whitepost, albeit, he said, only as an interim measure. He had previously been the RMO for 14. He continued, however, to work no more than a single 4-hour session a week at Whitepost (with an additional 1-2 hours each week outside normal working hours), whilst working for the remainder of the week in his NHS consultant post.

10.33 CONS4 accepted that in the time available to him, he could not provide an adequate standard of care to the 46 patients or so for whom he agreed to become the RMO. Agreeing to take on this responsibility was, in our view, a major error of judgment on his part.

The Failure of "Risk Assessment" at Shrewsbury Court

10.34 No risk assessment in any true meaning of the word, brief or otherwise, was ever carried out on RR after his admission to Shrewsbury Court.

10.35 We have already outlined, earlier in this Report, the gross inadequacies in the "risk assessments" purportedly carried out at Shrewsbury Court. Those inadequacies are manifest in the documentation relating to RR's time there. On 11 November 2004, CONS4 asked for a risk assessment to be carried out on RR. This was clearly an important assessment, following as it did RR's relapse at the end of October 2004. But the task was delegated to W2, RR's Named Nurse (who completed the assessment form on 18 November 2004). It was apparent from our interview with W2, that he had little understanding of risk assessment. Indeed, it was unclear whether he had received any form of training in it. We reiterate that we consider it extraordinary that risk assessment was devolved in this way to one member of staff, rather than being a multi-disciplinary issue. But it is all the more extraordinary that CONS4 should, on this occasion, have delegated this important task to the nursing staff when he ought, after his years working there, to have known of the limitations in their abilities in this regard.

There is, of course, little purpose in risk assessment, even of good quality, unless it is intimately associated with risk management. In other words, there is no point in identifying a risk, if this does not lead to the implementation of a coherent plan to reduce that risk. There is very little evidence at Shrewsbury Court that risk assessment, in as far as it existed at all, was accompanied by any form of risk management. This is exemplified by the form completed by W2 on 18 November 2004. In completing this form, W2 ticked "3-4" to indicate the risk was high or very high, for 6 of the 15 areas listed in the form namely, violence towards family, other residents, staff; risk of drinking or drug taking e.g. substance abuse; risk of self-neglect; problems with not taking prescribed medication; risk associated with activities of daily living; risk to physical health. There is a section on the Shrewsbury Court form headed "Risk Management Plan". W2 also completed this on 18 November 2004:

Action	By whom	Review date
1) To compliance with medications and therapeutic regime. 2) Relationship with women should be monitored	By all nursing staff on duty	18.2.2005
3) Deterioration on personal care 4) Very active physically to fellow clients. An expression of concern from others	By all nursing staff	18.2.05
5) To monitor [RR's] behavioural approach to smoking cessation	By all nursing staff	18.2.05

Items (1), (3) and (4) are simply restatements of problems without any suggestions as to management. Items (2) and (5) state that particular items should be "monitored". This in itself is meaningless, because it does not say how this should be done. In effect, it is stating that something should be done, without suggesting what. This was, unfortunately, something of a theme throughout RR's stay at Shrewsbury Court. It was repeatedly stated that his relationship with women should be *"monitored"*, but without saying what this actually meant.

10.36 There seems to have been no policy in place at Shrewsbury Court with regard to intimate relationships between patients. We were surprised that sexual relationships were permitted at all in a hospital, even one which seemed to have retained the culture of a residential nursing home. We do not know whether other mental health hospitals routinely allow intimate relationships between patients – we think that that would be surprising, but it is not an issue which we have investigated. However, our view is that

whatever a hospital's position might be in this regard, it should be clear to those purchasing services from that establishment.

10.37 It is our recommendation to NHS Trusts providing mental health services that, in order to avoid any ambiguities about this question, all units providing residential care to the mentally ill should have a formal policy relating to sexual relationships involving in-patients; and that whenever a placement is being considered "out-of-area", or in the independent sector, steps are taken to ascertain the policy adopted in this regard by the establishment(s) under consideration.

10.38 The existence of such a policy would mean that a care co-ordinator looking to place a patient, such as RR, who had a sexual component to his condition, would be able without difficulty to determine whether there was a danger that the patient might be allowed to form an intimate relationship with another patient. It would also be sensible for all units to make it a condition of admission that patients agree to abide by whatever the policy might be so that it is permissible for staff to say that, in the event that there is a breach of that policy, the patient will be removed from the unit. A clear policy also makes it a straightforward matter for staff to deal with, avoiding the sometimes difficult task of trying to balance whether one patient's right to confidentiality is outweighed by another patient's right to be fully informed about the dangers inherent in a relationship.

10.39 In addition to the deficiencies outlined above, the management plan on the risk assessment form of 18 November 2004 notably fails to include any mention of the risk of violence, even though this had been identified as *"high"* or *"very high"* on the score chart. It states that the recommended actions were to be carried out by *"all nursing Staff"*, but no one person was given responsibility for checking that the recommendations were carried through.

10.40 We should make it clear here that none of the above is intended to imply that W2's risk assessments were worse than anyone else's. Indeed, he seems to have made a rather greater effort than some of his colleagues, in that he did not simply copy out the previous assessment, as some staff members appear to have done. The main problem with the "risk score sheet", however, was that completing it was seen as all that risk assessment

involved. Once the form was completed, staff seem then to have proceeded on the basis that that was the end of the "risk assessment" process.

10.41 We accordingly turn to consider what should have been done in terms of risk assessment at Shrewsbury Court. The brief answer is that it was the RMO's responsibility to ensure that the issue of risk was addressed, both in terms of assessment and management. This should have been accomplished through regular interviews with patients and multi-disciplinary team discussion. Neither appears to have occurred at Shrewsbury Court. Modern psychiatric practice is predicated on multi-disciplinary working by professionals, but this did not happen at Shrewsbury Court. The psychologist only worked two or three sessions a week and did not take part in the ward round. There was, in reality, no junior doctor; the evidence we heard indicated that the social worker at Shrewsbury Court did not regularly attend ward rounds; and the nurses were poorly trained. Ward round reviews were largely left to the consultant and the nursing staff. CONS4 told us *"it became increasingly less likely"* that, if something important had happened, it would have been brought to his attention. In such a situation, it is perhaps not surprising that no meaningful risk assessment or risk management arrangements were in place.

Failure of Care Planning

10.42 The risks in RR's case were clear and were directly stated in the documentation available to Shrewsbury Court. There was a risk of violence to women, particularly in the context of developing relationships with women. Other factors were stress, for instance financial, and irregularities of depot administration. Warning signs were the development of a relationship, expressions of jealousy in the context of those relationships, musical hallucinations, and command hallucinations. It was stated that RR was sometimes reticent to reveal these and that he sometimes did so by asking for more medication. However, CONS4's care plan for monitoring and managing these risks and warning signs seems to have been limited to the following comments in his admission note of 22 June 2004.

"2) High risk of harm to others, low risk to self.

3) Increased obs. if there is an incident.

4) Search for weapons once a week."

10.43 All the problems and warning signs we have identified above occurred whilst RR was at Shrewsbury Court, but there was no plan in place to watch for them or to determine what action should be taken if and when they occurred. Although CONS4 states that he had seen all the paperwork (including CONS1's warnings), and notwithstanding his evidence that he was concerned about RR's case and that he was aware of the inadequacies of the quality of many of the nursing staff, he failed to put in place a structure to detect and react to warning signs of relapse and possible violence.

10.44 A detailed care plan should have been drawn up when RR was admitted to Shrewsbury Court. It is good practice for care plans to be drawn up before a patient is admitted, although, the care planning can only be completed once staff have had an opportunity fully to assess the patient and once the care has been discussed by the multi-disciplinary team. It would have been open to those assessing RR for admission to have noted details of the care plan at Witley 3 in order to indicate RR's likely needs if he were transferred. One of the purposes of the pre-transfer case conference was for the baton of the existing care plan on Witley 3 to be passed to the team at Shrewsbury Court. This baton was, in effect, dropped.

10.45 It is not for this Inquiry retrospectively to write a model care plan. However, we can point to the care plan in the CPA documentation following the meeting of 1 May 2003, which was available to W1 when he assessed RR in August 2003 and of which there was a copy in the Shrewsbury Court notes. We can also point to the care plan drawn up at the pre-transfer case conference on 21 June 2004, attended by W2. Other than the thoroughness and detail, the important element of these to note was the section entitled 'Crisis Plan'. This was split into two parts: 'Early warning signs/relapse indicators' and 'Nature of service response to a crisis'. In the Crisis Plan drawn up at the meeting attended by W2, the 'Early warning signs/relapse indicators' were listed as follows:-

"Command hallucinations – hears music

Illicit drug use

Irritable paranoid beliefs

Behavioural disturbance

His cognitive impairment can lead to behavioural changes and impulsivity"

Under "Nature of service response to crisis/Out of hours response', a plan was given for Shrewsbury Court to follow:

"Nursing home staff [sic] to contact on-call house manager, or GP, or on-call RMO, depending on the nature of the crisis.

Discussion with Witley 3 staff for advice (i.e. CONS3)

If admission required within the next 3 months, Chelsham House, Bethlem Royal Hospital, will admit.

After 3 months, Burnham Ward at Epsom General Hospital to provide a bed."

10.46 This was, we think, a perfectly reasonable plan, which Shrewsbury Court could simply have adopted. It could, perhaps, have been amplified by CONS4 following RR's arrival to take account of the limitations of the nursing staff at Shrewsbury Court. The plan need not have involved the complexity of the forms drawn up at the specialist Witley 3 service. It could and should have been simple, straightforward common sense, expressed in a way which was easy to understand. It should have listed the various warning signs and given specific instructions to nursing staff as to what to do if they were observed. Sensible instructions would, for example, have been to the effect that CONS4 should be telephoned if any of the warning signs were detected and further that, if there were any indications of immediate danger (such as command hallucinations, declarations of intent to kill or relationship jealousy), then RR should be put under arms-length observation until CONS4 had assessed him. However, this did not occur, the care plan being limited to the few short comments in CONS4's note of 22 June 2004.

Difficulties in the administration of medication

10.47 The administration of depot injections at Shrewsbury Court appears to have been poor in terms both of procedure and recordings. It is uncertain whether the last dose before the homicide was given and it appears that other doses may have been given late. In our view, there was also inadequate consideration of the prescription of oral anti-psychotic or anxiolytic medication.

10.48 CONS4 did not review RR's medication history whilst he was at Shrewsbury Court and we will, accordingly, briefly set one the history here, as it reflects on the issue of symptomatic relapse.

10.49 RR's dosage of Clopixol depot had been steadily lowered over the previous six years to a level at which "break-through" symptoms might be expected at difficult times. In the period up to December 1998, RR had been receiving 500mg Clopixol every two weeks. In December 1998, the dosage frequency was reduced to 500 mg every three weeks and on 8 November 1999 his depot dosage was reduced from 500 mg to 400 mg every four weeks. In December 2000, the frequency of his dosage was reduced to 400 mg every six weeks. RR then became symptomatic, complaining of hearing music. The dosage frequency was returned to four-weekly and his symptoms resolved. In November 2001, RR relapsed whilst on Clopixol 400 mg four-weekly, hearing tunes which he described as a "prelude to voices", combined with homicidal ideation. He became violent and needed to be admitted to hospital. This relapse was said to have been precipitated by stress. He was discharged on 19 December 2001 on 400 mg three-weekly. He needed to be readmitted to Chelsham House within five weeks of discharge after he was arrested for robbery. He continued thereafter to be prescribed 400mg Clopixol three-weekly throughout the period up to the homicide, at Chelsham House, at Witley 3 and at Shrewsbury Court.

10.50 However, during his stay at Chelsham House, he twice showed evidence of relapse. In June 2002, he experienced command hallucinations telling him to harm others, and in November 2002 he experienced musical hallucinations accompanied by violent behaviour. In December 2003, whilst an in-patient on Witley 3, RR began again to experience musical hallucinations. This was thought to be due to a problem with the administration of the last depot injection, which it was suspected might have been misplaced, with some leakage into fat. The symptoms resolved after the next depot injection. This incident is described

in the Witley 3 discharge summary dated 23 June 2004, which was sent to CONS4 at Shrewsbury Court. The risk assessment in that summary includes the passage:

"His risk of violent offending is related to the presence of psychotic symptoms. Relapse indicators include musical auditory hallucinations, command hallucinations or voices taunting him…..Relapse has reportedly been related to 'instability in his life, emotional involvement with females and excessive drinking of alcohol.' Our experience on Witley 3 has also highlighted the potential risk of inadequate treatment with psychotropic medication (due to faulty administration of the depot rather than non-compliance on [RR's] part) and illicit drug use."

10.51 In summary, therefore, the position was that RR was being given a depot dosage at which "breakthrough symptoms" were to be expected at times of adversity; and it had been established at Witley 3 that RR became symptomatic easily when there was a disturbance in the pattern of his depot injections.

10.52 The administration of depot injections at Shrewsbury Court was poor in procedure and recording. CONS4 told us that he had known instances when staff gave depot injections, but did not record them on the patient's drug chart. He said that he reviewed the charts at ward rounds, and we have seen or heard no evidence to the contrary. But if these reviews only took place every six weeks (at best) for each patient, then mistakes were unlikely readily to be noticed. We have already mentioned W10's evidence that an excess of depot medication on her return from leave led her to believe that medication had been signed up on the chart without actually being given.

10.53 The evidence relating to the depot injections administered to RR at Shrewsbury Court was as follows. He was transferred there on 22 June. The discharge summary from Witley 3, dated the next day, stated that the depot injection which RR was receiving was Clopixol 400 mg 3-weekly. It recorded that the last injection had been administered on 21 June 2004, a fact confirmed by a signature on the medication chart at Witley 3. The next dose was therefore due on 11 July.

10.54 The nursing notes record that 50 mg of Risperidone 50 mg was given to RR on 30 June. This was, however, not referred to on the prescription chart, and it is uncertain whether he was actually given this or not.

10.55 On 14 July C17, the GP, prescribed Clopixol 400 mg 3-weekly. The Shrewsbury Court notes record the following information about depot injections administered to RR during his stay:-

Injection 1) On 15 July, the nursing notes record that he was given his first Clopixol depot injection at Shrewsbury Court. This was therefore given four days late.

Injection 2) On 4 August, the nursing notes record that he was given his depot injection three weeks after the last dose. This is confirmed by the prescription chart.

Injection 3) According to the prescription chart, RR's next depot injection was given on the due date, 25 August. This was not, however, recorded in the nursing notes.

Injection 4) According to the prescription chart, RR's next depot injection was given on 15 September. Again, however, this was not mentioned in the nursing notes.

Injection 5) On 6 October the nursing notes record that the injection was administered and this is also recorded on the prescription chart.

Injection 6) On 27 October the prescription chart records the depot injection being administered. There is, however, no mention of this in the nursing notes.

Injection 7) On 17 November the prescription chart records that the depot injection was given, but this is not mentioned in the nursing notes.

Injection 8) On 8 December RR's next depot injection was due. There is, however, no record on the prescription chart of the depot injection being given on that day or subsequently. Neither is there any mention in nursing notes of the depot injection being administered at or around this time.

10.56 The evidence of the prescription record is therefore that the depot injection due four days before the homicide was not given.

10.57 RR's evidence to the Inquiry was that he felt that the depot injections had not been controlling his symptoms during his stay at Shrewsbury Court. He told us of the differences in those symptoms during the course of the three weeks between injections, saying:

"In week 1, I would hear nothing. In week 2, I would hear tunes. In week 3, I would hear the voices and I would tell them to eff off, and they would eff off".

10.58 His description is consistent with what could be expected if the depot medication was being administered at a dosage or frequency that was inadequate to control his symptoms.

By early December 2004, his mental state had probably been deteriorating for at least six weeks. This was in the context of a relationship with AT and of associated feelings of jealousy, which may have been delusional in nature. His depot injection was due on 8 December 2004. RR told us:

"The last thing I remember, which sticks in my brain, is that the last time I received an injection from Shrewsbury Court was on 18th November."

10.59 The last recorded date in the Shrewsbury Court prescription chart was 17 November, so RR's memory seemed to be fairly accurate. However, his evidence to us in this regard contradicted his account to the police after his arrest, when he said that he had received the injection two days before the homicide, adding that it was *"three, four days"* late.

10.60 Bearing in mind the stresses of the relationship with AT, a failure to give RR's depot injection on the prescribed date in December 2004 would have been far more significant than it had been in the month of July. It would have contributed quickly to a deterioration in his condition. If there was, as the records suggest, a failure to administer the depot medication on time in December 2004, that would, in our view, have been a

significant contributory cause of the deterioration in RR's mental state which led to this homicide.

10.61 A final issue with regard to medication concerns that of oral medication. Oral anti-psychotic medication or rapid oral tranquillisation could have been prescribed for RR to take on an "as required" basis, something which is commonly done in psychiatric units. The practice allows medication to be given when there is an indication of a need, such as the patient becoming more symptomatic or distressed, without the need to wait for a doctor to arrive. Despite the emergence of RR's symptoms in late October 2004, no PRN medication was written up.

10.62 Had a tranquilliser been available for W2 to dispense to RR on the morning of the homicide, it might have averted the homicide.

Confusions over observation policy

10.63 Apart from the very brief period immediately following his transfer to Shrewsbury Court, when RR was placed on 15-minute observations, the only occasion when it seems that RR was placed on a particular enhanced observation level was following the events of 29 October 2004.

10.64 However, there appears to have been confusion as to the meaning of 'close observation'. Some staff apparently thought this meant finding out where the patient was every half an hour. C7 told us:

"Constant observation is when you are passing by. You just make sure she is all right. If it is not put there '15 minutes' or 'an hour' or 'arm's length', observing somebody, I would consider it as constant observation". Discreet observation meant: "just keep an eye where he is".

10.65 CONS4 defined discreet observations as *"one-to-one but from a distance"* and said that continuous observations were *"general observation where staff are supposed to know where the clients are, particularly at mealtimes, drug rounds and so on."*

10.66 W19 told us that "close observation" meant *"the staff would keep an eye out on so-and-so"*, and this might mean checking on them every 15 minutes. He also said: *"it can be construed in different ways, and everyone might interpret it differently"*.

10.67 W7 said she did not know there was an observation policy. W13, a care assistant, told us she had never had any such policy explained to her.

10.68 When we asked W2 about the observation levels, he said they were *"continuous, everybody in Shrewsbury Court was on one-to-one"*. Asked how this could be, unless the number of nursing staff on duty equalled the number of patients, he replied: *"There are positions: there is one chair, that goes round that side, one chair here, that goes round that side…"* W2 said each patient was checked every half an hour at night, saying: *"when the time comes, you take a card and knock on the door individually to see how they are, because somebody might be dead"*. His evidence was that arms-length observations were sometimes asked for, but that more often than not, there were no extra staff provided to enable this to occur. He said that arms-length observations were rarely carried out in a literal sense, because staff were often called away for other duties.

10.69 In short, the position was that the nursing staff at Shrewsbury Court did not have a consistent understanding about what various levels of observation meant as a matter of practice. That meant that, if and when special observation levels were ordered, the result was necessarily unpredictable. It is, in our view, a further illustration of the ineptitude, lack of experience and lack of effective supervision of nursing staff at Shrewsbury Court.

Failure to prevent substance mis-use

10.70 RR's relationship with substances was problematic. His explanation for the robbery that led to his conviction at Croydon Crown Court in March 2002 was that he had been "*desperate for a smoke*". He had been noted to have taken ecstasy on one occasion whilst at Witley 3.

10.71 RR told us that he had chewed qhat at Shrewsbury Court during October and November 2004. Qhat is a stimulant drug, used in the UK mainly by members of the Somali, Ethiopian and Yemeni populations. Whilst it is not a controlled substance in the UK (unlike many other countries), it can cause psychiatric complications giving rise to paranoid psychoses in some people. In those with established psychotic disorders, qhat is known to act as a precipitant of relapse.

10.72 RR's evidence was that he had been introduced to qhat by another patient. He described chewing it for 10 minutes on each occasion and said that the effects, in the form of increased energy levels, came on within half an hour. RR told us that his chewing of qhat had preceded the voices by a number of days, but that he had not related the two. It is notable that the CPA summary of 24 June 2004 records under risk behaviour: *"The risk of psychotic relapse and behavioural disturbance is related to…illicit drug use."*

10.73 We found RR's description of qhat use credible. It is of concern that Shrewsbury Court was unable to prevent, or indeed, notice, drug-taking on the premises, particularly when this was proving harmful to the mental state of their patients.

Poor note keeping and lapses of memory

10.74 The two doctors and the psychologist involved in RR's case were, understandably, unable to recall all relevant events from the autumn of 2004. CONS4 is unable to remember being informed of the relationship between AT and RR on 12 October 2004, although the notes record quite clearly that he was informed and that he gave advice in response. He is unable to remember whether DR1 contacted him following the events of

29/30 October 2004, although he states that he would have remembered it, if he had been informed. DR1 is *"certain"* that she informed him of events, but does not remember actually doing so. W3 does not remember being contacted on 29 October 2004 and seeing RR, although he accepts that he must have done so.

10.75 We acknowledge that people may not remember events at more than two years distance, particularly where those events are unremarkable at the time and their significance only emerges at a later date. However, we find it very difficult to understand how such unusual and alarming symptoms and events could have slipped people's minds, particularly when their minds would have been directed back to the relevant events as soon as AT was killed and the police began a homicide inquiry.

10.76 In the end, we are left with the written account in the patient's notes. There are certainly omissions in the notes and it is unfortunate that, if DR1 informed CONS4 of the events of 29 and 30 October 2004, she did not record this. It is also unfortunate that W3's psychology notes did not form part of the running record, and that if there was a note of his attendance on RR at this time, it has been mislaid.

Key moments in RR's care: missed opportunities to avert the eventual outcome

10.77 From an examination of the chronology of events during RR's stay at Shrewsbury Court, we have identified seven occasions when action could and should have been taken, which might well have averted the homicide.

Key moment 1 – the start of RR's relationship with AT

10.78 Nursing staff knew as early as July 2004 that AT and RR were developing a close relationship. A nursing note in AT's file for 18th July 2004 states:*"Becoming very close to [RR]. We should keep an eye on her*

10.79 Given the repeated statements in the documentation provided to Shrewsbury Court about the danger that RR would pose to any woman with whom he developed a relationship, there should have been a plan in place to act promptly, if such a relationship did begin to develop. However, there was no such plan and no action was taken.

10.80 CONS4 told us he that he was not aware at this early stage of any relationship between AT and RR. Taking this evidence at face value, it shows at the very least that the systems of communication between nursing and medical staff were seriously inadequate.

10.81 As soon as there was any suspicion of a relationship between AT and RR, immediate steps should have been taken to ascertain its nature and extent, in particular whether it was emotional and/or sexual in nature. Both patients should have been interviewed in detail. It would then, we think, have been ascertained that the relationship was a close one, and steps should then have been taken to move RR out of Shrewsbury Court, as the contract with SLaM allowed. Until it was possible to move RR from Shrewsbury Court, the patients should have been kept apart as far as possible and one of them (AT or RR) should have been allocated one-to-one nursing.

Key moment 2 – the first threats made by RR towards AT

10.82 It is evident from the documentation that matters became more serious on 12 October 2004. By this stage, RR was not only clearly in a relationship with AT, but he had also begun to threaten her. AT's nursing record for that day reads:

"[AT] was reported to be distressed by staff member because she was threatened by a fellow resident (RR) who is her boyfriend. Issue was brought to the attention of CONS4 because she is more close to this patient and at times they lie in each other's rooms. CONS4 advised counselling and education for AT and to watch them".

10.83 At the time when he gave evidence to us, CONS4 had no recollection of being consulted about this episode. Given the passage of time this is not, perhaps surprising. He did, however, tell us that he was unaware of the relationship between AT and RR at

this time in early October 2004. It is hard to square this evidence with the entry of 12 October 2004 in the nursing notes: one party must be incorrect. In any event, it is noteworthy and concerning that there was no entry at all about this incident in RR's notes, and there is no evidence that either patient was examined by a doctor.

10.84 At this stage CONS4 should have carried out a detailed assessment of RR, with a view to removing him from Shrewsbury Court. CONS3 should have been telephoned for advice, and a case conference should have been called, involving both CONS3's team and that of CONS2, as well as the placement agencies. One-to-one nursing should have been instituted.

10.85 It should also be noted that this episode followed the meeting of the Adult Protection Inter-Agency Planning Meeting on 8 October 2004 which had specifically recommended not only that CONS4 should review RR's medication, but also that there should be a review of whether his placement at Shrewsbury Court was appropriate. There was, therefore, a further reason why a detailed assessment of RR should have carried out at this point.

Key moment 3 – the episode at the end of October 2004

10.86 By 29 October 2004, the seriousness of the situation had increased further. Not only was RR in a relationship with AT and threatening her, but he was now accusing her of being unfaithful and stating that he wished to kill her. Given the background, RR should have been urgently removed from Shrewsbury Court to an acute psychiatric admission ward, on a compulsory order under the Mental Health Act 1983 if necessary. However, this did not occur, notwithstanding nursing staff initiating two forms of review.

10.87 The first form of review was recorded in RR's nursing notes for 29th October 2004, where it is stated:

"W3 was consulted to intervene officially and asked to detail CONS4 for further action. W3 saw and talked with [RR] and promised to call CONS4."

The entry is signed *'Job'*, and is almost certainly by the staff nurse, W6. Unfortunately, the Inquiry was unable to contact him in order to invite him to give evidence to us. CONS4 has no memory of being rung by W3.

10.88 The fact that such a review by W3 occurred is confirmed by DR1 who wrote in the medical notes (in an entry dated 29 October 2004, but apparently mis-dated, and written on the following day):

"Seen by W3 the psychologist yesterday. [RR] was commenced on discreet observations. According to W3 although [RR] verbally threatened. [RR] did not appear to be psychotic, depressed or agitated."

10.89 Unfortunately, there are no psychology notes for 29 October 2004 or 30 October 2004. W3 told us that he now has no recollection of being contacted or of seeing RR at this time, but he did accept that he must have done, and he helpfully located a diary entry which recorded a meeting with RR on 29 October 2004. He suggested to us that DR1's note referring to his attendance at this time – the note which included the statement *"although [RR] verbally threatened, [RR] did not appear to be psychotic, depressed or agitated"* – reflected notes which he himself had made at the time, which had subsequently been mislaid.

10.90 In any event, W3 was adamant in his evidence to us that RR had not expressed to him any intention of harming AT. As mentioned above, however, given that W3 apparently saw RR on 29 October 2004, it would, in our view, have been most surprising if no one had told W3 that which was in fact recorded in the nursing notes – namely that RR had threatened to kill AT. Indeed, it seems to us very likely indeed that these threats were the very reason why W3 was asked to intervene at this time. It is possible that RR did not actually repeat these threats in the course of his meeting with W3, but if W3 is right in suggesting that DR1's notes recorded, in part, what W3 had himself recorded in notes now lost, then the reference to *"verbal threats"* strongly suggests that W3 was at least aware of RR making some threats. It is, therefore, difficult to reconcile the contemporaneous notes with W3's recollection that RR had never told him of hearing voices telling him to harm AT. It is not now possible to establish the truth of the matter. If, however, W3 was told, either by RR or by nursing staff, that RR had been hearing voices telling him to harm

AT, it would, in our view, have been appropriate for him urgently to contact CONS4 to pass on this information.

10.91 We should record here that W3 expressed the view to us that this would not have been a logical course of action, because of his limited role at Shrewsbury Court. He suggested that contact with CONS4 in these circumstances would have been a task for the senior nurse. It is, however, our view that W3 should, in the circumstances outlined above, at least have taken steps to ensure that someone made contact with CONS4.

10.92 In the event, the ward contacted DR1, who came to assess RR on 30 October 2004. This was apparently at the request of RR who, according to the nurse on duty, had continued to talk about a desire to kill. RR asked DR1 for more anti-psychotic medication, which she did not give him. He also asked to be sent *"to a lock-up"*. Given RR's background and the observation in the hand-over papers from Witley 3 that he sometimes asked for more medication, rather than reveal psychotic symptomatology, this was a significant development, which unfortunately DR1 failed to recognise. Given the inadequacy of the risk assessment papers, we consider it would be unreasonable to criticise her for this failure. If the risk assessment documentation had been properly completed, however, she would have been alerted to its significance.

10.93 DR1 told us that when she examined RR on 29 October 2004, there were, as her note in the medical file stated, *"No florid psychotic symptoms."* She agreed that this meant that he might have been experiencing psychotic symptoms which were not florid or which she simply was unable to elicit. The staff told her that RR had not been overtly aggressive or threatening. DR1 was reassured because RR's threats were issued in a *"robotic fashion"* and he appeared calm. This was, we think, an erroneous judgment, which we believe arose from DR1's lack of training or experience in this area. She told us that she was unsure whether she had been aware of the risk factors identified in RR's case or of the details of his history. RR had asked her for anti-psychotic medication to *"calm himself down"*, but she had not thought this necessary, as he appeared calm. She prescribed a sleeping tablet instead.

10.94 DR1 saw her role as holding things over the weekend until CONS4 could sort things out. Given that RR was being closely observed by nursing staff, her judgment was that matters could be contained safely until after the weekend. At face value, this appears reasonable, but in fact it proved most unfortunate. DR1 should have contacted CONS4 as a matter of urgency (and documented that contact). She points out that her status was junior and that she was essentially employed to cover physical problems, rather than psychiatric emergencies, but this is, we think, all the more reason why she should have made immediate contact with CONS4.

10.95 DR1 told us that she was certain that she had informed CONS4 of developments after the weekend, but CONS4 did not remember being informed. He told us that he thought the circumstances so unusual that he would have remembered them, if he had been informed. There was no note made by either doctor recording any discussion about the incident in question. There is no written evidence that the incident was reported to CONS4 at all.

10.96 DR1 evidently intended that RR would remain on one-to-one or continuous observations until CONS4 could sort the situation out. She told us that RR had already been placed on one-to-one observations at the time she came to see him, and in her note in the medical record, she stated that *"discreet observations"* should be continued. This, she told us, meant that he was to remain *"within eyesight of the observing staff all the time."* However, according to the observation chart, RR was, following the events of 29/30 October 2004, placed on the lowest form of special observation possible, level 5. This merely required nursing staff to know and record his whereabouts on an hourly basis.

10.97 The position is, however, confused because the nursing note on 31 October 2004 states:

"Continuous observations on one-to-one on vision maintained. Staff made sure there was no physical contact with him and A.O. " (sic)

10.98 This contrasts with the hourly recordings and level 5 specification noted on the observation sheet. We comment that if, as that observation sheet indicates, the

observation level that was effected amounted to his location being recorded just once an hour, that would not have been sufficient to protect AT, had RR chosen to do her harm.

Key moment 4 – RR's admission to East Surrey Hospital

10.99 The hourly observation notes were continued until RR was transferred to the East Surrey Hospital as a result of his physical health problems. However, there was no attempt to inform East Surrey Hospital about the episode which had just occurred or about the fact that, as a result, he was being kept under close observation. If RR was being closely observed at Shrewsbury Court because he had made threats to kill, East Surrey Hospital should have been told of this on his transfer there and RR should then have been allocated psychiatric nurses, either from Shrewsbury Court or from NHS resources, to maintain observations on him during his stay at that hospital.

10.100 More importantly, however, whilst at East Surrey Hospital, RR asked to speak to a social worker. He was seen by ESH1 who recorded that *"he would like to be moved as he has vowed to kill himself and his girl-friend."* It seems, however, that there was no psychiatric assessment carried out at East Surrey Hospital and no communication to Shrewsbury Court about this matter. This was, in our view, a serious omission. It is possible (although, bearing in mind the inadequacies of the service at Shrewsbury Court, not, we think, likely) that communication of these events might have led to the adoption at Shrewsbury Court of measures that could have prevented the homicide. RR's statement seems to have been over-looked at East Surrey hospital or at least accorded little importance, in that he was allowed to leave the hospital and return to Shrewsbury Court by taxi. Although he had apparently been on some form of enhanced observations before he had left Shrewsbury Court, these were not recommenced upon his return, nor is the issue mentioned or discussed in the notes. Whilst ESH1 tried to make contact with Q1, who was unfortunately on leave, it would have been better had she telephoned Shrewsbury Court to pass on what RR had said. That was, after all, where the object of RR's threats was located.

10.101 There was, in short, a serious failure of communication within East Surrey Hospital and between East Surrey Hospital, Shrewsbury Court and Sutton Social Services.

10.102 It is our recommendation, to NHS Trusts providing mental health services, that a formal handover / discharge report should be completed whenever an in-patient at a mental health hospital is transferred, even temporarily, to another hospital; and also when that patient is subsequently returned to the mental health hospital.

Key moment 5 – CONS4's review of 11 November 2004

10.103 The next entry in the medical notes is by CONS4 on 11 November 2004. CONS4 noted RR's *"close relationship with [AT]"*, that he *"seemed to be spending [AT]'s money"*, that he had been *"co-operative with shift, no aggressive behaviour. One episode of threatening behaviour. Talking about killing someone (illegible) under stress"*. There is no reference in CONS4's note to his having seen RR.

10.104 There is a nursing note by W10, timed at 7.20pm on 11 November 2004, which reads:

"[RR] was reviewed this p.m. CONS4 has now changed the Zopiclone to PRN at night. His behaviour was discussed…. At the time of the review, [RR] was out shopping with £100 of [AT]'s money."

10.105 CONS4 told us that he would on 11 November 2004 have read DR1's notes about the episodes on 29 and 30 October. Given that he made an entry on 11 November immediately below her notes and on the same page, it would, in the normal course of events, be astonishing if he had not done so. If CONS4 did not see RR on 11 November - and the nursing notes state he did not - this would mean that he did not see it as necessary to make any effort to see RR in November, despite the seriousness of the recent episode recorded by DR1.

10.106 But CONS4's position was not a normal one. He had taken on a workload which we think he could not possibly hope to discharge. We also comment that if he had read DR1's notes, then it was most surprising that the notes he made on 11 November did not refer to the incident at the end of October in any detail, or to DR1's involvement in that episode. Nor does this note refer to the threats RR had made to kill AT. We conclude that this makes it very likely that CONS4 did not read the nursing notes in any detail.

10.107 The information which he could and should have derived from those nursing notes was to the following effect:

- RR's relationship with AT had been recorded since 17 July 2004.
- RR had threatened AT on 12 October 2004.
- On 29 October AT had reported that RR had *"threatened to kill her"*.
- Later in the same day, AT had reported that he was *"spreading rumours about her which are not true."* It was noted that RR had said *"[AT] is an adulteress."*
- RR's nursing notes for 29 October recorded: *"[RR] called me aside to confide that he has found [AT] unfaithful with another client…He felt like strangling her on two separate occasions."*
- On 30 October, apparently in the early hours, the notes record: *"[RR] was still about (sic) [AT] not being faithful to him…"*
- Later that morning, it was recorded that *"[RR] continues to be upset and verbalising that he feels like killing someone…Also he expressed a wish to be seen by a doctor and be given a stronger dose of medication."* He wanted to *"discuss his medication with the RMO as he feels the present treatment is not helping."*

10.108 Furthermore, according to DR1's notes in the clinical records, RR reported that he had not been sleeping for 3 days. She also noted *"[RR] said he is very upset about what is going on with him and [AT], that he wanted to kill someone, go away from here. 'Wanted to go to a lock-up'"*.

10.109 RR is also noted to have requested *"Chlorpromazine 100 mg QDS"*, a substantial dose of an old-fashioned oral anti-psychotic medication, which was refused him.

10.110 This available information needs then to be compared with CONS4's record on 11 November 2004:

"One episode of threatening behaviour. Talking about killing someone (illegible) under stress."

10.111 In reviewing RR's medication on 11 November, CONS4 wrote *"No problems"* and he changed the sleeping tablet to *'when required'*. His care plan included: *"Review risk assessment"*. He also stated that the case should be reviewed *"in 6/52"* (i.e. in 6 weeks time)

10.112 It is difficult to imagine that CONS4 could have come to these conclusions had he been aware of the details in the nursing notes or the details of DR1's entry in the medical notes. It seems to us, therefore, that CONS4's review on this date was, no doubt as a result of the workload which he had taken on, more superficial than it ought to have been.

10.113 If CONS4 had been aware of all the relevant facts on 11 November 2004 (and we have real doubts that he was) then he should have intervened immediately. He should have increased RR's medication and put him on close observations. He should have rung CONS3 urgently for advice, with a view to arranging RR's immediate transfer to another hospital and calling an urgent case conference. Any one of these steps might have prevented the homicide. However, CONS4 took none of these steps. In our view, his failure to realise the seriousness of the situation, or (if this was the case) his failure adequately to review all of the notes was a crucial failure in the events that led to this homicide.

Key moment 6 – W2's risk assessment of 18 November 2004

10.114 On 18 November 2004 W2 completed a tick-box "risk assessment score sheet", presumably in response to CONS4's care plan of 11 November 2008. He recorded that the

risk of violence *"towards family, other residents and staff"* was 3 ('high') or 4 ('very high'). 'High' is defined by the Shrewsbury Court form as *'evidence indicates most likelihood of occurrence in the short term.'* 'Very high' is defined as 'evidence of occurrence exists now or the probability of it at any time.' The form states: *"any scores reflecting 3 or 4 must be actioned immediately."*

10.115 There is no evidence from the notes that any action was taken, and there is no reference to this assessment in the nursing or medical notes.

10.116 At this juncture, W2 should have communicated his findings to the senior nurse and CONS4 should have been informed. The fact that W2 did not seek to do so is, we think, illustrative of the isolated nature of the so-called risk assessment process and the disconnected and dysfunctional systems at Shrewsbury Court.

Key moment 7 – the morning of 12 December 2004

10.117 The most distressing example of the lack of any planned response to the appearance of factors associated with risk occurred on the day of the homicide. W2, when told by RR that he was hearing voices, did not know what to do. He told us that he was aware that the fact that RR was hearing voices was a "trigger" and that he accordingly decided to bring forward RR's morning medications. He did not seem to know that these were cardiac medications and would, accordingly, make no difference to the symptoms which RR was reporting.

10.118 If there been a straightforward plan of action, expressed in simple terms such as *"if RR reports hearing voices, put him on one-to-one observations until seen by a psychiatrist*", then, we believe, the death of AT would have been prevented. Likewise, if there had there been PRN tranquillisers prescribed, which W2 could have administered in response to RR's report of hearing voices, in order to calm him, this too might have prevented the homicide.

Summary

10.119 Shrewsbury Court, despite the administrative tag of 'independent hospital', was in effect functioning as a nursing home. It did not have the level of skills or staffing to provide adequate care for the types of patient that it was admitting, and it did not have the ability properly to manage a patient such as RR.

10.120 The standard of nursing care at Shrewsbury Court was inadequate. There was poor staff training; inadequate staffing levels; inadequate knowledge of, or adherence to policies and procedures; inadequate direction and supervision; inadequate risk assessment procedures; inadequate CPA procedures; poor communication systems; and a lack of multi-disciplinary working. All of these factors contributed, in our view, to the failures which we have identified above in the care and management of RR.

10.121 The procedures for assessing referrals to Shrewsbury Court were inadequate. Whereas patients might reasonably be admitted to a nursing home following a nursing assessment alone, a patient should not be admitted to a hospital without a medical assessment, particularly when that patient has, as RR had, a history of serious violence, is being referred by a forensic unit, and has already been refused because he was too dangerous.

10.122 A medical representative from Shrewsbury Court should have been present at the hand-over meeting at Witley 3. Had this occurred, it is at least possible that the resultant exchange of information about RR might have led to the whole story taking a different turn.

10.123 CONS4 agreed to look after 14 detained in-patients and, in September 2004, about 46 voluntary and detained in-patients. He was responsible for providing these patients with an adequate standard of care. We have concluded that, at least with RR, he failed to do so. We believe that the principal reason for this failure is that he attempted to fulfil his duties at Shrewsbury Court in just one four-hour session, plus one or two

additional hours, each week. He must have known that this was insufficient. It is right to record that he told us that he believed Shrewsbury Court was a nursing home until he was told otherwise in August 2004, and it is true that nursing homes may require less input than hospitals (medical input is usually from general practitioners as a block arrangement). However, we believe it must have been clear that Shrewsbury Court was different for the following reasons:

- The patients he was caring for at Shrewsbury Court until September 2004 (with the exception of RR from June 2004) were detained under the Mental Health Act 1983.
- The fact that his pay for, in effect, one session a week at Shrewsbury Court exceeded that for his NHS post (in initially ten and then, with the new contract, nine sessions, as a maximum part-time consultant)
- He was aware of the level of psychopathology at Shrewsbury Court from his experience of the wards.

10.124 We have also concluded that CONS4 failed to fulfil his commitment in his letter to DR2 of 1998, when he stated: *"I will also be intimately involved in the drawing up of operational policies, development of services, clinical audit and ensuring that the quality of care is high."* On his own account, he was aware that standards were low at Shrewsbury Court, but he did not take any effective action to try and change matters.

10.125 We also note that CONS4 appears to have had competing out-of-hours on-call commitments. He was, in effect, being paid by two separate organisations to provide an on-call service, a service which is, by its nature, exclusive. Whether this was a factor in his inability to attend at the end of October 2004, when RR made threats to kill AT we cannot tell. CONS4 was unable to recall why it was DR1 who dealt with this episode.

10.126 We have concluded that CONS4 failed to provide an adequate standard of care to RR in the following ways.

- He probably saw RR on no more than four occasions in the six months that RR was at Shrewsbury Court, and he probably did not see RR at all in the period between the first report of threats against AT on 12 October until the homicide on 12 December.

- Although he agreed that he had seen all of the earlier reports on RR and was aware, so he said, of CONS1's warnings, he failed to put in place a structure to detect and react to warning signs of relapse and possible violence. This was all the more surprising when his evidence to us was that he was concerned about RR's case and that he was aware of the poor quality of many of the nursing staff.
- The reports of RR experiencing voices telling him to kill should have led to decisive action. In effect, all the risk factors for serious violence were present by the end of October 2004. Even allowing for hindsight, we consider that CONS4 should have acted decisively by no later than 11 November 2004. He should by then have taken steps to ensure RR's immediate transfer elsewhere, and to put in place interim measures designed to eliminate any risk of RR being in a position to harm AT.

The issue of risk assessment

10.127 Appropriate risk assessment is of central importance to the management of the mentally ill. With RR, the principal concern was his dangerousness to women, which was so carefully described in the reports by CONS1. We have commented elsewhere in this Report on the specific shortcomings of the "risk assessments" at Shrewsbury Court, both in terms of the tools used – the standard "tick-box" form - and the "assessments" actually made of RR. Some more general issues do, however, merit comment here.

10.128 First, no standardised risk assessment instruments were used over the years. Clinical judgment of the issue of risk was not aided or structured by the use of evidence-based tools, the validity and reliability of which had been tested in clinical trials. The research evidence now available indicates that clinical judgment unsupported by such tools is unreliable and that the use of such tools without the addition of clinical judgment can be equally misleading, even where tools have a research base. The acceptable approach today is that of structured clinical judgment, in which the assessment tool acts as a form of *aide memoire* and framework for the risk assessment. By offering scores, such an instrument allows a judgment to be made about any change (or absence of change) in the level of risk a person poses. Examples of such tools are presented in the appendix to the Department of Health publication "Best Practice in Managing Risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services", referred to above.

10.129 The use of such structured clinical risk assessments tools has not until recently been widespread, and it could not have been expected that the services examined in this Report should have been using such tools at the time in question, (although CONS3 told us that one such tool, HCR-20 (Webster, C.D, Douglas, K.S., Eaves, D. & Hart, S.D. (1997) *HCR-20: Assessing Risk for Violence*. Version 2. Vancouver: Simon Fraser University) was being introduced to Witley 3 at the time that RR was an in-patient there). What can be said with certainty is that the use of *ad hoc* tick-box risk assessment lists which are not evidence-based should not now be considered acceptable.

10.130 We recommend to PCTs and Trusts that, when commissioning mental health services, whether from within the NHS or from the independent sector, evidence should be sought and obtained from service providers that they have incorporated the guidance from the Department of Health's "Best Practice in Managing Risk" publication into their risk assessment and management policies and procedures; and have adopted a structured, validated risk assessment tool with all clinical staff trained and regularly updated in its use.

10.131 A second issue concerns RR's age. As mentioned above, it was our impression that there was a genuinely held belief by some staff across the various services that RR's age and extensive physical problems meant that the risk he posed to others was substantially reduced. However, whilst he suffered, amongst other things, from severe obesity, congestive cardiac failure, chronic obstructive pulmonary disease and arthritis of the hips and knees, he was still mobile, cared for his own needs and was able to go out by himself on trips into the community. His physical state was not, so it seems to us, ever such that he was physically incapable of causing serious harm to others – particularly to a woman with whom he was having an intimate relationship and with whom he would often find himself alone. The belief of some that age and illness necessarily substantially reduced risk appeared to us to constitute an unfortunate form of ageism.

10.132 The emphasis placed by CONS2 (and CONS7) in their letter to Shrewsbury Court of 2 September 2002 on RR's physical health as a factor which reduced the risk which he posed to women was, therefore, surprising. Old age, even when accompanied with the

kind of physical problems which RR undoubtedly had, does not, of itself, mean that an individual's dangerousness is reduced. With an ageing population, it is increasingly important that there is recognition of this fact.

10.133 We accordingly recommend to the Department of Health that its advice on risk assessment should be adapted to incorporate (a) passages emphasising the difference between dangerousness and disturbed behaviour, and (b) a discussion of age and risk.

11. The care provided to AT from 2001 onwards

11.1 In this section of the Report we discuss the quality of the care and management of AT during the period from her transfer to Shrewsbury Court through to the date of her death. We include here discussion of the important question of the way in which her relationship with RR was managed. The comments which we make in that regard are, of course, directly relevant also to the management of RR during his time at Shrewsbury Court and cover similar ground to that discussed above.

The decision to send AT to Shrewsbury Court

11.2 We have seen no evidence which suggests, even with the benefit of hindsight, that the decision in 2001 to place AT at Shrewsbury Court was inappropriate. AT was considered to need full-time nursing care, and the information available to us indicates that this assessment was correct. The risk assessments carried out prior to her placement there appear to have been well considered and appropriate.

11.3 Son1 and Son2 were concerned about the selection of Shrewsbury Court, and told us that it had been presented to them as, in effect, the only option for AT, other than

staying where she was. They told us that, although not satisfied that Shrewsbury Court was the right place for AT, they agreed to the placement because it appeared to them to be better than the only alternative being presented. It has not been possible for us to ascertain whether this recollection is correct, because it has not proved possible to trace all those involved in the placement decision - most importantly, AT's consultant at the time, CONS9 - and because none of the witnesses to the Inquiry could recall why Shrewsbury Court was selected for AT. There is, however, nothing in the contemporaneous documentation to suggest that there were any difficulties in finding a placement for AT or that Shrewsbury Court was the only option. We found no evidence that AT's consultant, CONS9, had any particular links with Shrewsbury Court or a practice of sending his patients there.

11.4 Neither have we seen evidence that there was, in 2001, information in the public domain which ought to have caused concerns about the quality of care at Shrewsbury Court. Many of the criticisms in this Report concerning the care there relate to its failure to move away from the culture of a residential nursing home, and the fact that it did not meet the standards to be expected of an independent hospital. But as AT's needs were needs which would be met by a residential nursing home, these issues are not relevant to the decision to place her there in 2001. This was, of course, prior to its re-designation as an independent hospital in any event.

11.5 AT was assessed prior to her admission to Shrewsbury Court by W1. His recollection was that the assessment of AT was one of a small number of occasions when CONS4 did participate in the assessment. CONS4's evidence, however, was that, in his capacity as an employee of Whitepost, he had no involvement with the informal patients there at all, prior to September 2004. He said he could not remember AT as a patient and could not now remember having any involvement in her admission. There is no contemporaneous documentation available to us to determine what role, if any, CONS4 played in the assessment of AT prior to her admission to Shrewsbury Court. However, there was no reason why W1, or anyone else, should have considered AT to be unsuitable for admission to Shrewsbury Court.

The quality of treatment provided to AT at Shrewsbury Court

11.6 The management of AT's care at Shrewsbury Court was poor and fell far short of the standards which she, her family, and West Kent Health Authority were entitled to expect. The principal areas where there were serious shortcomings were as follows:

i. The risk assessments which were carried out on AT at Shrewsbury Court were, from the outset, inadequate, ill-informed and inappropriate.

ii. There was a failure properly to implement the CPA. Regular multi-disciplinary meetings were not held, and even when they did occur, there is little documentary evidence of proper preparation at Shrewsbury Court or of appropriate follow-up afterwards.

iii. There is no evidence of any attempt by staff at Shrewsbury Court actively to review whether it was necessary or appropriate for AT to remain as a resident there, and/or to consider whether she continued to need a placement where she was receiving 24-hour nursing care.

iv. The response of staff at Shrewsbury Court to AT's developing relationship with RR in the four or five month period prior to the homicide was wholly inadequate. There was no proper attempt to explain to her the full nature and extent of the risks to her that a relationship with RR carried and no proper attempt was made to protect her from the dangers inherent in that relationship. For the reasons discussed elsewhere in this Report, we take the view that staff there failed AT in:

    a. Deciding to accept RR as a patient at Shrewsbury Court in the first place, an issue discussed at length elsewhere in this Report;

    b. Allowing RR to remain at Shrewsbury Court, notwithstanding the development of his relationship with AT, and notwithstanding the episode at the end of October 2004, when RR told staff that he considered that AT was being unfaithful to him and that he felt like killing somebody, with specific threats being made to AT.

    c. Allowing RR and AT to spend long periods of time alone together, including nights, without any supervision.

11.7 The evidence presented to the Inquiry also shows failings by staff at Shrewsbury Court in many other areas of less direct relevance to the homicide. Whilst we concentrate in this Report upon the shortcomings at Shrewsbury Court which were, directly or indirectly, causative of the events of 12 December 2004, we will also touch on other areas of concern about her care and treatment at Shrewsbury Court. The existence of these additional failings is relevant to the issues which we discuss elsewhere in this Report as to the extent to which the shortcomings in the service at Shrewsbury Court could or should have been picked up either by the regulatory authorities - in particular the NCSC and the HC - or by those who commissioned services from Shrewsbury Court.

The risk assessments on AT

11.8 We have explained at length the inadequacies in the way risk assessments were carried out at Shrewsbury Court. These deficiencies are manifest in the "risk assessments" purportedly carried out on AT during her time at Shrewsbury Court.

11.9 The risk assessments on AT prior to her arrival at Shrewsbury Court clearly, and correctly, indicated she was a very vulnerable person who was open to emotional, financial and sexual abuse. This clear assessment of her vulnerability was not, however, translated into her risk assessments at Shrewsbury Court or into her nursing care plans there.

11.10 The first risk assessment on AT at Shrewsbury Court was on 4 May 2001 just 3 days after her transfer there. It assessed her vulnerability to sexual or financial exploitation at "0-2" (with no attempt being made to distinguish between the upper and lower ends of this category). This assessment was simply wrong, and it is impossible to understand on what basis it was reached bearing in mind that AT had been at Shrewsbury Court for just three days. It would not have been possible for the person completing this risk assessment form to have had time to reach a concluded view so very different to that reached by AT's consultant, CONS9, a few days earlier. The most likely explanation is that this assessment was completed without regard to AT's medical records and in ignorance of the risk assessment which had just been carried out by CONS9. We do not know who carried out this risk assessment - the signature is illegible - but there seems little doubt but that its inadequacies were a product of the inexperience and inadequate training given to staff at Shrewsbury Court in the task of carrying out risk assessments.

11.11 The error here was not just the error of the nurse who completed this initial risk assessment. On her arrival at Shrewsbury Court, AT's history and most recent risk assessments should have been considered by the psychiatrist who was to take over responsibility for her care. Because of the way in which arrangements were structured at Shrewsbury Court at the material times, AT, as an informal patient, would have fallen under the care of the local CMHT, based at Shaw's Corner. This would, in turn, have meant that her RMO would have been CONS4, albeit in his capacity as the consultant psychiatrist attached to the local CMHT rather than in his capacity as the consultant employed by Shrewsbury Court. It is clear that CONS4 did become her RMO because the records show that he attended two CPA meetings relating to her in that capacity – although, as mentioned above, he told us that he had no recollection of her at all.

11.12 Had a thorough review of AT's history, and of her most recent reports, been conducted by AT's new RMO, he could not have failed to note the discrepancy between the risk assessment which had been prepared on AT following her arrival at Shrewsbury Court and the assessment made by CONS9 a few weeks earlier. The only possible conclusions are that such a review was not carried out by or on behalf of CONS4 at all, or that it was carried out with insufficient care, or that it was carried out without the doctor concerned (and CONS4 may have delegated this task to his SHO/staff grade) knowing what the risk assessment at Shrewsbury Court said. Whichever of these explanations is the correct one, the position was unacceptable.

11.13 The error which was made on this initial risk assessment was one which we consider probably had long term consequences, affecting the way AT's vulnerability was thereafter assessed - and under-estimated - for the duration of her time at Shrewsbury Court. As we have noted above, the evidence we heard suggests that the lack of training for staff in how to carry out risk assessments properly meant that a practice developed, particularly with less experienced staff, of following closely any earlier risk assessment score sheet, and making changes to that earlier assessment only if there had been some obvious change in the patient's situation or presentation. It seems likely that subsequent risk assessments carried out on AT used this initial risk assessment as a "starting point", and that alterations were only made if staff identified some new aspect of AT or her behaviour which seemed to merit a change. The result was that the initial assessment

that AT was at low risk of being sexually exploited remained unaltered over the years. It is difficult otherwise to understand how a patient who was undoubtedly vulnerable to exploitation was, for almost all of her time at Shrewsbury Court, categorised as someone at low risk of exploitation.

11.14 Although CONS9's risk assessment of 26 April 2001 indicated that the assessment ought to be reviewed in three months time, the initial risk assessment at Shrewsbury Court was not reviewed until 5 months later. This was an unacceptably long period, bearing in mind that the initial assessment (even if competently performed) could only have been a preliminary view.

11.15 When the next risk assessment was performed on 5 October 2001, there was no material change from the assessment of 4 April 2001. This assessment was again wrong with AT still being assessed as a person at low risk of exploitation. This represents further confirmation that risk assessments at Shrewsbury Court were being carried out by staff who lacked the necessary training or experience properly to assess the risks faced by their patients.

11.16 The failure to carry out an appropriate risk assessment on 5 October 2001, identifying AT as vulnerable to exploitation, is concerning not only because her vulnerability had been spelt out in the documentation provided on her transfer from Kent, but also because there had been a well-attended CPA meeting on 16 August 2001 at which, according to C4's notes, it was specifically noted that AT was *"vulnerable and open to financial, emotional and sexual abuse"*, and that this required *"ongoing monitoring"*. We are satisfied that C4's contemporaneous notes of this meeting are an accurate record of what was discussed. The fact that such a discussion took place makes it all the more extraordinary that the next risk assessment on AT still failed to identify her vulnerability to exploitation. It can only be assumed that the person who completed this risk assessment in October 2001:

i. Had not attended the CPA meeting on 16 August 2001; and

ii. Had not had access to notes which recorded accurately what had been discussed at that meeting (so far as we can tell, there were, in fact, no detailed notes held at Shrewsbury Court recording the matters which had been discussed); and

iii. Had, in any event, failed to appreciate from his or her own dealings with AT that she was vulnerable to exploitation.

11.17 This is, therefore, in our view, further confirmation of the inadequacies in the systems in place at Shrewsbury Court at the material times with regard to risk assessment and the dissemination of information about patients.

11.18 It should also be noted that, prior to the completion of this second risk assessment on 5 October 2001, AT had been discovered having sex with another patient. Shrewsbury Court had a remarkably relaxed attitude towards the existence of intimate relationships between patients, a matter upon which we comment elsewhere in this Report, but it is startling that this episode did not have any impact whatsoever upon her risk assessment - which continued to assess her as being at low risk of sexual exploitation. An attempt should have been made, and documented, to ascertain the nature of the relationship and to find out if it was entirely consensual. It might conceivably have been concluded that AT was the exploitative person in the relationship, and that this needed to be reflected in her risk assessment – but whatever the nature of the relationship with J, there ought to have been careful consideration of the issues it threw up and the conclusions reached should have been documented and reflected in future planning for AT.

11.19 A further risk assessment was carried out on 5 January 2002 by W4. W4 was at that time employed as a Staff Nurse, and was AT's Named Nurse - it was only in March 2002 that he was promoted to the position of Clinical Nurse Specialist. It is, however, relevant to comment that this promotion means that he must, in January 2002, have been regarded as one of the more experienced and able of the Staff Nurses at Shrewsbury Court. It will be recalled that W4's qualifications were in learning disability - he was not an RMN.

11.20 W4's risk assessment did differ from those previously prepared in that it identified a high risk of depression and anxiety, and a high risk that AT might be responsible for fire

or arson. His assessment continued, however, to categorise AT as being at the lowest level of risk of sexual or financial exploitation. It is not possible to discern from AT's medical records or nursing notes why there had been a change in the assessment of the risk of depression/anxiety and in the assessment of the risk of fire or arson - a further illustration of the inadequacies in the record-keeping and assessment process at Shrewsbury Court.

11.21 We reiterate that AT was, throughout her time at Shrewsbury Court, a person who was, and ought to have been identified as, vulnerable to financial and sexual exploitation. It is concerning, therefore, that W4, who completed this risk assessment in his capacity as AT's Named Nurse, had not appreciated this vulnerability. It is disappointing that, as her Named Nurse, he had not apparently familiarised himself with the earlier correspondence, including the risk assessments carried out by CONS9 prior to AT's transfer which would at least have provided him with a "steer" in the right direction. It is also disappointing that, although he was her Named Nurse, he had not reached this conclusion himself. When we asked him if he considered that AT was sexually vulnerable, he replied: *"I suppose she was vulnerable full stop, yes"*. Regrettably, this appears to have been a view which he only reached after the event.

11.22 The failures referred to above were, in our view, very probably a result of the inexperience of staff at Shrewsbury Court and/or their lack of training in carrying out risk assessments. The use of staff with a training in learning disability as the Named Nurse for patients with mental health problems was inappropriate. The fact that W4 was not trained as an RMN very probably contributed to the errors in his assessment of AT.

11.23 The next risk assessment on AT was carried out on 16 June 2002 by W5. It was identical to the one carried out five months earlier by W4. The fact that members of staff continued to repeat the error of categorising AT as being at low risk of financial/sexual exploitation, (notwithstanding that it was at odds with the assessments which had been carried out before her transfer, and with the views which had been expressed at the CPA meeting the previous year), confirms our impression that it was commonplace for staff completing these assessments to assume that the previous risk assessment had been correct and complete, and to make alterations only if there had been some event in the intervening period requiring such an alteration. Such a practice was understandable given the lack of training, but it was an inappropriate practice. Even leaving aside the crucial

point that these risk assessments should have been a multi-disciplinary task, it is clear that the nurse in question ought to have been applying his or her mind independently to the level of risk posed by a particular patient, and should not have assumed that previous assessments had been complete and accurate.

11.24 W5 prepared this risk assessment of 16 June 2002 for a CPA meeting which took place on 18 June 2002. It is, therefore, concerning that, according to C4's notes of that meeting, it was not attended by W5.

11.25 More concerning still, however, is that C4's notes of the meeting again record that it was considered that AT was vulnerable to exploitation from others - the point having arisen in the context of a discussion about AT giving money to another resident. Notwithstanding this discussion at the CPA meeting, there was no subsequent alteration in the risk assessment on AT. On the contrary, the next risk assessment, which was also carried out by W5, and was dated 16 September 2002, was almost identical to that which had been prepared by her on 16 June 2002.

11.26 Our firm impression is that there was little attempt at Shrewsbury Court to co-ordinate the care and management of AT. Documents relating to her care and management were prepared in an *ad hoc* way, in order to have the necessary paperwork in place, rather than as a tool to inform and to guide her future care and management. The person who prepared the risk assessments did not attend CPA meetings. The discussions which took place at CPA meetings do not appear to have been appropriately documented by Shrewsbury Court representatives, and do not appear to have informed AT's subsequent management. The substance of the discussions at the CPA does not appear to have been communicated to the person responsible for preparing future risk assessments on AT, or indeed to have had any influence upon her ongoing care and management at all. Our impression is that the process of preparing these "risk assessments" was often perceived as no more than a question of ensuring that the necessary documentation was completed and in place, rather than as an important aspect of the care and management of AT which needed to be carried out with the benefit of all available information about AT.

11.27 The inadequacies in the risk assessments carried out by nursing staff at Shrewsbury Court do not appear, at any point, to have been identified by the medical staff, specifically by CONS4 who was a consultant with responsibility for AT (albeit, at this time, in his capacity as the consultant with the local CMHT, rather than in his capacity as an employee of Shrewsbury Court). It is extraordinary that the errors in the risk assessments which were carried out on AT over the years were never picked up by CONS4. He ought to have been fully aware of AT's history and the risk assessments which had been carried out by CONS9 prior to her transfer to Shrewsbury Court.

11.28 On 5 December 2002 a further risk assessment was carried out on AT. This differed from the previous ones in that it assessed AT as presenting a risk of being violent to others, and of sexually inappropriate behaviour. The reasons why AT was now considered to present a risk of sexually inappropriate behaviour can be inferred from the nursing notes, where there is reference at around this time to AT expressing her love towards a fellow patient, and stating that she now preferred this individual to J, the patient with whom she had been having a relationship (and with whom she had been discovered having sex the previous year). The nursing notes record how she was warned about the dangers of this behaviour and one can well understand that nursing staff would have been concerned about the danger of tensions developing within the unit if AT behaved in a manner calculated to cause jealousy in men competing for her affections.

11.29 It is, however, not possible to discern why this risk assessment suggested that there was a risk that AT might be violent towards others. One can only assume that there had been some incident which caused this change in the assessment, but which was not documented. It is, accordingly, impossible to assess, one way or the other, whether there was any sensible justification for this aspect of the risk assessment. Once again, it must be commented that if there had been some such incident, which affected AT's risk assessment, that incident should have been documented. The fact that it was not is yet a further illustration of the shortcomings in the documentation maintained at Shrewsbury Court.

11.30 This risk assessment, like all of those which preceded it, identified AT as being at low risk of being financially or sexually exploited by others. Subsequent risk assessments

on 5 March 2003 and 6 June 2003 were identical to the assessment on 5 December 2002. They continued, wrongly, to identify the risk of AT being sexually or financially exploited as zero.

11.31 On 29 May 2004 a risk assessment was prepared by W6, who was by now AT's Named Nurse. W6 was an RGN, not an RMN. It was noted, for the first time, that AT was at high risk of being financially exploited – and it is apparent that by this stage, there were the concerns about how much money AT was spending on other patients. W6 also prepared a CPA nursing report at around this time and recorded in that document that AT *"has a need for supervision and self care, and in the use of money"*, and that she was *"still financially vulnerable and unable to care for herself properly, if not supervised"*.

11.32 W6 also identified a small risk (assessed at 1 on a range of 0-4) that AT might exploit others sexually. It seems likely that, by this stage, the perception of staff at Shrewsbury Court was that AT tended to be the instigator of relationships with other patients, and that she was capable of switching her affections from one patient to another in a manner likely or calculated to cause jealousies. What staff failed, however, to appreciate, was that this behaviour was probably caused by her insecurities and need for attention, which rendered her vulnerable to sexual exploitation. Whether this was a result of their lack of experience or training in caring for mental health patients, or a simple misjudgment is not possible at this stage to say.

11.33 We take the view, therefore, that even this revised risk assessment was misconceived and that AT should have been identified as at risk of both financial and sexual exploitation. These risks should then have been reflected in a nursing care plan or risk management plan designed to manage and if possible to reduce those risks.

11.34 AT was seen by the clinical psychologist, W3, on 30 July 2004. He told us that said this was not prompted by any particular concern about AT's well-being, but was a result of concern on the part of management about a forthcoming inspection of Shrewsbury Court by the HC. It seems that, anxious to pre-empt possible criticism, it had been decided that it would be useful to demonstrate that each and every patient at Shrewsbury Court had

had the benefit of an assessment by the in-house clinical psychologist. We should record here that W3 told us that, although he saw AT on this occasion, he did not consider that she was under his "formal clinical care".

11.35 Whatever the reasons for W3's attendance, it was, nevertheless, an opportunity to undertake a broad review of AT's situation, and of her current risk assessment. The opportunity was not taken. W3 recorded that she was in an *"inappropriate relationship"* with *"some male clients"*. His evidence to us was that he was not given the names of the male patients concerned, but we consider it likely that those male patients would have included RR – that relationship had already been commented upon in the nursing notes. If this is right, we think it is surprising that W3 did not ascertain that that was the case; and that he was not informed of that fact, particularly if nursing staff had been alerted to the significance of RR forming relationships with female patients. In any event, W3 recorded no tangible advice as to what actions he felt should be taken to manage these relationships. His note that AT needed *"continuing care and support"* was, we think, vague and provided no real guidance to nursing staff as to what he felt needed to be done, in practical terms. The nursing notes contain no reference to this meeting between AT and W3, let alone any record of any actions which W3 may have advised were appropriate to assist in the care and treatment of AT.

11.36 The meeting between AT and W3 was a lost opportunity to identify the dangers to AT of her developing relationship with RR and to put in place some form of action plan to manage that risk. It is possible that the relationship described by W3 was not with RR, but this seems unlikely. As noted above, the first reference to the relationship in the notes was a reference in AT's nursing notes dated 18 July 2004 which recorded: *"Becoming very close to [RR]. We should keep an eye on her."* It is clear that W3 knew about RR's history - he had seen him on 16 July 2004 and his notes of that meeting had included a note that areas of concern included the need to monitor RR's relationships with women.

11.37 We have already mentioned that W3's role at Shrewsbury Court was an odd one. He worked largely in isolation from CONS4, dealing with only those patients who were referred to him. He told us that he did not regard either AT or RR as being formally under his care. His work does not seem to have been integrated with work done elsewhere. His

notes were kept separately from the clinical notes of the patients whom he was reviewing and he did not regularly attend ward rounds or CPA meetings. That was not W3's fault - it was the nature of the job he had been asked to perform. However, we consider that he could have done more, on this occasion to identify what should be done to address the problem of AT's *"inappropriate relationships",* and to give clear direction to the nursing staff in this regard.

11.38 Shortly after this assessment, a CPA meeting took place on 2 August 2004, the first for over two years. AT was described in the records of this meeting as being financially and sexually vulnerable. However, the focus of concern does not seem to have been upon the fact that she was in a relationship with a man known to have a history of violence towards women with whom he was in an intimate relationship but upon the fact that AT appears to have a somewhat erratic "love life", shifting her affections from one male patient to another, causing tension and disturbance. The "Action Plan" recorded with regard to this concern was simply to "*Observe client for exploitative relationships and counsel asap".*

11.39 Bearing in mind that there is clear evidence elsewhere within the documentation to suggest that the relationship between AT and RR had become, by this stage, very close, it is extremely concerning to see that there was nothing more tangible suggested by way of management of that relationship on this occasion. It is also relevant to note that although there was, for the first time, this reference to AT's sexual vulnerability, there appears to have been no alteration to the risk assessment on AT. There is nothing in the nursing notes reflecting any change in the approach which was to be adopted towards AT as a result of this new perception. Most concerning of all, there is nothing which suggests that there was any appreciation, let alone discussion, of the risk of physical harm to AT arising out of her relationship with RR.

11.40 It was not until 20 September 2004 that a revised risk assessment recorded, for the first time, that AT was perceived as being at a high risk of sexual and financial exploitation.

11.41 There were no subsequent risk assessments carried out on AT at Shrewsbury Court. There was never any risk assessment which identified specifically the fact that she was at risk of physical harm because of her involvement in an intimate relationship with a man who had a history of violence towards his partners. There was no attempt to formulate any clear plan as to how to try to manage this risk.

11.42 These were most serious shortcomings for which there is no proper explanation, other than that staff at Shrewsbury Court lacked the experience or training to appreciate and to address this type of risk. It is worth repeating here that when we asked W4, the Acting Manager, what training staff had in carrying out risk assessments, his response was *"Probably none"*. He himself had had no training in risk assessments. He told us that no such training was offered to new starters at Shrewsbury Court, and he also said that there was no continuing training programme.

11.43 All these responses are concerning, given that W4 was, in mid 2004, the Acting Manager. When talking about whether RR was appropriately placed, W4 replied *"Again I guess, because I'm not appropriately trained but have experience in mental health, I may rely too much upon the views of the two discharging RMOs that discharged him. I just went along with them"*.

AT and the Care Programme Approach at Shrewsbury Court

11.44 The CPA process was not properly adopted or applied at Shrewsbury Court. As described above, there was an inadequate understanding amongst staff at Shrewsbury Court as to how the CPA process should work. In the case of AT, regular CPA meetings simply did not take place. Indeed, she did not have a CPA review for over two years.

11.45 Even when CPA meetings were arranged, the evidence from AT's sons, Son1 and Son2, was that they were usually given very short notice of such meetings (such that it was impossible for them to make arrangements to attend). They also described occasions when CPA meetings were cancelled at the last minute because others could not attend.

Documentation provided to us by Shrewsbury Court does indeed show occasions when CPA meetings were arranged at short notice and when there were last minute cancellations. The result was that Son1 and Son2 never attended a CPA meeting at Shrewsbury Court during the time their mother was there.

11.46 On the limited occasions when CPA meetings did take place, the documentation which one would normally expect to see prepared for such meetings does not appear routinely to have been prepared. CPA meetings took place without a nursing report being prepared, and without any other documentation which summarised current concerns, reported on incidents which had occurred since the last CPA meeting, dealt with the extent to which the patient was compliant with treatment, and which set out recommendations and identified future goals.

11.47 Furthermore, Shrewsbury Court does not appear to have maintained proper records of discussions at CPA meetings. In all but one instance, we have been almost entirely dependent upon the notes taken by the representatives of the Dartford CMHT to ascertain what was discussed and what was decided. Importantly, however, Shrewsbury Court did hold a record of the last CPA meeting for AT which took place on 2 August 2004.

11.48 The history of the CPA meetings at Shrewsbury Court was as follows:

11.49 There was a CPA meeting on 16 August 2001. There was a brief reference to this in AT's nursing notes, although it was not identified there as a CPA meeting. It was attended by AT, CONS9, DR7, C5 (AT's CPN), C4 and an unidentified member of the ward staff at Shrewsbury Court. Surprisingly, therefore, there was no member of the medical team that was now responsible for AT at this meeting. There is no evidence that the family was invited to attend.

11.50 We have already commented that, although C4's notes of this meeting recorded that it was considered that AT was *"vulnerable and open to financial, emotional and sexual abuse"* and that *"this requires ongoing monitoring"*, this conclusion did not impact

in any way upon AT's risk assessment. Her notes also recorded that *"It is felt that her previous needs assessment and care plan are still appropriate as discussed in the Joint Assessment of Need"*. Whilst that was what this meeting concluded, the nursing plan in place at Shrewsbury Court for AT did not, in fact, reflect the conclusions set out in the Joint Assessment of Need.

11.51 There was what we consider to have been an unacceptable failure to take account of the views expressed at this CPA meeting in subsequently formulating the plan for AT's care and management. There was likewise a failure to appreciate that her risk assessment needed to be modified in the light of these discussions. It seems likely that this was caused, or at least contributed to, by the absence of any documentation held at Shrewsbury Court recording the discussions at this and later CPA meetings, but it is astonishing that there were discussions about AT's vulnerability at this meeting, and that the representative of Shrewsbury Court did not apparently appreciate that this was at odds with the current risk assessment.

11.52 It is unfortunate that the team from Kent did not review the risk assessment in place for AT at Shrewsbury Court. Had they done so, it would have been appreciated that that assessment was simply wrong, at least in so far as it assessed her vulnerability to exploitation as low. It ought, we think, to be a routine part of any CPA meeting to consider the current risk assessment and to discuss whether it remains appropriate or needs to be up-dated. Had such a review occurred in AT's case, it would have identified this error in the assessment of her vulnerability.

11.53 A further CPA meeting took place on 18 June 2002. The meeting was attended by C4, CONS4 in his capacity as AT's RMO, W4 the ward manager, AT's keyworker (identified only as "C18"), an occupational therapist and AT herself. It does not appear that either of AT's sons was invited.

11.54 The only written record of this meeting within the records at Shrewsbury Court is in the nursing notes. The only documentation prepared by staff at Shrewsbury Court for that meeting was, so it seems, the risk assessment carried out on AT on 16 June 2002. We

have already commented upon the inadequacies in that document and upon the fact that the person who prepared that assessment, W5, did not attend this meeting. There may have been specific reasons why it was not possible for her to attend, but the impression once again is of a lack of coordination in the care and management of AT.

11.55 No nursing report, or other document summarising any current concerns and future goals, was prepared. This was poor practice.

11.56 We comment that it is again disappointing that the team from Kent did not, apparently, review the current risk assessment, and ascertain why that assessment indicated that she was no longer regarded as vulnerable.

11.57 One of the consequences of this CPA meeting in June 2002 was that the Dartford CMHT took the view that it should, at least for the time being, no longer have an active involvement in AT's care and management because she was going to be staying at Shrewsbury Court for the foreseeable future. The Dartford CMHT did not, accordingly, press for any further CPA meeting to take place. There is no criticism to be made of the CMHT in this regard - once it had been concluded that AT was likely to remain at Shrewsbury Court for the foreseeable future, its role could properly be considered to have come to an end for the time being. Responsibility for arranging CPA meetings during the period that followed clearly lay with staff at Shrewsbury Court.

11.58 In the event, however, there was no further CPA meeting until 2 August 2004. The length of time that Shrewsbury Court allowed to pass between CPA meetings was wholly unacceptable. Such meetings should have been held at least once a year, even if AT's situation had been completely stable, a point to which we will turn in a moment. The conclusion we have reached is that, in the period between 2002 and 2004, Shrewsbury Court simply did not have appropriate systems in place to ensure that regular CPA meetings took place for each of its patients.

11.59 Primary responsibility for this failure lay with the management which failed to put such systems in place, but it is also a reflection of the inexperience or lack of training of those who were acting as Named Nurses at Shrewsbury Court during this period. AT's Named Nurse should have realised that no CPA meeting had taken place for a very long time and that this needed to be addressed.

11.60 The failure to arrange a CPA meeting for AT during this period is all the more concerning because there is evidence that, over time, AT's situation improved to the extent that there were, at the very least, reasons to reconsider whether she still needed nursing care 24 hours a day. This is an issue that we consider in more detail elsewhere but the point, for present purposes, is that the failure to organise a CPA meeting for AT for a period of over two years was even more unacceptable in a context where there is evidence to suggest that the placement at Shrewsbury Court was no longer necessary or appropriate for her.

11.61 The lack of systems at Shrewsbury Court to ensure that regular CPA meetings took place is further illustrated by the fact that when a CPA meeting was eventually arranged, it only took place because those funding the placement wanted to know whether AT's placement at Shrewsbury Court continued to be appropriate. It was only as a result of the follow-up visits that were made to AT by K1 and C6 of the Rehabilitation Continuing Care Team at West Kent Health Authority, that a further CPA meeting was finally arranged. There appears to have been some delay in action being taken following their visits, a point which we will discuss later. For present purposes, the point is that Shrewsbury Court itself had an active responsibility to keep under review the question of whether AT's placement there was necessary and appropriate. It failed to discharge that responsibility.

11.62 Following the reinvolvement of West Kent Health Authority and J1 of Dartford CMHT in early 2004, a CPA meeting eventually took place on 2 August 2004. It was attended by AT, with CONS4 and W6, from Shrewsbury Court, and with C9, K1, C8 and J1 from Kent. Once again (and very surprisingly, bearing in mind the proximity of the homicide) CONS4 had no recollection at all of attending this meeting.

11.63 There was discussion, on this occasion, about AT being financially and sexually vulnerable. Astonishingly, however, the focus of concern was not the fact that she was now in a relationship with a man known to have a history of violence towards women with whom he was having an intimate relationship, but upon the fact that AT appears to have a somewhat erratic "love life", shifting her affections from one male patient to another, causing tension and disturbance. There is no evidence to suggest that J1 was ever informed that AT was in an intimate relationship with a man with a known history of violence towards his sexual partners. J1 told us she had not known of the relationship, and we consider her evidence in this respect to be entirely credible.

11.64 The failure by staff at Shrewsbury Court to inform AT's care co-ordinator, J1, of that relationship, and the failure to discuss its implications with her were extraordinary omissions. This relationship ought to have been one of the most obvious and important topics for discussion at this CPA meeting. Even if the position, at this point in time, was that RR was one of two or more male patients with whom AT was flirting, the situation was fraught with danger, bearing in mind RR's history, the fact that the relationship could obviously develop, and the fact that suspected, let alone real, infidelity by RR's partners ought to have been recognised as a potential trigger for violence by RR towards AT.

11.65 The failure to raise these issues at the CPA meeting on 2 August 2004 is explicable only on the basis

i. That CONS4, who was undoubtedly aware of RR's history and his potential to cause physical harm towards any woman with whom he formed an intimate relationship, was unaware, at the time of this CPA meeting, of the developing relationship between AT and RR. If he had been aware of it, it would be impossible to understand how he could not consider it a necessary topic for discussion at this, the first CPA meeting held for AT in two years.

ii. That no one else attending the CPA meeting was aware of the nature and extent of the risk that RR posed to women with whom he formed a relationship.

11.66 The alternative hypothesis is that CONS4 did know of the relationship, but had taken the view that there were no issues which needed to be discussed arising out of that relationship. If that had been CONS4's view, it would, we think, have been an inexplicable view.

11.67 The failure by staff at Shrewsbury Court to recognise the significance of AT's developing relationship with RR or even to include any reference to this relationship in any of the documentation prepared for this CPA meeting was of crucial significance. Their failure to appreciate that the relationship was with a man who was known to pose a serious risk to women with whom he was in an intimate relationship and the failure to communicate that fact to J1, meant that a golden opportunity to identify the dangers and to put in place safeguards for AT was missed. J1 was deprived of vital information which she needed to discharge properly her role as AT's care co-ordinator. The omission was wholly unacceptable.

11.68 We have already commented that Shrewsbury Court's failure to organise a CPA meeting for AT for over two years was all the more concerning because there is evidence to suggest that the placement at Shrewsbury Court may no longer have been appropriate for her – that at least was the view of K1 and C6. The CPA meeting of 2 August 2004 was, accordingly, the first opportunity for proper discussion of this important question in a multi-disciplinary context. J1's evidence was that when the issue was raised, AT became very upset. That is, perhaps, unsurprising and it is confirmed by Shrewsbury Court's record of this meeting which notes how AT indignantly rejected the suggestion that she should be moved. J1 also told us however, that as soon as AT became upset, CONS4 gave her a categorical assurance that she would <u>not</u> be moved against her wishes. J1 said she felt this placed her in an impossible position, because it effectively pre-empted any discussion about the possibility of moving AT.

11.69 We considered J1's evidence to us about this to be credible for the following reasons. When she gave her evidence she did not have the benefit of her own file - this was only found and given to us after her evidence. The file contained her contemporaneous note of this meeting. This confirmed that what she had told us, based

largely upon her unaided recollection, was accurate in almost all respects. The note recorded:

"It is my responsibility to identify whether [AT] does not require the care at Whitepost and could easily live happily in a smaller home in the community. CONS4 reassured [AT] that they had no plans for her to leave. This obviously put me in a difficult position as [AT] was delighted he had said this. Therefore the only thing I could say was "AT, we look at possibly moving you in the future to a small place you can call home". I am very confused that it is not my decision to begin with, however. To assess whether [AT] should stay or move on is part of my position as a care co-ordinator."

This note provides corroboration both of her evidence about the assurance given by CONS4 to AT, and of her concern that he had taken such a step when she (rightly) considered that decisions as to AT's future placement ought to fall to her, as AT's care co-ordinator, or at least to the entire multi-disciplinary team.

11.70 As mentioned above, CONS4 had no recollection of any involvement with AT at all. He did, however, tell us that he would not have given AT such categorical reassurance as J1 suggested. He said that ultimate responsibility for placement decisions lay with AT's care co-ordinator, not with him, and he suggested that he would have given AT only general reassurance. In our view, however, even if J1's recollection is wrong, and even if all CONS4 did was to reassure AT that there were no current plans to move her on, that would still have been inappropriate, particularly given that CONS4 told us that he had had no substantive dealings with AT at all. Such an assurance could only properly be given to a patient after discussion with the multi-disciplinary team. It could never be appropriate to pre-empt such discussion and effectively to allow the patient's wishes to override any and all other considerations.

11.71 It is unlikely that this action made any difference to the outcome since it is improbable that any decision to move AT from Shrewsbury Court would have been made, in the face of her opposition, with such speed as to result in her transfer prior to December 2004. The result of this particular failure was that AT remained in a placement which, as an independent hospital, providing full-time nursing care, was perceived to be providing an unnecessarily high (and expensive) level of care. It could not have been anticipated that the consequence of her remaining in an establishment which ought to

have been providing her with a higher level of care and support than she fact needed would be that she would thereby be exposed to physical harm.

The monitoring of the relationship between AT and RR

11.72 Shrewsbury Court had a quite remarkably permissive attitude towards intimate relationships between patients throughout the time that AT was there. As commented above, as early as August 2001, there is a reference to AT having been discovered having sex with another patient. Although there was a reference in the nursing notes to AT having concerns that staff were planning to break up her relationship with that other patient - J - there is no indication anywhere else in the medical records, whether in AT's care plans, or in her nursing notes, or in the clinical notes, to suggest that such a plan had been formulated, or was ever even contemplated.

11.73 There are other references in the nursing notes at Shrewsbury Court to AT's relationships. There was one occasion in December 2002 when AT appeared to be getting into a situation where she had relationships with two of her fellow patients. She was given counselling, but it appears that this did not extend beyond her being encouraged not to engage in love affairs. There is no indication, at any point in the records which we have seen, that AT was told, in terms, that it was simply not permissible for her to have a sexual relationship with another patient and it is clear that nursing staff did not think it was necessary or appropriate, or any part of their role, to take any steps to prevent sexual relationships developing between patients.

11.74 There was some suggestion in the evidence given to us that any attempt to interfere would have amounted to an infringement of those patients' human rights, a view with which we do not agree. When we asked W4, who was, by mid-2004, the Acting Manager, whether male and female patients were allowed to spend the night together, he replied:

"There are no hard and fast rules about it at all. People were free to roam from one area to the next and to go into each other's bedrooms."

He went on to say that this approach was only questioned, and then changed, after the homicide. The evidence of W10, who was in 2004 the Clinical Nurse Specialist - and therefore in a relatively senior position at Shrewsbury Court - was to the like effect. W2 told us was that there was no policy regarding patients spending the night in each other's

bedrooms, but that it happened *"a lot"* - we comment that he generally worked the night shift, so was well placed to offer an opinion on this subject. He confirmed that AT had been allowed to sleep in J's bedroom before he died. He said that as a nurse, he had no right to stop this occurring *"because it is their right"*.

11.75 There appears to have been no appreciation by the management at Shrewsbury Court that it could legitimately have adopted a policy to the effect that any patient who chose to remain as a patient at Shrewsbury Court could not enter into a sexual relationship with any other patient there, and to the effect that patients were prohibited from spending time alone together in each other's bedrooms.

11.76 CONS4's evidence on this question was that he was unaware of the fact that patients were allowed to spend time in each other's bedrooms. He did not think that it was allowed, but he could not ever recall seeing any unit policy on the issue. His evidence, assuming it to be accurate, indicates a very worrying lack of communication between nursing and medical staff, and a surprising failure by CONS4 to acquaint himself with all relevant information about the patients for whom he had responsibility (whether as RMO at Shrewsbury Court, or in his capacity as the local NHS consultant).

The attitude adopted at Shrewsbury Court towards the issue of intimate relationships between patients there was extraordinary and misguided. There should, we think, have been a clear policy which prohibited patients from spending unsupervised time together in each other's bedrooms, and which prohibited patients from sleeping together. However, whatever the general policy adopted at Shrewsbury Court with regard to intimate relationships between patients, and whatever the merits or otherwise of the permissive approach adopted there towards such relationships, wholly different considerations should have applied to any intimate relationship which developed involving a man with RR's history. He was known to have a history of violence towards women with whom he was in an intimate relationship, particularly if he suspected infidelity. Staff at Shrewsbury Court should have been put on alert to watch for any signs of RR developing an intimate relationship with any of the female patients. Staff should have been instructed that in the event that there were signs of such a relationship developing, it was necessary for that

fact to be brought immediately to the attention of medical staff, and in particular to the attention of CONS4, who was RR's RMO.

11.77 In view of what was known about RR, we take the view that it was inconceivable that he was a man who could be allowed to develop an intimate relationship with any of the female patients at Shrewsbury Court. The warnings contained in CONS1's reports from 1990 and 1993 could not have been clearer. They are worth repeating. In 1990 he wrote:

"Although [RR] has managed to avoid actual violence with women at the beginning of relationships, in recent years this aspect has always emerged eventually. ... [RR] is a severe and continuing danger to any woman with whom he becomes sexually involved and, in my view, he may go on to kill the victim in the future. But somewhat bluntly and illiberally, if he is to avoid the risk of serious harm or death of a victim, he must not have sexual relationships with women. ...

I believe he has a personality disorder and sexual deviation entirely untreatable and all one can do is to minimise the risk through various management strategies. In my view, [RR] will always represent a very serious risk to that specified group of potential victims which I have identified. He needs either to be contained in hospital and with avoidance of sexual relationships or, if he were to leave hospital, he would have to have extremely close monitoring and in the context of knowing he is not in a sexual relationship."

11.78 By 1993, CONS1's views had modified somewhat in that he considered there was a possibility of moving RR into a 24-hour, highly staffed, hostel. He still wrote, however:

"As regards his dangerousness, my view remains that he is potentially very dangerous but only in very limited circumstances. That is, I believe that it is only in the context of sexual relationships that he becomes dangerous. ... Hence, I believe it would be safe to move him into a 24-hour highly staffed hostel, so long as he was monitored extremely closely and so long as there was continued recognition of the potential dangerousness should he form a sexual relationship of any sort. It would be very easy for him to move into the community and then to be presumed, perhaps in a year or two's time, to be not dangerous simply because he has lived satisfactorily in the community. It would be

necessary to remind the treating team at regular case conferences that he can be very dangerous in the context of sexual relationships. Hence, monitoring should not be only of his mental state but also of his relationships with others, specifically women."

11.79 The failure to communicate warnings of this seriousness to the staff at Shrewsbury Court, and the failure to provide staff there with the types of instruction referred to above - to be alert to watch for any signs of RR developing an intimate relationship, and to bring any such relationship to the immediate attention of RR's RMO - represents the clearest and most obvious of failures, a failure which had catastrophic consequences.

11.80 This was not the only information of crucial importance which was not adequately communicated to nursing staff. Staff should have been told that there were certain readily identifiable trigger factors which were known to precipitate RR's episodes of violence towards women. Specifically, staff should have been informed of the need to be alert for

i. Reports by RR of auditory hallucinations - specifically the hearing of voices which was often preceded by the hearing of musical sounds. Staff should have been made aware that those "voices" might direct RR to take violent action towards any woman with whom he was in a relationship, particularly if associated with allegations of infidelity by the woman concerned.

ii. RR suspecting infidelity by his partner. The important point which should have been communicated was that it mattered not whether the suspicion was well-founded - the fact that RR was entertaining the suspicion was, of itself, potentially sufficient to trigger violence towards the woman concerned.

iii. RR asking for additional medication, a circumstance which generally indicated a relapse in his illness about which he found it difficult to speak directly.

11.81 Had such instructions been given, what should then have occurred is that, as soon as there were signs of a developing relationship between RR and AT - and the evidence suggests that this would have been no later than early July 2004 - immediate steps should

have been taken to ensure that the relationship did not progress. In the event that it was not possible to prevent the relationship, CONS4 should then have taken immediate steps to have RR removed from Shrewsbury Court, and in the meantime to ensure that either RR or AT was kept under continuous observations, so as to ensure that there was never a moment when they were left alone unobserved.

11.82 Nursing staff were aware of the general instruction to *"monitor"* RR's relationships. However, the evidence suggests that they did not have any clear idea about what this meant in practice. RR's Named Nurse, W2, did not even consider that he had the right to prevent RR having an intimate relationship with AT, or to prevent him spending the night with her. We comment that, as he was the individual who had attended the discharge meeting at Witley 3, as well as being RR's Named Nurse, he was, without any doubt, the nurse at Shrewsbury Court who ought to have had the most complete knowledge of what was needed to manage RR's relationships with women.

11.83 W4's evidence is also relevant. When we asked him whether he knew about the relationship between AT and RR, he said *"Obviously we were all aware that he was having this relationship with [AT]."* He went on to say that he had had no concern about the relationship because AT had never complained that RR had acted inappropriately in any way.

" She never had any bruising, she never had any fractures, she never showed any signs of withdrawal, depression or never gave me any indication that he was posing a threat to her at all. … She would always go out and buy him presents and he would buy her presents. In my eyes and the other staff at the time prior to the murder, there were no problems".

11.84 When asked what the instruction that any relationship which RR formed should be *"closely monitored"* actually meant, his response was:

"Probably not a lot to be honest with you. As I said, if there was any cause for concern, [AT] saying "Oh he's physically sexually abusing me", then obviously we would place him on one-to-one or refer him to the psychiatrist. There would be precautions. They are more reactive I guess than proactive, the precautions that were in place".

His evidence in this regard demonstrated a total lack of understanding about the risks that RR presented to AT. It is a clear illustration of the limitations which we consider were an inevitable consequence of W4's lack of training in and experience of mental health issues. The fact that neither W2, RR's Named Nurse, nor W4, the Acting Manager, had an adequate understanding of what was meant by the requirement to "monitor" RR's relationships with women strongly suggests that none of the nursing staff at Shrewsbury Court would have had any proper understanding of this requirement.

11.85 There is no documentary evidence that CONS4 ever provided any meaningful clarification or explanation of what the requirement to *"monitor"* RR's relationships with women meant in practical terms. When we asked him about this he said:

"At the beginning when he first came, I said that there was quite a high risk to women. … I thought that we should monitor the exploitation and also, if he did make any kind of threat, particularly if he had a victim in mind, the risks were quite high."

When asked if he gave the staff instructions as to what they should do if they observed any threats, he replied:

"Normally they would contact myself and also increase the observations."

11.86 It was clear from CONS4's evidence that he did not regard the need to monitor RR's relationships as equivalent to preventing the development of an intimate or sexual relationship. The following series of questions and answers at his interview is revealing:

"CONS4: The main thing we were looking for was any kind of aggressive behaviour.

Q: If you [had instructed staff] to monitor the relationship, would you have just let them go away and get on with it or would you have had to give them specific instructions as to how this might be done?

CONS4: I should give them instructions how it might be done. I would normally expect them to be able to say how much time they spent together, maybe some idea of the quality of the relationship.

Q: In tangible terms, what does that mean? Do you envisage one-to-one observations or is it less than one-to-one observations and, if so, what?

CONS4: It would just be general observation - Obviously the staff would see the overall extent they were spending together at the time.

Q. And if they report that they are spending a great deal of time together, then what is the next step?

CONS4: Whether there were any threats or concerns about it.

Q. So if there were no threats you would not be concerned?

CONS4: You would carry on monitoring.

Q. By monitoring you mean general observations, not one-to-one observations?

CONS4: Yes."

11.87 This exchange reflects the fact that CONS4 - and accordingly, no doubt, all other staff at Shrewsbury Court - did not regard the fact that RR developed an intimate relationship with a female patient as, in itself, a cause for concern or for action to be taken. It suggests that there may have been a perception that, as long as an eye was kept on the relationship to ensure that RR was not exploiting AT and was not obviously acting in an aggressive or violent manner, the relationship could be allowed to develop. This was a serious misjudgment for which CONS4 must take primary responsibility.

11.88 Furthermore, it is relevant to re-emphasise here that CONS4's evidence was that, at the time when he saw RR on 7 October 2004, he was <u>still</u> unaware of the existence of the relationship between RR and AT. It had been noted that there was some form of developing relationship by 18 July 2004. This was not apparently reported to CONS4. Had staff been clearly instructed that signs of any developing relationship between RR and any female patient should be reported to CONS4, it would be remarkable indeed if there had been no report at all made to CONS4 of the relationship with AT. We have expressed elsewhere in this Report our concerns about the quality, experience and training of nursing staff at Shrewsbury Court, but for <u>all</u> of the staff there to have ignored, over a period of months, a clear and straightforward instruction from CONS4 would be remarkable indeed. It seems far more likely that what occurred was that all that was communicated to staff was the general, and regrettably vague, instruction to *"monitor"*

RR's relationships, and that there was no sufficiently clear instruction to report any such relationship to CONS4.

11.89 We reiterate that there is nothing in RR's Nursing Care Plan, or elsewhere in the documentation, which records the need to report the development of any intimate relationships to CONS4. On the contrary, the document prepared by W2 on 23 June 2004, headed "Multi-Disciplinary CPA", merely referred to the need to monitor RR's relationships with women and to *"inform future partners about risks of being hurt physically"* with no reference to passing information about those relationships to CONS4.

11.90 Our conclusion is, therefore, that there was a failure, again one for which CONS4 must take responsibility, clearly to instruct staff what *"monitoring"* RR's relationships meant, and what action needed to be taken in the event that any such relationship did develop.

11.91 We are also concerned about the warnings given to AT about RR. The document prepared on 23 June 2004 referred to the need to inform RR's partners about the risks of physical injury. However, none of the witnesses to the Inquiry were able to say, with any clarity, what warnings had actually been given to her, notwithstanding that those witnesses included W4, the Acting Manager; CONS4, who was, by September 2004, the RMO for both RR and AT; W10, the Clinical Nurse Specialist; W7, AT's Named Nurse at the time of the homicide W2, RR's Named Nurse, as well as DR1 and W3, and other nurses working at Shrewsbury Court at the material times.

11.92 CONS4 told us:

"I did speak to [AT] about the relationship and warned her that it was inappropriate for her to form this relationship. I did not say why and give the past history. She responded that she was in love with him and she knew all about him. So we just decided at that stage to monitor whether she was being exploited or not."

11.93 If this is what happened (and as noted above, there is no record of even this limited warning being given by CONS4), it was, in our view, inadequate. CONS4, above all

others, should have been aware of the true extent of the risks which RR posed, and merely telling AT that it was *"inappropriate"* to form this relationship fell, in our view, short of what AT ought to have been told.

11.94 The impression given by the witnesses who gave evidence to the Inquiry was that, to the extent that any warning was given to AT, it was expressed in general terms. The view was expressed by a number of these witnesses that it might have been an infringement of RR's right to confidentiality if full details of his history of violence towards women were given to AT. If this is the reason why AT was not given more complete warnings about the risks of her relationship with RR, we think it was misguided. We must emphasise, however, that our view is that, once the relationship between RR and AT had started to develop, and certainly once RR had threatened physical violence towards AT, the appropriate course was not merely to give AT warnings about the dangers of the relationship. Immediate steps should have been taken to move RR away from Shrewsbury Court.

11.95 There is, however, an important issue here. RR did have a right to expect that details of his medical history would be kept confidential. There was, however, also a duty to protect AT from the risk of violence. Finding the right balance between these competing interests can be a difficult exercise, and the right answer is not always obvious. In this instance, however, we take the view that once RR had threatened physical violence towards AT, then, given his history, it would have been appropriate for AT to have been told that RR's violence had occurred in the specific context of the sexual relationships which he had from time to time with women, and further warned that almost all of those relationships had ended with RR displaying serious violence towards the woman concerned. AT may, of course, have chosen, notwithstanding these warnings, to continue the relationship. Had she done so, it is, in our view, inconceivable that the relationship could have been allowed to continue. One of the patients would have had to be moved from Shrewsbury Court.

11.96 Furthermore, assuming for present purposes that it was appropriate for RR to remain at Shrewsbury Court at all, it would also have been appropriate for staff, in particular, CONS4, to have told RR that if he persisted in his relationship with AT he would

have to be moved away. It is not possible to say with any certainty what effect such a warning might have had on RR's attitude towards AT, but it might have had an effect. The fact is, however, that this course does not appear even to have been considered.

11.97 The position became still clearer in October 2004. On 12 October 2004 there was a report that AT was distressed because of threats made by RR. According to the nursing notes, this issue was, appropriately, brought to the attention of CONS4 who was told, in terms, that *"at times they lie in each other's rooms"*. CONS4 apparently advised counselling and education for AT and *"to watch them"*. (Although, as recorded above, CONS4 had no recollection of this, and did not think that he would have ever given such advice, it is difficult to envisage how this entry came to be made in the nursing notes if the events recorded had not in fact occurred.) There is no note in the documentation which has been made available to us that such advice or counselling was given. It is not at all clear to us what CONS4 meant by the imprecise instruction to *"watch them"*, or how this was interpreted by nursing staff.

11.98 In the context of RR's history, which was or ought to have been known to CONS4, we consider that the response by CONS4 to this report on 12 October 2004 was seriously inadequate. The development of an intimate relationship - involving RR and AT lying together unsupervised in their bedrooms - ought to have raised major concerns. Steps should have been taken to bring an immediate end to the relationship, or to remove RR from Shrewsbury Court. At the very least, action should have been taken to ensure that AT and RR could not spend time together alone.

11.99 Furthermore, even the limited advice which CONS4 did apparently give was not appropriately documented by him. At least as recorded in the nursing notes, his advice was ambiguous and imprecise, with no guidance being given as to what the *"counselling and education"* for AT ought to be. There is no indication in the nursing notes that CONS4's instructions were interpreted as requiring nursing staff to maintain close or continuous observations, let alone one-to-one observations.

11.100 However, the events of late October 2004 are in a different category altogether. At this time, over a period of a day or so, RR reported hearing voices telling him AT was being unfaithful, and that he wanted to kill her or someone else. It is difficult to imagine a clearer warning of the events which were to follow. The failure by the medical and nursing staff at Shrewsbury Court to respond to these events at the end of October 2004 by taking immediate steps to have RR removed from Shrewsbury Court, and, pending his removal, to ensure that he was kept under continuous observations, and was never alone with AT, or any other patient, was, in our view, a major error.

11.101 According to the nursing notes and DR1's subsequent notes, W3 was the first member of the medical (as opposed to nursing) staff to be involved with RR on this occasion. It is unfortunate that W3 has no recollection of his attendance upon RR on this occasion and that no notes have emerged of that attendance. W3 does, however, accept that he must have met with RR on this occasion, and it seems to us very likely that the reason he was asked to see RR was because RR had been making threats to kill AT. In these circumstances, and notwithstanding that W3 has no recollection of such threats being made, we think it very likely that W3 was told, in October 2004, that those threats had been made by RR.

11.102 If this is right, then it is our view that W3 should have ensured that CONS4 was informed about what was going on, and, if CONS4 was unable personally to attend, he should have sought his advice as to the steps to be taken to safeguard AT.

11.103 DR1's approach suggests that she had a limited understanding of RR's history and hence of the seriousness of what the nursing staff were reporting to her. She appears to have accepted the assessment of others that RR's threats were *"verbal only"*. She appears to have been reassured by the fact that relations between RR and AT appeared to be improved by the time that she became involved.

11.104 As we have explained above, DR1 had only limited psychiatric experience. Her role at Shrewsbury Court was essentially to deal with physical health issues, and to *"hold the fort"* in psychiatric matters if CONS4 was unable to attend immediately. Her response

to this episode must be assessed in the light of these limitations. In our view, however, she should have tried to familiarise herself with RR's history, and having done so, she ought, at the very least, to have taken steps to ensure that, until CONS4 had had an opportunity to express a view about the appropriate course, AT and RR were kept well away from each other and, in particular, could never be left alone together. Her advice to AT merely to *"try"* not to go to RR's room until the following Monday (which would have been 1 November 2004) was inadequate.

11.105 We do not think, however, that DR1 should bear primary responsibility for the misjudgments at this time. It is not at all clear why it was she, not CONS4, who was called out to deal with the crisis which had arisen. Assuming, however, that CONS4 had other commitments over this particular weekend which prevented him from attending, as RR's RMO, he should, as soon as he became aware of the incident, have obtained full details of what had occurred.

11.106 The evidence suggests that CONS4 may not have seen RR at all after this episode at the end of October 2004. We have referred above to the fact that, although there is an entry in RR's medical records dated 11 November 2004, the nursing notes record that RR was out shopping at the time of CONS4's review. We reiterate our view that if he did not arrange to meet with RR, that was a serious and inexplicable error. He had a duty not only to RR, but also to AT, to ascertain for himself, first hand, what the significance of that episode was.

11.107 Even if, however, he did meet with RR on 11 November 2004, he does not appear to have regarded the recent episode as of any particular concern. His note of the close relationship with AT refers also to the fact that RR had threatened to kill *"someone",* but fails to respond to that information in a meaningful way. CONS4 should have appreciated, amongst other things, that AT was, to put it at its most neutral, somewhat flirtatious in her relationships with patients and that this could reinforce any delusions of infidelity that RR might, from time to time, have.

11.108 When we asked CONS4 about this, his response was:

"When he was seen at the ward round [on 11 November], there was no evidence of any affective or psychotic symptoms. He did not have any thoughts of harming [AT] or anyone

else, so at the time he did not have any of those kinds of features in his mental state which would suggest that in the short term, at least, he would present a risk. That was probably the main reason why our concern was not raised. ...

From seeing him, it just seemed like a temporary [episode]. ... The staff felt he [had been] under stress and he made these threats, and then he was no longer expressing them. So it just seemed that this was only a temporary phenomenon."

11.109 CONS4's failure to appreciate the seriousness of what had occurred in October 2004 is difficult to understand or explain. Even if CONS4 did not think that what happened was serious enough to merit RR's immediate removal from Shrewsbury Court, it is difficult to understand or explain why he did not, at least ensure:

i. That RR and/or AT were kept under continuous observations, so as to ensure that RR was never alone with AT;

ii. That he spoke himself to AT about the dangers of being in a relationship with RR, and of the "trigger factors" which, if they occurred, meant that there was a very real and proximate danger of violence towards her; and

iii. That there was an absolute prohibition upon RR going into AT's bedroom; and vice versa.

11.110 CONS4 did take some action. The nursing notes record that following this review by CONS4 on 11 November 2004, he *"suggested"* that, if there should ever be an aggressive outburst of threats, then *"one-to-one observations should recommence especially if there is a victim in mind"*. This suggestion fell very far short of a sufficient response to what had occurred. There does not appear to have been any effective communication by CONS4 to staff at Shrewsbury Court of the seriousness of what had occurred. He should, in our view, have emphasised to staff the vital necessity of ensuring that any incident involving RR and AT, or any episode when RR indicated that he was again having auditory hallucinations and/or was having concerns about AT's fidelity, was to be regarded as indicative of a potential crisis and needed to be reported to him, CONS4, immediately.

11.111 Coincidentally, so it would seem, CONS4 had also been due to see AT on 11 November 2004. The nursing notes record that AT refused to see CONS4, saying that she thought he was going to *"pick on her";* and that following a discussion between members of staff, it was decided that it would be a good idea to have both RR and AT sit down and have a discussion. The notes do not make it clear what the intended purpose of the discussion was going to be, but the context suggests that it was primarily to discuss the amount of money that AT was spending on RR, rather than to try to bring an end to their relationship. In the event, this joint discussion never took place. There is indeed no evidence that such a meeting was ever discussed with either AT or RR. Accordingly, even if one of the objectives which CONS4 may have had in mind in suggesting that such a meeting should be set up was to try and stop the relationship, that attempt was never made and another opportunity to try to address that problem, and to try to protect AT from the risks inherent in that relationship was lost.

11.112 The shortcomings at Shrewsbury Court with regard to the management of the relationship between AT and RR can be summarised as follows.

i. RR should probably never have been allowed to become an in-patient at Shrewsbury Court. However, once he was there, staff should all have been made aware of his history, and in particular, his history of violence towards women with whom he was having a relationship.

ii. Staff (most importantly RR's Named Nurse) should have been explicitly instructed that RR could not be allowed to form an intimate relationship with anyone. Those instructions should have been reflected in RR's Care Plan. Staff should have been instructed that, if they perceived any signs of such a relationship developing, they should take the following steps:

    a. They should immediately inform CONS4;

    b. They should take such steps as they could to discourage the relationship, including but not limited to ensuring that the woman concerned was informed clearly and unequivocally of RR's history and of the dangers which were inherent in any kind of intimate relationship with him;

c. They should ensure that RR and the woman concerned were never left alone and unobserved;

d. They should be alert for, and should warn the woman concerned to be alert for, any of the known trigger factors.

iii. The development of the relationship between RR and AT ought, of itself, to have prompted immediate action to move RR from Shrewsbury Court. At the very least, the relationship should not have been allowed to develop and RR and AT should not have been allowed to be alone together.

iv. Even if the relationship could, initially, have been considered acceptable, the events of October 2004 should have changed that perception and prompted immediate action to move RR from Shrewsbury Court. If there was any delay in bringing that about, steps should have been taken in the interim to ensure that there were no occasions upon which RR and AT were alone together.

We regret, therefore, that the management, at Shrewsbury Court of the relationship between RR and AT was catastrophically deficient. It is our view that had these shortcomings not existed, this homicide would probably not have occurred.

Room Searches / Room Keys

11.113 In October 2002, two penknives were confiscated from AT, having been found in the course of a routine check of her room. However, the nursing staff do not appear to have made any attempts to ascertain how or why she had obtained these pen-knives. No change was made to her risk assessment or care plan as a result of this discovery.

11.114 It should have been routine for the discovery of prohibited items such as penknives to result in some form of investigation into how and why she had obtained those items, with a view to trying to prevent a recurrence. If such enquiries had been carried out, nursing staff might well have learned of AT's fascination with knives, and steps would have been taken to try to ensure that she was not able again to bring such items back to Shrewsbury Court. AT's care plan might, for example, have been changed to incorporate

spot checks or searches of her room. It is relevant, in this context, to note that the weapon which RR ultimately used in the homicide was a knife which had, apparently, been purchased by AT some two months prior to her death, and was given by her to RR.

11.115 Notwithstanding the discovery of these penknives, there do not appear to have been any further searches of AT's room until 8 December 2003 when 24 Paracetamol tablets were found. AT told staff that she bought these when she was feeling *"down",* but that she had no intentions of overdosing. The notes record that she was counselled about this incident and was told that it would be reported to CONS4. There is, however, no documentation suggesting any follow-up by CONS4.

11.116 It was also noted, on this occasion that *"All staff must be more aware and regular checks to be made."* There are, however, no records of any further searches being carried out of AT's room during the remainder of her time at Shrewsbury Court. It cannot be known whether such searches would have led to the discovery and confiscation of the knife that was eventually used to kill her, but the failure to carry through the intention of carrying out regular checks of her room is another example of the poor standard of nursing care at Shrewsbury Court. It is another omission which, had it not occurred, might conceivably have prevented this homicide.

11.117 All staff had a 'master' key which opened all the patients' bedrooms. Some patients, including AT and RR, were issued with their own room keys. W13 told the police in her statement following the homicide that AT wore her key around her neck on a piece of string. She also said she thought RR had his own key, but was not sure. RR told us that both he and AT had their own keys and used to swap them.

11.118 There was no clear policy at Shrewsbury Court as to which patients had their own room key. There did not appear to be any formal assessment or multi-disciplinary decision-making regarding which patients were given their own key. There was nothing in RR's or AT's nursing or clinical notes that recorded whether they were issued with their own key. It is perhaps not surprising that such a lax approach was adopted bearing in

mind the relaxed attitude with regards to patients spending time in each other's bedrooms.

AT's financial affairs

11.119 The management of AT's finances over her time at Shrewsbury Court was a cause for concern, particularly to her family. It was also an issue for staff. As early as 11 June 2001, there is a reference in the nursing notes to AT having given money to another patient. In May 2002 AT's son, Son2, was sufficiently worried about this issue to contact Kent Social Services to express his concerns.

11.120 The attitude of those members of the nursing staff who gave evidence to the Inquiry was that they did not feel they could stop AT spending her money as she chose. From a strictly legal standpoint, and bearing in mind that AT was a voluntary patient, it was right to say that staff could not prevent AT from accessing her own money. However, they did have an obligation to protect AT as best they could from financial exploitation. Furthermore, financial planning and budgeting skills would be an important aspect of her rehabilitation programme.

11.121 Some action was taken by staff at Shrewsbury Court with regard to this problem of excessive spending. There are records of numerous discussions with AT about the issue, and even though these may have been prompted by the concerns communicated by AT's sons, the discussions did at least take place.

11.122 Furthermore, on 10 August 2004 staff persuaded AT to sign an agreement aimed at trying to control her spending. We think that this agreement represented a sensible attempt to control a difficult situation. The objective was to try to get AT to exercise a degree of restraint in her expenditure by ensuring, among other things, that she thought in advance about what she was going to buy, and prepared a list of her planned spending before she went shopping. In this respect at least, therefore, we take the view that the staff at Shrewsbury Court did demonstrate an appropriate approach, although it is difficult

to understand why it was only in August 2004 that it was adopted. There must have been earlier opportunities for staff to have sought to enter into this kind of agreement with AT and to provide her with full counselling on financial issues.

11.123 The issue of the control of AT's expenditure ought also to have been discussed with her, her family, and her social worker at CPA meetings - which makes the failure to organise such meetings all the more regrettable.

11.124 Furthermore, if it was considered that AT was being financially exploited by another patient - and this could have been a real concern during the time that AT was involved in her relationship with RR - it would have been possible to involve that other patient in these discussions. There is no evidence at all within any of the documentation which we have seen to suggest that any attempt was ever made to talk to RR about the extent to which he was taking advantage of AT's generosity and exploiting her financially. It would have been entirely possible and appropriate to warn him that such behaviour would not be tolerated and that if it continued it would not be possible for him to remain at Shrewsbury Court.

11.125 The evidence we heard suggests that AT was hostile towards any suggestion that she could not spend her money as she wished. When, in November 2004, her sons raised concerns about her spending with W7, who was by then AT's Named Nurse, AT's response was that her money was nothing to do with her sons, saying *"it was her money and she would do what she wanted with it"*. However, there is no reason to believe that RR would not have been responsive to a warning of the type described above, and it is not clear why no attempt was made to pursue this as a possible solution to the concerns about the extent to which AT was being financially exploited by RR.

11.126 However, of all of the aspects of AT's care and management at Shrewsbury Court, this is one area where it is at least possible to identify some positive action being taken by staff albeit rather later in the day than one might have hoped.

Other shortcomings

11.127 Compared with the shortcomings outlined above, the other deficiencies in the care given to AT during her time at Shrewsbury Court are of less importance, at least when considering factors which could have prevented her death. We consider, however, that they need to be noted in this Report in order to provide a full picture of the wide-ranging shortcomings which existed in the care being provided at Shrewsbury Court.

Medication Issues

The nursing notes relating to AT show that mistakes were made in the recording of the medication given to AT and, more significantly, in the administration of the prescribed medication. By way of example, on 5 May 2003, the nursing notes contain the following entry: *"Depixol 400mgs IM once a week given this a.m."*

11.128 AT should have been receiving one weekly injection of 400mgs of Clopixol, a different preparation from Depixol. It is to be hoped that this entry is a simple error, with the name of the wrong drug being written down, but on the face of it, AT was given the wrong drug. It is particularly concerning to note that four days later, on 9 May 2003, a "Weekly Report" is included within the nursing notes which merely noted that AT had received her weekly injection, but it did not pick up on the fact that the wrong medication appeared to have been given. The same mistake appears to have occurred on 6 October 2003 when the nursing notes again record that AT was given Depixol, not Clopixol.

11.129 Equally concerning is a note on 9 August 2004 to the effect that AT had refused her depot injection. There is no record that this was ever administered, and there is no record of any action as a result of this refusal. So far as one can tell from the records maintained at Shrewsbury Court, this injection was simply missed.

11.130 It is also noteworthy that, over the three and a half years that AT was at Shrewsbury Court, we have managed to find only one entry in the nursing notes (in June 2002) that refers to nursing staff carrying out observations to see if AT was experiencing side-effects from her medication. Observations of this kind, and the making and recording of such observations, should be a routine part of the care of any patient receiving psychotropic medication.

Rehabilitation

11.131 We have seen little evidence of attempts being made actively to rehabilitate AT. On the one occasion when she did attend a "Life Skills Training" course at Fern Cottage, there was no evidence of any assessment subsequently being carried out of the benefits, if any, which she had derived from her attendance, and there appears to have been no follow-up.

11.132 Linked to this is the fact that there is, in the documentation which we have seen, no evidence of active consideration being given by anyone at Shrewsbury Court to the question of whether it was in AT's best interests to remain there. She was placed at Shrewsbury Court at a time when she was assessed as needing 24-hour a day nursing care. There is evidence that strongly suggests that by 2004, her condition had improved to the extent that some other placement could sensibly have been considered. This was the approach which was adopted by K1 and his team from West Kent Health Authority in 2003 and early 2004 when they raised the possibility that AT might be more appropriately placed in a community support scheme - specifically the community support scheme run by C8 in Sheerness. The point, for present purposes, is not whether this assessment was right or wrong. The point which is of concern to us is that there is no evidence to suggest that any consideration was given by staff at Shrewsbury Court, at any time, to the possibility that AT might be able to move on from Shrewsbury Court. There appears to have been an entirely passive approach, proceeding on the basis that AT was resident at Shrewsbury Court and that it was not any part of the function of the staff there to consider whether that remained an appropriate placement for her.

11.133 Our concerns about this are heightened by the evidence from J1 about the CPA meeting on 2 August 2004. As we have noted above, she told us that, when the possibility of AT moving on from Shrewsbury Court was raised at this meeting, and when AT expressed her opposition, CONS4 immediately reassured her that she would not be moved on if she did not want to leave. Far from engaging in active debate about what was in AT's long term interests, it appears that CONS4 effectively prevented such debate taking place.

The follow-up of AT's placement - Should she have remained at Shrewsbury Court?

11.134 Following AT's move to Shrewsbury Court in 2001, there was, initially, good follow-up of the placement. C4 and DR7 visited her there on 18 May 2001 to see how she had settled in, and CONS9, DR7 and C4 attended the CPA meeting on 16 August 2001. There appears to have been appropriate consideration at this meeting of whether AT should remain at Shrewsbury Court, and the decision that she should stay there seems to have been reached by a multi-disciplinary team in an entirely appropriate manner.

11.135 However, the team from Kent did not notice, on this occasion, or subsequently, that the risk assessments carried out at Shrewsbury Court following AT's transfer had failed to recognise her vulnerability to exploitation. Our view is that the up-to-date risk assessments on AT ought to have been considered at the CPA meeting on 16 August 2001. If that had occurred, the erroneous assessment of AT as a person at very low risk of financial or sexual exploitation ought, at the very least, to have been discussed in depth, bearing in mind the mismatch between this assessment and the assessments which had been made by CONS9 prior to the transfer to Shrewsbury Court. The failure to identify this issue was all the more surprising bearing in mind that C4's notes of the CPA meeting recorded that AT was *"vulnerable and open to financial, emotional and sexual abuse"* and that *"this requires ongoing monitoring"* – which appears to indicate that the risk assessment had been discussed on this occasion.

11.136 If this issue was indeed discussed at the CPA meeting, then that ought to have resulted in a reconsideration of the risk assessment which was in place at Shrewsbury

Court. The principal criticism here must be of the staff at Shrewsbury Court, firstly for failing to make an appropriate risk assessment; and secondly for subsequently failing to reconsider and modify that risk assessment in the light of the matters which were discussed and apparently agreed at the August 2001 CPA meeting. However, it is a cause for concern that neither CONS9, nor DR7, nor C4 seems to have reviewed the up-to-date risk assessments (or if they did, that they failed to note the inconsistency between the Shrewsbury Court assessment and the views of CONS9.)

11.137 C4 visited Shrewsbury Court again on 17 January 2002. She expressed concerns on this occasion about aspects of AT's management - specifically, the management of her finances and the fact that Shrewsbury Court had failed to give her the name of the individual at Shrewsbury Court who had been allocated to take responsibility for AT's care. C4 followed up these concerns appropriately, arranging a further meeting at Shrewsbury Court on 16 March 2002. It is recorded that C4 reviewed the nursing notes and made a note to the effect that there was an up-to-date care plan in place, but once again, we are concerned that the inappropriateness of the risk assessment in place for AT, which still failed to record her vulnerability to exploitation), was not picked up.

11.138 It might also be considered surprising that there was no discussion at this meeting of the fact that Shrewsbury Court had become an independent hospital. However, as commented elsewhere in this Report, CONS4 appears to have been unaware of this change in status before September 2004, and there is no suggestion that any attempt was made by Shrewsbury Court to inform those purchasing services from it that there had been a change in status. It seems unreasonable therefore to expect C4 to have worked out that Shrewsbury Court had just started to operate as a hospital. It is in any event unlikely that that information would have made any difference at this stage to the decision to keep AT there. The change in the categorisation of Shrewsbury Court was in many respects one of form rather than of substance. Throughout the time that AT was at Shrewsbury Court, the residents had included detained patients, so the re-classification did not mean she would necessarily be living with a more dangerous class of patients than previously. It meant that the establishment had to meet higher regulatory standards, but there was no reason to fear that the change in 2002 would significantly impact, at least in the short term, on the patient mix at Shrewsbury Court.

11.139 The information that Shrewsbury Court was an independent hospital might, however, have been material in 2003 and 2004, when West Kent Health Authority was considering whether it was necessary or appropriate for AT to remain in such an expensive placement.

11.140 By the time of the CPA meeting on 18 June 2002 there was a consensus that AT would stay at Shrewsbury Court for the foreseeable future and it was decided that it was, accordingly, no longer necessary for a social worker from the Dartford CMHT to have an active continuing involvement in her care and management. The result of this decision was that responsibility for AT's care lay clearly with Shrewsbury Court. It had the obligation to implement the CPA – an obligation which we have concluded it failed properly to discharge.

11.141 It also had the responsibility to assess whether it was appropriate for AT to remain in a hospital, or whether her rehabilitation had progressed to the extent that a less structured environment would be more appropriate. We have seen no evidence to suggest that this question was ever actively considered at Shrewsbury Court. We should reiterate, in this regard, that it has proved impossible to locate the notes relating to AT's attendances at Shaw's Corner Out-Patient Clinic, and it is possible that these might have recorded some discussions of this issue. However, if active consideration had ever been given to the question of whether it might be possible to move AT to a less structured environment, it would be astonishing if there was no hint of that in any notes held at Shrewsbury Court itself. Furthermore, AT's RMO was CONS4 – it was he who attended such CPA meetings as took place for AT during her time at Shrewsbury Court – and, as recorded above, when the question of moving AT was discussed at the meeting on 2 August 2004, J1's evidence was that his response, apparently "off the cuff", was to assure AT that she would not be moved. This seems to us further evidence that those at Shrewsbury Court with responsibility for AT's care never properly addressed their minds to the question of whether she continued to be appropriately placed there. That was wholly unsatisfactory, but it was a reflection of the absence of any systems there to ensure proper implementation of the CPA. It was also, we think, a reflection of the detached approach of AT's RMO, CONS4, who, to our considerable surprise, had no recollection at all of ever attending any meetings relating to AT, even though he had in fact attended her CPA meeting just four months before her death. This suggests that he did not involve himself

closely in her care. It may be, of course, that her case was primarily handled by one of his junior doctors at Shaw's Corner. But even if that was the case, one would have expected CONS4 to have acquainted himself fully with her situation before 2 August 2004 when he attended the first CPA meeting for her in over two years. That he did not even recall this meeting, even though AT was killed some four months later, is most surprising.

11.142 It was still necessary for West Kent Health Authority to continue to monitor the placement because the authority needed to remain satisfied that it was still an appropriate and cost-effective placement. The documentation we have seen is not complete, but it appears that the Health Authority did have procedures to follow up individuals placed in the independent sector. There is evidence that AT was visited by K1 and C6 of the Rehabilitation Continuing Care Team at West Kent Health Authority sometime in late 2002 or early 2003. Although the notes which must have been made of that visit can no longer be located, it does appear from an e-mail dated 2 March 2004 that K1 thought, even at this stage, that AT's condition had improved to such an extent that it was possible to look for another, possibly cheaper, placement for her.

11.143 However, there then appears to have been a lengthy and unexplained delay by West Kent Health Authority in following up K1's views. It was not until September 2003 that C6 contacted the Dartford CMHT to find out what was going on with AT and it was not until April 2004 (following K1's e-mail of 2 March 2004) that a new social worker was appointed formally to assess whether it was still appropriate for AT to be placed at Shrewsbury Court. It seems, therefore, that West Kent Health Authority did not take prompt steps to follow up the assessment by its own Rehabilitation Continuing Care Team that Shrewsbury Court might no longer be the appropriate place for AT. However, without sight of the relevant documents from the 2002/2003 visit, and without evidence from K1, it is not possible to be categorical about whether this apparent failure was simply an oversight or had some reasonable explanation. It should in any event be emphasised that the assessment by the Rehabilitation Continuing Care Team was, in effect, that Shrewsbury Court was providing a level of care and support to AT in excess of that which it was considered she needed. It cannot, accordingly, be suggested that the failure by West Kent Health Authority to follow up more swiftly upon the suggestion that Shrewsbury Court was no longer the appropriate place for AT has any causal connection with the events which subsequently ensued. Rather the contrary - the consequence of this failure was

that AT remained in a placement which, as an independent hospital, providing full-time nursing care, was perceived to be providing an unnecessarily high level of care and support.

11.144 An entirely separate question, however, is whether those responsible for assessing, from time to time, whether AT was appropriately placed, ought to have had concerns about the quality of care which was being provided at Shrewsbury Court. In other words, regardless of the question of whether a hospital, providing 24-hour nursing care, was still necessary for AT, the question arises as to whether there ought to have been concerns about the quality of care being provided at Shrewsbury Court.

11.145 Our view is that there were some indications of grounds for concern about the quality of service at Shrewsbury Court. Firstly, there was the information in the reports of the NCSC and the HC to which we have referred above. Those reports disclosed that there were, throughout the period from 2002 onwards, a considerable number of areas where Shrewsbury Court fell some way short of the standards to be expected of independent hospitals.

11.146 Secondly, a full consideration of the risk assessments on AT carried out at Shrewsbury Court would have disclosed some grounds for concern about the ability of staff there appropriately to assess her risks. As commented above, AT had been assessed, in the formal risk assessment which was carried out at the pre-discharge conference before her move to Shrewsbury Court, as at risk of financial, sexual and emotional exploitation. C4 herself continued to hold the view, which she appropriately documented, that AT was vulnerable in these areas. Anyone who had considered the Shrewsbury Court risk assessment on AT would have seen that staff there had assessed this risk of exploitation as very low. This would surely have raised concerns about the extent to which proper consideration had been given to that risk assessment.

11.147 Thirdly, there must, by 2004 at any rate, have been an appreciation that CPA meetings for AT had been infrequent during her time at Shrewsbury Court. Again, this would have been some indication that patients at Shrewsbury Court were not receiving the

level of care which one would expect and hope would be provided by an independent hospital.

11.148 None of the factors identified above did in fact trigger concerns about whether Shrewsbury Court was providing AT with an appropriate level of service. We appreciate the danger of approaching these matters with the benefits of hindsight, but there were, we have concluded, indications which should at least have raised questions about whether Shrewsbury Court was an appropriate placement for AT - for reasons other than whether her needs still justified the expense of a placement at an independent hospital.

11.149 It is our recommendation to PCTs and NHS Trusts providing mental health services that the process of monitoring a patient's placement in an "out-of-area" hospital should include active consideration of whether the hospital in question is providing a service of an acceptable quality. One starting point for any such consideration ought to be a consideration of the most recent reports from the HC and the other regulatory authorities. But our recommendation is that, on any occasion when a CPA meeting is held for a patient who is placed "out-of-area", consideration ought also to be given to the question of whether there are grounds for concern about the quality of care being provided. A checklist of points to consider should be prepared. Such a checklist should include, as a minimum, consideration of the most recent reports from the regulatory authorities; whether the patient, or the patient's family, have raised any concerns about the quality of service; whether there are any obvious environmental issues apparent when visiting the premises; and whether the documentation prepared for the CPA meeting complies with the standards normally to be expected. This should be a routine part of any CPA meeting in respect of a patient placed "out-of-area". It should also be a routine part of this process to consider whether CPA meetings are being arranged with appropriate frequency/regularity.

<u>The Management of Events on 12 December 2004</u>

11.150 We have already commented in the section of this Report which discusses the care provided to RR whilst at Shrewsbury Court, on the failure by nursing staff, on the

morning of 12 December 2004 to respond effectively to RR's report that he had been hearing voices. The only action which was taken by W2 was to bring forward RR's morning medications, the nurse apparently unaware that these were cardiac medications which would make no difference to RR's mental state. In this section of the Report, we consider the action taken immediately after the discovery of the attack on AT.

11.151 The first observation which we make is that only two staff nurses were on duty on the morning of 12 December 2004, namely W10 and C7. As the most experienced nurses on duty, they had a responsibility to take charge. One or other of them should have assumed this responsibility, co-ordinating the response to this emergency, assigning to available staff, tasks such as ensuring rapid access to the unit for emergency and police personnel, as well as ensuring that care for other patients in the hospital was not prejudiced. Bearing in mind that suspicion immediately fell upon RR, it would also have been appropriate for a member of staff to be allocated to maintain observations upon him.

11.152 Our impression, however, is that there was panic, although there appears to have been almost no delay in placing the telephone call to the emergency services. An ambulance and police arrived within minutes of that call.

11.153 It is, however, very concerning that, notwithstanding that this tragedy occurred within the confines of a hospital, no attempt appears to have been made by staff there to establish whether there were any signs of life, or to resuscitate AT, before the police and ambulance services arrived. The discovery of AT was, no doubt, a deeply shocking experience, and it may well have been thought that AT was already dead, but it is extremely disappointing that neither of the two staff nurses even attempted to check for signs of life, by checking whether AT was breathing or had a pulse. Nothing in the evidence which we have seen suggests that there was, at this stage, any realistic prospect of saving AT's life, but as we note elsewhere, the ambulance crew did manage to detect signs of life. It is true that this was a mental health hospital, but merely waiting for the emergency services was an inadequate response at a hospital of any sort.

11.154 It goes without saying that it is to be hoped that emergencies of this nature are a rare event at any hospital, psychiatric or otherwise. However, the response of staff at Shrewsbury Court to this tragedy illustrates the need for all mental health hospitals to ensure that staff are adequately trained to respond to both medical and psychiatric emergencies.

12. Regulatory control

12.1 At the times with which this Inquiry is concerned, that is to say, the period leading up to December 2004, two regulatory bodies had responsibilities for standards at organisations such as Shrewsbury Court. They were the Mental Health Act Commission (the MHA Commission) and the Healthcare Commission (the HC), the predecessor to which was known as the National Care Standards Commission (the NCSC). It is useful therefore briefly to summarise the roles and powers of those bodies at the material times, as well as their involvement with Shrewsbury Court. It should be noted, however, that it is anticipated that the Government will soon be introducing new legislation, the Health and Social Care Inspection Bill, which will create a new body combining the functions of the HC and the MHA Commission (as well as the Commission for Social Care Inspection) into a single unified inspectorate.

The Mental Health Act Commission

12.2 The MHA Commission was set up under s.120 of the Mental Health Act 1983. Its purpose is to monitor the implementation of that Act, to visit and interview patients detained under the Act, and to investigate complaints made by or in respect of a person who is or has been detained under the Act.

12.3 Evidence was given to the Inquiry by G1, who is presently the Regional Director for the MHA Commission with responsibility for London and the South East. G1 rightly emphasised that both RR or AT were informal patients and were not accordingly within the remit of the MHA Commission. The MHA Commission had an involvement with Shrewsbury Court only because other patients there were detained under the Mental Health Act 1983. Nevertheless, the MHA Commission did have a regulatory role with regard to Shrewsbury Court and bearing in mind our conclusions about the poor standard of care at Shrewsbury Court, it is relevant to consider the MHA Commission's role and its observations about conditions there. It is, however, important to bear in mind the limited parameters of the role of the MHA Commissioners, and the fact that their function is simply to monitor the implementation of the Mental Health Act 1983, not to inspect generally or to assess the overall quality of the establishments which they visit. The Commissioners would be acting

outside their remit if they were to extend their inspections to consider the care and treatment of informal patients.

12.4 The MHA Commission visited Shrewsbury Court on 18 February 2003, following which the Commissioners reported a number of concerns. These included:

i. The policies in place with regard to … CPA reviews on detained patients at Shrewsbury Court.

ii. The very broad patient mix at Shrewsbury Court.

They also noted that the environment at Shrewsbury Court was poor, with a strong smell of urine in some areas and other environmental issues. Similar comments were made following the Commissioners' visit on 27 August 2003.

12.5 The MHA Commissioners also visited on 27 February 2004. Their report again expressed concerns about the patient mix and the extent to which the multi-disciplinary approach was being adopted. Concerns were raised with regard to the quality of documentation maintained at Shrewsbury Court - particularly in relation to the CPA and risk assessments; the administration of medication; and environmental issues.

12.6 There was, coincidentally, a MHA Commission visit to Shrewsbury Court on 13 December 2004, the day after the homicide. G2, who gave evidence to the Inquiry, together with G1, was one of the local Commissioners who visited on that day. It was her first visit to Shrewsbury Court, and she described her immediate impressions:

"The first thing that struck me was the patient mix, … it hit me as soon as I walked into the main open ward. For example, there were relatively young patients - probably early 30s, late 30s - and also elderly patients who I guess would be in their seventies. There were also some very frail patients, and … in one of the wards I [saw] urine on the floor, so patients were obviously urinating in an open ward, so they had patients who had physical problems. I was very concerned about that, because usually you do not want to mix a young mentally ill patient with an elderly frail patient … Also there were patients who appeared to me to be physically demanding, and [in need of] quite intensive medical treatment, so what were they doing mixed with young mentally ill patients?"

12.7 We comment that it seems to us significant that this problem was so immediately visible to G2. It can be inferred, we think, that it was a problem which could have been identified by those responsible for RR's placement at Shrewsbury Court before he was transferred there, not only by considering the reports of the MHA Commission, but also when Shrewsbury Court was visited to assess its suitability for RR.

12.8 Although the patient mix and the lack of a clearly defined admissions policy were identified in the MHA Commission's reports as problem areas from February 2003 onwards, and although "action plans" were produced by Shrewsbury Court in response to the MHA Commission's reports, the admissions policy remained ill-defined and unfocused. The fact that this issue remained unresolved over a lengthy period concerned us. When we asked G1 about the length of time for which the problems at Shrewsbury Court had persisted, notwithstanding the MHA Commission's reports and recommendations, he said:

"It was quite tough for outsiders to stimulate and generate change, and there was a limitation to how much more we could do. The Healthcare Commission receives our reports and [those reports] inform their investigations. We probably, I suspect, should have raised the stakes more, which is a matter of concern to me as I look back over this."

12.9 In the light of the serious deficiencies which we have concluded existed in the services being provided at Shrewsbury Court in the period immediately before this homicide, and in view of these comments by G1, we have considered whether the MHA Commission, as one of the regulatory bodies concerned in maintaining standards at establishments such as Shrewsbury Court, should have adopted a more proactive stance and attempted more aggressively to require Shrewsbury Court to take the steps necessary to address the Commissioners' concerns and to raise standards.

12.10 We do not, however, consider that the evidence which we have heard would justify this sort of criticism in this Report.

12.11 We reiterate that the MHA Commissioners are concerned exclusively with the implementation of the Mental Health Act 1983 and the treatment being provided to patients detained pursuant to that Act, and that this Inquiry concerns two informal patients. We have heard no evidence which directly concerns the standard of care being provided to those patients at Shrewsbury Court who did fall within the remit of the MHA Commissioners, and we have heard no evidence, therefore, which demonstrates that there were such serious and obvious shortcomings in the standard of care being provided to those patients as to make it mandatory for the Commissioners to adopt a more proactive approach.

The Healhcare Commission

12.12 The HC is the health watchdog for England. It checks that healthcare services meet the required standards in safety, cleanliness, waiting times and many other areas. It was created under the Health and Social Care (Community Health and Standards) Act 2003. It started work on 1 April 2004, taking over various responsibilities from other Commissions. In particular, it took over the private and voluntary healthcare functions of the National Care Standards Commission (the NCSC) which ceased to exist on 31 March 2004.

12.13 The HC is responsible, amongst other things, for the registration and inspection of private hospitals and clinics. The Private and Voluntary Healthcare (England) Regulations 2001 (S/I 2001 No. 3968] set out requirements with which a service provider must comply. Service providers are also expected to comply fully with the relevant National Minimum Standards for Independent Healthcare. Every independent healthcare establishment which falls within the jurisdiction of the HC is subject to inspection, in order to ascertain whether it is meeting the applicable National Minimum Standards, as well as the requirements of the Care Standards Act.

12.14 We were told that when the HC was formed one of the Government's Better Regulation Objectives was to ensure that regulation of the private sector in healthcare became more targeted and proportionate, with a view to reducing the overall burden of

regulation. Its strategic goals include safeguarding the public by ensuring that healthcare providers maintain appropriate standards. We were told that it is anticipated and intended that, in the future, there will be greater emphasis on self-assessment by care providers, with higher levels of risk assessments, the intention being that inspections can be more focused or "targeted", so as to concentrate resources on establishments where the risk of shortcomings is perceived to be greatest.

12.15 There has, since December 2004, already been a significant change in the way the HC approaches its inspections. Up to 2006, the HC was required to carry out a "comprehensive" inspection of each independent mental health hospital each year. A comprehensive inspection involved assessing whether the establishment complied with each of the 32 Core Standards (applicable to all independent hospitals), set out in the National Minimum Standards as well as with each of the Standards specific to mental health institutions. This type of comprehensive inspection was referred to as a "baseline inspection". The result of a baseline inspection was a lengthy report, listing each of the relevant Standards, and assessing the establishment's compliance with each of them. The objective was that, once areas of non-compliance had been identified, there would be a follow-up visit during the year to ensure that appropriate steps had been taken to address the issues identified.

12.16 This type of baseline inspection necessarily involved "sampling" by the inspectors (examining, for example, only a small number of the policies and procedures in place to see whether they were comprehensive and appropriate). The requirement to carry out a baseline inspection at each establishment every year nevertheless placed a very considerable workload on NCSC/HC inspectors and it appears to have been difficult for them to find time to follow up their inspections effectively, so as to ensure that their requirements and recommendations were being implemented.

12.17 The HC has accordingly moved towards a new approach, which is described as more "risk-based". As a result of regulatory changes made by the Department of Health, there is no longer a legal requirement for the HC to carry out an inspection of every establishment each year. The legal requirement is now that an inspection must be carried out not less than once every five years. As a corollary, the emphasis has, since in or about

2005, been more on identifying establishments and/or specific areas within establishments where it is assessed that there are significant risks or problems and focusing resources accordingly. The intention is that establishments where risks are identified will be visited more frequently. We were also told that current trends indicated that mental health services would probably be visited more frequently than the legal minimum of once every five years.

12.18 Greater reliance is now placed on:

i. Self-assessment by the establishments - that is to say, upon the establishments' response to questionnaires circulated by the HC inviting them to evaluate their own performance, providing corroborative documentation where possible. Self-assessment has always been a part of the regulatory process, but more reliance is now placed upon this process.

ii. The areas of non-compliance or risk identified in previous inspections.

iii. Information supplied to the HC by third parties which might suggest possible failures to comply with standards.

We were told that this development is part of the continuing objective of reducing the overall burden of regulation.

The HC's Powers

12.19 The HC has powers to enter and inspect premises registered under Section 2 of the Care Standards Act 2000. It has ancillary powers to inspect and copy records, including medical and other personal records, to interview persons at the registered premises, including staff and patients, and in certain circumstances even to examine patients who appear not to be receiving proper care.

12.20 The HC also has the power to require a service provider to provide any information deemed necessary for the proper performance of its functions. It has power to prosecute a provider for breach of The Private and Voluntary Health Care (England) Regulations 2001, or for breach of any condition in force in relation to the registration of an

establishment. Importantly, the HC has the power also to cancel an existing registration, and it would be an offence for the provider thereafter to carry on operating unregistered.

12.21 Until 1 April 2004, there was, we were told, uncertainty amongst inspectors as to whether they had the power to inspect confidential patients' records. As of 1 April 2004, however, the HC's power to inspect such records has been confirmed by an amendment to Section 31(1A) of the Care Standards Act 2000.

HC Witnesses

12.22 We heard evidence from HCC3, the head of Mental Health Strategy at the HC. Prior to 1 April 2005, he was the head of the Mental Health Team for the Private and Voluntary Healthcare Division (a Division which no longer exists). HCC3 was accompanied, when giving his evidence, by HCC4, the HC's senior legal adviser.

12.23 We also heard evidence from two of the inspectors who had carried out inspections of Shrewsbury Court prior to December 2004. HCC1 visited Shrewsbury Court on 27 August 2004. He was also the lead inspector on the very detailed inspection of Shrewsbury Court which occurred in January 2005, following the homicide. HCC2 inspected Shrewsbury Court in May 2004, and again with HCC1 on 27 August 20004. We have also been greatly assisted by written responses, with accompanying documentation, provided on behalf of the HC in response to a number of questions we raised.

The NCSC and HC and Shrewsbury Court

12.24 Various of the comments from the reports provided, over the years, by the NCSC and the HC have been set out above, in the part of this Report which discusses the weaknesses in the service at Shrewsbury Court in the period prior to this homicide. It is nevertheless useful for present purposes to summarise briefly these various reports, so as

to provide an overview of the NCSC/HC's impressions of the service provided by Shrewsbury Court and a summary of key aspects of their reports.

12.25 The first report on Shrewsbury Court which is of relevance to the issues discussed in this Report is that by the NCSC, based on an announced inspection of Shrewsbury Court on 17/18 February 2003. The Summary of the Inspection's Findings recorded the following observations:

"Observations

... There is a considerable mix of needs within the unit, particularly on the main unit, ranging from people who are elderly and/or incontinent through to young people with considerable social needs. It is possible that the needs of all patients cannot be met, leading to some difficulty with meeting the dignity needs of all groups.

Policies and procedures-

The policies and procedures are lacking in many areas, particularly mental health ….

Management: -

There is no clear management structure. Each person appears to have a specific role and, when that person is not available, other team members are not able to obtain access to required information. The legal role and responsibility of the Registered Manager does not seem to be fully understood. …

National Minimum Standards:

The service has been inspected for the first time against the National Minimum Standards. As a consequence, it is possible that a substantial number of Requirements and Recommendations may have been highlighted. It is anticipated that the number will fall significantly at the next inspection as the management begin to adjust their systems and protocols to take account of the National Minimum Standards and take action to meet them."

12.26 The report went on to set out 47 Requirements, each indicating instances of non-compliance with the Care Standards Act 2000. The Registered Owner, DR2, was required to comply with each of these Requirements within a specified time. Nine of

these Requirements needed to be met *"henceforth",* indicating a significant degree of concern by the inspectors. The dates for compliance with the other Requirements varied between 15 March 2003 and 1 July 2003.

12.27 The significance of the 47 Requirements, in terms of the quality of day-to-day care provided by Shrewsbury Court, varied enormously. Many related to the absence of written policies and procedures. Others related to environmental issues. There were breaches of almost all of the Core Standards and of most of the Standards specific to mental health institutions.

12.28 Overall, the impression given by that report is that Shrewsbury Court had done little to ensure that appropriate policies and procedures were in place, but that the inspectors took the view that the first step was to require the Registered Owner to put those policies and procedures into place before the NCSC investigated further. It appears from the evidence to the Inquiry that the situation at Shrewsbury Court, at least as it appeared on the face of this NCSC report, was far from unusual. From April 2002 any establishment providing care to a patient detained under the Mental Health Act 1983 was categorised as a "hospital". As a result, a large number of establishments which had carried on business as residential homes had, for the first time, an obligation to meet the standards applicable to a hospital. It is clear from evidence which we have heard that many such establishments were unprepared for the full implications of this change in their categorisation, and many initially fell a long way short of these standards. Shrewsbury Court was just such an establishment.

12.29 NCSC inspectors took the view that it was appropriate to work with these establishments to help them carry out the necessary improvements. There was a willingness at the NCSC to allow time for these establishments to come to terms with the new regime to which they were subject, and with the new standards with which they had to comply. That approach was a realistic one. The intention of the re-categorisation was, no doubt, to raise standards in these establishments, but they had, of course, been providing care to detained patients before April 2002, so a transitional period, providing time to make the necessary adjustments, was both realistic and reasonable.

12.30 Bearing in mind, however, the extent to which Shrewsbury Court fell short of compliance with the National Minimum Standards, and the number of Requirements set out in the February 2003 report, a follow-up visit to Shrewsbury Court in the near future was clearly appropriate. That follow-up visit was carried out in July 2003.

12.31 The July 2003 inspection was again by two-inspectors and it lasted two days. Of the 47 Requirements which had been identified in the February 2003 report, it was recorded that 17 remained to be attended to. These included:

i. A Requirement for a written policy, with supporting procedures, reflecting the Mental Health National Service Framework.

ii. A Requirement that clinical audit programmes were undertaken. The inspectors noted that some clinical audit did take place, but that it needed to develop further in order fully to meet the requisite Standard – which, they said, was *"almost met"*.

iii. A Requirement that all clinical staff received training on the values, principles and broad standards of the National Service Framework for Mental Health. The inspectors noted that training for all clinical staff was in the process of being arranged and that there was a plan for all staff to receive training in risk assessment by September 2003.

It was noted that there was a written risk management policy in place but that no annual audit had yet taken place. The inspectors wrote:

"Although unable to look at individual patients' notes, through observation and discussion with several patients, there was evidence that patients' views are considered."

12.32 Once again, specific dates were given for the implementation of the Requirements set out in this report, but none had to be implemented immediately - the dates given varying between 29 February 2004 and 31 March 2004. Even after taking into account the willingness of the HC to allow establishments which had become hospitals in April 2002 a reasonably lengthy transitional period, this was, we think, a generous period of time.

12.33 The overall impression given by this NCSC report was that Shrewsbury Court had made significant progress in putting in place the requisite written policies and procedures, but that there remained considerable work to be done even in this respect. Importantly, however, it is clear that the inspectors had still inspected none of the patient records at Shrewsbury Court, so they had not been able to check whether the policies and procedures relating, for example, to the implementation of the CPA, or the maintaining of appropriate and up-to-date risk assessments, were actually being put into practice. It might, perhaps, have been assumed that an establishment which was organised enough to put into place the relevant policies and procedures would also be organised enough to ensure that those policies and procedures were implemented. However, the auditing of sample files must, we think, be an essential part of a regulatory inspection. Without it, there is, we think, a real danger that an organisation might tend to prioritise the task of ensuring that the requisite documentation was in place, without simultaneously taking on the more onerous, and certainly more important, step of ensuring that those policies and procedures were fully understood by staff and were being implemented on a day-to-day basis.

12.34 The inspectors were clearly still inhibited by concerns about whether they were allowed to inspect confidential patient records. This was most unfortunate, and it is surprising that no steps were taken to clarify the situation, and to ensure that inspectors had that power, if they thought it necessary. A regulatory body which lacked the power to check whether policies and procedures were being followed, as a matter of day-to-day practice, could never be expected to perform its regulatory role effectively.

12.35 As noted above, however, this issue has now been addressed. There is now no doubt that the inspectors have the power to look at patient records if they think that is necessary in order to perform their regulatory function.

12.36 The next inspection of Shrewsbury Court was in May 2004 and was carried out by the newly formed HC. This inspection was a follow-up to the July 2003 inspection by the NCSC and its objective was to check whether Shrewsbury Court had now complied with the Requirements of the July 2003 report. The inspection lasted one day and was conducted by HCC2 and C19. Neither had been involved in the July 2003 inspection, although they

had access to that report. It should be noted that this was the first inspection which took place following the resignation of W1 from the post of Registered Manager, and his replacement by W4 as Acting Manager.

12.37 In his evidence, HCC2 described his impressions of Shrewsbury Court following his visit in May 2004. He described himself as having been *"horrified"* at what he had seen. He said that, whereas at other establishments which he had visited there were structures in place and the problems he identified were largely a result of people not doing their jobs properly, the position at Shrewsbury Court was different:

"... It was about structures not being in place, people not doing their jobs, no idea about clinical governance at all - it was just amazing really."

He said that he formed the view that many of the problems were a result of the transition from being a registered care home to an independent hospital, combined with the management's lack of understanding of what needed to be done to comply with the standards applicable to a hospital.

12.38 HCC2's evidence was that, following this visit, he had telephoned his manager, HCC3, to express his concerns about Shrewsbury Court. That is, however, evidence which it is not possible to reconcile with what HCC3 said about Shrewsbury Court. HCC3's evidence to the Inquiry was that Shrewsbury Court was not, so far as he was concerned, perceived as a particular problem establishment. The phrase which he used was that it *"didn't register on the radar"*. This tension between the evidence of HCC2 and the evidence of HCC3 is not one which it is possible for us to resolve with any certainty, although HCC2's co-inspector, HCC1, confirmed that HCC2 had been very concerned about Shrewsbury Court. It does, however, highlight the fact that the HC did not at this time maintain any formal record of which establishments were perceived to be of particular concern or meriting particular attention, relying, instead on the knowledge held by individual inspectors to guide how the HC's limited resources could best be used. This is an issue upon which we comment further later in this Report.

12.39 Although no formal report was generated following this visit in May 2004, HCC2 did write to DR2 at Shrewsbury Court on 25 May 2004. The letter conveyed a sense of HCC2's concern. He wrote, amongst other things:

"The objective of our visit was to meet with W4, Acting Manager, to discuss what progress had been made on meeting the Requirements of the July 2003 inspection report. We were concerned to discover that, despite having adequate time to implement the Requirements, very few had been implemented. As the Responsible Individual, you must ensure the following National Minimum Standards that are Requirements of the July 2003 report are met."

The letter then referred to various of the National Minimum Standards and continued:

"If action is not taken to implement these Requirements by 31.7.04, the Healthcare Commission may consider enforcement action. ..."

12.40 HCC2 described in his evidence to us how co-operative DR2 had been on the occasion of this visit, and we should record that DR2 did ensure that there was, at least on paper, an appropriate response to the HC's concerns in the form of action plans addressing the various Requirements raised. It is necessary, however, to ask the question of how it was that, more than two years after April 2002 (when Shrewsbury Court became an independent hospital, with the concomitant obligation to maintain the National Minimum Standards) and notwithstanding reports from the NCSC in February and July 2003 identifying what needed to be done, Shrewsbury Court was still failing to meet those Standards and was facing threats of enforcement action.

12.41 The conclusion which we have reached is that DR2 placed a substantial degree of reliance upon the NCSC/HC in that he perceived these bodies as, in effect, setting or defining the standards which needed to be met at Shrewsbury Court. We think that he proceeded on the basis that, unless these bodies had expressed concerns or imposed some formal Requirement, the service at Shrewsbury Court could be considered at least adequate. As a result, the position was that, in the absence of concerns being expressed by the NCSC/HC, the management of Shrewsbury Court generally did not actively seek to identify and address shortcomings in the service being provided there. Indeed, the impression which we have formed is that, even when concerns were expressed or Requirements imposed by the NCSC/HC, DR2 did not think they needed to be addressed as

a priority unless and until it appeared that a failure to do so might affect the continued registration of Shrewsbury Court by the HC. When we asked DR2 about the continuing failure to meet the National Minimum Standards between 2002 and 2004, he made the point that the HC had allowed Shrewsbury Court to keep its registration and to continue to carry on business as an independent hospital, emphasising that he regarded this as evidence that the HC must have been satisfied that Shrewsbury Court was providing a service of sufficient quality, whatever outstanding Requirements still remained to be met.

12.42 DR2 was unable to provide us with any satisfactory explanation of why Shrewsbury Court continued to fail to comply with these Standards for such a lengthy period, other than to say that he had been let down by the management team he had employed. He was unable to provide any satisfactory explanation of why, if the management team which had the responsibility to address the issues raised by the HC was not doing so effectively or expeditiously, he, as Registered Owner, had failed to take any action.

12.43 Our view is that DR2's failure to take action was probably a result of a combination of factors. There was DR2's belief that, because the HC was not threatening to withdraw Shrewsbury Court's registration as an independent hospital, then, whatever deficiencies existed, they could not be so serious that they made immediate action essential. There was also probably a reluctance to take potentially expensive or disruptive action to address the points raised by the HC, when there was no commercial imperative to do so. In the absence of an immediate threat to Shrewsbury Court's registration as an independent hospital, and with no apparent difficulty in filling beds, there would, we think, have been no real commercial pressure on DR2 to take action.

12.44 Our view is that DR2, in relying upon the HC to define standards, and in proceeding on the basis that, unless the HC expressed concerns, the service being provided at Shrewsbury Court could be considered adequate, was operating under a serious misapprehension about the role of the HC. The inspections carried out by the HC were no more than spot checks upon the service being provided. They could not be a substitute for the management there giving appropriate consideration to what was needed to provide a good quality service, and, in our view, DR2 should have realised this. To the extent that he regarded the continuation of Shrewsbury Court's registration (or more accurately the

absence of direct threats by the NCSC/HC to remove that registration) as some sort of an endorsement of the quality of service at Shrewsbury Court, DR2 was very much in error.

12.45 In any event, as a result of HCC2's visit in May 2004, and the concerns which he expressed, a further one-day inspection of Shrewsbury Court took place on 27 August 2004. The inspection was conducted by HCC2 and HCC1. HCC1 is named on the subsequent report as the lead inspector, but in his evidence to the Inquiry, he explained that this was because, when the report came to be written, HCC2 had left the HC, and it was, accordingly, considered more appropriate for HCC1 to be named as the lead inspector. The inspection was only a one-day inspection because it was considered as a "follow-up" inspection to the visit in May 2004 – indeed, according to HCC1, he was involved for only half of the day. It was not the formal annual baseline inspection which the HC was required, at that time, to undertake for all independent hospitals.

12.46 The August 2004 report, which was, we should record, only received at Shrewsbury Court in January 2005, recorded that the inspectors were *"impressed by the time and thought that had gone into working to improve standards since the visit of 13.5.04."* HCC2 told us that, whilst his overall impression of Shrewsbury Court was that its service was of a very low standard, he formed the view that the manager's *"heart was in the right place"*. He said *"I could see that they were trying"*. He expressed the view that the problem was that it was being run as a nursing home not a hospital, and that the Acting Manager, W4, was probably out of his depth.

12.47 The August 2004 report also recorded, however:

"Shrewsbury Court is an establishment that does not meet the majority of the National Minimum Standards. ...

Several areas of practice that gave cause for concern were identified during the course of the inspection. The ... Inspectors were concerned about:

- *Consultant/RMO and multi-disciplinary reviews were not occurring regularly for all patients.*
- *All patients were not being properly maintained under the CPA.*

- *A full programme of training was not occurring at Shrewsbury Court."*

HCC1 told us that it was rare, in his experience, that an establishment failed to meet the majority of the National Minimum Standards.

12.48 A total of 31 Requirements were set out in the body of the report. Of particular relevance to this Inquiry are the following.

i. There was a Requirement that all patients of Shrewsbury Court must have a regular and appropriate RMO or consultant/multi-disciplinary team review that informed individual treatment and care plans. It was this Requirement which led to CONS4 being asked to take on in September 2004 formal responsibility, as RMO, for all patients at Whitepost, detained or informal.

ii. There was a Requirement that the Registered Provider had to ensure that all aspects of clinical audit and governance policy were implemented. As noted above, it was commented that clinical audit at Shrewsbury Court had not been effectively implemented, although progress was being made.

iii. There was a Requirement that all staff should read policies and procedures relevant to their area of work. The inspectors noted that there was no evidence provided to them that staff were undertaking continuing professional development, or having appraisals to identify their training or educational needs. Linked to this was a Requirement that a full programme of training be provided at Shrewsbury Court, involving all appropriate members of staff and including training in risk assessment.

iv. It was noted that improvements needed to be made to ensure that patients' care plans adequately reflected all interventions made by clinical staff, including the clinical psychologist. The commentary within the report also noted that not all patients were having an individual clinical risk assessment by the multi-disciplinary team every three weeks as required.

12.49 HCC2 told us that, if he had had the time and resources, he would probably have sought to commence enforcement action against Shrewsbury Court at this time, although he emphasised that such action was always a matter which would have to be discussed with his manager, HCC3. HCC1s' evidence was that he had formed the impression that

Shrewsbury Court was a poor establishment, probably in the bottom 5% of those he had visited. He did say, however, that it was not the worst establishment that he had inspected. He said that there was concern at the HC about Shrewsbury Court and that had it been discussed with the management there. He confirmed that HCC2 was very concerned about Shrewsbury Court.

12.50 HCC1 also told us a number of points of concern which were identified in the HC report from August 2004 only came to light because a Vulnerable Adults meeting happened to be taking place on the day of their visit. HCC1 took the opportunity to speak to the local social worker who was chairing that meeting. It was that social worker who explained to HCC1 that regular CPA meetings were not taking place in relation to some of the patients there, and that with other patients, the external care co-ordinators (the representatives of the authority who had placed the patients at Shrewsbury Court) were not turning up for review meetings. Reference was also made to inappropriately placed patients being at Shrewsbury Court. HCC1 recalled that it was because of this contact with the local social worker that the inspectors had learned that the RMO only had responsibility for detained patients at Shrewsbury Court. Whether some or all of these problems would have come to light even if the Vulnerable Adults meeting had not been taking place at the time of the inspectors' visit cannot be known, but it was a valuable source of information for the inspectors, of which, very sensibly, they took advantage.

12.51 In accordance with the usual practice of the HC, a feedback meeting was held with representatives of the management of Shrewsbury Court immediately after the inspection in August 2004. Its purpose was to inform the management of the findings that had been made and which would, in due course, be set out in the formal report. DR2 made available to the Inquiry Shrewsbury Court's minutes of that feedback meeting, and we discussed these with him at some length.

12.52 The notes begin in an encouraging manner.

"[HCC2] congratulated on improvements made, which were noticeable everywhere. Staff happier, approaching inspectors with positive comments about [W4] and [DR2], were committed to improving and meeting standards. Lots of evidence of good things - decor,

fresh painting. Still a lot to do. … [DR2] said a post-inspection action plan would be in place by next week."

Later, however, the notes record significant concerns expressed by HCC2. In relation to staff qualifications, it is recorded that HCC2 made the following observations.

"[HCC2] - concerned about RGNs working in [psychiatric] unit. "Care and treatment from suitable qualified persons". Also Code of Conduct for nurses - "you must be competent in the field". Not saying they can't work there, but needs to be under supervision and needs training.

[DR2] - do our best to employ RMNs. Agreed that as long as one RMN on duty, RGN is OK if supervised.

[HCC2] - would be especially concerned if numbers of RGNs should increase."

12.53 It is relevant to note that, according to records supplied to the Inquiry by DR2, at the time of the homicide in December 2004, Shrewsbury Court employed 16 trained nurses (including W4, the Acting Manager, and W10, the Clinical Nurse Specialist). Out of this cohort of 16, eight were RMNs; six were RNLDs (including both W4 and W10); and two were RGNs.

12.54 The minutes then record an important discussion about medical cover at Shrewsbury Court. It is relevant to set out this passage in the minutes in full.

"Medical cover

Detained [patients] have RMO cover, informal [patients] don't have cover? [DR2] - yes.

[HCC1] - not acceptable for patients in [mental health] Hospital. All patients should have RMO cover to provide a decent quality of treatment and care, if no RMO why are they in hospital?

[DR2] - not hospital.

[HCC2] - Yes, under Care Standards Regulations, you are a hospital. Registered as Independent Hospital. Hospital taking patients liable to be detained under Mental Health

Act. If you choose not to call yourselves a hospital, up to you, but leads people to think you are a nursing home, which you are not.

[DR2] - some patients get better, not detained. Others get worse, detained. For detained, RMO is responsible, supported by another clinical assistant. Not detained, problems ascertained by GP, then referred to psychiatric service because they live within community, have a right to referral to psychiatrist.

[HCC2] - no. Placed here for care and treatment. Independent Hospital. Fees charged are for care and treatment. If you are not providing psychiatric treatment, it is provided by NHS - not acceptable. In a care home, yes, but not hospital. Need to employ doctor but needs to be 24/7, 7/52, 52 weeks a year. We are asking you to do the same as any other independent hospital and the NHS. If you want to continue you need to think about whether you are a hospital or not. Doctor is on call, he [is] also working for NHS. Cannot be on call at NHS and here. When he is here, OK, but when at NHS other arrangements in place.

[DR2] - not the only establishment following this practice - number of people who have the same model of care.

[HCC2] - give us the names. We inspect the whole of this area. One other hospital at the moment, putting procedures in place. If you don't, we will take action. Regulations 44-47 - "you must have ....". It is implied in these regulations that you have to have a psychiatrist to provide that treatment. If you don't, then you are not a hospital. You have CONS4 and DR1. If the doctors on call are not working in the NHS at the same time, carry on.

[DR2] - if a problem, informally arranged for CONS4 or assistance to help us cope.

[HCC2] - must be a formal arrangement for psychiatrist to attend here 24 hours a day, etc. If that can't be provided you need to think about what you are.

[HCC1] - some kind of evidence that medical cover is in place for on-call doctors outside normal hours. Psychiatric cover for all patients here."

12.55 This section of the minutes clearly reflects the serious concerns which the inspectors had about the lack of RMO input at Shrewsbury Court, and about the fact that CONS4, the consultant psychiatrist, had responsibility only for the detained patients not the informal patients. The position was that even though the informal patients were in-

patients in a private hospital, they were receiving treatment for their psychiatric problems on the NHS. If they needed the input of a consultant psychiatrist, that would be achieved through a visit to the local GP, who would then make a referral to a consultant psychiatrist (usually CONS4) on the NHS. DR2 thought this was an acceptable situation because he regarded the informal patients as being *"in the community"*. It is true that some of the residents at Shrewsbury Court may well have been placed there, before the change of status in 2002, on the basis that it was a community setting. The expectation, in relation to these patients at least, may well have been that they would receive care in the community through the local GP, and that they would not need the level of care appropriate to an in-patient in a hospital. One can understand, therefore, how DR2 may have formed the view, in relation to these patients, that the transition of Shrewsbury Court to an independent hospital did not alter the way in which their care should be provided. It may also have been the case that the contractual terms negotiated for those patients placed at Shrewsbury Court because it represented a community setting did not require all treatment and medication to be provided by Shrewsbury Court within the agreed fee.

12.56 We think it significant, however, that DR2's initial response to the points being made by the inspectors to him in this regard was that Shrewsbury Court was <u>not</u> a hospital. There must have been, at the very least, some confusion in his mind about the precise status of Shrewsbury Court. In his evidence to the Inquiry, DR2 categorically stated that he was aware that Shrewsbury Court had become a hospital in April 2002 – indeed he asserted that there had been a positive decision made before April 2002 to go down the road of becoming a hospital (with all of the more onerous obligations that entailed). It is, however, difficult to reconcile this evidence with what he is recorded as having said at the "feedback meeting" in August 2004.

12.57 Leaving this issue to one side, the overall picture which emerges in relation to the inspection in August 2004 is that the HC continued to have major concerns about unresolved Requirements and about Shrewsbury Court's continuing failure to meet the National Minimum Standards. However, apart from the question of the lack of RMO cover, there does not appear to have been such concern as to cause the inspectors to take any steps other than exhorting Shrewsbury Court once again to take the action needed. The time allowed to Shrewsbury Court to take that action seems to us to have been generous,

a full six months from the date of the inspection. It is fair to comment, however, that the formal report would normally follow weeks or even months after the actual inspection, so that by the time Shrewsbury Court received it, the time period allowed for fulfilment of the Requirements would have been significantly reduced – and as noted above, DR2 told us that Shrewsbury Court did not receive the formal report until January 2005.

12.58 In the event, because of the homicide in December 2004, the HC revisited as a matter of urgency. Shrewsbury Court was required immediately to carry out risk assessments on all patients there. It was also required, as a matter of urgency, to review the observations policy; to improve the work being done to separate the male and female patient areas; and to review and rewrite its admissions policy.

12.59 These tasks had almost been completed by 22 December 2004 when representatives of the HC visited Shrewsbury Court to assess progress. A full inspection of Shrewsbury Court was carried out at the beginning of January 2005. The inspection on this occasion was carried out by a team of six mental health inspectors, and it was carried out over a period of three days, on 5, 6 and 7 January 2005, with a further visit on 14 January 2005.

12.60 The summary of findings again recorded:

"Shrewsbury Court is an establishment that does not meet the majority of the National Minimum Standards. ... Several areas of practice that gave cause for concern were identified during the course of the inspection. The ... inspectors were concerned about:

- *Inadequate arrangements for reviewing the quality of patient treatment and care through a process of audit and governance;*
- *Processes for the assessment of new referrals;*
- *Overall quality of the arrangements of patient assessment and review."*

This was the briefest of summaries of the numerous and wide ranging deficiencies identified in the body of the report. The deficiencies recorded related to matters that were of fundamental importance to the quality of care being provided at Shrewsbury Court.

12.61 A total of 57 Requirements were raised, and 26 Recommendations were made. Reference can be made to the report itself for full details of the findings made, but we have highlighted the findings relevant to this Inquiry elsewhere in this Report. There were criticisms of the admissions procedures and the lack of proper clinical governance. The report noted deficiencies in staff training; in the maintenance of full and appropriate patient records – including the absence of a single multi-disciplinary record for each patient; and in the procedures around the administration of medication.

The HC's use of its powers of enforcement

12.62 HCC3's evidence was that the NCSC/HC had only once, in 2003, cancelled the registration of an independent mental health hospital. We were told that the situation in that hospital was significantly worse even than that which was found to exist at Shrewsbury Court in January 2005. When we asked HCC3 how close Shrewsbury Court was to having its registration removed in 2005, he replied:

"From my recollection at the time, cancellation wasn't a consideration. It wasn't something that we considered as an option following that inspection."

He went on to explain that the view was that, unless there was an immediate risk of danger to the patients at the time of an inspection, the normal procedure would be to consider what could be done to improve the situation, rather than to use the power to cancel an establishment's registration. The improvements which have been brought about at Shrewsbury Court since January 2005, as reflected in subsequent reports from the HC, could be said sufficiently to justify that decision.

12.63 The shortcomings in Shrewsbury Court which were identified before December 2004 were very significant. Our initial view was that this fact, combined with the serious nature of many of the shortcomings identified by the HC in, for example, the August 2004 report, provided a sufficient basis for more vigorous enforcement action. However, as mentioned above, the evidence given to the Inquiry by HCC3 was that Shrewsbury Court was not *"on*

the radar" as an establishment giving cause for concern. He told us that, in the year 2002-2003, well over 50% of the establishments at which baseline inspections had been carried out had failed to meet the majority of the National Minimum Standards. He also said that, whilst the position had improved in 2004, there was still a significant proportion which failed to meet the majority of these standards in that year as well. Whilst this information was remarkable in its own right, it did go a long way to explain his evidence that Shrewsbury Court did not appear, at that stage, to be an establishment that was dramatically out of the ordinary.

12.64 This evidence from HCC3 should be contrasted with the evidence of the two inspectors who visited Shrewsbury Court prior to the homicide in December 2004, HCC2, and HCC1. As recorded above, HCC1 described Shrewsbury Court as being in the bottom 5% of the establishments which he had visited, but said that it was not the worst, just the second worst. As recorded above, HCC2's evidence to us was that he was *"horrified"* by some of the practices which he saw at Shrewsbury Court and that, had he had more time/resources available to him, he would have contemplated recommending enforcement action to his superior, HCC3.

12.65 We cannot now resolve this tension between HCC3's recollection, and the evidence which the two inspectors gave to us. Our view is, however, that this highlights the need for the HC to adopt, at least internally, some form of objective and quantifiable measure of the extent to which an establishment is perceived as a cause for concern.

12.66 One other general observation which we should make is that it appears, from the evidence presented to us, that the HC only very rarely uses its powers of enforcement. No doubt, a significant part of this reluctance derives from the fact that the public interest is best served by having independent hospitals brought up to standard, rather than being closed down. However, it is surprising that an establishment which fell so far short of the requisite standards as Shrewsbury Court in January 2005, did not even give rise, in HCC3's mind, to the possibility of closure. No doubt, if DR2 had not taken immediate steps to address the concerns raised by the HC following the inspection in January 2005, enforcement action would have been considered within a relatively short time, but we do

think that there seems to have been an undue reluctance on the part of the HC to "use its teeth".

12.67 We think it very likely to us that Shrewsbury Court would have devoted greater resources to meeting the HC requirements if it had been made clear to DR2 that continued failure to meet them would result in enforcement action. This is, after all, what occurred when HCC2 and HCC1 raised with DR2, at the feedback meeting following the August 2004 visit, their concerns about the fact that informal patients did not have the benefit of an RMO at Shrewsbury Court. The possibility of action being taken against Shrewsbury Court was raised, and DR2 thereupon took steps to address the situation. It is true that the action he took - persuading CONS4 to agree to be the RMO to all patients at Shrewsbury Court - was inappropriate, leaving CONS4 with an excessive and unrealistic workload. The point for present purposes, however, is that once DR2 was threatened with enforcement action, he did take immediate (albeit misguided) action. His response to the January 2005 investigations by the HC has also been a positive one.

12.68 Our view is that the approach of any individual running a small stand alone independent hospital – which is, it must be remembered, a commercial organisation – is inevitably going to be influenced by commercial considerations. Meeting requirements imposed by the regulatory authorities is likely to cost money. It is likely, therefore, that there is going to be a degree of reluctance to place the task of meeting those requirements at the top of the list of priorities, unless there is a good commercial reason to do so. Commercial pressure might come from market forces, if it were the case that a failure to meet formal Requirements imposed by the HC meant that the establishment had difficulty filling its beds. But as this Report demonstrates, there was no apparent difficulty in filling the beds at Shrewsbury Court, notwithstanding the NCSC and HC reports had recorded numerous shortcomings in the service there. Indeed, RR's placement was actually delayed because of the need to wait for a bed to become available. Elsewhere in this Report, we emphasise the need for those purchasing services from the independent sector to pay more heed to reports of the regulatory authorities when making placement decisions. However, commercial pressure can be applied by the regulatory authorities themselves, using the powers of enforcement available to them. With an independent hospital which depends upon registration with the HC to carry on business, the possibility

of that registration being withdrawn is likely to be a far more powerful and immediate means of bringing about necessary improvements than a reliance on market forces.

12.69 The facts of this case clearly demonstrate, in our view, that market forces alone are not sufficient to ensure a high quality service in the independent sector, and that the role of the regulatory authorities is, accordingly, of crucial importance in maintaining standards.

HC's Resources

12.70 The evidence to the Inquiry made it clear that the HC's resources were over-stretched in the period leading up to December 2004. As outlined above, on 1 April 2002, as a result of the coming into full force of the Care Standards Act 2000. Establishments previously registered under the Registered Homes Act as mental nursing homes were required to be registered as independent hospitals if they wished to continue to provide care for detained patients.

12.71 In 2002 a decision was made within the NCSC to create a small Private and Voluntary Healthcare (PVH) division, to start work in October 2002 covering the independent sector. HCC3, who had joined the NCSC in July 2002, was asked if he would manage the mental health team within that new division. He agreed and began work on recruiting staff. He was given a budget for just seven mental health inspectors. The budget was based on a "best guess" as to what was needed because, as HCC3 explained to us, there was uncertainty about how many establishments would be regulated by the new PVH division. HCC3's recollection is that suitable candidates were identified from existing employees of the NCSC, without the need for outside recruitment.

12.72 It quickly transpired that the provision for seven mental health inspectors was inadequate. As noted above, the HC was required at this time to carry out annual baseline inspections for all establishments falling within the PVH Division's jurisdiction. As a rule of thumb, it was considered that two inspectors would be involved in such an

inspection, with the inspection lasting two days - a total, therefore, of four "inspector days" for the actual inspection of each establishment, with a considerable amount of further time being spent subsequently writing up the report. It was eventually established that there were about 170 establishments which fell within the jurisdiction of the mental health division of the new PVH division.

12.73 In addition to these obligatory baseline inspections, the seven mental health inspectors also had to cover all of the NCSC's other work in dealing with new applications for registration, complaints and various follow-up issues.

12.74 The situation was made worse because the new PVH division only started work in October 2002. HCC3 told us that relatively little work was done at the NCSC in the period from 1 April 2002 through to October 2002 as far as independent mental health establishments were concerned, because it was known that the new division was going to start work in October 2002 and would be responsible for inspecting these establishments. All 170 establishments had to be inspected within the year to April 2003, but by October 2002 far less than 50% of them had actually been inspected. HCC3's inspectors were required to inspect the majority of the 170 establishments for which they were responsible in a period of just six months. HCC3 described the mental health division of the newly formed PVH division of the NCSC as *"seriously under-resourced"* during this period.

12.75 In spite of these pressures the PVH section did manage to carry out baseline inspections for about 92% of the mental health establishments in its jurisdiction before 31 March 2003. HCC3 told us that this was achieved by inspectors working under very considerable pressure and putting in up to 60 or 70 hours a week. HCC1 confirmed in his evidence to us how extremely busy the inspectors had been just trying to meet the HC's obligation to carry out these baseline inspections, leaving little time for effective follow-up to see if its Requirements and Recommendations were being implemented. It is, with the benefits of hindsight, unfortunate that in this period between 2002 and 2004, the HC was legally required to carry out a baseline inspection of every independent mental health establishment every year, even if that establishment had generated no particular concerns. That requirement seems to us to have unduly stretched the limited resources

available to the NCSC/HC. In retrospect, a legal framework which would have allowed the HC to prioritise inspections of establishments such as Shrewsbury Court – perhaps at the expense of carrying out full inspections of some of the long-established and apparently well-run hospitals within the PVH section's jurisdiction – would have been a more sensible approach.

12.76 A measure of the extent to which HCC3's team was under-resourced during this period is the fact that for the following year, commencing 1 April 2003, HCC3 was given a budget to recruit up to 17 full-time inspectors - more than doubling his team. He was not, in the event, able to recruit this many staff. Whilst the number of inspectors did increase during the course of the year 2003/4, the mental health team within the PVH division continued to be under-staffed. HCC3 said that the difficulties in recruitment were attributable to a combination of the unattractive salary being offered, and the lack of appeal of regulatory work. HCC3 also made the point that whilst internal candidates (that is to say, from within the NCSC) needed little or no additional training, candidates recruited externally did require a period of training - which meant that they were not immediately able to pick up a full workload, further contributing to the pressure of work on his team.

12.77 The impression we obtained from HCC3 was that induction training for new recruits was initially somewhat *ad hoc*, and not standardised. He described input being provided by an external firm of legal advisers, and told us that independent experts were also commissioned to provide training in relation to the application of the Mental Health Act 1983, the Care Standards Act 2000, and the Police and Criminal Evidence Act 1984. He also said, however, that once the pressure on the PVH division to complete baseline inspections on the 170 odd establishments for which it was responsible had passed, a more formal training programme was put in place, with inspectors attending a course provided by Birmingham University. HCC1 (who joined the HC in October 2003) described his training as quite brief with considerable emphasis being placed on learning from more experienced inspectors by accompanying them on their inspection visits. HCC2 also described the training at the start of his time with the HC as being relatively brief. He told us that he only received more formal training some eight to ten months after he started work there, shortly before he made the decision to leave.

12.78 The issues with under-resourcing have reduced in more recent years, but the inescapable conclusion is that the NCSC/HC's ability to perform its regulatory functions in the period leading up to this homicide was significantly impaired by a lack of resources. It is not surprising that the quality of the inspections which were carried out, particularly in the period up to 31 March 2003, may have fallen short of the standards which the inspectors themselves would have hoped to achieve. We also comment that with this enormous pressure, the scope for follow-up by inspectors of establishments which were thought to be falling short of the requisite standards was very limited.

12.79 On the basis of the evidence given to this Inquiry, we have concluded that it was unrealistic to expect the limited number of inspectors employed by the NCSC in 2002 and 2003 to provide effective regulatory control over all independent mental health hospitals with the resources which were then available. The inadequacy of the resources available was recognised in the most tangible of ways, with the provision for the following year of a greatly increased budget allowing the number of inspectors to be more than doubled. Unfortunately, recruitment difficulties meant that there continued to be too few inspectors employed to perform the functions required of the NCSC, even in the year 2003/2004.

12.80 We accordingly turn to consider the question of whether, had more resources been available to the regulatory authorities during this period, that would have made a significant difference to the way in which Shrewsbury Court was operating. After the homicide had occurred, and when the HC devoted very considerable resources to an investigation of the quality of service at Shrewsbury Court, significant and wide-ranging Requirements were imposed. Subsequent HC reports show that there has now been a substantial improvement in the quality of service being provided. It might be said, therefore, that if only such resources had been available to the HC before the homicide, the steps necessary to improve the service at Shrewsbury Court and to prevent this homicide might have been taken.

12.81 It can be said with some certainty that if all the deficiencies that were identified in January 2005 had been identified a year earlier, then it is likely that this homicide would not have occurred. However, the resources which were devoted by the HC to

Shrewsbury Court in January 2005 were wholly exceptional, a direct response to the homicide. The resources available to the PVH division of the HC would have had to have been vastly increased to allow for this type of very detailed inspection of all the establishments falling within their remit, or even of those establishments which failed to meet more than 50% of the National Minimum Standards. We do not think that it could realistically be suggested that an investigation on this scale should have been undertaken prior to the homicide, unless something of major concern had been identified during routine inspections of Shrewsbury Court. In this context, we note again that HCC3's evidence to the Inquiry was that Shrewsbury Court was not flagged up as a particular cause for concern at any time during the period before the homicide in December 2004. Whilst the evidence from HCC2, and to a lesser extent from HCC1, suggested that they did have real concerns about the quality of the services at Shrewsbury Court, that evidence needs to be viewed in the context of their August 2004 report which, whilst identifying numerous shortcomings at Shrewsbury Court and setting out numerous Requirements, nevertheless stipulated only that these Requirements needed to be addressed by 28 February 2005, some six months later. This does not suggest to us that the inspectors considered that they had found anything of such grave concern that immediate action was needed, let alone that an investigation of the scale of that undertaken in January 2005 was required.

12.82 It is however, self-evident that if the PVH division of the HC had had greater resources available to it in the period up to December 2004, then more frequent and/or more detailed inspections could have been carried out of establishments such as Shrewsbury Court. It seems to us likely that such inspections would at least have resulted in greater concern at the HC about standards at Shrewsbury Court. Whether that would have brought about changes there which would have meant that this homicide could not have occurred can, however, only be a matter of speculation.

12.83 We turn then to consider the question of whether the inspectors could or should have identified the seriousness of the problems at Shrewsbury Courts during their August 2004 inspection.

12.84 It is impossible to answer this question with complete certainty, because we do not know what, precisely, HCC2 and HCC1 actually examined in the course of the August 2004 inspection. Even if we had tried to investigate that question in detail, it would still be impossible now to determine whether that material ought to have flagged up greater concerns than those which were, in the event, identified in the report which was produced following the August 2004 inspection.

12.85 However, our conclusion is that criticism of the inspectors would not be justified. In the course of a short inspection, lasting only one day, there was, we think, no realistic possibility of undertaking the sort of in-depth investigations which would have disclosed the seriousness of the problems at Shrewsbury Court. To expose the deficiencies in risk assessment, in multi-disciplinary working, in record-keeping and in the administration of medication, an investigation would have needed to include a careful examination of a number of sample patients' files. But the HC's remit at this time extended to a consideration of Shrewsbury Court's compliance with all of the Core Standards, and all of the Standards specific to mental health establishments. These Standards cover an enormously wide area, including environmental issues, clinical governance, and the drafting of policies and procedures. The sheer size of the task would have meant that the HC inspectors could only, realistically, "scratch the surface" when investigating an establishment's compliance with each of these Standards. Random sample investigations, and feedback from discussions with staff or patients might throw up a serious problem, but the HC's limited resources, and the limited time available to inspectors, would make discovering serious deficiencies as much a matter of luck as judgment.

12.86 It is our view, therefore, that the overwhelming probability is that the failure by the HC inspectors, in August 2004, or previously, to identify the full nature and extent of the problems which existed at Shrewsbury Court and/or to recommend that enforcement action be taken was a result of the inadequate resources available to the HC at the time, not inadequacies in the inspections carried out. Having said this, however, our view is that the systems which were in place at the NCSC and the HC in the period 2002-2004 could have been improved upon, both in terms of what was reported following baseline inspections and in following up those baseline inspections.

Follow-Up by the Inspectors [2002-2004]

12.87 HCC3 explained that there were no formal procedures for following-up baseline inspections in order to ensure that appropriate improvements were put in place when establishments fell short of the requisite standards, saying it "*was very much down to inspectors*". He explained that, in the second year of the PVH division, after the baseline inspections had all been carried out, its resources were generally prioritised based on the a consideration of the nature and extent of the Requirements which had been imposed at the baseline inspection, and of information given to the NCSC/HC by other agencies.

12.88 He accepted that the NCSC/HC's reports did not actually spell out whether the inspector had considered that the establishment was in a state where follow-up was an urgent priority. He acknowledged that the system relied on the individual inspectors' judgment, and on informal reports made by inspectors to their supervisors. There was no formal system at the NCSC/HC which identified establishments in need of urgent follow-up or which provided any kind of "risk rating" or prioritisation.

12.89 Such an *ad hoc* system could work satisfactorily within a relatively small organisation with good employee continuity. However, it is difficult to see how the system could work properly, so as to enable resources to be appropriately targeted at establishments in need of follow-up, when there was significant employee turnover. It is also difficult to see how resources could be effectively targeted, and establishments appropriately prioritised for follow-up, without some system that identified, in some formal and objective way, the degree of concern which the NCSC/HC (or the individual inspectors there) had about particular establishments.

12.90 When we raised this with HCC3 and HCC4, HCC4 explained that the HC now uses more formal criteria to decide whether a follow-up inspection is necessary. He told us that there is now what he called "*a defined escalation procedure*", and that the HC is now organised in teams with knowledge about particular establishments being shared within the team, so as to ensure that it is not lost when individual inspectors move on.

12.91 This is certainly a significant improvement over the informal, almost "word-of-mouth" system which appears to have existed back in 2003/2004. It is, we think, an essential development bearing in mind the change of approach at the HC, with the emphasis now being upon what is described as a more "risk based" approach.

12.92 We recommend to the HC that it should continue to work towards producing a system of categorising establishments by reference to objective criteria, with a view

- **to producing some form of objective assessment of the overall quality of an establishment.**
- **to providing an internal record of the extent of concern about an establishment and, accordingly, information about the extent to which that establishment was in need of follow-up.**

We further recommend that this information should be incorporated within the publicly available reports about each establishment, so as to provide service-users with a clear and easily accessible picture of the HC's overall views about that establishment.

12.93 The detail of such a system must, of course, be a matter for the HC, but one of the documents produced to the Inquiry was the HC's "Inspection Manual: Independent Healthcare". This dates from August 2005 and it identifies four key issues for the "Main Findings" to be incorporated in the reports prepared by HC inspectors. The four areas identified are:

i. Do the patients get a good service?
ii. What is the environment like?
iii. How well established are the quality systems?
iv. Is care evidence-based?

12.94 One system which the HC might consider adopting would be to use these four main areas as the basis for "scoring" the establishment, with reports providing a short summary of the inspectors' findings or conclusions under each of these four headings, with a "score" or "star rating" for each of those four categories. That section of the report

would, we think, provide a helpful and easily comprehensible summary, that would be readily accessible to healthcare professionals and the public alike. Assuming that inspectors are following the Manual referred to above, it would presumably be straightforward for the inspectors to provide an overall evaluation [or "score"] for each establishment under each of these four headings, so that the HC's concerns would be readily identifiable.

The Presentation of HC Reports [2002-2004]

12.95 We were concerned that it was not at all easy to discern from the reports generated by the HC and the NCSC on Shrewsbury Court during this period, the overall view which had been formed as to the quality of the establishment. At a very basic level, a reader could see how many of the Minimum Standards had not been met, and how urgently the inspectors wanted various problems addressed. But the significance of the various standards varies enormously. By way of example, one of the Core Standards is that there must be a written policy which states whether or not "research" is carried out at the establishment. A failure to comply with that Standard has no significant practical implications so far as the quality of care being provided. Merely looking, therefore, at the number of Standards that were not being met does not necessarily provide a meaningful insight into the quality of care. What was lacking, particularly with the earlier NCSC/HC reports which we examined, was any cogent summary from which the reader could immediately discern whether the establishment was one about which the inspector had real concerns, or whether the view was that whilst there might have been technical breaches of a number of Standards, the overall quality of service was good.

12.96 HCC3 agreed that this was a valid criticism of the HC's older reports, and that there had probably not been enough differentiation between criticisms that were fundamental to the quality of care being provided to the patients, and criticisms which were of a more technical or trivial nature. It was, he accepted, sometimes difficult to see the "wood for the trees" when reading these reports.

12.97 HCC3 stated, however, that this problem is being addressed, and that the drafting of more recent reports aims to give readers a more rounded perspective of how well the

organisation is performing, both in terms of its statutory responsibilities and its wider performance. He also told us that work was taking place at the HC to try to make its website more user-friendly and to present the information on that website in a way that makes it easier for the reader to ascertain the HC's overall views about a particular establishment; and to enable the reader to make comparisons with similar establishments. HCC4 added that work had very recently been done on revising the format of reports, with more emphasis being placed upon a narrative description, rather than the report being merely a list of Standards, detailing whether or not those standards had been met. The objective of these changes was, again, to give the public a clear overall impression of the establishment in question.

12.98 We do not for a moment suggest that this homicide would have been averted if only the HC's reports on Shrewsbury Court had been formatted or presented in a different way. As we have recorded earlier in this Report, it does not appear that those involved in the decision to place RR at Shrewsbury Court were aware of the content of any of the relevant NCSC/HC reports. Likewise, it does not appear that those involved in AT's care adopted the practice of checking the latest HC report on Shrewsbury Court when making decisions as to whether it was appropriate for AT to remain there.

12.99 Nevertheless, the changes in the way the HC reports are being presented are to be welcomed. The HC reports should, in our view, play a significant role in guiding those charged with commissioning services and making placement decisions. The provision of a straightforward summary in each report, giving a concise overall picture of the quality of the establishment, and perhaps incorporating some form of rating in a number of key areas - such as those referred to in the preceding section of this Report – would, we think, be very useful.

The New "Risk-Based" Approach

12.100 As noted above, the HC no longer has an obligation to carry out an inspection of every independent mental health hospital every year. Its obligation now is to ensure that each such establishment is inspected at least once every five years.

12.101 The regulatory framework that existed between 2002 and 2004 failed to pick up the seriousness of the deficiencies at Shrewsbury Court. As explained above, we consider that this was, in large measure, a result of inadequate resources, resulting in inspections being insufficiently detailed, and in Requirements and Recommendations not being followed up as vigorously as they should. It is, accordingly, of concern to us that there may now be a reduction in the number of occasions upon which establishments such as Shrewsbury Court are actually inspected by the HC. That is an alteration which, at first sight, seems to increase the chance of similar problems in another establishment being missed.

12.102 It is obvious that it would be ideal if every establishment were the subject of a comprehensive inspection, every year, during which the inspectors could assess the establishment's performance in all of the areas covered by the National Minimum Standards. Likewise, it would be ideal if every shortcoming which resulted in the inspectors making a Requirement or Recommendation was followed up by the inspectors so that it could be ascertained that establishments were rectifying those shortcomings within the timescales set out by the HC inspectors.

12.103 However, it must be recognised that this approach would be extremely expensive, and that (in the absence of vastly increased resources) the HC is in a position where it has to make difficult decisions as to how best to allocate finite resources. We accept, therefore, that it is appropriate for the HC to have moved to a system in which its resources are focused on establishments, or areas within establishments, where it is felt that there are, or may be, grounds for concern. It was unfortunate that between 2002 and 2004, the limited resources then available to the PVH division were spread as thinly as they were, because, in part, of the legal requirement on the HC/NCSC to inspect every independent mental health establishment, every year, even if that establishment had generated no particular concerns. Our view is that the approach of "targeting" resources is, accordingly, a sensible response to the problems posed by finite resources.

Self Assessment

12.104 We were told by the witnesses from the HC from whom we heard evidence that somewhat greater reliance is nowadays being placed upon "self-assessment" by establishments - including independent hospitals - when determining how best to allocate resources, and when deciding which establishments should be visited more frequently than others. It was explained to us that self-assessment is only one part of this process. We were told that the HC looks at a wide variety of other sources when making these decisions, including:

- the findings made by the HC in previous reports - and whether shortcomings were identified in a particular area;
- the findings made by the MHA Commissioners;
- the number of complaints there have been about the establishment;
- whether there have been concerns expressed by the organisations with responsibility for the protection of vulnerable adults.

An analysis is done of all of these areas, and a decision is then made as to the extent to which resources need to be devoted to the establishment in question.

12.105 However, the firm impression we received from the evidence we heard was that self-assessment has increased in importance, certainly since the period between 2002 and 2004, the period which is the primary focus for this Inquiry. This is not, in our view, a desirable development so far as the regulation of the independent sector is concerned.

12.106 The first and most basic point here is this. Either the owner/manager of an independent hospital is aware of the deficiencies at that establishment - in which case one would hope that he/she would intend to rectify those deficiencies in any event; or the owner/manager is unaware of those deficiencies - in which case self-assessment is unlikely to be of much value in identifying those problems. This may perhaps be over simplistic, but self-assessment in the independent sector seems to us to add little to the safeguards available to the public.

12.107 Furthermore, it seems to us that self-assessment in the independent sector is a very different matter from self-assessment in the NHS. In the NHS, identifying deficiencies can be a precursor to an application for greater funds to be allocated in order to address that deficiency. There is, accordingly, almost an incentive to highlight concerns on a self-assessment declaration in order thereby to provide a basis for a request for additional funding. Different considerations, however, apply when dealing with the independent sector - that is to say, with commercial organisations with financial interests directly affected by any onerous requirements which might be made by a regulatory body. Identifying deficiencies and informing the HC will inevitably lead to an obligation being imposed upon the establishment to address that deficiency. It is very likely that that will involve expenditure, and in the independent sector, that means reduced profits or, in an extreme case, putting the organisation out of business altogether. One might hope that there would be long term commercial benefits as a result of improvement in standards, but, as the history of Shrewsbury Court shows, poor standards do not necessarily mean empty beds.

12.108 When we raised these concerns with HCC3, he told us that any self-assessment declaration submitted would, as far as possible, need to be backed up with documentation justifying the assessment made. He emphasised that the HC do not accept declarations at face value, and often ask for additional supporting documentation, which is then cross-checked against other information available to the HC. He also commented that the self-assessment process was not limited to checking that systems were in place - he told us that the HC might additionally ask an establishment to provide audit results or action plans to provide evidence that systems were being appropriately implemented.

12.109 It remains our view, however, that a system which involves the HC placing significant emphasis upon the documentation provided by an independent hospital when deciding whether or not to carry out an inspection of that hospital has obvious dangers. It is a system which, we think, might well tend to encourage hospitals to focus resources more on ensuring that its paperwork is in order - for example that the relevant policies/procedures are in place and appropriately drafted – and less upon ensuring that those policies/procedures are actually being followed, day-in, day-out.

12.110 HCC3 told us that a lot of the work of the HC involved checking to see whether systems were in place (as opposed to checking to see whether those systems were being implemented in practice). He made the point that if a hospital is organised enough to have all the requisite policies and procedures in place, it is also likely to be organised enough to be providing a good quality of care. The assumption may, perhaps, be justified in the majority of cases, but it is an assumption which, if taken too far, would permit an establishment to satisfy the regulatory authorities by ensuring that the requisite documentation is in place, without ensuring that those policies and procedures are being adhered to by staff on a day-to-day basis.

12.111 If self-assessment is to be a significant part of the future regulatory regime, it is our view that it should, in the independent sector, be no more than a supplement to other, more robust, methods of acquiring intelligence to determine which establishments should be targeted for further investigation.

12.112 It is our recommendation to the HC that it reconsiders the extent to which reliance upon "self-assessment" declarations by establishments in the independent sector, is of any significant value in determining how best to allocate the HC's resources, and in deciding the frequency with which such establishments are visited by the HC's inspectors.

Intelligence Gathering with the New "Risk-Based" Approach

12.113 The approach of targeting resources in areas or upon establishments where the need is perceived to be greatest is one which must, in our view, be accompanied by steps to ensure a far wider recognition by the general public of the role of the HC - indeed of its very existence and role with regard to the regulation of independent hospitals. "Feedback" in the form of comments or complaints from the public - in particular, from relatives or friends of patients in independent mental health hospitals – would, we think, surely provide valuable information for the HC to enable problem areas or problem establishments to be identified.

12.114 The impression which each of this Inquiry Panel members has, albeit in what might be described as a general or anecdotal fashion, of the profile of the HC, is that there is little public awareness of its precise role. We accordingly asked HCC3 and HCC4 about the extent to which the Commission publicises its role to the general public. Their response was that it is a requirement for a hospital to have a statement of purpose and a patient guide available for patients and prospective patients to inspect. Their understanding was that such a guide would mention the HC and provide information about its role, together with contact details. They also made the point that a hospital must have a registration certificate from the HC which it is required to display at the premises, and they indicated that it was their understanding that this document would contain information about how to contact the HC.

12.115 This may very well be the case. However, our view is that these two methods of publicising the role of the HC are unlikely to result in widespread public awareness of its role. We think it is unlikely that members of the general public have any real appreciation of its work. This impression was strongly reinforced when HCC3 and HCC4 were asked about the level of complaints received by the HC from members of the public. The reply was that most complaints come from members of staff and healthcare professionals, such as GPs, rather than from the public. Neither HCC3 nor HCC4 had exact figures about the level of complaints received, but helpfully indicated that it was likely to be in the region of no more than two or three a month. That number strongly suggests to us that it is unlikely that there is widespread public awareness of the HC, let alone a perception that it is an appropriate place to take a complaint or concerns about a particular establishment. It seems to us that the probabilities are that a member of the public with a complaint would, in the first instance, take that complaint to the establishment in question. It may be that a particularly determined or irate member of the public would then learn of the existence of the HC, and would forward a complaint there as well, but the evidence of just two or three complaints a month suggests that this is relatively unusual.

12.116 We should record here that HCC3 did not accept that the number of complaints actually received by the HC was a reliable indicator of the public's awareness of the HC's role. He pointed out that the HC had only a limited role in investigating complaints from patients in independent sector establishments, and suggested that this might explain why

so few such complaints were actually received. On the wider issue of the public's awareness of the HC's role, he told us of what he described as *"numerous engagement events involving a multitude of stakeholders, including patients who use the independent sector"* and he drew attention to the significant amount of national and local media attention generated by a number of high profile reports produced by the HC. He also pointed out that, when planning an inspection, the HC will send posters and leaflets to the hospital in question, advertising the forthcoming visit, thereby giving patients and carers an opportunity to meet and talk on the day of the inspection.

12.117 We have not attempted, in the course of this Inquiry, to carry out any form of survey of the public's perception of the role of the HC. As mentioned above, however, the impression which each of us has is that there is little public awareness of the precise nature of the HC's role. The fact that it receives so few complaints from members of the public strongly reinforces that impression. We think it very possible, therefore, that the views expressed by HCC3 on behalf of the HC about the public's perception of its role may be over-optimistic. It seems to us, for example, that the information set out on posters and leaflets sent to a hospital in advance of an inspection is likely to reach only a limited number of members of the public – no more than a proportion, at best, of the friends and family of the patients at that establishment. Furthermore, since 2006, such inspections could, unless the HC is made aware of specific causes for concern, be taking place just once every five years.

12.118 We also comment that the point here is not whether the HC has a formal role in investigating complaints about hospitals in the independent sector. The issue is whether the HC could improve upon the methods which it currently uses to acquire information about problems with independent hospitals in order to assist in determining which establishments should be inspected more frequently than the legal requirement of once every five years. In our view, the more that the HC intends to place reliance upon information supplied to it in order to decide where to focus its resources, the more it needs to encourage local intelligence from as many sources as is possible. Such sources must include patients, family and friends, as well as healthcare professionals. Repeated complaints from members of the public about the quality of service at a particular establishment must surely be, at the very least, a useful indication of whether there might be something at that establishment which merits the attention of the HC inspectors.

Whether the HC has a role to play in actually investigating those complaints is, we think, of secondary importance - although it would be relevant and useful to the HC at least to know the outcome of such complaints.

12.119 In our view, therefore, the HC ought now to take further and better steps to ensure that all those involved with the provision of healthcare at independent mental health hospitals, including patients and their families, are fully aware of the HC's role, and, more importantly, are encouraged to provide information, positive or negative, to the HC about those hospitals.

12.120 We recommend therefore, that the HC give urgent consideration to the ways in which it might better publicise its role, with a view to ensuring that members of the public who may have concerns about an independent hospital are aware that the HC exists; that it has a regulatory role; that it exists to ensure that standards are maintained at independent hospitals; and that it is an appropriate place to communicate concerns about standards at an independent hospital.

12.121 The people who first realise that an establishment's standards are slipping are often the healthcare professionals who deal with that establishment on a day-to-day basis - the social workers, the local GP, and the local NHS hospital. It seems to us that it is increasingly important for the HC to put in place systems to enable it to tap into such sources of knowledge. HCC3, in the course of his evidence to us, spoke of the way in which the HC inspectors would seek to elicit information about an establishment from, for example, the MHA Commissioners; from those at the relevant local authority responsible for commissioning services from the establishment; and from other agencies such as the Health & Safety Executive. No doubt information from all of these sources is valuable, but the ability to elicit information from those working "on the ground" would be, in our view, be equally, if not more, useful. At the very least, we consider that it would be sensible for the HC to put in place systems designed to encourage those sorts of people to communicate any concerns which they might have about a particular establishment to the HC.

12.122 We should, in this context, record that HCC4 told us that if there were concerns about a particular organisation, then the HC would extend its enquiries to other, more local, organisations, but it is our view that it would be sensible to seek to elicit information from these local sources in all cases, not merely in those cases where concerns were expressed at the higher levels described by HCC3.

12.123 We recommend, therefore, that the HC takes steps to encourage not only members of the public but also healthcare professionals to communicate to the HC any concerns which they may have about standards at any independent hospital with a view to creating a culture in which a healthcare professional who has such concerns will automatically communicate those concerns to the HC.

12.124 Such publicity would also help, we think, to avoid the situation where those in contact with the independent sector (whether members of the public or commissioning authorities) assume that an independent hospital necessarily complies with the National Minimum Standards merely because that hospital has its registration from the HC and because the HC is not taking enforcement action against it. We think it is likely that, as things stand, a member of the public would assume that, because a regulatory body exists and because that body has not taken action against a particular establishment, the establishment must meet certain minimum standards. However, it is clear from what we have been told that this conclusion would not necessarily be warranted. We reiterate that we were told that many establishments inspected in 2002 and 2003 failed to meet even the majority of the National Minimum Standards. We also reiterate that no one involved in the decision to place RR at Shrewsbury Court was aware of the contents of the most recent HC reports or of its failure to meet the majority of the National Minimum Standards.

12.125 It may not just be service-users who have a misconceived idea of the extent of the regulatory control exercised by the NCSC, and latterly by the HC. We have recorded above, our impression that DR2 regarded the HC inspections and the subsequent reports as providing a benchmark by which he could determine whether the service Shrewsbury Court was providing was adequate. In a letter to the HC dated 13 August 2004, DR2 (after

outlining the action plan which had been prepared following the inspection of 13 May 2004) concluded as follows:

"Excellence has no finishing line. Our efforts and endeavours to improve our standards therefore are continuous and relentless. We rely heavily on your advice in the various aspects of our work in Shrewsbury Court and are confident in the knowledge that we can approach you with any difficulties that we have for your advice and guidance."

12.126 DR2's description of the "efforts and endeavours" to improve standards may, in retrospect, be seen as a wildly optimistic assessment of the progress being made, but this letter does illustrate both the extent to which he seems to have relied on the input of the HC and the misconception which we believe he was labouring under with regard to the role of its inspectors. His approach was further illustrated in the course of his evidence by the emphasis he placed upon the fact that staffing levels at Shrewsbury Court had met with HC approval - or had, at least, not been the subject of criticism by the HC - such that, he believed, there was no need for further recruitment. The same approach can also be identified in the contemporaneous documentation. When the Adult Protection Inter-agency Planning Meeting took place on 8 October 2004, concerns were expressed about staffing levels at Shrewsbury Court. The follow-up meeting on 30 November 2004, was told that DR2's response was that the HC was satisfied with the staff: patient ratio (although we should also record that DR2, through W4, expressed a willingness to co-operate if the meeting deemed additional staffing necessary). HCC2, who inspected Shrewsbury Court in May 2004 and again in August 2004, told us that his impression had been that the management at Shrewsbury Court had positively welcomed support from the inspectors - possibly, he thought, because they were under the mistaken impression that the HC set or defined the requisite standards.

12.127 It is our view, therefore, that DR2's approach was that the HC inspections could be used as a benchmark to determine whether it was necessary or appropriate for action to be taken to improve services at Shrewsbury Court, and that he was proceeding on the basis that, if the HC inspectors did not identify a problem, there was no problem. As we comment elsewhere, this was misconceived. The inspectors were only ever in a position to take a snapshot of services at Shrewsbury Court. We think this should have been obvious to DR2 (even making allowance for the fact that he did not have a background in mental health) that staff: patient ratios should be assessed by reference to the specific

needs of the specific patients at Shrewsbury Court. He should have known that the HC inspectors could not possibly know enough about the nature or extent of the needs of each of the patients there to provide anything more than general guidance on the issue of appropriate staffing levels.

12.128 We do not suggest that the HC inspectors ought to have anticipated DR2's belief in this respect. We simply comment that it is an illustration of a general misconception of the role of the HC. A higher profile to the HC's role would, we think, make it difficult for such a misconception to arise in the future.

12.129 Of course, a proliferation of complaints from the public to the HC will, in itself, have a significant impact upon the workload there, and, accordingly, give rise to resourcing issues which will need to be addressed. However, we nevertheless consider it essential for the HC to encourage communication from healthcare professionals and from members of the public, in order to enable its policy of targeting its resources to be as effective as is possible.

12.130 A further source from which we think the HC could usefully obtain information which would assist in the targeting of its resources is the PCTs and NHS trusts which purchase services from the independent sector. As we suggest elsewhere in this Report in the section relating to the steps which could have been taken by SLaM before placing RR at Shrewsbury Court, any purchaser within the NHS ought, before purchasing services from an independent hospital, to carry out some form of assessment or investigation into the quality of the services provided by that hospital. The nature and extent of that investigation would necessarily depend upon the level of services being purchased. It may in certain circumstances amount to no more than a visit by a care co-ordinator, or perhaps by a member of the clinical team, to the establishment in question, and the spending of perhaps half a day talking to staff there in order to form an impression of the establishment. That issue is discussed elsewhere in this Report.

12.131 The point for present purposes, however, is this. The results of any such investigation/assessment, however detailed, should be formally recorded by the PCT or

Trust. Such assessments would, we think, provide a useful source of information to the HC when it decides which establishments need to be targeted. In most cases, no doubt, the appraisal would be a positive one, but even positive feedback should be of value to the HC in deciding how to prioritise its resources.

12.132 In many cases, the authority or NHS trust which places patients in independent hospitals already employs an individual or a team to follow up such patients on a regular basis, and to ensure that the placement remains appropriate and cost-effective - as we discuss elsewhere in this Report, we consider it is essential for patients who are placed in the independent sector to be followed up in this way. For present purposes, however, the point is this. Such follow-up will necessarily involve further consideration of the suitability and quality of the independent hospital. It would, we believe, be relatively straightforward for the individual or team, as the case may be, responsible for following up these patients to prepare an annual report for the HC setting out such intelligence as may have been gathered with regard to the quality of the establishment in question. One would hope that in the vast majority of cases that report would be a positive one. However, such reports would provide a route for concerns about matters such as the regularity or efficiency with which the CPA meetings were arranged or about the quality of staff involved in such meetings, as well as any concerns raised by the patient, to be passed on to the HC.

12.133 We understand from evidence provided by HCC3 to the Inquiry in March 2008 that the HC has developed an active dialogue with Strategic Health Authorities and with commissioners, as a result of which he believes that awareness of the HC's role has now improved significantly. In particular, he informed us that commissioners are now encouraged to consider the reports generated by the HC before commissioning services from the independent sector and to report any concerns which they may have to the HC. This is, we think, encouraging. It is a process which, we think, can sensibly be built upon and formalised, so that there is a regular flow of information from those purchasing or commissioning services from the independent sector to the HC which can help to inform the HC in determining how best to allocate its resources, and in deciding which establishments may need to be visited by the HC inspectors.

12.134 We recommend, therefore, that consideration should be given by those purchasing or commissioning services from the independent sector to the creation of a post, or a team, specifically employed to follow up (or to ensure the follow-up of) patients placed in the independent sector, with a view to ensuring that the placement remains appropriate and cost-effective and with a view also to preparing annual reports for the PCT upon each independent hospital from which services are being purchased. These annual reports should be accessible to all involved in making placement decisions and also provided to the HC to assist it in the process of determining how best to focus its resources.

12.135 In preparing such a report, it would be essential to elicit the views of the care co-ordinators involved with each individual patient in order to get the ground-level view of how the establishment in question was functioning.

12.136 We also recommend that the HC should liaise with those responsible for commissioning/purchasing services from the independent sector with a view to putting in place systems whereby:

i. **Those commissioning/purchasing services from the independent sector prepare regular formal assessments of the quality of care being provided by establishments in the independent sector, ideally with criteria being agreed with regard to the nature and extent of those assessments; and**

ii. **Those assessments are provided to the HC to assist in the process of assessing how best to focus resources.**

12.137 One possible means of obtaining valuable information which HCC3 mentioned was the extension of the Mental Health Patient Survey, which has been used in the NHS, to the independent sector. He told us that valuable feedback had been obtained from the use of this survey, which had, in particular, helped the HC to ascertain whether policies and procedures were actually being implemented on a day-to-day basis. HCC3 told us that nothing of this sort has ever been commissioned for the independent sector, but that a study had recently been carried out into the feasibility of extending the Patient Survey to the independent sector. He explained to us that the decision whether or not to extend

the survey to the independent sector was one for the Department of Health, not the HC. He also told us that there was, at present, no statutory requirement for establishments in the independent sector to participate in such a survey.

12.138 It seems to us that in a context where increasing reliance is placed upon information from external sources, any procedure which provides the regulators with feedback from actual service-users is going to be very valuable. It is to be hoped that the issues which HCC3 described to us can now swiftly be addressed so as to allow the Patient Survey now to be extended to the independent sector.

12.139 It is our recommendation to the HC that it makes representations to the Department of Health, urging it to take such steps as may be necessary to enable the Mental Health Patient Survey to be extended to the independent sector.

Announced/Unannounced Inspections

12.140 Although HCC3 told us that the HC does undertake a considerable number of unannounced inspections, particularly where there are concerns about an establishment, we were a little surprised by the extent to which the HC has relied upon, and continues to rely upon, announced inspections in the independent sector. The purpose of a regulatory body is to ascertain whether the establishments for which it has responsibility are complying with the relevant regulations.

12.141 Providing an establishment with an opportunity to prepare for an inspection also provides an opportunity for it to try and "paper over the cracks". We are not suggesting that such attempts are commonplace. We are not suggesting that there was any such attempt made by staff at Shrewsbury Court. However, it must be remembered that independent hospitals are commercial organisations. They are subject to commercial pressures which may make it desirable for them to avoid a critical report from the HC and/or to avoid the immediate need to implement changes which might prove expensive. This would not matter if announced inspections were conducted in such a depth that one

could be confident that the inspectors would be able to detect any such efforts. However, we doubt whether the resources available to the HC are such that one could have any great confidence that an inspector would be able to spend sufficient time at an establishment to detect attempts to provide short-term fixes for longer-term problems, in order to get through the inspection.

12.142 There is a place for announced inspections. One point made in the evidence we received was that, with an announced inspection, the inspectors could be sure that all of the relevant individuals, such as the Registered Owner and the Registered Manager would be available on the day to deal with any queries which the inspectors might have. The point was also made that, if patients and their families were given notice of an inspection, they could consider in advance whether there were any matters they wanted to raise directly with the inspectors. However, these benefits would still be available if announced inspections were used only for the purpose of a follow-up inspection.

12.143 It is our view that, at least for establishments in the independent sector, unannounced inspections should be standard practice, with announced inspections being used primarily for follow-up visits to address issues identified on those unannounced inspections.

12.144 We accordingly recommend to the HC that it reviews the issue of whether it is appropriate for establishments in the independent sector to be given advance notice of impending inspections by the HC, and that it should aim to minimise the number of occasions upon which such notice is in fact given.

The Small "Stand Alone" Independent Hospital

12.145 We discussed with those witnesses who had a connection with the HC the extent to which compliance with the 2001 Regulations and with the National Minimum Standards had proved more of a problem for smaller independent hospitals, which were not part of a wider organisation but were, in effect, stand-alone units - typically, a family-run

organisation like Shrewsbury Court. The evidence, perhaps unsurprisingly, was that such establishments did indeed have more difficulty in complying with all the requirements expected of an independent hospital. HCC3 referred in his evidence to a statistical analysis carried out in 2005/2006, which confirmed this. The reasons are not hard to discern. Producing all relevant policies and procedures and putting in place appropriate clinical governance requires significant administrative input. A nationwide organisation, running several, perhaps many, independent hospitals, has far greater resources to allow the costs of putting in place the appropriate procedures to be absorbed. For a stand-alone establishment, the expense of engaging staff for the specific purpose of ensuring compliance with the regulatory regime is likely to be a higher proportion of the establishment's turnover, and there might, therefore, be a temptation to cut corners, perhaps using existing staff to address these regulatory requirements, rather than incurring the expense of recruiting specialist staff.

12.146 We recommend to SHAs, therefore, that consideration should be given to ways of encouraging smaller independent hospitals, which have only limited infrastructure for the implementation of clinical governance, to look at partnership working with other providers or to join appropriate networks to access expertise and peer support.

12.147 Given that the HC has only finite resources, we consider that it must be sensible for these stand-alone units to attract more attention from the inspectors than the more substantial, nationwide organisations. It is, perhaps, unfortunate that consideration was not given, at an earlier stage, to prioritising these establishments. We are told, however, that this is an issue which is now being addressed, with greater resources being targeted towards the smaller "stand-alone" establishment.

The Appointment of Registered Managers at Independent Hospitals

12.148 We have commented above upon the fact that, before appointing W4 as Deputy Manager at Shrewsbury Court, DR2 sought the views of the NCSC. By a letter dated 22 January 2004, HCC2 said he saw no reason why W4 should not be appointed as Deputy Manager to W1. HCC2 was not invited to comment on the appointment of W4 as Acting

Manager following W1's resignation as Registered Manager in March 2004. However, he made no adverse comment about the appointment of W4 when he visited Shrewsbury Court in May 2004. The HC report following the inspection in August 2004 did, however, impose a Requirement that DR2, as the Registered Owner, should make reasonable efforts to fill the vacant post of Manager at Shrewsbury Court, with a date for compliance of 28 February 2005.

12.149 In the HC report which followed its inspection in January 2005, it was commented that no evidence had been produced by Shrewsbury Court of pro-active attempts to recruit a new Registered Manager since 17 May 2004. This was the date when, apparently, the recruitment agency retained by Shrewsbury Court had told DR2 that they had been unable to recruit to the position – which presumably meant that it had been unable to identify any suitable candidates for consideration by DR2. That inactivity is a further illustration of the failures of senior management at Shrewsbury Court up to December 2004, but the point for present purposes is a different one.

12.150 Our view is that one of the principal causes for the deficiencies at Shrewsbury Court was the fact that the establishment was managed throughout the critical years up to the end of 2004 by individuals who had no particular experience or expertise of working with the mentally ill. W1 was at least an RMN, but he had no substantial experience of working in mental health before he moved to Shrewsbury Court. His successor, W4, was trained only in learning disability. W10, the Clinical Nurse Specialist, was likewise trained in learning disability, not mental health nursing. DR2 himself had no background in mental health. It appears to us that CONS4, the consultant psychiatrist, provided little input to the management of Shrewsbury Court.

12.151 There was a serious lack of experience in mental health issues amongst those involved in the management of Shrewsbury Court. Even when W1 was the Registered Manager, we consider it likely that there was less than a full appreciation of just what needed to be done to raise standards to a level appropriate to a hospital. It is, therefore, perhaps unsurprising that there were such serious deficiencies there – put at its simplest, the management did not have the experience or expertise to know how the service needed improving. It probably did not have the experience or expertise even to know

(without being told by the HC) that the service needed to be improved, let alone to appreciate how necessary it was that improvements were carried out. This may be a substantial part of the reason why the management there was essentially reactive – responding to criticisms, requirements or recommendations made by the regulatory authorities and/or other third parties, but not pro-actively seeking to identify and to address deficiencies.

12.152 The role of the Registered Manager at an independent hospital is of central importance to the quality of the establishment. It is an appointment over which the HC can exercise direct control. The Private and Voluntary Health Care (England) Regulations 2001 (S/I 2001/3968) state that when a manager is appointed, notice of the appointment must be given to the HC, and further provide that a person shall not manage an establishment unless *"he is fit to do so."* The National Minimum Standards include in the Core Standards a requirement that the Registered Manager can demonstrate that he/she has undertaken periodic training to update their knowledge, skills and competence to manage the establishment (Core Standard C8) and make it clear that the Registered Manager is accountable for the delivery of services to the requisite standards, and needs to be registered with the HC.

12.153 It is accordingly possible for the HC to ensure that an independent hospital is managed by an appropriately experienced and qualified Manager. That power was not effectively used here. The HC inspectors recognised that W4 did not have the requisite experience / expertise to be the Manager of Shrewsbury Court. That is clear from the Requirement, contained in the report following the August 2004 inspection referred to above. However, the time limits on that Requirement meant that he was allowed to remain in that post, for which he was, we think, seriously under-qualified, for at least a further six months. We were surprised also that the HC inspectors did not comment, following their visit in May 2004, upon the recent appointment of W4 as Acting Manager, and upon the urgent need for someone with appropriate experience/qualifications to be recruited as the Registered Manager as soon as possible. This omission was particularly surprising bearing in mind that W4 had not, in fact, undergone the additional training which HCC2 had recommended in his letter of 22 January 2004. No doubt the inspectors on this occasion (one of whom was HCC2) were assured that efforts were being made to recruit a suitable replacement. It is, however, of concern that, according to the HC

report from January 2005, such recruitment efforts as were being made apparently came to an end on 17 May 2004. The timing may be a coincidence, but it may be that, in the absence of adverse comment by the HC inspectors about W4's appointment as Acting Manager, DR2 felt that there was no pressing urgency to the task of finding a replacement for W4.

12.154 Be this as it may, our view is that the HC's power to ensure that an independent hospital is managed by an appropriately experienced and qualified manager is a valuable power which adds significantly to the HC's ability to maintain standards in the independent sector. The quality of management is crucial to maintenance of standards - as the facts of this case demonstrate, the HC cannot be expected pro-actively to audit every aspect of a hospital's performance. Ensuring that the person with responsibility for the day-to-day management of an establishment (whether that is the Registered Owner/Provider or Registered Manager) is appropriately experienced and qualified for that task, is likely to be one of the most effective ways for the HC to ensure a good quality service, and compliance with the National Minimum Standards.

12.155 Pro-actively investigating the qualifications and experience of Registered Managers and, where necessary, imposing and vigorously enforcing Requirements designed to ensure that such Managers are appropriately trained and undergo regular training to update their knowledge and skills, is clearly a cost-effective way for the HC to maintain standards within the independent sector and HCC3 told us that the HC places considerable importance upon the need for a competent and suitably experienced manager. He said that, before the HC reaches any decision about the registration of such a manager, applicants for the position are required to attend an interview in order that the HC can satisfy itself that they are indeed *"fit persons"* for the post.

12.156 We have no reason to question the thoroughness of the investigations which the HC carry out when asked to assess an applicant for the post of Registered Manager at an independent hospital. In this instance, however, and notwithstanding visits by the HC to Shrewsbury Court in May 2004 and in August 2004, that establishment was, from March 2004, when W1 resigned as manager, through to the time when this homicide occurred, actually being managed by someone who, in our view, lacked the requisite qualities to be the Registered Manager of an independent hospital. The problem was picked up at the

time of the August 2004 visit, and the inspectors required that steps be taken to rectify the position, but the time allowed for that process was, in our view, surprisingly generous. It is to be hoped that one of the lessons to be learned from the events described in this Report is that the HC will ensure that it will not again be possible for an independent hospital to continue in business without an appropriately qualified manager in place for such a lengthy period.

12.157 We recommend to the HC that it should use its powers of enforcement to ensure that, save in exceptional circumstances, no independent hospital is without a Registered Manager, who has been approved by the HC as a "fit person", for a period of more than six months.

Competition/Market Forces as a Means of Maintaining Quality

12.158 There is a view to be discerned in the documentation which has been produced to this Inquiry, and in some of the evidence given to us, that market forces, or competition, within the health service is the most effective way to ensure the quality of service in the independent sector. The concept is that the commissioning authorities will maintain and improve standards in the independent sector by favouring establishments where quality is high and declining to commission services from establishments which do not meet appropriate standards. This is, in particular, the impression the proposals presently being advanced by the Department of Health with regard to the new regulatory body which will take the place of the HC "The Future Regulation of Health and Adult Social Care in England" (issued in November 2006). This includes the following:

"In all public services, we are making a radical shift from top-down, target driven performance management to a more bottom-up, self-improving system built around the individual needs of service-users and influenced by effective engagement with the public. Increasingly, improvement will be driven by the choices made by service-users and healthy competition between different service providers. The NHS and adult social care services are no exception.

Later in the same document, it is stated:

"…that health reform seeks to drive continuous improvement through strong and effective commissioning by PCTs and practice-based Commissioners. This is the bedrock of health reform, so Commissioners (PCTs and practice-based Commissioners) will be the key to achieving service improvements in future."

In other words, it is anticipated that those commissioning services will ensure the quality of service in the independent sector, because commissioners will not contract to procure services from establishments which are below standard, or will at least demand improvement before commissioning services from them.

12.159 We do not express any view as to the merits or otherwise of this *"radical shift"* as a matter of general policy. That is a political question outside the remit of this Inquiry. We can understand how, in a context where PCTs and/or patients have a number of choices, market forces could be an effective means of driving up quality. We think, however, that in the context of mental health services, the belief, implicit in the sort of policy statement set out above, that competition is an effective way of ensuring the quality of the services in the private sector and of encouraging improvement in those services, needs further consideration.

12.160 With a "difficult to place" patient, such as RR, the authority seeking to place that patient will have few, if any, options. If options exist, they may often be defined, not by what is best for the patient, but by which establishments, if any, are prepared to accept that patient, and/or by cost considerations. The reason why RR went to Shrewsbury Court was, primarily, because it was prepared to accept him, and because SLaM was unable to identify any other establishment which would. The position may not, perhaps, be as extreme with other "difficult to place" patients, but the fact remains that there does not exist a true open market with such patients. An establishment like Shrewsbury Court which is prepared to take the "difficult to place" is likely to be regarded as an attractive option <u>for that reason alone,</u> if there are no other alternatives, or if those other alternatives are markedly more expensive.

12.161 The point is well illustrated on the facts of this particular case and by the reasoning which underpinned the decision at SLaM to consider Shrewsbury Court in the first place. Shrewsbury Court was first thought of, so it appears, because it had previously

taken a "difficult to place" patient from SLaM. Because that placement had not broken down, it was regarded as a success. More than one witness referred to Shrewsbury Court having a reputation for taking the difficult patients, the patients who could not be placed elsewhere. HCC1 of the HC, for example, told us, in terms, that Shrewsbury Court had a reputation for taking the *"difficult to place"* who were then *"forgotten about"*.

12.162 The very wide patient mix at Shrewsbury Court and the lack of a focused admissions policy, was the subject of comment even before AT's death and the subsequent investigation - by the HC inspectors, the MHA Commission and the Adult Protection Inter-agency Planning Meeting on 8 October 2004. It was not, however, a circumstance which caused commissioning authorities to place their patients elsewhere. On the contrary, it was a circumstance which meant that Shrewsbury Court was perceived as a possible candidate in circumstances where other establishments were not prepared to take a patient.

12.163 Market forces will not, by themselves, cause an establishment such as Shrewsbury Court to fail. On the contrary, Shrewsbury Court's willingness to take difficult patients filled a gap in the market. It is only by effective and proactive regulatory control that standards at such an establishment can be brought to and maintained at an appropriate level. Different considerations may apply in other parts of the health service where the concept of the "difficult to place" patient may be less familiar. But in the context of mental health services, an attempt to rely on market forces as a means of ensuring a good quality of service is, we believe, misguided.

12.164 Furthermore, whilst in other areas of the health service, there is a reasonable expectation that patients will themselves express concerns about sub-standard service, there can be no such expectation when the patients concerned are the particularly vulnerable, the mentally ill. The families of such patients could express concerns about the establishment, but mental health is an area where those most directly affected by the quality of service - the patients themselves - are the least likely to be able to articulate complaints or concerns, and/or are the least likely to have such complaints or concerns taken seriously.

12.165 It seems to us, therefore, that at least in the context of mental health, it is important to avoid placing excessive reliance upon the concept of market forces as a basis for ensuring the quality of service in the independent sector.

Conclusions

12.166 In the context of the limited resources which were available to the regulatory bodies in the period 2002-2004, we do not consider that it is fair or appropriate to criticise the inspectors who carried out the various regulatory inspections at Shrewsbury Court for failing to detect the widespread problems which were eventually identified in the course of the January 2005 inspection. The failure to detect the full nature and extent of those problems was a combination of factors:

i. The inadequate resources available to the NCSC/HC, resulting in too few inspectors;
ii. A lack of a comprehensive training programme for new inspectors.
iii. The problem with inadequate resources being exacerbated by the difficulty of focusing resources on problem establishments in circumstances where there was a legal requirement upon the NCSC/HC to carry out a full baseline inspection on every establishment every year (generating lengthy and unwieldy reports which were no doubt time-consuming to produce).
iv. The inability of inspectors, until April 2004, to examine patient records in order to establish whether, in at least a sample selection of cases, all policies and procedures were being appropriately implemented.

12.167 It is not possible now definitively to assess the extent to which the lack of resources contributed to the failure to identify the shortcomings in Shrewsbury Court which were identified at the inspection in January 2005. It would have required an enormous (and unrealistic) increase in the available resources before the HC could have been in a position to undertake the type of detailed inspection which was undertaken at that time, engaging six inspectors for up to four days each.

12.168 With the benefit of hindsight, it would have been sensible for greater resources to have been made available to the regulatory authorities in the period immediately after 1

April 2002, so as to enable every establishment to be inspected, in detail, as soon as possible after that date, with the resources thereafter being targeted upon establishments which were perceived as being problem establishments. Such an approach would have required the NCSC/HC to have had a system for prioritising these establishments, with a robust system for following up baseline inspections so as to ensure that Requirements and Recommendations were being implemented within the timescales laid down by the inspectors. This would have involved substantial resources being devoted to the regulatory process for a year or so after 1 April 2002, but the position should soon have been reached where establishments were largely compliant with the requisite Regulations and where, therefore, the level of detail necessary on inspections could be commensurately reduced. The resources necessary to ensure that establishments are maintaining standards ought, as a generality, to be rather less than the resources necessary to bring establishments up to standard in the first place.

12.169 Regrettably, budgetary constraints, combined with a lack of foresight on the part of those responsible for setting those budgets, resulted in a regulatory system which was overstretched and which did not have the resources effectively to ensure that all independent mental health hospitals were up to the requisite standards. Possibly the most important of the HC's strategic goals, namely safeguarding the public, was one it was not realistic to expect the NCSC/HC inspectors to achieve in the period up to 2004 with the resources then available.

12.170 It may be that a part of the reason for removing the legal requirement that the HC must carry out an inspection of every establishment every year, and the associated shift towards the more targeted type of work now being undertaken, was the fact that the resources simply did not exist to allow the HC to carry out comprehensive inspections of every hospital each and every year. In the context of only limited resources being available to the HC, this change in approach seems to us to make sense.

12.171 However, the facts of this case illustrate in the clearest possible way the need for a robust regulatory system. We cannot help but be concerned by the apparent move towards self-assessment and five-yearly inspections, when an establishment which, even under the old annual inspection system, nevertheless fell short in so many ways of the requisite standards. We are particularly concerned if self-assessment is to play a large

role in determining whether or not inspections of an establishment will take place more frequently than once every five years. It is a tool which has, we believe, only limited value in the context of the independent sector, and we are concerned that its use may result in establishments placing more emphasis upon the task of ensuring that all appropriate policies and procedures are in place, rather than ensuring that they are properly implemented. The existence of appropriately drafted policies and procedures is merely a starting point, and it is essential that there are robust systems in place to ensure that the policies and procedures are actually being followed on a day-to-day basis.

12.172 Given the HC's decision to adopt a policy of targeting inspections upon establishments, or areas within establishments which are considered to be potential problem areas, we consider it is vital that the HC seeks to maximise the intelligence it gathers from those best placed to express a view on whether day-to-day care at an independent hospital is of an appropriate standard. That necessarily involves putting in place systems to obtain as much feedback as possible from those commissioning services from the independent sector, from care co-ordinators and from other healthcare professionals, as well as from the patients themselves, and their friends and families.

13. Recommendations

13.1 In concluding this Report, we make 32 recommendations.

13.2 These have been set out below according to their subject area, although we also identify the organisation(s) to which each recommendation is principally addressed.

13.3 Although this Report reviews events relating to patients from two SHA areas, in our recommendations we refer to SHAs, PCTs, and Trusts generally because the issues we cover are likely to have wider application and relevance beyond NHS London and NHS South East Coast.

Shrewsbury Court

R1 We recommend that Whitepost Healthcare Group now commissions an independent, top to bottom, governance review at Shrewsbury Court with the objective of consolidating and building upon on the improvements made there since the homicide and supplementing the Recommendations and Requirements provided to date by the HC. **(8.294)**

Commissioning and patient placement issues

R2 We recommend to the Department of Health and to SHAs that consideration should be given to the creation of a National Directory of organisations (both within the NHS and in the independent sector) which provide services to the mentally ill, with details of those organisations' admission criteria. **(9.28)**

R3 We recommend to Primary Care Trusts (PCTs), NHS Trusts providing mental health services (Trusts) and Social Services that, whenever placement decisions are being made, care co-ordinators should be required to compile and maintain a formal record, in a single, easily accessible document, which sets out each of the placement options considered from time to time for the patient in question; which documents the approaches made to each, and the response(s) received; and which explains the reasons

why the placement eventually selected was chosen in preference to other possible options. **(9.21)**

R4 We recommend to PCTs, Trusts and Social Sevices that, when considering commissioning services from a hospital in the independent sector, those involved in the placement decision should, as a matter of routine, always look at the latest reports prepared by the HC and the MHA Commissioners on any hospital under consideration, in order to ascertain whether there are any concerns about the establishment which might be material to the placement decision. **(9.42)**

R5 We recommend to PCTs, Trusts and Social Services that in any case in which an out-of-area placement is being considered at an establishment with which those responsible for the patient's care are unfamiliar, it should be mandatory for a visit to be made to that establishment, in order to assess its suitability for a patient, and that such visits should be made by an individual, or by a team which has both a proper understanding of the patient's needs and sufficient experience/expertise to make an informed assessment of the establishment in question. **(9.53)**

R6 We recommend to PCTs, Trusts and Social Serivces that when an "out-of-area" placement is being considered, care co-ordinators should obtain and formally record a standard set of basic information relating to the establishment under consideration and the care which they provide before services are commissioned. The nature and extent of the information to be gathered in this way is a matter for detailed consideration – this Report includes a number of suggestions in this regard. **(9.100)**

R7 We recommend to PCTs, Trusts and Social Services that those responsible for placing patients in the independent sector should consider adopting significantly more detailed contracts with the hospitals with which they contract, with a view to imposing specific and detailed contractual obligations with regard to level of service to be provided, and with consideration also being given to the imposition of proportionate financial penalties in the event of non-compliance. **(8.186)** Among other matters, we recommend that it should be made clear to service providers that it is expected, as a matter of routine, (and will be required, as a matter of contract) that at the pre-transfer case conferences, both hospitals will be represented by appropriately senior staff; and

that, in all but the most straightforward cases, this means that there should be a multi-disciplinary representation, including the presence of both the transferring and the receiving consultants. **(10.14)**

R8 We recommend to Trusts that consideration should be given to the adoption of a policy that, when teams are referring a patient "out-of-area", or to a unit in the independent sector, they should routinely ask to see the written assessment report carried out by the assessing team at the establishment to which the transfer is contemplated; and ensure that that assessment is reviewed by or on behalf of the current RMO before the transfer takes place. **(9.108)**

R9 We recommend to PCTs, Trusts and Social Services that cases brought to a placement panel should be accompanied by a full, up to-date, chronology, with a view to ensuring that all past behaviour is fully realised and considered by the panel when deciding whether or not to endorse a recommended placement. **(9.60)**

R10 We recommend to PCTs, Trusts and Social Services that the process of monitoring a patient's placement in an "out-of-area" hospital should always include active consideration of whether the hospital in question is providing a service of an acceptable standard. A starting point for any such consideration ought to be a regular consideration of recent reports from the HC and the other regulatory authorities. But additionally, on any occasion when a CPA meeting is held for a patient who is placed "out-of-area", consideration ought specifically to be given by the care co-ordinator to the question of whether there are any grounds for concern about the quality of care being provided. A "checklist" of points to consider should be prepared. Such a checklist should include, as a minimum, the most recent reports from the HC; whether the patient, or the patient's family, have raised any concerns about the quality of service; whether there are any obvious environmental issues apparent when visiting the premises; and whether the documentation prepared for the CPA meeting complies with the standards normally to be expected. This should be a routine part of any CPA meeting in respect of a patient placed "out-of-area". It should also be a routine part of this process to consider whether CPA meetings are being arranged with appropriate frequency/regularity. **(11.149)**

R11 We recommend to PCTs, Trusts and Social Services that consideration should be given by those purchasing or commissioning services from the independent sector to the creation of a post, or a team, specifically employed to follow up patients placed in the independent sector, with a view to ensuring that the placement remains appropriate and cost-effective; and with a view also to preparing annual reports for the PCT upon each independent hospital from which services are being purchased. These annual reports should be accessible to all involved in making placement decisions and should also be provided to the HC to assist it in the process of determining how best to focus its resources. **(12.134)**

R12 We recommend to PCTs, Trusts and Social Services that it should be re-emphasised to those involved in making recommendations for placements for psychiatric patients that the primary concern must always be the patient's individual needs, rather than financial considerations. **(9.32)**

R13 We recommend to SHAs that consideration should be given to the question of whether the needs of patients with a significant forensic history, who would normally fall within the care of the forensic services, are adequately met by existing old age psychiatric services; or whether there is a need, locally or regionally, for a unit with the expertise to provide care, to the level of medium security, specifically for older adult males with a forensic history. Similarly, the need for forensic psychiatrists, and for multi-disciplinary forensic teams, specialising in old age should be assessed and appropriate posts created accordingly, as a central initiative if necessary. **(9.26)**

R14 We recommend to Trusts that a formal handover / discharge report should be completed whenever an in-patient at a mental health hospital is transferred, even temporarily, to another hospital; and also when that patient is subsequently returned to the mental health hospital. **(10.102)**

Risk Assessment

R15 We recommend to PCTs and Trusts that, when commissioning mental health services, whether from within the NHS or from the independent sector, evidence should be sought and obtained from service providers that they have incorporated the

guidance from the Department of Health's "Best Practice in Managing Risk" publication[2] into their risk assessment and management policies and procedures; and have adopted a structured, validated risk assessment tool with all clinical staff trained and regularly updated in its use. **(10.130)**

R16 We recommend to the Department of Health that its advice on risk assessment should be adapted to incorporate (a) passages emphasising the difference between dangerousness and disturbed behaviour; and (b) a discussion of age and risk. **(10.133)**

Interface Issues

R17 We recommend to SHAs that interfaces between general psychiatry, old age psychiatry services and the forensic psychiatry services in each region should be clearly defined. Clear protocols and pathways for the transfer of care and responsibility between different elements of a psychiatric service should be drawn up by provider organisations. **(9.129)**

Issues relating to Hospital Managers

R18 We recommend to Trusts providing mental health services that no reports for Managers' hearings or Mental Health Review Tribunals should be prepared in isolation from other members of the multi-disciplinary team. **(9.150)**.

R19 We recommend to Trusts that the guidance given to Hospital Managers, in the course of their training, should include the strongest possible caution against discharging a detained patient against the advice of the RMO without having first taken oral evidence from the RMO **(9.155)**.

R20 We recommend to Trusts that there should be a comprehensive review of the nature and extent of the training given to hospital managers before they sit on appeals of cases admitted under Part III of the Mental Health Act **(9.162)**.

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511

R21 We recommend to SLaM that the nature and extent of the training given to hospital managers before they sit on appeals of cases admitted under Part II and Part III of the Mental Health Act 1983, in order to assess whether that training, even as already improved in the aftermath of AT's death, is sufficiently detailed and wide-ranging to enable those managers to have a proper understanding of the legal principles which need to be applied, and of the distinction between issues concerning the "nature" of the mental illness and the "degree" of that illness. **(9.163)**

R22 We recommend to the Ministry of Justice that the new guidance to be issued to judges in 2008 make prominent the fact that hospital managers can (and do) discharge Section 37 Orders against medical advice, if restriction orders under Section 41 are not made concurrently. **(9.166)**

Sexual relations between in-patients

R23 We recommend to Trusts that all units providing residential care to the mentally ill should have a formal policy relating to sexual relationships involving in-patients**;** and that whenever a placement is being considered "out-of-area", or in the independent sector, steps are taken to ascertain the policy adopted in this regard by the establishment(s) under consideration. **(10.37)**

Regulatory issues

R24 We recommend that the HC give urgent consideration to the ways in which it might better publicise its role, with a view to ensuring that members of the public who may have concerns about an independent hospital are aware that the HC exists; that it has a regulatory role; that it exists to ensure that standards are maintained at independent hospitals; and that it is an appropriate place to communicate concerns about standards at an independent hospital. **(12.220)**

R25 We recommend to the HC that it takes steps also to encourage healthcare professionals to communicate any concerns which they may have about standards at any independent hospital to the HC, with a view to creating a culture whereby any healthcare professional who has concerns about a particular establishment will communicate those concerns to the HC. **(12.123)**

R26 We recommend to the HC that it should liaise with those responsible for commissioning or purchasing services from the independent sector with a view to putting in place systems whereby

i. Those commissioning/purchasing services from the independent sector prepare regular formal assessments of the quality of care being provided by establishments in the independent sector, ideally with criteria being agreed with regard to the nature and extent of those assessments; and

ii. Those assessments are provided to the HC to assist in the process of assessing how best to focus resources. **(12.136)**

R27 We recommend to the HC that it should continue to work towards producing a system of categorising establishments by reference to objective criteria, with a view

- to producing some form of objective assessment of the overall quality of an establishment.
- to providing an internal record of the extent of concern about an establishment and, accordingly, information about the extent to which that establishment was in need of follow-up.

We further recommend that this information should be incorporated within the publicly available reports about each establishment, so as to provide service-users with a clear and easily accessible picture of the HC's overall views about that establishment. **(12.92)**

R28 We recommend to SHAs that consideration should be given to ways of encouraging smaller independent hospitals, which have only limited infrastructure for the implementation of clinical governance, to look at partnership working with other providers or to join appropriate networks to access expertise and peer support. **(12.146)**

R29 We recommend to the HC that it reconsiders the extent to which reliance upon "self-assessment" declarations by establishments in the independent sector is of any significant value in determining how best to allocate the HC's resources, and in deciding the frequency with which such establishments are visited by the HC's inspectors.(**12.112)**

R30 We recommend to the HC that it makes representations to the Department of Health, urging it to take such steps as may be necessary to enable the Mental Health Patient Survey to be extended to the independent sector. **(12.139)**

R31 We recommend to the HC that it reviews the issue of whether it is appropriate for establishments in the independent sector to be given advance notice of impending inspections by the HC, and that it should aim to minimise the number of occasions upon which such notice is in fact given. **(12.144)**

R32 We recommend to the HC that it should use its powers of enforcement to ensure that, save in exceptional circumstances, no independent hospital is without a Registered Manager, who has been approved by the HC as a "fit person", for a period of more than six months. **(12.157)**

Department of Health

R33 We recommend to the Department of Health that it consider taking ownership of many of the recommendations of this Inquiry and incorporating them into central guidance.

APPENDICES

Appendix A - Dramatis personae

The description of the role of each of the individuals listed below is confined to a description of that role as it was at the time of that individual's involvement with RR/AT, except in cases where it is relevant for the purposes of this Report to identify the individual's role at some other time.

W6:	Employed at Whitepost as a staff nurse. AT's Named Nurse for a period in early 2004. Qualified as an RGN.
W13:	Employed at Whitepost as a care assistant.
CONS2:	Consultant in old age psychiatry, working at the material times at Chelsham Ward, Bethlem Royal Hospital. Provided a report on RR to the Croydon Crown Court in 2002; Had responsibility for RR's care on that ward.
DR7:	CONS9's SHO; visited AT at Shrewsbury Court as part of the follow up after her transfer there.
K1:	Continuing Care Project Manager with West Kent NHS and Social Care Trust. Visited AT at Shrewsbury Court in late 2002 and again in 2004.
C15:	Consultant in old age psychiatry, working at the material times with the Elderly Community Mental Health Team in Purley during RR's time at the Jubilee Nursing Home.

CONS6:	Consultant in old age psychiatry. Provided a report on RR to the Croydon Crown Court in 2002.
W21:	Employed at Whitepost to take responsibility for quality assurance. A Consultant in the independent care industry, his qualifications include being qualified as an RMN and as an RGN.
M1:	A locum employed by SLaM for a short period in 2004 as Placements Nurse.
BRH2:	Nursing Team Leader on Witley 3 ward at Bethlem Royal Hospital. Qualified as an RMN, and has a diploma in forensic mental health care studies.
C16:	Mental Health Act Manager for SLaM; member of the panel which heard RR's appeal against the continuation of the section 37 Order on 15 April 2002.
W1:	Registered manager of Whitepost between 1998 and March 2004. From March 2004, employed by Whitepost as its marketing consultant. Qualified as an RMN.
Son1:	AT's eldest son.
Son2:	AT's second son.
DR2:	Registered Owner of Whitepost. Working full time as a general practitioner in Harrow.

HCC3:	Currently Head of Mental Health Strategy at the HCC. Previously head of the Mental Health Team for the Private and Voluntary Healthcare Division) at the HCC.
J1:	Social Worker working for Dartford CMHT. Appointed as AT's care cordinator in early 2004.
Q1:	Social worker with Wallington CMHT. RR's care coordinator social worker from in or about late 2003.
W12:	Sutton Borough Director, and chair of one of the placement panels involved in RR's placement at Shrewsbury Court.
C7:	Employed at Whitepost as a staff nurse. Qualified as an RNLD.
W9:	Social worker employed by Whitepost.
W8:	Appointed as Registered Manager of Shrewsbury Court following the homicide. Qualified as an RMN.
G2:	Mental Health Act Local Commissioner; visited Shrewsbury Court on the day of the homicide.
CONS1:	Consultant Forensic Psychiatrist. Reported on RR on two occasions in 1990 and 1993.
HCC4:	Senior legal adviser to the HCC.

W17:	Registered manager of Whitepost up to 1998.
CONS7:	Consultant forensic psychiatrist for the community forensic team in Croydon. Provided a report on RR to the Croydon Crown Court in 2002.
G3:	Mental Health Act Manager; member of the panel which heard RR's appeal against the continuation of the section 37 Order on 15 April 2002.
W11:	Assistant Borough Director of Croydon, and chair of one of the placement panels involved in RR's placement at Shrewsbury Court.
W10:	Employed at Whitepost as the "Clinical Nurse Specialist". Qualified as an RNLD.
CONS8:	Clinical director for the adult mental health service in Croydon. Consultant psychiatrist.
DR1:	Employed at Whitepost as a staff grade doctor. Also working, at the material times, full time with the Redhill CMHT's continuing needs and assertive outreach team
BRH1:	Ward manager on Chelsham Ward, Bethlem Royal Hospital whilst RR was an in-patient there. Qualified as an RMN.
G1:	Regional Director of Mental Health Act Commission covering London and the South East

CONS4:	Consultant psychiatrist working at Whitepost, and RMO for RR during his time there. At all material times also working as a consultant psychiatrist with the East Surrey Priority Care NHS Trust.
C4:	Social worker working with Dartford CMHT; involved with AT at the time of her placement at Shrewsbury Court and in the follow-up to that placement.
BRH3:	Staff nurse working on Witley 3 ward at Bethlem Royal Hospital. Qualified as an RMN. Prepared a nursing report on RR for the Hospital Managers meeting of 15 April 2002.
W4:	Employed at Whitepost initially as a staff nurse. AT's Named Nurse for a period in 2002. Subsequently appointed to the post of Clinical Nurse Specialist; then to the post of acting deputy manager and, in March 2004, to the post of Acting Manager of Shrewsbury Court. Qualified as an RNLD.
DR6:	CONS3's SHO on Witley 3 ward at Bethlem Royal Hospital. Prepared a report on RR prior to his transfer to Shrewsbury Court.
CONS3:	Consultant forensic psychiatrist on Witley 3 at Bethlem Royal Hospital.
W3:	Clinical psychologist employed at Whitepost.
W2:	Employed at Whitepost as a staff nurse. RR's Named Nurse. Qualified as an RMN.

J2:	Team Manager at Dartford CMHT. Accompanied both J1 and C4 when they gave evidence to the Inquiry.
HCC1:	Mental Health Inspector employed by the HCC. Inspected Shrewsbury Court in 2004.
W16:	Employed as the training officers at Whitepost. Has a BSc in health studies, an MBA diploma in nursing, and a diploma in teaching. Also qualified as an RGN.
W5:	Employed at Whitepost as a Staff nurse.
CONS9:	Consultant pyschiatrist, and RMO for AT prior to her transfer to Shrewsbury Court.
Q2:	Approved social worker working with Wallington CMHT. RR's social worker in 2002.
W7:	Employed at Whitepost as a staff nurse. AT's Named Nurse for a short period and at time of the homicide. Qualified as an RGN.
DR3:	CONS2's SHO on Chelsham Ward, Bethlem Royal Hospital. Prepared report for the Hospital Managers meeting of 15 April 2002. Visited Whitepost in late 2003.
Q3:	Social worker with Wallington CMHT. RR's care cordinator/social worker from in or about 2002 to late 2003.

ESH1:	Member of the Social Care Team at East Surrey Hospital. Spoke to RR on 1 November 2004.
W15:	Employed as Whitepost as part of the management team; a qualified accountant.
DR4:	CONS2'S Senior Registrar on Chelsham Ward, Bethlem Royal Hospital.
HCC2:	Mental Health Inspector employed by the NCSC and the HCC. Inspected Shrewsbury Court in 2004.
M2:	Mental Health Act Manager for SLaM; member of the panel which heard RR's appeal against the continuation of the section 37 Order on 15 April 2002.
W19:	Employed at Whitepost as a Staff nurse. Qualified as an RNLD.
W14:	Employed at Whitepost initially as a staff nurse. Appointed in August 2004 to the post of acting deputy manager. Qualified as an RMN.

Appendix B – List of interviewees

W13
CONS2
C15
W21
BRH2
C16 – with M3
W1 –
Son1 – with solicitor
Son2 – with solicitor
DR2 – with solicitor (twice)
HCC3 and HCC4
J1 - with J2
W12
C7
W8
G2
CONS7
W11
G3 – with M3
W10
CONS8
DR1
CONS3
BRH1
G1
CONS4 (twice)
C4 - with J2
W4
W3 (twice)
W2
HCC1
RR
W16
W7
HCC2
M2 - with M3
W19

Appendix C - References list

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