Medway Primary Care Trust

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Medway Council

Independent Inquiry into the Care and Treatment of Richard Loudwell

March 2006

Medway NHS
Teaching Primary Care Trust

Medway
COUNCIL

Chair

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All witnesses came to meet with the panel and were able, and willing, to assist. We want to record our thanks. We do not underestimate the stress and worry involved with this type of inquiry. We felt that the generally positive attitude of individuals towards our inquiry process, even when they may have anticipated criticism (and indeed no longer worked for the service) was impressive.

We are very grateful to family members who helped us and we recognise the distress which reliving events caused them.

We could not have completed this report without the support of the team at Verita, in particular Mary Walker, Helen White, Fiona Shipley and Ed Marsden.

ABBREVIATIONS AND REFERENCES

We refer to Richard Loudwell throughout as RL. This is simply because it is a convenient shorthand we chose to adopt during the inquiry process. We have generally referred to individuals by name. We have however referred to Richard Loudwell's sister and brother-in-law as Mr and Mrs D and the victim of the alleged assault committed by RL prior to the homicide as AB.

We frequently refer in the footnotes to transcripts of meetings with witnesses. For example, the reference 'Dr Petch page 4' refers to the fourth page of the transcribed evidence of Dr Petch.

ASW	Approved Social Worker
CAMHS	Child and Adolescent Mental Health Service
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DLA	Disability Living Allowance
GP	General Practitioner
MAPPA	Multi Agency Public Protection Arrangements
MAPPP	Multil Agency Public Protection Panel
MHA	Mental Health Act 1983
OT	Occupational Therapist
SHO	Senior House Officer
SUI	Serious Untoward Incident
PCT	Primary Care Trust

1 INTRODUCTION

1.1 On 2 December 2002 Richard Loudwell (RL) killed Joan Smythe. On 22 April 2004 at the Crown Court at Maidstone he pleaded guilty to manslaughter on the grounds of diminished responsibility. The court ordered that he be made subject to an interim hospital order under section 38 Mental Health Act 1983. RL was then detained in Broadmoor Hospital where he was assaulted on 25 April 2004 by Peter Bryan, another patient. RL subsequently died on 5 June 2004 from the injuries he had sustained. On 15 March 2005 at the Central Criminal Court Peter Bryan pleaded guilty to manslaughter on the grounds of diminished responsibility. The court ordered that Peter Bryan be detained under section 47/49 of the Mental Health Act 1983. This inquiry considers only events to the date of the death of Joan Smythe; RL's killing in Broadmoor is the subject of another independent inquiry. A third inquiry is being conducted into the circumstances surrounding the care and treatment of Peter Bryan prior to his admission to Broadmoor on 15 April 2005.

1.2 National Health Service Guidelines issued in May 1994 require an inquiry to be independent of the service providers when a person in contact with mental health services commit a homicide. This inquiry was initially commissioned by the Medway Primary Care Trust on 21 September 2004. On 24 May 2005 Medway Council became joint commissioners of the inquiry alongside the Trust.

1.3 The inquiry was conducted by: Anthony Harbour (chair), Dr Humphrey Needham-Bennett and Linda Bolter. The inquiry panel started work in October 2004 and was co-ordinated by Mary Walker on behalf of Verita.

Anthony Harbour is a solicitor and partner in a London solicitor's practice specialising in health and social service law. He has chaired other inquiries of this nature. He is a legal member of the Mental Health Review Tribunal and the Family Health Service Appeal Authority.

Humphrey Needham-Bennett is a consultant forensic psychiatrist at the Bethlem Royal and Maudsley hospitals. He is accredited in

general and forensic psychiatry and is the Caldicott guardian for the South London and Maudsley NHS Trust.

Linda Bolter is a Mental Health Act Commissioner, an independent mental health consultant/supervisor and has been a panel member on a number of independent mental health inquiries, including homicide inquiries. She was formerly an Approved Social Worker and mental health service manager with a local authority.

1.4 The terms of reference of our inquiry **(Annex 1)** include reviewing all documentation made available in RL's case **(Annex 2)** and providing a preliminary report to the Medway Primary Care Trust. This report was delivered at the end of March 2005. Following the delivery of the preliminary report, we met with a number of witnesses. **(Annex 3)** This report therefore draws on the preliminary report, all available documentation and the testimony of the witnesses.

1.5 Mary Walker made contact with the family of RL and with the daughter of Joan Smythe. Joan Smythe's daughter did not wish to meet with the team. The family of RL, however, agreed to meet with two members of the team.

1.6 On 23 March 2005, Linda Bolter and Humphrey Needham-Bennett met with RL's sister, Mrs D and latterly also with her husband, at their home in Gillingham. They returned there on 13 April 2005 when Mrs D took them to visit her mother at the farmhouse which was RL's home throughout his life.

2 OVERVIEW OF THE REPORT

2.1 The report begins with a narrative summary of events and an account of meetings with members of RL's family. We then analyse, chronologically, RL's care, treatment and assessment both when he lived in the community and while he was a psychiatric inpatient.

2.2 In April 1998 North Kent Healthcare NHS Trust and Thameslink Healthcare Services NHS Trust merged to create Thames Gateway NHS Trust. In April 2002 Thames Gateway merged with Invicta Community Services NHS Trust to create West Kent NHS and Social Care Trust.

2.3 RL was admitted as an informal psychiatric inpatient on five occasions from 1997 onwards. On each occasion he was admitted and treated on Shelley Ward (a psychiatric ward) at Medway Hospital. The dates of his admissions to psychiatric hospital are as follows:

7.3.97 – 12.3.97
10.2.98 – 23.2.98
2.7.99 – 5.8.99
6.3.02 –12.3.02
25.5.02 – 27.5.02

2.4 He would have been admitted in April 2000 but there were no beds available: 'it was not possible to admit Richard due to a bed shortage.'[1]

2.5 We concentrate our chronological analysis on 2002 because in conducting this type of detailed retrospective inquiry, the greater the distance from events, generally the less that can be learnt. This is mainly because systems, organisations and individuals rapidly move on. 2002 was the year that RL was twice treated as an inpatient and was twice assessed in the community. In December of that year he killed Joan Smythe. It is our view that the lessons to be learnt from our investigation are in the main, but not exclusively, rooted in 2002.

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[1] Dr Mohammed to Dr Bhasme 13 April 2000

2.6 We then turn to the organisations responsible for the care of RL, in particular the Gillingham CMHT. We find that the Gillingham CMHT was not functioning effectively in 2002 when RL was being cared for in the community.

2.7 RL had complex psychiatric and medical needs. We next analyse the various diagnoses that were attached to his psychological conditions. We also consider the treatment he received for his psycho-sexual difficulties.

2.8 A section on care plans follows. Our terms of reference require us to evaluate how far RL's care plans were delivered and complied with. We have considered plans drawn up by Liz Finnerty (social worker) and plans drawn up following his two periods of inpatient psychiatric treatment in 2002.

2.9 Remaining with the delivery of health care to RL, we then look at the contact he had with his GP, Dr Bhasme. As RL's GP from 1994 onwards, Dr Bhasme worked effectively with him and his family while he was responsible for RL's medical care.

2.10 RL was convicted of a Schedule I offence in 2000, he was made the subject of a probation order and was placed on the Sex Offenders Register. He therefore was the subject of statutory supervision by the probation service. From 1999 onwards the police service had contact with RL: dealing with his prosecution for offences of indecent assault, monitoring the risk that he presented in the community while he was on the Sex Offenders Register, and dealing with the investigations of the assault on AB and the murder of Joan Smythe in December 2002. In separate sections we consider the role of both the police and the probation service.

2.11 Our terms of reference require us to look at how far RL's care corresponded with 'statutory' obligations and we consider the application of relevant statutes, namely the Mental Health Act 1983 (MHA) and Carer's (Recognition and Services) Act 1995. Our analysis of the use of the MHA reflects the fact that its use was never explicitly considered in RL's case. Mrs Loudwell's entitlement to assessment under the carers' legislation was never properly met.

2.12 An analysis of the ways in which services comply with the Care Programme Approach (CPA) is central to all the investigations undertaken by independent inquiries following a homicide. We consider these in the CPA section and it is integral to our discussion of risk assessment and joint working. We identify significant deficiencies in compliance with the requirements of the CPA.

2.13 Unlike the CPA, Multi Agency Public Protection Arrangements (MAPPA) were not well developed in 2001 and 2002. RL fell within the ambit of MAPPA and so we have tried to understand the operation of MAPPA at this time, in particular as a vehicle for promoting effective inter-agency communication.

2.14 We have focused throughout this report on the processes of risk assessment and management. The purpose of the section on risk assessment/joint working is to identify how effectively agencies on their own or with others understood the information available to them and reached conclusions. RL's risk assessment throughout his probation order reflected both the experience of Colin Croft and PC McGowan and the use of risk assessment tools available to them at the time; Dr Shobha in her capacity as RL's care co-ordinator concluded that RL's CPA status should change. There was no communication between the agencies represented by these individuals at this time.

2.15 As expected, the organisations involved in the provision of care and treatment to RL evaluated their performance following the homicide. Similarly, both the police and probation services participated in inter-agency (with no health or social service involvement) reviews. We consider the adequacy of these organisational responses.

2.16 In Chapter 18, we deal with the question that we posed to a number of witnesses: how have services changed since the homicide?

Records

2.17 A general observation about the records made available to the inquiry: the records presented by the police, the probation service and social services have been, in the main, clear and comprehensible. They provide clear audit trails. The records maintained by the various arms of the health service

have not been so easily accessible or clear. We have, however, read some clear and accurate records. For instance the March and May inpatient nurse care plans. The apparent absence of records from the CPN service is of particular concern.

Performance

2.18 Some of our appraisal may appear negative; to balance this we want to record that we both heard and read about positive examples of the practice of individual professionals:

- Dr Bhasme who offered ongoing support to the family and made appropriate referrals to mental health services.
- Liz Finnerty who offered regular support to the family and was a good communicator between health, probation and social care services.
- Colin Croft provided diligent supervision and maintained contact with RL's family.
- PC McGowan (who we did not hear from) worked effectively and well with Colin Croft to monitor RL

Many of the witnesses we heard from, particularly those in management positions, expressed an awareness and an understanding of the need for change. We accept that the Gillingham CMHT has undergone many changes since 2002; we were impressed by the forceful advocacy offered on behalf of the current team by Philippa Macdonald, Kevin Lindsay, John Hughes and Claude Pendaries.

Gillingham CMHT

2.19 The organisational context of our inquiry was that in 2001-2002 health and social care staff of the mental health services in Gillingham were located in separate sites and managed by separate team managers. This meant that it was difficult to build constructive relationships and there were frequent examples of disagreements between professionals particularly around admissions to and discharges from hospital. Caseloads were high and there were staff shortages. Procedures were not sufficiently robust to ensure a good quality of assessments, particularly in respect of risk.

2.20 It was partly to overcome these difficulties that Medway Council took its decision to transfer the management of all their mental health services to the West Kent Trust, so that these issues could be addressed. That transfer took place during the summer of 2002, i.e. during the critical period of our inquiry.

MAPPA

2.21 Multi Agency Public Protection Arrangements, that were (and continue) to be developed to assist in the management and risk of particular categories of offenders, were not sufficiently advanced to assist in a case of this nature. This was because RL's problem behaviours, and his mental disorder, were uniquely difficult to assess and did not fit easily into the MAPPA structure that existed at that time.

3 SUMMARY OF EVENTS

3.1 RL was born on the 10 August 1944. He lived in the same farmhouse in Kent all his life, as a child with his parents and two sisters and, after the death of his father in May 1999, solely with his mother. On leaving school, he undertook an apprenticeship and continued to work in Chatham Dockyard until he was made redundant when it closed in 1986. He subsequently found work at GEC Avionics in Rochester, but was again made redundant a few years later. Thereafter he tried several times to find work, including with a kitchen-fitting company, but with no real consistency.

3.2 In July 1994, the GP records indicate that RL was depressed and anxious and he was consequently prescribed an anti-depressant. In August his GP made the first of several referrals to the mental health services, when he was (according to the GP records) seen by a CPN, although no notes of the meeting(s) have been found. Later that year, in November, RL was referred to the psychology department at All Saints Hospital, Chatham for treatment of erectile dysfunction. He was again referred to mental health services in January 1995, when he was once more treated with anti-depressants and during that year continued to see a psychologist regarding relationship problems associated with impotence.

3.3 By March 1996, due to a further period of depression, characterised by RL remaining in bed for lengthy periods, his GP referred him to the emergency clinic, Medway Hospital where he was seen as an outpatient, prescribed an anti-depressant and referred to the Christina Rossetti Day Hospital. He stopped going there in June, was seen again in outpatients in August when he was described as 'doing well' and was discharged from the day hospital.

3.4 By January 1997, after a minor car accident, RL was again treated for depression. He took to his bed for at least four weeks. At this time he was experiencing extreme financial difficulties because he had unwisely loaned a lot of money to a 'friend'. Following a further emergency assessment, RL was informally admitted, for the first time, to the Medway Hospital, from 7-12 March, where he was treated for a 'brief depressive episode'. During a ward round, his sister reported that he had a tendency whilst at home to stand naked at the door. She also highlighted the possible deepening of his financial difficulties. He was discharged to outpatients with anti-depressant

medication. During April, RL's sister drew to the attention of the mental health services his inappropriate sexual advances towards women. Throughout the rest of 1997, he continued to be seen at outpatients, complained of continuing depression and impotence and spent an undue amount of time in bed. By December he had ceased taking his anti-depressant medication.

3.5 In January 1998, at outpatients, RL complained of feeling low, of poor appetite and sleep disturbance and was again referred to the day hospital. However, at the end of January, his GP was sufficiently concerned to request his admission once more. Following a domiciliary visit on 6 February by Dr Rao, where his family raised concerns about his escalating inappropriate behaviour, he was admitted informally to hospital, where he remained from 10 – 23 February. The family's concerns, that his behaviour should be stopped before something regrettable happened, were relayed to the hospital by the GP. At this time RL had a fear of imposing on his parents because of his behaviour and depression. Shortly after his discharge, when he was visited at home by an OT, she noted that he was preoccupied with sexual difficulties and that he touched her three times on the arm in a way she felt was inappropriate.

3.6 Throughout the rest of that year RL continued to be depressed, to have suicidal thoughts and to be concerned about his sexual difficulties. He was referred to a sexual and marital therapist at the psycho-sexual clinic at Medway Hospital. This followed an assessment by a senior registrar who was apparently unable to get corroborative history of his inappropriate sexual advances, as RL attended the clinic alone and flatly denied the allegations.

3.7 By early 1999, RL continued to be depressed, particularly by his lack of employment, but also about his father's deteriorating health. In May, his father died suddenly at dinner in front of the family. Shortly after this, his dog also died and his depression, coupled with suicidal thoughts, led once more to his informal admission to hospital, from 2 July to 5 August, when for the first time in the medical records, RL was described as experiencing psychotic symptoms.

3.8 It was at this time that the police first became involved with the family, as RL's mother had received a number of threatening phone calls from an

older woman who claimed that RL, allegedly her gardener, had stolen property from her. Mental health services independently assessed the woman and identified her as suffering from dementia.

3.9 Following a referral to the Gillingham Mental Health Team on his discharge from hospital, RL's case was allocated to a social worker, Liz Finnerty, who began a care management assessment with the aim of creating a care package to meet his needs. He was placed on enhanced CPA, known at this time as CPA level 3. Shortly after allocation, however, RL was arrested on 30 August, following an alleged indecent assault of an adult female member of his family. She also alleged that he had had sexual contact with her when she was a child, but that no charges had been brought against him at that time. During 1999 the police had concerns for the safety of his mother, as RL was reported to have been abusive and threatening towards her on a number of occasions.

3.10 The nature of Liz Finnerty's work with RL and his mother changed as a result of his arrest. Liz Finnerty provided a significant amount of support to both in dealing with the ramifications of the prosecution. Social work records indicate that the SHO spoke with the consultant, Dr Rao, who concluded that RL's mental health problems were not relevant to his offending and would not have a bearing on the police investigation.

3.11 In December 1999, RL pleaded guilty to indecent assault (both for the current offence and that which had occurred when the victim was a young child) and he was bailed for sentencing. Meanwhile he continued to receive regular support from Liz Finnerty, who had concerns regarding his mental health and referred RL for additional outpatient appointments when she felt it necessary.

3.12 In January 2000, RL was referred by his solicitors to Dr Gilluley, based at the Maudsley Hospital, for the preparation of an independent court report. He stated in his report that RL was the primary carer for his elderly and frail mother and that a custodial sentence would cause a relapse of his depressive illness. Dr Gilluley further contended that RL was not at a high risk of re-offending, noting that both offences were against the same family member and that he had no persistent paedophilic interest or history of predatory sexual offending.

3.13 On 19 January RL's care was transferred from Dr Rao to Dr Shobha. On 11 February, RL was sentenced to a two year probation order with a requirement to attend a sex offenders group and on 15 February, at Rochester Police Station, he was placed on the Sex Offenders Register for five years. For the next few months, he attended the day hospital spasmodically, continued regular contact with his social worker, but remained severely depressed, with delusions of poverty, sleep problems and anxiety about his forthcoming attendance at the Sex Offenders Group.

3.14 At an outpatient review in March 2000, the SHO recorded that RL needed to be admitted to hospital but it was not possible due to a bed shortage. By July, however, he was seen by his consultant, Dr Shobha, who recorded in her letter to the GP that he 'had made a remarkable recovery' and was 'back to his normal self'. By September, however, she found him to be low and depressed, due in part to the proposed commencement of the Sex Offenders Group. This month too, he was diagnosed as suffering from diabetes and referred to the diabetic clinic. In October, he had a change of probation officer to Colin Croft, who shared responsibility for his supervision, with PC McGowan, the Sex Offender Liaison Officer.

3.15 In December, at a CPA review attended by RL and his mother, a decision was reached that his CPA level be reduced and his contact with Liz Finnerty also to be gradually reduced. It was agreed that her involvement would terminate in May 2001, after the ending of RL's attendance at the Sex Offenders Group. Although it is recorded that Liz Finnerty spoke with Colin Croft on 12 December 2000 he was not invited to the CPA review meeting.

3.16 In early 2001 RL was reported as spending most of his time in bed, but he continued to attend his 12-weekly outpatient appointments. In March, police stopped him and searched his car, having received a report from a member of the public that someone fitting his description had been acting suspiciously, climbing over fences, looking in windows etc. Shortly afterwards, RL disclosed to his probation officer that he had had a two year sexual attraction for the female member of his family (whom he was convicted of assaulting) when she was a child.

3.17 In April RL was reported as responding well to the Viagra which had been prescribed for his erectile dysfunction. Police received information at this time, from a child care social worker, that RL was planning to move in with his girlfriend, a woman with young children. In a joint police/social services visit to the woman, she disclosed that they had met through a lonely hearts column and that she had no intention of allowing him to move in, or indeed of seeing him again. Police subsequently had reports that RL was frequently at another woman's home, having been reported by members of the public for parking his car dangerously on the pavement.

3.18 In June, Liz Finnerty closed the case (as agreed in December 2001), following a final visit to the family. RL's CPA level was consequently reduced to standard and the care co-ordinator role passed to his psychiatrist, Dr Shobha, who was seeing him in outpatients. During a visit by the police and probation officer that month, RL's mother and sister expressed concerns about RL's strange behaviour, stating that he had exposed himself to an electrician working at the family home. They also drew attention to his extremely arrogant and argumentative demeanour, and the fact that he was dressing strangely. Subsequently, the police and probation officer decided that they should raise RL's risk assessment from medium to high, as he had admitted exposing himself and there were further complaints from members of the public about his behaviour while working as a kitchen sales adviser. Although at RL's outpatient appointment in July Dr Shobha could find no clinical evidence of depression, by October, Dr Bhasme once more referred him to mental health services, requesting an urgent assessment and community support, as his condition had apparently deteriorated.

3.19 The Gillingham CMHT responded to the GP stating that RL should be referred to Dr Shobha rather than to them. RL was seen once more by Dr Shobha, when she diagnosed him as suffering from a further depressive illness and arranged a further outpatient appointment for 12 weeks' time.

3.20 By January 2002, in a joint visit by police and probation, RL was considered at 'high risk' until after his supervision ended in February, because of his behaviour and attitude. At this point, Dr Shobha considered that his depression was in remission and at around that time the GP noted that RL appeared euphoric. In late February there are numerous records of police

involvement; at one point he was found wandering in Folkestone claiming he had lost his car or that it had been stolen, was apparently mistaken for an illegal immigrant and kept in the cells overnight. On another occasion RL had asked directions of a stranger, with his trousers around his ankles and pornographic magazines were seen in his car. Three days later he was involved in a road accident and the other party considered that RL was drunk; police found him to be vague and confused and took him to hospital, but he was discharged the same night. The GP, being informed of concerns by the family, requested a further urgent psychiatric review.

3.21 Dr Shobha saw RL on 27 February, accompanied by his sister, who re-iterated her concerns that he had been acting strangely for about six weeks, had been aggressive and wandering around naked. He was admitted informally to hospital on 6 March, from the outpatient clinic. He was reported as acting inappropriately to female patients and persisted with this behaviour, despite being requested to stop and being threatened with assault by other patients. RL was discharged on 12 March, apparently because of his sexually inappropriate behaviour, which he had been unable or unwilling to control. His discharge plan made no reference to his CPA status, despite a review the previous day. His medication was changed, including that for hypertension and vitamin B12 was added. He had been referred for a CT scan in view of his behavioural changes, including apparent disorientation. The results of the CT scan were received on 17 June and indicated that he had cortical atrophy.

3.22 On 13 May, in a letter to Dr Shobha, the GP requested an early out-patient appointment and CPN visit, after the family raised concerns about RL neglecting himself, ceasing to take his medication and hoarding it. He was consequently admitted informally to hospital once more on 24 May. He was discharged after three days. Following RL's discharge, Dr Shobha, his care co-ordinator, attended an allocation meeting at Gillingham CMHT with a view to him being assessed, one reason being that the family had asked for more community support.

3.23 RL was assessed by two members of the CMHT, Alex Turner CPN and Matthew Graham ASW on 24 June, but they considered that his presenting problems did not at this point 'warrant CPA care-co-ordination', which is understood to mean he did not meet the criteria for enhanced CPA. A

further visit, on 11 September, this time solely by the CPN, resulted in a similar assessment.

3.24 In early October 2002 police received a report that RL was sitting in a petrol station with a pornographic magazine, with his trousers open and his penis exposed. Dr Ratnaike (locum associate specialist) reported that RL had pre-senile dementia and a referral was made to a psychologist, and his diagnosis changed accordingly. A letter from an SHO (Dr Lam), which once more sought to reiterate RL's need for community support, was answered by the CMHT manager, Edwina Morris, on 21 October, confirming that RL did not warrant CPA care co-ordination. This was the last reference to RL's case by the community mental health services apart from a self-referral by RL for help in completing a further DLA form

3.25 In late November police received worrying reports about RL; a pharmacy sales assistant reported RL had called into the shop, naked from the waist up, discussing intimate sexual details and requesting to take her photograph; RL was found with an 11-year-old girl, who was returned to her home in Margate. On 30 November, RL was arrested for the assault and rape of a man in Canterbury and was taken to Canterbury Police Station, where he was seen by the custody nurse. RL described himself as 'manic depressive and bi-sexual', indicated that he had been in hospital for depression and stated that he had 'no control over his sexual urges'. He was deemed fit for interview and admitted certain aspects of the indecent assault, but denied rape. He was bailed to return to Canterbury Police Station on 31 January 2003. On the 30 November, Colin Croft, the probation officer who had maintained informal contact with RL and his family since the cessation of his probation order in February received a phone call from RL, requesting a visit. Consequently, Colin Croft and PC McGowan visited the farm and met with RL's mother, learning from her that he had apparently visited the GP, returned home and gone to visit a male friend in Cliftonville.

3.26 At 8.00am on 2 December, Mrs D, RL's sister, tried to phone her mother as she was concerned about the impact on Mrs Loudwell of RL's increasingly bizarre and troubled behaviour. She then telephoned Colin Croft to register her concerns and to seek assistance. Mrs D received no reply and left a message on his mobile phone. She then visited the farm and found her

brother to be emotional and suicidal. An argument developed, culminating in RL threatening to take his own life. At 9.45 the same morning, Mr D, RL's brother-in-law, telephoned and spoke to RL and asked him to remain at home. Mr D described RL's behaviour as almost childlike, manic and threatening.

3.27 Evidently RL decided not to remain at home and instead drove to Rainham. Here he met an elderly woman, who coincidentally lived in the same property as an aunt of his (although in a separate flat). He apparently assisted her home with her shopping and was invited indoors. RL sexually assaulted and killed Joan Smythe in her home later that day. He was subsequently convicted of her homicide and was undergoing assessment in Broadmoor when he was assaulted by another patient and later died from his injuries.

4 RICHARD LOUDWELL'S FAMILY

In this section of the report we refer to RL's sister as Mrs D and her husband as Mr D.

4.1 Mr D had known RL since childhood and they continued to be friends when they worked together at the Chatham Dockyard. The friendship cooled, however, when they were about 20, when Mr D felt that RL started to change, behaving oddly, being unable to mix well with others and at times being verbally abusive.

4.2 Mr and Mrs D had become aware of RL's sexual interest in a member of the family when that person was a young girl, but discussion of this had caused a rift within the family and had not been reported at the time. (The offences for which RL pleaded guilty in 2000 were indecent assaults perpetrated both on this family member when she was a child and when she was an adult.) Mrs D indicated that 'things started to go wrong' for her brother in about 1992, when he took to his bed for weeks at a time. When he subsequently rose, he seemed to bring chaos to the family; making a huge loan to a 'friend', which was never recovered, making bizarre purchases, often behaving and dressing inappropriately and frequently being naked around the house.

4.3 According to Mrs D, RL was coarse, hateful and abusive towards his mother on occasions. Mrs Loudwell drew attention to his habit of scribbling things down on paper, his lessening interest in working in the garden, which he used to enjoy and that, to her knowledge, he had never had a proper girlfriend. She was therefore pleased when he proposed to a woman, but was also mindful that he may have been financially exploited by her. Mr and Mrs D indicated during the interview with panel members that they had both been concerned that RL might 'do something terrible' one day if he did not get the help he needed.

4.4 In terms of the contact which RL and the family had with professionals, family members considered their dealings with the social worker, Liz Finnerty, to be positive. Apparently she was helpful in her endeavours and interactions with them and worked hard for RL. Mrs D indicated that once Liz Finnerty had closed the case, the GP, Dr Bhasme, became their sole

source of contact in a crisis. Dr Bhasme apparently visited the farmhouse quite readily when requested at times of difficulty.

4.5 The family members told us that they were unhappy in that they had expressed concerns to various other health professionals which they felt had not been taken seriously. Apparently Mrs D had taken her brother to Shelley Ward, Medway Hospital on a number of occasions. She had attended case conferences/CPA meetings and felt that these did not help, but pushed the problem on to someone else. Family members were not aware of any crisis plan from the hospital. Mrs D added that she had seen a number of different doctors at Medway Hospital, but felt both that the family were not listened to or believed. Mr D felt that their dealings with hospital staff were 'an utter waste of time; he's there because of a mental problem, but when it happens, they discharge him'. (This was a reference to RL's inappropriate sexual behaviour towards other patients on the ward, which led to his discharge in March 2002.) When asked if the question of 'sectioning' RL had ever been discussed with them, they confirmed this had not arisen. Mr D said that if RL was given the opportunity, i.e. was unaccompanied, he would touch people; hence they would never leave him alone with the grandchildren.

4.6 The family told us that they had kept a diary demonstrating that RL was spending 23 hours in bed and caused chaos when he got up. They said that staff seemed to believe he was the carer for his mother, whereas the opposite was in fact the case. Mr and Mrs D stressed that RL had the capacity to deceive professionals, with plausible denials of family-based concerns.

4.7 Although Mr D was somewhat scathing about the effectiveness of the 'Sex Offender Treatment Programme,' the family were, nonetheless, grateful for the support and assistance they received, latterly on an informal basis, from the probation officer, Colin Croft. In fact, on the day RL committed the homicide, Mr D confirmed that he had written to Colin Croft, voicing his extreme concerns, because he felt that Colin Croft was the only person who might 'do something useful' as there was 'no-one from Medway interested'. They had also telephoned Colin Croft and left a message on his answer phone, seeking his help.

Comment

4.8 The key issue was that the family felt they were not listened to, that their concerns were minimised and so they felt excluded from any decision making process. The family because of their knowledge of RL had significant ongoing information about his behaviour. The risk assessors from mental health services, particularly in 2002, failed to give this information the weight that it deserved.

5 CARE, TREATMENT and ASSESSMENT

Psychiatric care and treatment before 2002

Inpatient treatment

5.1 RL was admitted as an informal psychiatric inpatient to Shelley Ward, Medway Hospital, on three occasions before 2002. A brief summary of the circumstances of his admissions follows:

> 7.3.97 – 12.3.97 – RL was referred to hospital by Dr Bhasme, his GP, with a history of depression and suicidal ideas. He was admitted, diagnosed as having a depressive episode and advised to continue anti-depressant medication
>
> 10.2.98 – 23.2.98 – RL was admitted following a domiciliary visit by Dr Rao, Consultant Psychiatrist. RL was tearful and felt he had nothing to live for. He had been neglecting himself and had reduced appetite. Dr Rao noted his high level of anxiety and a fear of imposing on his elderly parents. On admission, muddled thoughts, poor concentration and lethargy were noted. His medication was changed to a new anti-depressant.
>
> 2.7.99 – 5.8.99 – RL was admitted due to lethargy, irritability, low mood and odd behaviour. He was reported to be scared of using electricity. He was diagnosed as having a severe depressive disorder.

Comment

5.2 From 1997 there appears to have been clear evidence of a relapsing depressive disorder with some evidence of these relapses being associated with non-compliance with medication or social pressures, for example his father's health, failure to find regular work and the death of a pet. RL's illness was characterised by low mood, sleep disturbance, tearfulness, self-neglect and spending much of his time in bed. With the benefit of hindsight, there appears to have been some worsening of his condition throughout this period with psychotic symptoms and increasing severity of depressive disorder noted in the 1999 admission.

5.3 Throughout this period, there are references to RL's inappropriate attire, his making sexual advances to women and his complaints about impotence and ruminations about sexual inadequacy. While his impotence may have been explained by physical health problems (i.e. diabetes) and his ruminative concerns may have related to his depressive disorder, it is unclear how those treating RL regarded the relevance of his sexual advances to women in the context of his pre-existing diagnosis and personality. RL often blamed his impotence on the prescribed medication which may have accounted for his non-compliance. It was shortly after his third admission in 1999 that he was arrested (on 30 August 1999) for indecently assaulting a member of his family.

Outpatient treatment

5.4 From his third admission in 1999 to his admission in 2002, RL continued to attend outpatient follow up. In March 2000 he was noted to be severely depressed and expressed delusions of poverty and sleep disturbance. His delusions of poverty had improved somewhat by April 2000 although he continued to experience a number of physical complaints such as headaches, abdominal and chest pain.

5.5 The difficulties in evaluating his fluctuating mental state can be simply illustrated: on 13 July 2001, Dr Orimalade (SHO to Dr Shobha) was writing to Dr Bhasme stating that RL's condition had improved since the last review and that he was 'very well' with 'no clinical evidence of depression.'[2] By 9 October 2001, Dr Bhasme was writing to the CMHT requesting an assessment.

Comment

5.6 As previously noted, the main focus of our inquiry commences in 2002. However, we note that by 2001 there was substantial information potentially available to mental health services. This never led to an attempt to understand the relationship between his mental condition and the reasons for his offending.

[2] Dr Orimalade to Dr Bhasme 13 July 2001

The March 2002 admission

5.7 The information that was available to the treating team on his admission on 6 March 2002 was summarised by Dr Raleraskar, Associate Specialist to Dr Shobha, as:

> *Richard behaving very odd and strange wandering around, sometimes confused aggressive towards mother...*[3]

5.8 The nursing care plan, prepared shortly after his admission, stated:

> *[RL] needs to obtain full mental health assessment related to sudden change of behaviour as evidence [d] by disorientation, euphoria, unable to recall events, aggression, socially inappropriate behaviour.*[4]

5.9 The purpose of the admission, so far as Dr Shobha was concerned, was to conduct a reassessment of him:

> *because he was never assessed under my care before... because of the repeated concerns of the GP and the family, we wanted to do a reassessment and to reassess his needs.*[5]

5.10 On 9 March 2002, an entry in the notes reports that his actions (implying sexual remarks to others) were putting him at risk of retaliation from other patients. This is confirmed in a further report on 10 March 2002 when it was recorded that others were threatening to hit him. He was told 'in no uncertain terms' about desisting from making such remarks to others. It would appear that throughout this period RL kept promising to desist from repeated sexually provocative and disinhibited comments to others, although he did not do so.

5.11 On 11 March 2002 there was a ward round and the notes suggest Dr Shobha was advised of RL's disinhibited sexual remarks and his inappropriate dress.

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[3] 6 March 2002 Dr Raleraskar's notes
[4] Inpatient nursing care plan 7 March 2002
[5] Dr Shobha (first interview) page 21

The ward round further heard from his family (mother and sister) on issues relating to his memory problems and his money spending. His family was advised that the team could find no evidence of mental illness. The ward round heard that his mother '...does everything for him'. Mrs D, his sister stated that RL had been stopped by the police and he appeared to be lost and was unable to find his car. The ward round further heard that he would remain on the 'sex offenders' list' for another three years.

5.12 Plans were made for an urgent CT brain scan and for his discharge 'on Wednesday'. If he made further sexual remarks RL was to be discharged immediately. [6]

5.13 On 13 March 2002 a Dr Chang (Locum SHO to Dr Shobha) was advised, by nursing staff, that RL was making further sexually disinhibited remarks. Dr Chang spoke to Dr Shobha who advised Dr Chang to set in place the discharge plan. The discharge plan reports that crisis relapse indicators consisted of 'feeling anti everything, mood changes and sleep changes'. The intervention which was advised at this point was to seek advice from the GP and an urgent duty psychiatric assessment.

5.14 The reason for RL's discharge was his sexually inappropriate behaviour, which was referred to on a number of occasions. He was regarded as a risk to other vulnerable patients on the ward. He was castigated by staff for his inappropriate behaviour towards women on the ward. RL was even told he would be discharged if the behaviour did not cease.

5.15 As a consequence of the March assessment, Dr Shobha and the team came to a provisional differential diagnosis of organic disorder possibly due to head injury or hypertension. There was no evidence of 'active mental illness or florid mental illness.'[7]

5.16 Dr Shobha and the team decided RL's detention under the Mental Health Act was not warranted. No arrangements were made to transfer him to another unit, no forensic assessment was arranged and he was not placed on

[6] Inpatient's progress record - 6, 8,11,12 and 13 March 2002
[7] Dr Shobha (first interview) page 23

enhanced CPA. 'We decided to continue the investigation and the needs assessment in the community.'[8]

5.17 The information that Dr Shobha provided to the inquiry team in justifying the decision not to ensure that he was placed on enhanced CPA prior to his discharge, was as follows:

> *RL was a good attendee at outpatient clinics and his mental state was regularly monitored by Dr Shobha's associate specialist, a senior experienced doctor. RL was also seen by Dr Raleraker [sic] for psychosexual counselling at that time. On discharge he was due to have regular frequent outpatient appointments with further investigations...* [9]

5.18 No proper risk assessment was completed before RL's discharge. If it had been, the following facts would have been established from Dr Raleraskar's admission summary; it was known that the GP was concerned, RL was behaving aggressively and oddly, had a possible head injury, was sexually disinhibited on the ward, had a history of indecent assault, had seen a probation officer and had attended a sex offenders group. Also Dr Raleraskar had not seen RL for any psycho-sexual counselling since 1998.[10]

5.19 Dr Shobha had no communication with Colin Croft or PC Mcgowan. If she had, she told us she would have considered obtaining a forensic assessment. RL's probation order ceased in February 2002, although he remained on the Sex Offenders Register. This meant that the process for formal communication between health, probation and police services was via Multi-Agency Public Protection Arrangements (MAPPA). At this time MAPPA was a new process and still being developed. At the level that RL's risk was assessed there was no routine involvement in the process by mental health services. Unless, therefore, there were existing links between Dr Shobha (as care co-ordinator) and the probation officer about RL's case, there was little chance of communication about risk.

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[8] Dr Shobha (first interview) page 23

[9] Dr Shobha's written statement to inquiry.

[10] Dr Raleraskar, told the panel that the 'only involvement I had as a psychosexual therapist with him was in May and July 1998, page 5.

Comment

5.20 We read in the minutes of the ward round on 11 March 2002 that the relatives were told that no signs of mental illness could be found.[11] This was at the time when Dr Shobha told us that her preferred diagnosis was one of organic disorder due to head-injury or hypertension. We can see no evidence that the relatives were ever told about this diagnosis. The discharge summary (sent to Dr Bhasme) does not contain any information about this preferred diagnosis. As Dr Shobha was now considering organic disorder, we found it surprising that the relatives and the GP were not notified of this fact.

5.21 If the Eligibility Criteria in the CPA guidance[12] in use in 2002 had been applied – see table below – we have no doubt that RL would have been eligible for enhanced CPA.

The Eligibility Criteria	Application in RL's cases
Recurrent moderate and severe depressive disorder	Recurrent depressive disorder
Severe organic disorder	Organic disorder possibly due to head injury or hypertension
Heightened level of risk relating to self harm	RL had a history of a relapsing severe depressive disorder – now with unusual and new behaviour. This, at the very least, should have raised the statistical risk even if it could not be inferred from his own accounts.
Heightened level of risk relating to harm to others	Sex Offenders' Register
Additional needs caused by personality factors	March 2002 admission – aggression prior to admission and inappropriate sexual behaviour on ward.

5.22 In March 2002, those caring for RL were seeking understanding for a diverse range of increasingly problematic behaviours, including 'socially inappropriate behaviour.' Yet when these behaviours were repeated in an inpatient context, they were not managed, he was simply discharged. If a risk analysis had been undertaken before RL's discharge it would

[11] Inpatient records 11 March 2002
[12] Care Programme Approach; Joint Policy between Thames Gateway NHS Trust, Medway Council Social Services and Kent County Council Social Services, Appendix 4 Eligibility Criteria for Enhanced CPA, (The policy we have read was undated, although we were advised, operational until September 2002).

have been possible to have predicted a probability of further disinhibited behaviour, on the basis of RL's pattern of increasingly disturbed behaviour and previous sexual offending. As Dr Shobha agreed, RL being on the Sex Offenders Register 'would have heightened any evaluation of risk.'[13]

5.23 We consider that the decision to discharge RL in March without ensuring he was placed on enhanced CPA was a mistake. There were alternative ways to address his management rather than with the threat of discharge, for example, moving him to another inpatient facility, possibly an all-male ward, where an assessment could have continued. At the very least, placing him on enhanced CPA, with a carer's assessment requested, should have been arranged before his discharge. Had it been decided he was not detainable and that he should be discharged because of his behaviour, a post-discharge meeting should have been arranged.

5.24 Taking into account all the reported information available to Dr Shobha and the inpatient team, we fail to see a reasonable argument to discharge him without a clear(er) formulation of risk and a management plan which should have been under enhanced CPA. The historical information available to them was also not summarised or analysed.

The May 2002 admission

5.25 RL was again admitted on 24 May 2002. It would appear that this admission was precipitated by the discovery of his hoarding anti-depressant medication in the lead-up to the anniversary of his father's death, coupled with non-compliance with medication, self-neglect and a tendency to isolate himself. The inpatient nursing assessment on admission refers to RL not attending to self-care, not coping, spending increasing time in bed, being dishevelled and still awaiting an urgent CT scan.

5.26 Dr Oke (SHO) advised the subsequent ward round that RL did not want to remain on the ward, and as it was judged at this stage that he was no longer suicidal, the decision was taken to discharge him. Throughout this

[13] Dr Shobha (first interview) page 12

three day period as an inpatient, RL remained unmotivated, quiet, subdued, had minimal interactions with others and still wore inappropriate clothing.

5.27 The May admission lasted from 24 to 27 May 2002. RL's behaviour during that time was not characterised by the disinhibited behaviour that had occurred in March. The focus of the assessment and treatment related to his depression and there is no reference in the inpatient notes to the diagnosis of organic disorder described by Dr Shobha in relation to RL's March admission. Before his discharge on 27 May 2002 there was a ward round. Dr Shobha told us that she was clear by the time of this meeting that RL should be on enhanced CPA. Even though Dr Shobha may have been clear, her views were not apparently communicated to others and were not reflected in the minutes of the ward round. The hand-written notes of the ward round refer to:

> *Kevin Halpen may be replacing Liz Finnity [sic] probably Alex Turner*

5.28 While this suggests the appointment of a care co-ordinator (we note that Liz Finnerty left the CMHT around December 2001), typed minutes of the ward round meeting refer to RL being on standard CPA and:

> *Geoff is to ask Alex to see Richard. HE MUST HAVE MALE WORKER [sic] because of his sexual orientation toward women.*

Comment

5.29 No proper risk assessment was undertaken before RL's discharge in May. For instance, there was no attempt to link the risk information available after his March admission with the risk information obtained from the May admission. On one level the purpose of the admission was satisfied, insofar as his mental state was evaluated to eliminate concerns that he was a suicide risk. By this time, however, the information about the risk that he presented was incomplete and partial. RL was discharged from hospital because he did not want to stay, and he was no longer regarded as at risk of suicide.

5.30 Dr Shobha's explanation for concluding that RL was eligible for enhanced CPA following the May inpatient admission, and not eligible in March was

because further concerns had been expressed to her since March by Dr Bhasme, RL's GP.[14] We found her reasons puzzling given that the documented risks to others that RL presented in March seemed more concerning than in May. The provisional diagnosis of severe organic disorder offered by Dr Shobha in March was potentially serious and was barely alluded to in the May inpatient notes.

5.31 There was a lack of clarity around RL's CPA status following his May discharge which we regard as being symptomatic of the poor communication, poor relationships and organisational confusion that appeared to be characteristic of the operation of the Gillingham CMHT during 2002.

The allocation of RL's case

5.32 In 2002 the procedure for allocating cases within the Gillingham CMHT was either at weekly team meetings, or by direct referral from the manager of the team to a worker[15]. We have not been provided with any minutes of the allocation meetings and we do not know the date of the meeting attended by Dr Shobha. (It would have been between RL's discharge from hospital on 27 May 2002 and his assessment by Alex Turner and Matthew Graham on 24 June 2002.)

5.33 Dr Shobha attended the team meeting at the Gillingham CMHT with the purpose of arranging for an assessment. Edwina Morris remembered Dr Shobha specifically attending this meeting. Edwina Morris told us that Dr Shobha:

> *felt that he needed to be allocated. There wasn't much she could do, he wasn't really taking the medication properly, she wanted it monitored and she needed someone to make an assessment to see what we could offer… She wasn't asking for us to take the case, just for an assessment at that stage.*[16]

[14] Dr Shobha (second interview) page 17
[15] Geoff Turner (first interview) page 10
[16] Edwina Morris page 9

5.34 Dr Shobha summarised the view of the CMHT as being:

> *We can't put him straight on enhanced and there has to be an assessment.*[17]

5.35 We have also been provided with the Clinical and Practice Review Report into the care of RL, which met on 13 January 2002, to provide the Trust with an analysis of the events surrounding the homicide. Dr Shobha was part of the review. It is stated in the review document that:

> *she attended the CMHT allocation meeting specifically to ensure that a community assessment was undertaken by the CMHT.*[18]

5.36 Dr Shobha identified that in 2002 (and before) decisions were made at CPA, and other multi-disciplinary meetings, by professionals without reference or consideration to medical opinion. We have seen a letter from Kevin Lindsay dated 26 July 2002 to 'all team managers.' The letter states:

> *If a patient has been seen and assessed by a Consultant Psychiatrist and following this assessment the patient is referred onto the CMHT, it is the Team Leader's responsibility to ensure any proposed treatment or follow up is allocated (in the absence of the Consultant Psychiatrist from the allocation meeting). Any alteration to the Consultant Psychiatrist's prescribed treatment/follow-up should be discussed and agreed with the Consultant Psychiatrist prior to any change being implemented.*

Comment

5.37 Even if Dr Shobha had concluded that RL was eligible for enhanced CPA by the end of May this was not clearly recorded and communicated. Dr Shobha was able to initiate only a community assessment. Kevin Lindsay's letter post dates Dr Shobha's request for an assessment of RL, and is therefore not directly relevant to events in May and June, although it sheds light on some of the difficulties to which Dr Shobha alluded.

[17] Dr Shobha (second interview) page 24
[18] Clinical and Practice Review into the Care of RL 13 January 2003 page 2

The June assessment

5.38 Alex Turner (CPN) and Matthew Graham (ASW) conducted the June assessment of RL. Alex Turner described his role in the June assessment as being:

> *To engage with him and his mother in the context of an initial visit*[19]

5.39 The purpose of the assessment, so far as Alex Turner was concerned, was:

> *to determine what extent, if any, RL's day to day life may have been impacted upon by an experience of mental health problems*[20]*.*

5.40 Matthew Graham regarded the purpose of the assessment to assess RL's mental health needs and to:

> *Look at what support, if any, we would be able to offer to RL*[21]

5.41 He regarded the meeting as an opportunity to meet the user, share information and to formulate an opinion to present back to the team meeting.

5.42 No written referral was available to Alex Turner or Matthew Graham. Alex Turner considered that, with hindsight, he should have been more assertive in requesting a written referral.

5.43 Alex Turner was not able to recall the preparation he undertook for the first meeting, although he stated:

> *I would have done some digging around*[22]

5.44 Matthew Graham said that he did not have any communication with the probation service, although he knew that RL was on the Sex Offenders Register and subject to a probation order. He accepted there had been little preparation time before the assessment and it appears unlikely that

[19] Alex Turner page 7
[20] Alex Turner page 17
[21] Matthew Graham page 3
[22] Alex Turner page 7

he had a chance to read the inpatient records relating to the March and May admissions.

5.45 Alex Turner and Matthew Graham reached a conclusion that RL was not eligible for enhanced CPA. This conclusion did not appear to be reached on the basis of the application of CPA criteria, and no CPA documentation was completed. Alex Turner justified their joint conclusion on the basis that

> *RL was himself dismissive of psychiatric and social services and expressed no wish for community interventions.*[23]

5.46 Matthew Graham was co-signatory of the letter that stated that RL did not 'warrant CPA care co-ordination'. When asked what he meant by this Matthew Graham said:

> *He didn't present as having any kind of acute mental distress that would have warranted any support from an enhanced mental health service.*[24]

5.47 Alex Turner then took the case back to the team meeting and shared his findings with the team. We have not seen any minutes of these meetings, as they were not made available to us.

The August assessment

5.48 Alex Turner conducted this assessment on his own. This was prompted by a verbal request from Dr Raleraskar.

> *I am being asked to go back there because he's not eating and drinking. From his own account and his mother's account, lo and behold he's eating and drinking all right now and he's not spending so much time in bed.*[25]

5.49 As a consequence of this visit Alex Turner again concluded, as he had in June, that RL did not 'warrant CPA care co-ordination.'

[23] Alex Turner's letter to inquiry team 7 September 2005
[24] Matthew Graham page 7
[25] Alex Turner page 15

5.50 In his letter to Dr Shobha, Alex Turner referred to RL as being on the Sex Offenders Register. Alex Turner explained that he did this to signal concerns to Dr Shobha, with which he did not feel competent to deal.

5.51 The August assessment did not develop the earlier assessment further. Alex Turner focused on the existence of a depressive disorder, found none, and again concluded that RL did not warrant CPA care co-ordination. There was no evidence that the application of CPA eligibility criteria, the completion of a CPA risk inventory and the possibility of a carer's assessment had been considered.

Comment

5.52 Both Alex Turner and Matthew Graham put their dealings with RL in the context of their other commitments. Alex Turner told us that there were two other people on his caseload who he regarded as presenting a much greater risk than RL. Matthew Graham told us that he felt under pressure at the time as he had just completed his ASW training and was care co-ordinating around 25-30 cases. He felt that this sense of being overwhelmed may have been a factor impacting on his approach to the RL assessment. He also stated that he had not had any supervision for about 18 months. We were not able to reconcile this evidence with the evidence from his supervisor, Geoff Turner, which contradicted this statement.

5.53 When Alex Turner and Matthew Graham were first asked to assess RL in June they were not given a clear brief by Dr Shobha, RL's care co-ordinator. In turn they did not seek clarification from her. We consider that Alex Turner and Matthew Graham's decision that RL was not eligible for enhanced CPA in June, and Alex Turner's decision in August, were both incorrect. The mistake was made for a number of reasons:

a. **A lack of clarity in the original referral. Dr Shobha considered that RL, at least in May, met the criteria for enhanced CPA. Alex Turner told us that he was not aware of her views. A written referral clarifying the risk issues identified by the inpatient team would have assisted.**

b. Essential information both as to diagnosis and risk was not available to the assessors. For example, when Alex Turner focused on the diagnosis of a depressive disorder in August, he was not aware of the diagnosis of severe organic disorder made by Dr Shobha following the March and May inpatient admissions. We consider it unlikely that before undertaking the June assessment either Matthew Graham or Alex Turner was aware of the risk factors that would have been apparent from the March and May inpatient admissions. They would also not have been aware of the concerns about RL's behaviour identified by the police and the probation service, because by this time there was no contact between these agencies and mental health services. We do not consider that Liz Finnerty's notes had been read by either Matthew Graham or Alex Turner. If they had been read then two essential strands of information would have been identified: that RL had complex needs and that it was possible to work effectively with both him and his mother.

c. The CPA criteria were not robustly applied. No comprehensive CPA risk assessment was completed in either June or August.

d. RL's unwillingness to engage with services was rationalised as a reason for not offering him a service. We do not consider this to be a correct analysis as RL had engaged with other professionals, namely his previous care co-ordinator Liz Finnerty and his probation officer Colin Croft, as well as his GP, Dr Bhasme. Also we do not consider that the pressure on the team in 2002 was any greater than it was in 2000/2001. At that time Liz Finnerty had been the care co-ordinator and had managed to be in contact with RL and/or his family at least weekly for some periods of her involvement. We note that Dr Bhasme considered that some of RL's needs would have been met by regular visits:

> *He wanted mainly somebody to talk to him really, a bit of counselling ongoing, whenever he is down...*[26]

[26] Dr Bhasme page 13

e. It is also possible that the lack of clarity between Alex Turner and Matthew Graham as to who was responsible for the case hampered the gathering of information, for example making contact with the probation service, or reading Liz Finnerty's notes. As Alex Turner and Matthew Graham did not consider that RL required enhanced CPA, neither regarded themselves as his care co-ordinator and therefore no responsibility was allocated for gathering information beyond what they regarded as necessary to conduct their assessment/s.

f. There appeared to be limited communication between members of the same team, even though the care co-ordinator (Dr Shobha) and the community assessor (Alex Turner) worked together. Alex Turner told us that he never discussed the case with Dr Shobha; Dr Shobha told us that she had discussed the case with him. We were not able to reconcile this conflict of evidence.

CPA eligibility

5.54 Edwina Morris was the manager of the Gillingham CMHT at the time of the June and August assessments. Her approach to RL's CPA eligibility was contradictory. She said that RL was not eligible for CPA because he did not want help; she also accepted that one of the eligibility criteria for enhanced CPA was non-compliance. In discussing the eligibility criteria Edwina Morris accepted that RL was eligible both in terms of his diagnosis and his multiple care needs. Her analysis was seemingly pragmatic; she accepted that the phrase 'Richard's problems do not at this stage warrant care co-ordination' actually meant something different. In reality she considered that the type of service that RL needed simply could not be provided:

> *What I heard from Geoff and Cec was that they felt that the input we could give would not help RL. There was no way we could do assertive outreach; there was no way we could have done, at that stage. We had so few members of staff with so many cases to monitor, there was no way we could actually put in someone to visit*

him, like on a weekly basis, or on a daily basis to monitor medication.[27]

5.55 We also wondered whether Edwina Morris's response was partly characterised by difficulties in her working relationship with Dr Shobha. John Hughes told us:

> *The one thing I can remember of my early supervision sessions with Edwina Morris is that she would be saying Dr Shobha is always making requests to the team. She doesn't understand that we don't have the staff. We don't have the resources.*[28]

Comment

5.56 Edwina Morris rationalised RL's reported unwillingness to engage with the service as a reason for not offering him a service. This was an approach also adopted by the community assessors. We do not consider this to have been a correct analysis. If he was eligible for a service which could not be provided, then this should have been recorded as an unmet need.

5.57 There is also a fundamental contradiction here, as identified by Kevin Lindsay when he gave evidence:

> ***If they felt that he needed an Assertive Outreach service, then why say he did not need an enhanced service?***[29]

Outpatient psychiatric care

5.58 Between his two hospital admissions in 2002, RL was, in the main, monitored by regular review in psychiatric outpatient clinics, and in meetings with his GP. Following his discharge from hospital at the end of May 2002, RL was seen in Dr Shobha's outpatient clinic. He was seen on 7 June 2002 (he had stopped taking medication), 12 July 2002, 9 August 2002, 11 September 2002 and 18 October 2002. (At this last appointment he was

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[27] Edwina Morris page 9
[28] John Hughes page 8
[29] Kevin Lindsay page 14

given another appointment to attend in eight weeks – the homicide occurred on 2 December 2002.)

September - the request for a further assessment

5.59 Dr Lam (Locum Staff Grade to Dr Shobha) saw RL on 13 September 2002 in an outpatient clinic. He reported features of recurrent depressive disorder of moderate severity, with RL not washing, poor self-care, spending much of his time in bed and pondering matters without achieving any targets. Dr Lam then wrote to the Gillingham Mental Health Team:

> *I reviewed Mr Loudwell on 13 September; he has features of a recurrent depressive disorder (moderate severity). He is not washing, his self-care has deteriorated and he spends most of his time at home in bed, pondering over matters without achieving any targets. He stated that he called the community befriending scheme who then informed him that "this is not a dating line." This set back has made it very hard for him to find basic trust in other schemes and he has not been able to muster up sufficient motivation to engage.*
>
> *I think there are severe reservations regarding his management: currently his regular input is a psychiatric outpatient appointment lasting twenty minutes, primarily based on medication review. He does not exhibit sufficient motivation nor structural/team support in the community to achieve a successful change in his daily life. Mr Loudwell's mother also confirmed that although Richard has not deteriorated to the extent of previous years he has certainly not moved on. I have titrated up his Venlafaxine to 225mgs once a day in order to treat his depressive symptoms. However depression cannot be treated in a social vacuum and this question of community input needs to be addressed if Richard's mental health issues are to be tackled seriously. I would appreciate another assessment with regards to meeting Richard's needs. From my brief experience of meeting Richard I cannot advocate any directive approaches without actual implementation and it is quite clear from both Richard's and his mother's report that he is unable to achieve direction following instruction to engage with a social*

network, his symptomatic procedures have become too entrenched over the years to respond to such a light intervention and requires much more in terms of rehabilitation in the community.

5.60 On 21 October 2002 Edwina Morris wrote in response to that letter from Dr Lam, dated 16 September 2002, that 'it does not appear that he would warrant CPA care co-ordination.'[30]

Comment

5.61 The letter from Dr Lam was calling for a further assessment and multi-disciplinary team involvement under CPA. We regard the response from Edwina Morris as wholly inadequate. Dr Lam identified a serious mental disorder and a deterioration in RL's condition. We note that Dr Lam did not refer to the diagnosis of organic disorder reported to us by Dr Shobha when she gave evidence. That information should have triggered a further assessment. The response simply rehearsed the earlier reasons for non-intervention, reasons which we have discussed previously as having little substance. It is also apparent that the absence of a proper risk assessment earlier in the year was now severely impacting some months later, on the ability of the CMHT to respond properly.

[30] Edwina Morris to Dr Lam dated 21 October 2002

6 ORGANISATIONS RESPONSIBLE FOR THE CARE AND TREATMENT OF RL

NHS TRUSTS

6.1 From July 1999 to April 2002 the statutory authority/ies responsible for the management of the Gillingham Mental Health Team were Medway Council Social Services Department together with Thames Gateway NHS Trust. From April 2002 the provision of mental health services passed to West Kent NHS and Social Care Trust, and social services staff were seconded to the Trust (remaining in the employment of the Council.) Lead responsibility for commissioning mental health services was transferred from West Kent Health Authority during 2002 to five Primary Care Trusts including Medway Primary Care Trust:

> *We don't have a properly pooled budget. It would be my wish that we should have but we are working towards doing that now. We run parallel budgets for the mental health services. The mental health service budgets are committed by the PCT, but the fact that the largest proportion of those budgets is staffing, and the staff are employed by the council and seconded to the West Kent Trust, it means that we still have the money in our accounts. However, the decisions taken about how to spend the money are taken by the staff in the West Kent Trust and, indeed by the Medway Primary Care Trust.*[31]

6.2 Within the West Kent NHS and Social Care Trust, the Gillingham Community Mental Health Team (CMHT) was one of three CMHTs delivering mental health care to the residents of the Medway towns.

THE GILLINGHAM CMHT 2001 AND 2002

Integration

6.3 When Ann Windiate took over as Director of Social Services for Medway Council in July 1999, her view was that the CMHTs were not at all integrated and that little advance had been made in integration[32]. John

[31] Ann Windiate page 2
[32] Ann Windiate page 2

Hughes told us the service was essentially operating as a series of different services.[33] Kevin Lindsay stated that the 'concept of "team" did not really exist[34]' at the time he began his job as Director of Mental Health (East) West Kent NHS Mental Health and Social Care Trust in April 2002.

Resources

6.4 The Gillingham CMHT was delivering mental health services in a deprived area with a high incidence of psychiatric illness. We were told that the Medway towns' mental health services had always been under-resourced, and at the 'critical time' (2001 to 2002) the proportion of funding in mental health seemed to be significantly less than in other areas.[35] Mike O'Meara told us that in 1999 the Trust received money to develop community services and extra money was allocated to appoint CPNs for Gillingham.[36] From a social care perspective Ann Windiate informed us that it was health teams that were under funded not the social care teams:

> *There were sufficient posts to recruit to but never sufficient qualified Approved Social Workers to fill them, no matter how many times we advertised. As a result we continued to try and 'grow our own' and train people in house. Another factor here was that Medway's staff were paid on different scales from Kent's staff, so there was difficulty in retaining people in Medway.*[37]

6.5 John Hughes' approach to suggestions that resource difficulties faced by the Gillingham CMHT contributed to the problems in 2001 and 2002 was that there was an absence of objective evidence, although he accepted that the team had to deal with a large number of referrals, large caseloads were carried and there were not enough staff. He did not consider that the Gillingham Team's resource difficulties put them in a better or worse position than either the CMHTs in Rochester or Chatham[38]. Peter Hasler, employing a different comparator, told us that other teams in the Thames Gateway Trust (the predecessor Trust to West Kent NHS and Social Care

[33] John Hughes page 3
[34] Kevin Lindsay page 3
[35] Peter Hasler page 1
[36] Mike O'Meara page 5
[37] Ann Windiate to Verita 3 February 2006
[38] John Hughes page 13

Trust) that is Dartford, Gravesend and Swanley 'were very much better resourced.'[39]

6.6 Mike O'Meara told us that between 1997-2002:

> *we had begun to improve the resources to the community teams. Also there were more consultants recruited during that period and we had begun to address the integration of team bases in terms of having social workers and nurses sitting alongside each other.*[40]

He felt the single management of the community teams remained outstanding.

6.7 In the Medway teams Peter Hasler described the basic infrastructure as not robust and in particular the number of CPNs was low. The multi-disciplinary team approach was fragmented.

Workload

6.8 Although we did not receive specific figures in relation to workload, the following are some of the comments we received:

> *I had the impression that it was more of a crisis type of approach to dealing with referrals, with not too much in management of people with long-term mental health problems.*[41]

> *They were dealing with an awful lot more referrals on a day-to-day basis than many other teams… effectively what they were doing was crisis-managing a lot of cases*[42].

Recruitment difficulties

6.9 James Sinclair told us that Medway social care staff had recruitment problems in terms of ASWs, and retention of staff.

[39] Peter Hasler page 3
[40] Mike O'Meara pages 10-11
[41] Peter Hasler page 3
[42] Peter Hasler page 8

Organisational difficulties

6.10 Between 2001 and 2002 the Gillingham CMHT appeared to be experiencing significant organisational difficulties. These difficulties were described to us by a number of witnesses. They variously commented upon: a chaotic case allocation process, problematic working relationships between professionals, information not being shared between CPNs and social workers, staff shortage, low attendance at intake meetings and CPA reviews, conflicts about the assessed needs of clients and poor accommodation with staff on different sites. We were told about the team being under strain because of the pressure of referrals and about an absence of clear management and leadership allowing professionals, depending upon their personal interests, to choose what they wished to do.

6.11 Ann Windiate was alerted to problems in the Gillingham CMHT in mid 2003. The problems were discussed with John Hughes and Kevin Lindsay. The agreed resolution was that the team manager retired and Philippa Macdonald took over in January 2004. Philippa Macdonald did not find the team dynamic as problematic as she expected when she became team manager in January 2004.

Team/allocation meetings

6.12 We discuss elsewhere[43] the unsatisfactory procedure for case allocation that existed in 2002. We heard no evidence to indicate that cases were being allocated on the basis of objective assessment of need against standard criteria.

Comment

6.13 The Clinical Practice Review into the care of RL identified that concerns were expressed regarding the inadequate resources allocated to the Gillingham CMHT.[44] We are unable to come to a definite conclusion as to whether the Gillingham CMHT was 'under-resourced' in comparison with other teams in the area. It was undoubtedly busy, and the team members felt that they were under pressure. We are also unable to

[43] Chapter 5 Care, treatment and assessment
[44] Clinical and Practice Review into the care of RL 13 January 2003

determine whether the Gillingham CMHT was more organisationally flawed than any other team in the area. The witnesses who candidly gave us their views about the difficulties faced by the team clearly felt it was not operating as it should.

6.14 We can be clear that the team was not integrated in any meaningful sense. Organisationally it was dysfunctional, apparently lacking strong and effective leadership, characterised by poor relationships between some professionals and the delivery of effective care was impaired by the failure to adhere to procedures, particularly in relation to the CPA.

THE GILLINGHAM CMHT SINCE 2002

6.15 Ann Windiate considers the team has only been able to operate effectively as a team since the staff were all brought together under one roof, and managed as a single group. All staff now work in Kingsley House.

6.16 We heard convincing evidence from a number of witnesses of significant change. For example, Peter Hasler told us:

> *I went in and sat on one of the allocation meetings, and although it was not run exactly how I would run it, it was not too bad. The people were there, including the doctors, cases and concerns were discussed and some solutions were found. This is the kind of thing I would be expecting to see, which I think just did not exist a few years ago.*[45]

6.17 When Philippa Macdonald joined the team her impression was of:

> *very highly skilled individuals not necessarily all pulling together… We have a better vision now of where they want to go as a team, and there is less "that is not my role.'* [46]

6.18 Philippa Macdonald further advised us that the case allocation system, which is a key part of the decision-making process in deciding whether a person is CPA eligible, was under review.

[45] Peter Hasler page 10
[46] Philippa Macdonald page 10

Comment

6.19 We were impressed by the approach of Philippa Macdonald, John Hughes and Kevin Lindsay. We asked them specifically to measure change, and each in their own way effectively advocated that the Gillingham CMHT is now operating in a qualitatively different way than it was in 2001 and 2002. This must be partly attributable to the personalities involved and partly to the changes in service we discuss in Chapter 18, Service developments since 2002.

7 PSYCHIATRIC EVALUATIONS

In this section we summarise the evaluations undertaken of RL by psychiatrists from 1996 to 2004.

Dr Tullett

7.1 Dr Bhasme referred RL to the psychiatric services at Medway Hospital for an emergency assessment for treatment for depressive illness.[47] He was seen on 13 March 1996. Dr Tullett, Senior Registrar to Dr Rao, noted that RL had not been seen by a psychiatrist before.[48] Dr Tullett diagnosed RL as suffering from moderately severe depressive disorder and in March 1996 he was prescribed Fluoxetine and Propanolol.

Dr Gilluley

7.2 In late 1999 Dr Gilluley, Consultant Forensic Psychiatrist at the Maudsley Hospital, was instructed by RL's solicitors to prepare a court report In connection with the indecent assault charges. He completed his report around 10 January 2000. The purpose of the report was to assist the sentencing judge and we consider it likely that that the sentencing judge read the report, although there is no confirmation of this. Dr Gilluley was at the time locum consultant for the forensic outreach team at the Maudsley Hospital. This was the only time that RL was assessed by a forensic psychiatrist.

7.3 Dr Gilluley reported that RL suffered from recurrent depressive illness with strong social precipitating factors. Dr Gilluley stated RL was the primary care-giver for his elderly and frail mother, that a custodial sentence would cause a relapse of his depressive illness and that it was Dr Gilluley's opinion that he was not at high risk of re-offending. He went on to note that both offences were against a single victim, a member of the family group with no persistent paedophilic interest or predatory sexual offending.

[47] Dr Bhasme to psychiatric senior registrar 13 March 1996
[48] Dr Tullett to Dr Bhasme 15 March 1996

Comment

7.4 The report is, in the main, accurate apart from the reference to RL as being the 'primary carer for Mrs Loudwell, his elderly and frail mother.'[49] It was in fact she who was the primary carer for her son, with support from her daughter, Mrs D. The report also omits the references in the inpatient records to RL's inappropriate attire, and to his making inappropriate sexual advances to women. Dr Gilluley's account of RL's sexual proclivities was based entirely on self-report. We also note that the account that RL gave his probation officer Tim Craven (the author of the probation report dated 8 February 2000) about his sexual activities was markedly different to the information he gave Dr Gilluley. Dr Gilluleys's assessment in 2000, referring to RL being a low risk of re-offending, cannot have affected subsequent decisions as all the key health professionals who dealt with RL after 2000 were unaware of this assessment.

7.5 It is unfortunate that the only full forensic psychiatric assessment of RL was commissioned by his own solicitors specifically to provide information to the sentencing judge. It is also unfortunate that nobody involved in RL's care and treatment from 2000 onwards was aware of this assessment. The report would not have been neutral in value to the mental health professionals. It would have reinforced to Dr Shobha and the community assessors that RL had a recurrent mental illness of an affective nature and a history of sex offending. In addition RL had been wrongly identified by Dr Gilluley as being the main care-giver to his elderly mother.

Dr Shobha

7.6 Although Dr Shobha, Consultant Psychaitrist at Medway Hospital, took over RL's care on 19 January 2000, it was not until March 2002 that she had an opportunity to assess him. In her words:

[49] Dr Gilluley report – opinion paragraph 5 (Undated)

We wanted to do a reassessment of him, because he was never assessed under my care before, he was never admitted, and the last admission was under Rao.[50]

7.7 Dr Shobha told us that by the end of the May 2002 admission, her diagnostic formulation was:

He was suffering from recurrent moderate and severe depression... and severe organic disorder due to brain damage query, and dysfunction due to physical disease. This causes significant personality or behavioural disorder.[51]

7.8 Dr Shobha arranged a CT scan to help develop her diagnostic formulation. The scan was initially requested in March 2002. It needed to be rebooked in May 2002 probably because RL was discharged prematurely.

Dr Petch

7.9 Dr Petch, Consultant Forensic Psychiatrist was responsible for RL's care when he was admitted to Broadmoor for assessment after being charged with murder. His diagnostic formulation, after an in-depth assessment lasting from 15 January to 30 March 2004, was:

In my opinion there is evidence to suggest that Mr Loudwell suffers from a number of mental disorders. It is probable that Mr Loudwell suffers from a long-standing abnormality of personality, which could include Asperger's Syndrome. He developed a number of paraphilias (alternative sexual preferences). He appeared to function with these disorders without too much difficulty – that is to say he did not come to the attention of services or the police - until the early 1990s. At this time a number of adverse events occurred, and may have made a contribution to the development of recurrent moderately severe depressive episodes. A change in his presentation began to emerge in the late 1990s, when he started to deteriorate in different areas of functioning, including expression of his pre-existing paraphilic interests. As time has progressed a slowly

[50] Dr Shobha – first interview page 21
[51] Dr Shobha – first interview page 31

progressive dementing illness has become apparent, the cause of which has been difficult to determine. Lastly, his physical health is beginning to deteriorate.[52]

Comment

7.10 The diagnoses of depression made by a variety of clinicians from the time of RL's first admission to psychiatric hospital in 1997 seem legitimate and he was tried on a range of appropriate medication. Dr Petch, who treated RL in Broadmoor, considered and discounted the possibility of RL suffering from a bi-polar disorder.

7.11 Whatever diagnoses were made, we accept that RL was difficult to diagnose, manage and understand. From January 2004 until April 2004 Dr Petch treated RL in Broadmoor. When Dr Petch gave evidence, he told us that:

> *[RL] was uniquely complicated, and that any conclusions reached about his previous management should be taken in that context.*[53]

[52] Psychiatric Court Report Dr Petch 30 March 2004
[53] Dr Petch page 4

8 PSYCHO-SEXUAL TREATMENT

Introduction

8.1 RL had a long history of concerns (starting in 1994) relating to impotence for which he sought professional help and guidance. In 1987 RL was referred for treatment of genito-urinary warts, which implies previous sexual relationships.

8.2 We know that RL was variously concerned about impotence in 1994 and 1997, he demonstrated anxiety about the size of his penis in 1995, and is recorded as being pre-occupied[54] with sexual difficulties in March 1998. He remained sufficiently concerned by the problem to return for outpatient clinic visits for further diagnosis and treatment in April 2001 and the other dates shown below. Dr Petch refers to RL's impotence recorded by his GP as early as 1990.[55]

Prescription of Viagra

8.3 RL was referred by his GP, Dr Bhasme, to a urologist on 4 June 2000. Although it is unclear from the record, he was possibly prescribed Viagra then. RL was prescribed Viagra in September 2000 and further prescriptions were made by Dr Bhasme on 21 March 2001 and 29 November 2002. RL requested more Viagra on 4 January 2001 and 1 October 2002. The last prescription for Viagra was made on the day RL was arrested for the alleged assault on AB, three days before the homicide. We do not know whether the medication under this prescription was dispensed.

8.4 The Viagra was prescribed for erectile impotence and it is likely that his diabetes may have contributed to his erectile impotence. RL's concerns about potency pre-date the diagnosis of diabetes which was arrived at only in around October 2000.

[54] Christina Rossetti Day Hospital notes 28 April 1998
[55] Psychiatric Court Report Dr Petch 30 March 2004

8.5 Throughout RL's contact with psychiatric services there are frequent references noting his concerns about potency. There is recognition that this may have affected his mood and compromised compliance with anti-depressant medication, on which he occasionally blamed his impotence. Given that his diagnosis was, until his March 2002 admission, one of a recurrent depressive disorder, the need to ensure compliance with anti-depressant drugs and the lack of historical evidence of association between his erectile competence and his known offending at that stage, it seems reasonable to have prescribed Viagra.

8.6 Whatever the outcome of a review of the desirability of the continuing prescription of Viagra, Dr Bhasme should have been advised about the psychiatric teams' recommendations, and any further prescriptions should have been made from a single source.

Comment

8.7 RL was, on occasion, reported as being pre-occupied with sexual difficulties. We need to differentiate between the use of the expressions 'concerned about' and 'pre-occupation with' a particular problem, such as impotence. The description of 'pre-occupation' is a way of supporting the contention that the concern is not in proportion to the problem and as such another cause needs to be identified, such as in his case, depression. We have no doubt that he was at times pre-occupied with his sexual difficulties.

Psycho-sexual counselling

8.8 In 1994 RL was referred to the psychology clinic for erectile problems when with women – he self-reported that he did not experience problems when masturbating. In 1995 he was seen for erectile failure and size anxiety. He was seen by David Carter, a psychologist. RL complained of erectile incompetence for eight years in a number of relationships and reported that women taunted him over the size of his penis.

8.9 In 1998 he was seen twice by Dr Raleraskar. Following these meetings she referred to herself in correspondence with Dr Bhasme as a 'Sexual and Marital Therapist'. This was the only involvement he had with her in that capacity, as Dr Raleraskar told us:

> *he didn't want it [therapy] because it was all physical from his point of view.*[56]

8.10 RL was first seen by Dr Raleraskar, on 20 May 1998 after a telephone referral from the Christina Rosetti Day Hospital and one failed appointment. He reported erectile difficulties of three months duration that he blamed on the anti-depressant medication. He also expressed concern that his penis and testes were small. Dr Raleraskar suggested the GP refer him to a urologist for a physical examination. The second appointment took place on 22 July 1998 when RL reported being off medication and felt his mood had lifted recently. Dr Raleraskar had no further involvement with RL in her psycho-sexual clinic.

Comment

8.11 Hypertension, diabetes, anti-depressant medication, anti-psychotic drugs, depression and dementia can all cause loss of libido or impotence. Viagra is purely a treatment for erectile impotence. It is unlikely that there was a clinically significant interaction between Viagra and any anti-depressants or anti-psychotics RL was receiving.

8.12 Dr Shobha told us that by March she had arrived at a preferred diagnosis of organic disorder. This was not apparently communicated to Dr Bhasme. (Neither the March nor May discharge summaries refers to this diagnosis.) With hindsight, if by March 2002 there had been a comprehensive review of RL's history and a formal risk assessment, his continuing prescription of Viagra could have been reviewed either by the psychiatric team, or by Dr Bhasme. The review would then have taken into consideration the following factors:

[56] Dr Raleraskar page 5

a. The interest in treating RL's impotence, which was a significant concern to him and something he complained about frequently, may have contributed to his non compliance with anti-depressant medication.

b. Viagra would not 'cause' sexual disinhibition and whilst it was prescribed, there was no clear evidence to suggest that in RL's case it was used either to facilitate offending or contributed to inappropriate behaviour.

8.13 A formal risk assessment in March 2002 would have involved a comprehensive review of RL's sexual problems, the circumstances in which the problems occurred and details of RL's sexual activities. A decision to prescribe would then have been premised on the fact that the need to ensure compliance with anti-depressants outweighed the (at this stage theoretical) risk to others. With hindsight, if all the facts had been known, we think it unlikely he would have been prescribed Viagra.

8.14 Similarly, if the unfolding events in December 2002 had been known, then Viagra should no longer have been prescribed. It was only after the alleged rape of AB that the evidence suggested the possibility of penetrative sexual offending. This information, however, was not available either to mental health services or to Dr Bhasme at the time. It should also be stressed that Viagra does not cause sex offending, nor does the prescription of the drug. We also note that there are ways to obtain Viagra without prescription.

9 CARE PLANS

Introduction

9.1 We read a number of care plans, some drawn up by those responsible for RL's inpatient care psychiatric, and others drawn up by Liz Finnerty. We have considered only the psychiatric plans in 2002 as this is the most relevant period for our inquiry.

Psychiatric

9.2 In March 2002 the nursing care plan stated that RL needed a full mental health assessment related to sudden change of behaviour, as evidenced by disorientation, euphoria, inability to recall events, aggression, and socially inappropriate behaviour. Dr Shobha stated that the intention was to 'do a reassessment and to reassess his needs'.

9.3 The March discharge summary is silent about CPA or an after-care plan. There is no entry about a risk or crisis plan. It is signed only by a SHO. The discharge summary reports the diagnosis to be recurrent depression with no depressive symptoms elicited and notes that he was 'a bit disinhibited on the ward.' There is no comment on risk. The plan shows an outpatient appointment for 15 March 2002, to attend his GP for repeat prescriptions and identifies emergency phone numbers. The crisis relapse indicators consisted of 'anti-everything, mood changes, and sleep changes.' These were in fact identified on his admission on 6 March 2002.

9.4 A document[57] dated 12 March 2002 completed by Dr Tran (locum SHO) and sent to Dr Bhasme notes that RL was discharged because of inappropriate sexual advances to female patients. We could not identify any clear risk assessment in the discharge documentation.

9.5 The discharge summary completed on 25 May 2002 refers to 'Admitted due to non-compliance, self neglect, and isolating self.' The care plan dated 27 May 2002 summarises assessed needs as 'relapse of mental health' and identifies only outpatient attendance, compliance with medication and contact with care manager as actions to be taken. The ward round meeting

[57] Discharge Letter & Prescription 12 March 2002

notes for 27 May 2002 reports RL saying he is not suicidal and notes in capitals he: 'MUST HAVE A MALE WORKER'.

9.6 The discharge plan gives RL an outpatient appointment on 7 June 2002 and a meeting with a care co-ordinator to be arranged. The crisis plan identifies sleep disturbance, neglecting hygiene, poor dietary intake and isolating self by staying in bed. It suggests intervention to be input from a carer, and 'admission as a last resort'. The CPA documentation dated 27 May 2002 identifies a desired outcome as 'to be mentally stable'. It records 'no' against section 117 but 'yes' by supervision register. The discharge summary is silent on care programme status, 117 review and risks, and refers to an after-care plan consisting of outpatient appointments.

Comment

9.7 We considered whether the March and May 2002 care plans led to effective community services being delivered to RL. The plans did not, and added little to his overall management except that the May plan, during the short inpatient admission, established that RL was not suicidal.

9.8 The crisis plans failed to address significant behavioural problems that were by then known about RL. The identification of relapse indicators was incomplete, for example the risk he presented to both himself (hoarding medication) and others (sexually inappropriate behaviour). We also question the utility of formulaic phrases such as 'admission as a last resort' and 'to be mentally stable' as a desired outcome.

9.9 In summary, we consider the March and May discharge care plans to have been inadequate. We have, as we have already commented, read some clear and accurate records, for instance the March and May inpatient nurse care plans.

Social work

9.10 Liz Finnerty undertook a care management Initial needs assessment, which was partially completed on 20 August 1999.

9.11 In this she identified mental health needs, difficulties in forming and maintaining relationships, a lack of day-time occupation (both work and leisure activities), perceived financial difficulties, (partially due to an unwise loan to a friend) loneliness and isolation.

9.12 While this assessment was being carried out, RL was arrested in relation to the assault on a family member and as a consequence much of the emphasis of the care planning changed. Nonetheless, in relation to the above identified needs, Liz Finnerty attempted to secure his attendance at the day hospital, to introduce him to an advocate to help with his finances and to the Gillingham Volunteer Bureau and Adult Education classes. She assisted him in completing his DLA application. Additionally, Liz Finnerty provided continuing support to RL and his mother and assisted in monitoring his mental state and compliance with medication. She also liaised regularly with his probation officers. We saw no record, however, of a formal care plan for this period.

9.13 The first CPA review (entitled 'Care Management Review Meeting', in the notes), following the initial needs assessment, took place on 16 June 2000 and a care plan was drawn up, which picked up on the above-mentioned areas, with aims identified and suggestions about how, and with help from whom, these could be achieved. No CPA level was recorded on the form and the care co-ordinator was not specified, but it was evident that this role was performed by Liz Finnerty.

9.14 A further review, entitled 'CPA Review Plan', took place on 15 December 2000, where Liz Finnerty was identified as RL's care co-ordinator. The main emphases, at this point, were on attendance at the Sex Offenders Group and at the probation office and on Liz Finnerty providing on-going support, on a weekly basis. This was to be reduced after 12 weeks, following discussion with RL, with a view to reducing his CPA level thereafter. It was agreed that Liz Finnerty would close the case at the time of the completion of his Sex Offenders Group, in about May 2001. A crisis/contingency plan

was drawn up, with contact details recorded of Liz Finnerty, Dr Shobha and Colin Croft (probation officer), as well as his mother/carer, Mrs Loudwell. Risks of self-neglect, self-harm and re-offending were identified.

9.15 This was, in fact, the last CPA review that took place in that year and in 2001. Liz Finnerty closed the case on 18 May 2001. In a closure summary, dated 7 June 2001, she recorded that Colin Croft was still involved with the case and RL was to be seen on a three-monthly basis by Dr Shobha. When Liz Finnerty wrote to Dr Shobha she stated:

> *I have advised Mr Loudwell to use our Duty System if needed in the future.*[58]

9.16 The CPA level was consequently reduced from enhanced to standard, with Dr Shobha becoming his care co-ordinator.

Comment

9.17 Liz Finnerty's initial assessment highlighting RL's needs appeared accurate and, in the absence of a subsequent formal care plan, she tried to help meet those needs. The emphasis changed with his arrest and consequent prosecution and she modified her initial work accordingly.

9.18 At the time of the first Care Management (CPA) review in June 2000, although Liz Finnerty was playing an active part in monitoring his mental state, this function was not attributed to her in the care plan. It is not evident from the notes whether Colin Croft, the probation officer was invited to the review, but his statutory supervision of RL was recorded as part of the plan and his attendance at the review would have been helpful. The absence of a recorded CPA level and named care co-ordinator, as well as the title of the review, reflects the fact that CPA did not have a high profile at that time, although it was introduced in the early 1990s.

9.19 The CPA review plan of December 2000 did identify the CPA level and the identity of the care co-ordinator and the previous plan was largely adopted, with the addition of a crisis/contingency plan, giving contact

[58] Liz Finnerty to Dr Shobha 6 June 2001

details of relevant professionals and of RL's mother. The decision at this point to reduce the level of involvement after 12 weeks, with closure of the case at the time of the completion of RL's Sex Offenders Group, was premature. This was the last review to take place during the involvement of Liz Finnerty. The closure of the case, without a further review, and without explicit recording of CPA responsibility thereafter, was not a correct decision by the participants. This failure may have contributed to the cessation of all communication between mental health services and probation. The probation records show that Colin Croft was informed on 21 May 2001 that:

> *S.W.Department have now closed case although they have left Richard with contact numbers in case of emergency.*[59]

The probation service did not appear to be given any indication of Dr Shobha's ongoing involvement in the case, nor was the relationship between the 'S.W. Department' and mental health services accurately described.

[59] Probation service contact sheet 21 May 2001

10 PRIMARY HEALTH CARE

Introduction

10.1 RL was a patient of the GP practice at 19 Railway Street, Gillingham. He had been a patient of that practice since at least 1969. In 1994 he was referred to the CPN service by his then GP, Dr Mansuetto, for depression. Dr Bhasme took over his care the same year. RL had regular contact with Dr Bhasme for a range of physical and psychological difficulties and he referred RL to psychiatric services on a number of occasions.

Dr Bhasme's description of RL and RL's relationship with his mother

10.2 Dr Bhasme described RL as a patient who:

> *Didn't know what he wanted. He would come and tell you what's wrong with him but he wasn't keen to accept treatment or he wouldn't accept what you would tell him about the side effect of the tablets and those sort of things.*[60]

10.3 Dr Bhasme described RL's mother as doing everything for her son.[61]

Contact with RL

10.4 Dr Bhasme prepared, and made available to us, a schedule of his contact with RL. Dr Bhasme was also Mrs Loudwell's general practitioner between 1994 and 2002 and so the schedule reflects the number of times he had contact either with RL or a member of RL's family to discuss RL's health.

Year	Number of times RL, or a member of his family, met with or had contact with Dr Bhasme
1995	5
1996	9
1997	9
1998	18
1999	11
2000	5
2001	8
2002	17

[60] Dr Bhasme page 6
[61] Dr Bhasme page 15

Summary of contact

10.5 From this schedule, and the medical notes, we have listed a summary of some of Dr Bhasme's contact with RL during the time he was his GP:

a. Dr Bhasme referred RL to the Psychology Department at All Saints Hospital, Chatham on the 15 November 1994 for treatment for his 'erectile dysfunction.'

b. Dr Bhasme referred RL to Medway Hospital for an emergency assessment for treatment for depressive illness.[62] He was seen on 13 March 1996. (Dr Tullett, senior registrar, notes that RL had not been seen by a psychiatrist before.[63])

c. Dr Bhasme saw him on 6 March 1997 with his sister and uncle. RL was 'depressed and weepy,' was referred to a psychiatrist and sent to Shelley Ward.

d. On 3 April 1997 Dr Bhasme visited him at home. Dr Bhasme then referred RL to the CPN service on 4 April 1997:

> *I would be grateful if you would see this man early. He has become more depressed in the past weeks with suicidal ideas sometimes.*[64]

e. On 8 January 1998: 'mum phoned still the same does not want to get off bed.'

f. 30 January 1998 Dr Bhasme wrote to the psychiatric registrar at Shelley Ward: 'I would be grateful if he could be admitted to give break to his elderly parent.'

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[62] Dr Bhasme to psychiatric senior registrar 13 March 1996
[63] Dr Tullett to Dr Bhasme 15 March 1996
[64] Dr Bhasme to CPNs 4 March 1997

g. Between January and March 1998 Dr Bhasme wrote to Dr Rao:

> *his family are concerned about his inappropriate sexual advances to women in the area… family are concerned he may do something regrettable.*

h. On 11 January 1999 Dr Bhasme visited him at home. RL 'complains of hearing noise the same as before seems to be getting worse.'

i. On 18 June 1999 RL saw Dr Bhasme with his mother and sister 'had been very upset in the past 2-3 days threatening to kill himself.' RL was sent to Shelley Ward.

j. On 8 December 2000, in refusing an invitation to attend the CPA meeting, Dr Bhasme writes to Gillingham Mental Health Team 'he appears to be progressing well and I have not seen him recently.'[65]

k. On 8 October 2001 his mother and sister talked about him still spending most of the time in bed, a missed psychiatric appointment and 'not getting support from the community mental health team like last year'.

l. On 9 October 2001 Dr Bhasme faxed a letter to the Gillingham Mental Health Team requesting an assessment. (See paragraph 10.6)

m. On 27 February 2002 Dr Bhasme wrote to Dr Shobha requesting an urgent outpatient review. 'He seems to have had a personality change in the past 4-5 weeks.'[66]

n. On 9 May 2002 RL was visited at home by Dr Bhasme. 'He has taken to his bed for the past few days, aggressive at times.'

o. On 10 May 2002 RL's mother and sister came to see Dr Bhasme:

> *[RL] Got up and had food yesterday after my visit. Did not want to come today. Mum is getting tired of looking after*

[65] Dr Bhasme to Edwina Morris 8 December 2000
[66] Dr Bhasme to Dr Shobha 27 February 2002

him. Daughter asked her to go and stay at her place for a while but cannot leave her house. Discussed about Richard's problem – depression and behavioural problem.

p. On 13 May 2002 Dr Bhasme wrote to Dr Shobha requesting a CPN visit.

q. On 23 May 2002 Dr Bhasme noted that he 'was angry with mum who is getting concerned in case he hurts her.'

Referral to Gillingham CMHT 9 October 2001

10.6 On 9 October 2001, Dr Bhasme faxed a letter to the Gillingham Community Mental Health Team requesting an assessment.

> *he [RL] has gone down steadily in the past several months, feeling depressed… his elderly mother is trying to cope with him with great difficulty… does not take the anti-depressants prescribed because of side effects.*[67]

10.7 The response was:

> *this was discussed in our allocation meeting when it was identified and agreed that it would be more appropriate for you to refer [RL]to Dr Shobha for a psychiatric assessment.*[68]

Comment

10.8 Although Dr Bhasme told us that he regarded the specialist mental health service as responding adequately to emergencies,[69] we regard their response to his October referral as muddled, inadequate and unhelpful. This may have been a function of the organisational shortcomings that characterised the CMHT at that time.

10.9 Dr Bhasme appears to have been alert to RL's mental health difficulties and referred him appropriately. The two periods of inpatient treatment

[67] Dr Bhasme to Edwina Morris 9 October 2001
[68] Gretta Kitney (Administrator CMHT) to Dr Bhasme 16 October 2001
[69] Dr Bhasme page 12

that RL received in 2002 were both triggered by referrals from Dr Bhasme. Dr Bhasme also communicated directly with outpatient psychiatric services when he considered that his patient needed urgent treatment.

10.10 Dr Bhasme worked effectively and assiduously with RL and would respond to requests to visit him at home. All the requests for house calls would come from his mother.[70]

[70] Dr Bhasme page 3

11 POLICE SERVICE

Introduction

11.1 The police service involvement with this inquiry falls into two discrete areas: with RL as a registered sex offender and with RL as a suspect for allegedly raping and indecently assaulting a 34-year-old man, on 29 November 2002. RL was also subject to MAPPA.

11.2 The Review of the Agency Involvement with RL, commissioned by Detective Chief Superintendent Turner and conducted by the Kent Crime Case Review Team (commissioned on 3 January 2003 and completed on 3 August 2003) has provided much of the information about the police service involvement with RL, particularly from the time the case was closed by Liz Finnerty in May 2001. We were not able to interview PC McGowan.

Police service involvement from August 1999 to November 2002

11.3 The police first became involved with RL when they were investigating his indecent assault of a member of his family for which RL was subsequently convicted. Following RL's conviction, the police accumulated significant information about RL through PC McGowan (the Sex Offender Liaison Officer) and general intelligence-gathering. If this information had been shared outside the police and probation service, the risk profile of RL developed by the mental health service, would have been significantly altered. We accept the point that Detective Chief Inspector Chandler made in correspondence[71] with us that merely sharing information does not mean that active and substantive interventions can necessarily be made.

11.4 For example, in June 2001 the Review Team recorded[72] a home visit that PC McGowan and Colin Croft made to RL. It was noted that RL's behaviour was bizarre:

> *It was a hot, June day and he was sitting by a roaring log fire wearing shorts, boots and sunglasses only. It was noted that he was spending a lot of money, consorting with prostitutes, was*

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[71] DCI Chandler to Verita 18 January 2006

[72] Review of the Agency Involvement with RL Kent Crime Case Review Team page 17

argumentative and childlike in mood. Exposed self to adult male friend of family "last week". Felt to be at high risk due to unpredictable behaviour.

This information was not known to the mental health services.

11.5 On 13 June 2001 PC McGowan and Colin Croft decided that, due to recent incidents and RL's behaviour, they should raise his risk assessment from medium to high. This was to be reported to the next Sex Offender Panel for the Medway area.

Comment

11.6 Within days of RL being 'removed' from enhanced CPA by mental health services, we read about him being upgraded from medium to high risk by another agency. There are a number of reasons information was not shared with the mental health service. By this time, the care co-ordinator was Dr Shobha who had no contact with the probation officer, unlike Liz Finnerty who had been RL's care co-ordinator until May 2001 and had regular contact with Colin Croft. Mr Croft did not consider mental health issues relevant to the risk RL presented as evidenced by the fact that he made no contact with mental health services following Liz Finnerty's closure of RL's case. The formal structures to promote inter-agency communication, MAPPA, were not sufficiently developed at this time to facilitate communication at the level of risk that RL presented.

Police service involvement 29 and 30 November 2002

11.7 On 30 November 2002, RL was in police custody following an allegation of rape. We have read the custody record log. The section covering medical history indicates that RL did not appear to be suffering from mental illness or disability.[73] It is recorded:

States he is manic-depressive and on prescribed medication. Admits to being bi-sexual. Has had admissions to hospital for depression. Has no control over his sexual urges. Very eccentric in his

[73] Kent County Constabulary Custody Record Log – page 1

behaviour. Fit to be interviewed and does not require further assessment.[74]

11.8 RL was then seen by Dr Bundy who wrote he was 'fit for interview.' Dr Bundy's records of the examination are attached to the custody record log, with reference made to RL being in a 'manic phase'[75] and then becoming calmer. Dr Bundy records:

If staying overnight will require medication although in my opinion (that) to keep him in custody overnight might prejudice his health.

11.9 On 30 November 2002 PC Wilson interviewed RL in the presence of a solicitor and appropriate adult. The Kent Crime Case Review Team states that:

He admitted certain aspects of the indecent assault but denied raping [AB].[76]

He was later granted bail, without charge.

11.10 DC Wilson (formerly PC Wilson), in correspondence[77], provided the following information:

a. The decision to bail Richard LOUDWELL to return to the police station at a later date was based on the fact the police were not in a position to prefer a charge, as they required items to be submitted to the forensic laboratory for analysis.

b. The Genesis record would have shown that Richard LOUDWELL had been elevated from a medium risk to high risk sex offender on 13.06.2001.

c. The details of the indecent assault offences in 1975 and 1999 were contained with the Genesis record.

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[74] Kent County Constabulary Custody Record Log – page 4
[75] Record of examination by a police surgeon/doctor – page 1
[76] Kent Crime Case Review Team report page 27
[77] DM King Case Review Team to Verita 30 November 2005

d. *The information that Richard LOUDWELL was the sole carer for his elderly mother came from him while in custody at Canterbury.*

11.11 The Kent Crime Case Review Team concluded that it was:

entirely appropriate for LOUDWELL to have been bailed pending further investigation.[78]

Comment

11.12 We considered two matters in relation to RL's arrest in 2002 for the alleged assault on AB. The first was whether it would have been reasonable for the police to have requested an assessment under the Mental Health Act, and/or a psychiatric opinion, taking into account the information recorded by Dr Bundy. The second was whether it was reasonable to release RL to return to the police station at a later date without charging him.

11.13 We heard no evidence from Dr Bundy and so we were not able to follow that line of inquiry. On the information available, therefore, we understand why the police concluded, on the basis of Dr Bundy's opinion as recorded in the custody record, that no further psychiatric evaluation was needed.

11.14 According to the Kent Crime Case Review Team report[79], RL admitted certain aspects of the indecent assault but denied raping AB. We are not in a position to judge whether a lesser charge (i.e. indecent assault) could have been preferred. Without a charge, RL had to be granted bail without conditions.

[78] Kent Crime Case Review Team report page 36
[79] Kent Crime Case Review Team report page 27

12 PROBATION SERVICE

12.1 RL was sentenced to two years probation on 11 February 2000. He was also required to register with the police for five years under the Sex Offenders Act 1977. The pre-sentence report was prepared by Tim Craven. The case was managed by Kevin Matthews who transferred it back to Tim Craven in March 2000. Tim Craven then transferred RL's case to a temporary probation officer. In September 2000 Colin Croft assumed case management responsibility, and managed the case until the order finished in February 2002. He then maintained some informal contact (mainly by telephone) with RL and his family until shortly before the homicide.

12.2 The probation service had information about RL's psychiatric history as Dr Gilluleys' report was on the probation service file. In February 2000 Liz Finnerty recorded:

> *Kevin [Matthews] was not aware that Richard [RL] had a mental health problem or that I had been working with him. We discussed Richard's case, and way forward. Kevin agreed that Richard's mental health problems should be taken into account (and will be) during future work with him.*[80]

12.3 Colin Croft obtained background information from Liz Finnerty. He told us that he regarded Liz Finnerty's involvement as a 'low grade thing'.[81] He maintained contact with her until she closed the case. Although he was aware of the case closure, he was not told that Dr Shobha remained RL's care co-ordinator.[82] From the time the case was closed in May 2001 Colin Croft had no contact with anybody from mental health services, and did not feel the need to discuss the case with them.

12.4 Colin Croft described that when he took over RL's case from a colleague the first thing he did was 'up' the level of supervision. This was partly to prepare him for the Sex Offender Group and also because:

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[80] Medway Council Social Services Department Contact Sheet No. 24 entry dated 23 February 2000
[81] Colin Croft page 10
[82] See Chapter 9 Care Plans paragraph 9.19

All sorts of warning bells were starting to ring, in terms of aspects of his behaviour.[83]

12.5 Although Colin Croft viewed RL as vulnerable to mental health difficulties, when he visited RL in June 2001 with PC McGowan, he did not find RL's behaviour bizarre or demonstrative of mental disorder, but simply 'wilful.'[84] RL's risk status, following that visit, was moved from medium to high - the significance of this step is discussed elsewhere.[85]

12.6 Colin Croft had what he described as a 'strong line of information' with Mrs D, RL's sister, who would phone him if she had concerns. At no stage during his involvement with RL (neither during the period of the probation order nor the informal contact he maintained with the family after the cessation of the order) did he have concerns about RL's mental health. Colin Croft was not told that RL continued to receive psychiatric treatment on an outpatient basis in 2001. Nor was he told that RL was admitted as an inpatient in 2002. (After the probation order had ceased but whilst Colin Croft was still in contact with the family.)

Comment

12.7 We were provided by Kent Probation Service with contact sheets and other documentation. As with Liz Finnerty's notes, these records provided a useful account of what was happening, from both a probation and social work perspective. The managers of Kent Probation Service advised us that the records concerning RL met the required national standards. RL's case was also supervised in accordance with national and local policy guidelines current between 2000 and 2002.

12.8 Colin Croft accepted that he was not aware that RL was subject to the CPA in 2001 and 2002. Both he and his supervisor Maurice O'Reilly accepted that their knowledge of the CPA was limited.[86] Colin Croft was not informed that Dr Shobha was responsible for RL's psychiatric treatment from May 2001 onwards and was thus his care co-ordinator.

[83] Colin Croft page 3
[84] Colin Croft page 7
[85] See Chapter 15 Multi Agency Public Protection Arrangements (MAPPA)
[86] Maurice O'Reilly page 5 'It is only in my fairly recent experience that I have come to know about CPA and enhanced CPA and what this means.'

It was therefore difficult for Colin Croft to know who he could contact in mental health services regarding the change in RL's risk assessment. On the other hand RL's mental health problems were known to the probation service and we consider it likely that if Colin Croft had considered RL's mental health issues relevant to the risk RL presented, he would have attempted to have made contact with mental health services. If he had discussed the case with Dr Shobha, or another mental health professional, this would have been of great benefit to each service.

12.9 Colin Croft impressed the panel members who interviewed him as a conscientious and experienced professional. Although he acknowledged that the killing of Joan Smythe by RL was not predictable, he nonetheless appeared to regard himself as somehow failing in his assessment and management of the risk RL presented. He can perhaps draw some comfort from the analysis of Dr Petch (see Chapter 7, Psychiatric evaluations) who treated RL in Broadmoor from January 2004 until April 2004.

13 COMPLIANCE WITH STATUTORY OBLIGATIONS

The Mental Health Act 1983

13.1 RL received psychiatric inpatient treatment in Shelley Ward, Medway Hospital on five occasions between March 1997 and May 2002. He agreed each time to informal admission. Generally, he complied with the inpatient treatment regime offered to him. His discharge in March 2002, however, was precipitated by his sexually inappropriate behaviour. On 27 May 2002 it was recorded that RL 'does not want to remain on the ward.'[87]

13.2 In the community there were aspects of his treatment with which RL did not always comply, in particular attendance at the day hospital and also his medication regime. Although RL rejected treatment in the day hospital, this course of action was pursued by mental health services, presumably because it was the only suitable resource available. In relation to his medication, when he was reviewed by Dr Mohammed (Dr Shobha's SHO) in July 2000, he was recorded as having stopped all his medication.[88] When he was reviewed by Dr Raleraskar (Dr Shobha's Associate Specialist) in June 2002, RL was again recorded as having stopped taking medication.[89]

13.3 Detaining RL under the Mental Health Act to ensure his compulsory treatment in hospital was never recorded as being actively considered. Dr Shobha, in reply to the question 'was any formal consideration given by you at that time to assessing him under section 2 of the Mental Health Act?' answered:

> *We always discuss that in the ward reviews, with the nursing staff, and following the admission ...we do not necessarily document everything that we consider, only what we consider necessary.*[90]

13.4 Apart from March 2002, the other opportunity in 2002 for a Mental Health Act assessment was when on 30 November 2002 when RL was arrested and was in police custody. This was following an allegation of rape on an adult male. We considered whether it would have been reasonable for the police

[87] Evaluation of care plan and nursing assessment for patient reviews 27 May 2002
[88] Dr Mohammed to Dr Bhasme 27 July 2000
[89] Dr Raleraskar to Dr Bhasme 7 June 2002
[90] Dr Shobha (second interview) page 22

to request an assessment under the Mental Health Act and/or a psychiatric opinion, taking into account the information recorded by Dr Bundy. Unfortunately we were not able to hear evidence from Dr Bundy and so were not able to follow that line of inquiry.

Comment

13.5 **Given the extent to which RL's risk was considered at the time, it is not surprising that no active consideration was given to his detention under the MHA. It is unfortunate that such a step was not taken in March 2002. If, rather than agreeing to his discharge, a section 2 assessment had been initiated, the criteria for detention would have been met. The differential diagnosis of organic disorder (or affective disorder) would have fallen within the classification of mental disorder. A more robust assessment of risk could have identified links between RL's inappropriate and disinhibited behaviour on the ward and the aggressive behaviour that he displayed before admission to hospital. By this stage, RL was not a compliant inpatient, as evidenced by his failure to desist from sexually inappropriate behaviour which put others at risk. RL's mental disorder remained without a firm diagnosis and required further assessment.**

Carers' Assessments

13.6 The statutory entitlement for carers to be assessed is contained in the Disabled Persons (Services, Consultation and Representation) Act 1986 and the Carers (Recognition and Services) Act 1995.

13.7 RL's mother was entitled, as carer for her son, to an assessment under both these Acts. There is little evidence that her needs as a carer were ever considered separately from the needs of her son, apart from the time that Liz Finnerty acted as RL's care co-ordinator and offered Mrs Loudwell support.

13.8 In addition, the National Service Framework for Mental Health[91] sets as a key standard (which was expected to be delivered by April 2000) the following:

> *All individuals who provide regular and substantial care for a person on CPA should have an annual assessment of their caring, physical and mental health needs; and have their own written care plan, which is given to them and implemented in discussion with them.*

13.9 The CPA policy current when Liz Finnerty was care co-ordinator is silent about assessment of carers' needs. The local CPA policy (current in 2001) states that:

> *Individuals providing 'regular and substantial' care to a person subject to CPA will be offered an assessment by the care co-ordinator. This offer will be repeated on an annual basis.*[92]

13.10 There was a failure to ensure that an assessment of Mrs Loudwell's needs, independent of the needs of her son, was undertaken. This assessment could have been undertaken before 2002. For example, in 2000 Liz Finnerty gave Mrs Loudwell details of a local carers' group. She told us she:

> *would have done a carer's assessment in my head, but not formally on a piece of paper.*[93]

13.11 Liz Finnerty felt that the kind of support that Mrs Loudwell needed was emotional in nature and as such she attempted to provide this, particularly in supporting Mrs Loudwell through RL's court process in February 2000.

13.12 Dr Bhasme recognised that Mrs Loudwell was her son's carer and was in Dr Bhasme's words 'doing everything' for RL. Although Dr Bhasme never explicitly requested an assessment, he communicated his concerns to mental health services on a number of occasions, but these never prompted an assessment.

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[91] National Service Framework for Mental Health DofH 1999 Standard 6 Caring about Carers page 69

[92] Care Programme Approach -Joint Policy between Thames Gateway NHS Trust, Medway Council Social Services and Kent County Council Social Services paragraph 11.1

[93] Liz Finnerty page 8

13.13 When RL was assessed in June 2002 by Matthew Graham and Alex Turner and by Alex Turner on his own in August 2002, no consideration was given to Mrs Loudwell being assessed in her own right, as was her statutory entitlement. We think it unlikely that either in June or August RL and his mother were seen separately.

13.14 Alex Turner did not understand Mrs Loudwell's entitlement to a carer's assessment. He thought that this entitlement was linked to RL being on enhanced CPA. We consider the fact that Mrs Loudwell was not seen on her own, to have inhibited the possibility of communication between her and the assessor/s.

13.15 As RL was often considered to be his mother's carer[94] this may provide a partial explanation as to why Mrs Loudwell's needs were never formally assessed. Another reason was given by Edwina Morris:

> *I don't think we really felt that there was anything much that we could offer.*[95]

Comment

13.16 In the light of the comments of Edwina Morris and Ann Windiate, we considered what service could have been offered to Mrs Loudwell. When Liz Finnerty was care co-ordinator she specifically addressed Mrs Loudwell's needs and tried to help meet those needs.[96] Thereafter no professional (apart from Dr Bhasme) specifically considered the needs of Mrs Loudwell. Mrs Loudwell would have benefited from a carer's assessment, through which participation in a carers' group could have been encouraged or facilitated. A separate worker for carers might have been able to encourage this. If her needs had been specifically considered, more significance might have been given to her concerns and to those of her daughter about RL's problem behaviours.

[94] See Chapter 7 Psychiatric Evaluations paragraph 7.3 concerning Dr Gilluley's assessment
[95] Edwina Morris page 12
[96] Liz Finnerty page 9

14 THE CARE PROGRAMME APPROACH

Introduction

14.1 The delivery of all mental health services is framed within the Care Programme Approach (CPA) as set out in circular HC (90)23/LASSL (90)11 and in the Welsh Office Mental Illness Strategy (WHC (95)40) national guidance. Building Bridges, published in 1995, states that the CPA is the cornerstone of the government's mental health policy[97] and provides detailed guidance about the operation of the CPA. Some requirements of the CPA were modified in 1999, these modifications are contained in a booklet entitled Effective Care Co-ordination in Mental Health Services - Modernising the Care Programme Approach.[98]

RL and the CPA

14.2 RL was a mentally ill patient 'accepted' by specialist mental health services, and therefore eligible for the Care Programme Approach. Levels of need (standard or enhanced CPA) are described in the national guidance. According to this, RL's characteristics should have led to his being on enhanced CPA from 2001 onwards.[99] These characteristics included; multiple care needs in relation to his mental health and social circumstances, contact with a number of agencies (including the criminal justice system) and being likely to need frequent and intensive interventions.

14.3 The four main elements to the CPA (as modified in 1999) include systematic assessment of the patient's needs, formation of a care plan to address those needs, appointment of a care co-ordinator, regular review and changes to the care plan where necessary.

[97] Building Bridges – a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people. DofH 1995, paragraph 3.0.3.
[98] Effective Care Co-ordination in Mental Health Services - Modernisng the Care Programme Approach DofH 2001
[99] Effective Care Co-ordination in Mental Health Services - Modernisng the Care Programme Approach DofH 2001 Part 3 page 15

Compliance with CPA local operational policies

14.4 The local policies that are relevant to our inquiry are, as follows:

i. West Kent Health Authority, Dartford and Gravesham Social Services & Thameslink Healthcare Services - Joint Policy on the CPA to the care of the mentally ill. (Operational until February 2001)

ii. Care Programme Approach - Joint Policy between Thames Gateway NHS Trust, Medway Council Social Services and Kent County Council Social Services. (Operational from February 2001)

iii. Kent & Medway Care Programme Approach Policy & Procedures (Operational from September 2002)

iv. East and West Kent Health Authorities Kent and Medway Social Services Joint Eligibility Criteria for adults with mental health problems (Operational from May 1999 to October 2003)

14.5 The 2001 local guidance (see ii above) reflects the definition of enhanced CPA set out in the national guidance. It also contains eligibility criteria for enhanced CPA including 'one or more of the following underlying conditions':

recurrent moderate and severe depressive disorders.

severe organic disorders due to brain damage and dysfunction or due to physical disease (sic) this causes significant personality and/or behaviour disorders.

If not subject to the Mental Health Act, the user will be severely mentally ill with one or more of the following factors present:

- *Heightened level of risk relating to self – harm, harm to others, serious self neglect or harmful exploitation by others.*
- *Risk of being made homeless, unemployed or imprisoned as a consequence of the illness.*

- *Known reluctance or inability to ask for or to accept help from services at times when informal care or support is insufficient.*
- *Additional needs caused by personality factors, aggression, criminal history, learning disability, substance misuse or brain damage.*

14.6 Paragraph 14.1 of the guidance (see ii above) deals with moving people between types of CPA:

> *For service users moving between Standard and Enhanced CPA, a decision is made by the Care Co-ordinator/CPA Keyworker in discussion with the service user and the Responsible Medical Officer based on the assessed need.*

14.7 The 2001 guidance (see ii above) is silent about the procedures to be followed when a client is discharged from CPA. Paragraph 2.9 of the 2002 CPA guidance (see iii above) deals with the discharge of a client from secondary mental health services/CPA occurring when a client recovers or when they no longer need secondary mental health services. The decision to discharge a client should take place within a CPA review process and must take account of the views of the client and, where relevant, the carer.

Comment

14.8 Professionals involved in the care of RL in 2002 failed to agree about whether RL was eligible for enhanced CPA. Dr Shobha took the view that he was not eligible in March but was eligible in May. Although Alex Turner said he was not clear about the criteria, he accurately described an enhanced CPA case as complex:

> ***where there are several different disciplines involved… there's a high degree of risk.[100]***

14.9 Alex Turner then rationalised his decision that RL was not eligible for enhanced CPA on the basis that RL was unlikely to engage with services. Matthew Graham appeared to take a position that RL could have been eligible for enhanced CPA under the criteria but as there was no service

[100] Alex Turner page 12

available for RL, and as he would not engage with any service, this somehow validated the decision not to place him on enhanced CPA.

14.10 We discuss elsewhere[101] the contradictions in Dr Shobha's approach to CPA eligibility between March and May 2002. No consideration appears to have been given, either by Alex Turner or Matthew Graham, to applying the enhanced CPA criteria in a systematic way when RL was assessed in June and August 2002. This less than thorough assessment undertaken by Matthew Graham and Alex Turner was accepted by Edwina Morris and used as grounds to justify RL's ineligibility for enhanced CPA. We conclude that this outcome was related to a belief that RL's needs would not be easy to provide for and/or to general work pressures within the team. We take into account that the method of contact that Liz Finnerty provided when she was RL's care co-ordinator helped keep him out of hospital and gave support to his mother. If reference had been made to her notes when RL was assessed in June and August 2002, the type of support that had worked previously would have been identified.

14.11 Edwina Morris told us that an assertive outreach function would have been ideal for RL in 2002[102]. As the service was however not available, she suggested that this justified the decision not to place him on enhanced CPA. No consideration was given to using the local policy, with the pro forma provided, to record a level of unmet need.[103] RL was simply regarded as not eligible for a service without reference to existing criteria.

Chronological summary of CPA processes

14.12 1997- 1998

After RL's discharge in 1997 he was recorded as not being a Care Programme Approach patient. After his discharge from hospital in February 1998 RL was allocated to CPA second tier. According to policy at the time there were four tiers to CPA, the second tier covering patients not posing a

[101] Chapter 5 Care, treatment and assessment

[102] Edwina Morris page 10

[103] 'Instances when resources are not available must be recorded on form CPA 6.' Care Programme Approach - Joint Policy between Thames Gateway NHS Trust, Medway Council Social Services and Kent County Council Social Services paragraph 8.3.

serious risk but needing regular multi-disciplinary review. RL's key worker was Ralph Craig, a CPN. We were informed that it was not possible to locate the CPN records for the relevant period.

14.13 1999-2000

During RL's inpatient treatment in 1999 a referral was completed and faxed to Gillingham Mental Health team. His case was allocated to Liz Finnerty. There is no record of the CPA level at the time of allocation. When she undertook her assessment on 20 August 1999, Liz Finnerty indicated RL was eligible for CPA level 3.[104] His case was then subject to regular review, with a care plan and care co-ordinator (Liz Finnerty). The assessment she undertook in August 1999 was the last comprehensive community assessment of RL's needs.

14.14 RL was recorded as on enhanced CPA on 15 December 2000. There was a CPA review at this time where it was stated that his CPA level was to be reduced after 12 weeks. It was also decided that Liz Finnerty would close the case after the end of the Sex Offenders Treatment group in May 2001. The 15th December 2000 review was the last review of RL's case while he remained on enhanced CPA.

14.15 2001

On 21 May 2001 Liz Finnerty recorded 'closes file'. The reason stated on the closing summary, dated 7 June, was 'No further input needed from Social Services at this time.'[105] From that date onwards the care co-ordinator was Dr Shobha. During 2001 RL was seen in outpatients by Dr Shobha's junior staff.

Comment

14.16 From 5 August 1999 to 21 May 2001 the evidence indicates that RL's case was effectively managed according to CPA guidance. The decision to close the case is not explicable in the context of multi-agency/disciplinary working. If the case was being managed within a properly integrated CMHT, the reference to social services input would never have been made. We heard evidence from Liz Finnerty, however,

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104 Mental Health Care Management Initial Needs Assessment, current at the time, did not require registration of the CPA level

105 Liz Finnerty to Dr Shobha 6 June 2001

that the teams were functioning quite separately at the time of allocation and that it was only in April 2001 that the CPNs moved into the same work base as the social workers, which marked the beginning of a move towards a more integrated service.

14.17 2002

RL was admitted twice to Shelley Ward, Medway Hospital in 2002. Inpatient care plans were developed on both occasions:

On 11 March 2002 his care plan included the following:

- Comply with medication
- Monitor and record mood behaviour, thought and perception
- Have regular multi-disciplinary team meetings to monitor progress and review medication
- Ventilate feelings related to anxiety and stress
- Participate in ward-based activities

On 27 May 2002 his care plan included the following:

- Attend regular outpatients
- Comply with medication
- Keep in regular contact with care manager/community psychiatric nurse

14.18 Neither of these care plans indicated the level of CPA, the identity of the care co-ordinator or a review date. Dr Shobha maintained that RL did not meet the eligibility criteria for enhanced CPA following his March admission. In May she concluded that he did meet the criteria.

14.19 As discussed elsewhere,[106] two domiciliary visits (24 June and 7 August 2002) followed at the request of Dr Shobha. The assessors in June were a CPN, Alex Turner and an ASW, Matthew Graham. Alex Turner recorded after both visits that his view (agreed by Matthew Graham) was that RL did not 'warrant CPA care co-ordination.'[107]

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[106] Chapter 5 Care, treatment and assessment

[107] Alex Turner to Dr Shobha 24 June 2002 and Alex Turner to Dr Abdelhamid 7 August 2002

Comment

14.20 We contrast the way RL's discharge from hospital was dealt with in 1999 compared with that in 2002. In 1999, following his discharge from hospital, a full discharge summary was completed, a detailed needs assessment was undertaken and he was allocated to CPA level 3 (equivalent to enhanced CPA under later guidance) with a named care co-ordinator. In 2002, although care plans were prepared, there was no indication of CPA level and apart from preliminary risk assessment forms which were completed while he was an inpatient, no risk assessment was completed. The adequacy of these risk assessments is discussed in Chapter 16 Risk Assessment/ joint working.

15 MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA).

Background

15.1 Over the last ten years formal arrangements have been developing between the police, probation and prison service to protect the public from sexual, violent and other potentially dangerous offenders.

15.2 Prior to the Sex Offenders Act 1997, risk assessment and management of convicted sexual and violent offenders, subject to supervision, were the responsibility of the probation service. The Act led to the development of Sex Offender Assessment Panels and placed a requirement on police to maintain a database of all offenders convicted of sexual offences.

15.3 Multi Agency Public Protection Arrangements (MAPPA) were established on a statutory basis by section 67 of the Criminal Justice and Court Services Act 2000. This Act required police and probation services to actively manage the risk presented by convicted sexual and violent offenders.

15.4 The aims of MAPPA are to assess and manage risks posed by those previously convicted of sexual and violent offences, in order to reduce the risk of re-offending after release into the community. The first year of operation of MAPPA was 2001-2.

15.5 The formal involvement of other agencies in these arrangements was put on a statutory basis by the Criminal Justice Act 2003, which established a 'duty to co-operate' between the responsible authorities (police, probation and prison service) and a number of agencies, including social service authorities, health authorities, NHS Trusts and Primary Care Trusts.

The evolution of MAPPA in Kent

15.6 In 1997, from the Sex Offender Panels, Kent Probation and Kent Police developed 'Potentially Dangerous Offender Panels'.

15.7 Following the Criminal Justice Court Services Act 2000, Kent developed a two-tier system for management of sexual and violent offenders; local

MAPPA (Multi-agency Public Protection arrangements) and Kent MAPPP (KMAPPP).

15.8 One role of the local MAPPA (previously known as or taking over the role of, the risk panel or sex offender panel, or Local Public Protection Panel) was to take over the risk assessment or management of convicted sex offenders. The local MAPPA dealt with those offenders not identified as posing a very high and imminent risk of harm to the public.

15.9 Those offenders assessed as posing a very high and imminent risk of harm to the public were managed by the Kent MAPPP.

15.10 For the sake of clarity we note that the local MAPPA would now be referred to as level 1 and 2 MAPPA, and KMAPPP would be level 3 MAPPP.

Comment

15.11 **During 2001 and 2002 the MAPPA system was a new process and consequently, the focus was initially on establishing systems to manage high risk offenders. RL's identified level of risk placed him within local arrangements and their development was still embryonic. This is reflected in the lack of clarity about the systems then in place and the nomenclature that was applied to them. The Kent Crime Case Review Team also noted that the lack of a standardised approach to LMAPP across the nine policing areas gave 'cause for concern'.**[108]

15.12 **Although it was recognised that general psychiatric services would be critical in assessing and managing offenders, their contribution was made only at KMAPPP (as it was then known). At this time links between health services and MAPPA were not sufficiently developed to involve as a matter of routine non-forensic psychiatrists or other staff from mental health services in the assessment and management of offenders at local MAPPA. DCI Chandler informed us that current practice today is that, if the police are aware that mental health services are involved with an offender on MAPPA level 2, they would be invited to participate in discussions about that person.**

[108] Kent Crime Case Review Team – report page 37

Changes in MAPPA from 2002 to the present

15.13 Criteria are now in place for defining offenders to be referred to MAPPA:

a. sexual offenders will be defined by part 1 of the Sex Offenders Act (1997)

b. violent and unregistered sex offenders

c. any other offender who is considered to pose a serious risk of harm to the public.

15.14 Three levels of MAPPA are now recognised.[109] This system has been adopted in Kent with a centralised system (Kent-wide) to deal with very high risk offenders (level 3 MAPPP).

Level 1: risks posed by the offender can be managed by one agency without actively or significantly involving other agencies. Offenders are generally low to medium risk. In health terms, case management needs are met by the framework of the CPA. In practical terms the level 1 meeting may consist of meetings between police and probation where the public protection officer (PPO) feeds back to the meeting so that the level of risk can be reviewed and acted on accordingly. DCI Chandler reported that the roles of sex offender liaison officers (SOLO) and dangerous offender liaison officers (DOLO) have now come together in the public protection officer (PPO).

Level 2: this refers to local inter-agency risk management - the active involvement of more than one agency is required to manage risk and may involve fortnightly or monthly meetings to allow the systematic review of risk management plans. Representation at such meetings is determined by which agencies have a role in giving general or case-specific advice. Mental Health Trusts can play an active role in level 2 management but the need for regular involvement from health at this level remains uncertain. Again, risk management of psychiatric patients will often be met by follow-up within the CPA framework. In practical terms a level 2 MAPPA will

[109] The Royal College of Psychiatrists: Psychiatrists and multi agency public protection arrangements. http://www.rcpsych.ac.uk/members/membership/public_protection.htm

deal with cases that can be managed in the local area without additional resources. Level 2 MAPP meetings now occur bi-monthly, with chairmanship alternating between senior managers from the police or the probation service. Sitting members include representatives from social services, housing, victim liaison, police and probation. DCI Chandler told us that:

> *Health is not in regular attendance unless there is a specific issue.*[110]

Level 3: Multi Agency Public Protection Panels (MAPPPs) – these panels concern only the 'critical few' assessed as posing high or very high risk of causing serious harm, or presenting risks that can be managed only by a plan which requires close co-operation at senior level due to the complexity of the case, or because of the unusual resource commitment needed. Allocation to this group depends on the level of risk the offender currently poses.

Probation Order and Sex Offender Registration

15.15 On 11 February 2000, RL was sentenced at Maidstone Crown Court, receiving a two-year probation order with the condition of attending a sex offender treatment programme (SOTP), and was required to register as a sex offender for five years.

15.16 In 2001 the local arrangements dealing with RL comprised the Sex Offender Liaison Officer (SOLO) PC McGowan and Probation Officer, Colin Croft. Colin Croft told us that:

> *the local MAPPP could really be just Kieran and I – that would be it*[111]

15.17 At time of RL's involvement with MAPPA there was no specified requirement on PC McGowan regarding how often to monitor RL.

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[110] Norah Chandler page 8
[111] Colin Croft page 9

15.18 The assessments of PC McGowan and Colin Croft contributed to the local sex offender risk assessment panels set up in each of the nine police areas in Kent. This structure provided a means by which the risks posed by sex offenders, both registered and unregistered, were managed.

15.19 Over the course of the probation order, RL came to police and probation attention on a number of occasions. During this time he was undergoing medical and psychiatric treatment.

15.20 Colin Croft and PC McGowan visited RL together on two occasions in June 2001. On 13 June 2001, RL's risk assessment was raised from medium to high.

15.21 This led to a discussion with the 'Risk Panel' in August 2001. (The Kent Crime Case Review Team refers to a report 'to the next Sex Offenders Panel Meeting for the Medway area' made following an incident in June 2001.[112]) PC McGowan told the Kent Crime Case Review Team that the August 2001 panel meeting decided RL was not a case for immediate attention, but he did need monitoring.[113]

15.22 The Kent Probation Service quarterly review plan relating to RL (6 August 2001 to 6 November 2001) records a reduction of his risk assessment to 'medium to low' risk of re-offending.

15.23 RL's probation order ended in February 2002. Colin Croft reminded RL in their final session on 5 February 2002, both of the requirements of sex offender registration and his own responsibility to manage the risk he presented. Colin Croft noted that risk had varied considerably during RL's period under supervision.

15.24 Colin Croft told us that when RL's probation order ended on 11 February 2002, he remained concerned about RL*:*

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[112] Kent Crime Case Review Team Review of the Agency Involvement with Richard Loudwell 15th February to 2nd December 2002 page 18

[113] Kent Crime Case Review Team Review of the Agency Involvement with Richard Loudwell 15th February to 2nd December 2002 page 33

because of my concerns for Richard, I said, 'you have the opportunity, for a year's voluntary free care.[114]

15.25 At the end of RL's probation order, PC McGowan had to continue monitoring RL as he was still on the Sex Offenders Register. Colin Croft only had a statutory responsibility for the duration of the probation order and his involvement thereafter was on a voluntary basis.

15.26 Hilary James (now Chief Officer Kent Probation Area) described current arrangements for managing cases still regarded as high risk at the end of a probation order:

> *…if we have a case terminating which we regard as still being a high risk in the community, we would make sure that other agencies were aware of that. We would expect, obviously, the police to be involved in that and… the fact that we would not…be further involved in it, is that once an order or licence is finished, we don't have any sanctions… so there is nothing we can do (if we think somebody's behaviour is becoming risky), other than to report it to the police and for them to take whatever action they are able to take*[115]*.*

Upgrading RL's risk

15.27 Maurice O'Reilly (now Area Manager - Public Protection and Victims Kent Probation area) advised us that the level of supervision afforded RL did not change in the light of the raised level of assessed risk as:

> *he was already being supervised appropriate to his assessed risk of harm level.*[116]

He also surmised that PC McGowan and Colin Croft increased the level of assessed risk:

> *…to offer a greater level of surveillance and monitoring*[117]

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[114] Colin Croft page 12
[115] Hilary James page 9
[116] Maurice O'Reilly's letter to Verita 2.2.06
[117] Maurice O'Reilly page 13

15.26 When asked about Colin Croft's notes of 13 June 2001, Maurice O'Reilly told us that he had discussed the raised level of assessed risk with him on 10 July 2001:

> *I have agreed that the behaviour was changing and that we should increase the level of reporting and monitoring of this offender.*[118]

15.27 Hilary James noted that the purpose of the raised risk assessment was:

> *to raise awareness levels and increase levels of monitoring.*[119]

15.28 David Stevens (a retired detective superintendent) gave evidence that in 2001, when RL was elevated to high risk, there was a routine process of evaluating everyone on the Sex Offenders Register and that LMAPP arrangements grew out of this process but with no apparent health representation. He agreed that, using subjective intelligence on RL, he was appropriately elevated to high risk, but this was different from very high risk which now would equate to level 3 MAPPP (or KMAPPP as it was then known). David Stevens concluded that RL never fitted into the 'very high risk criteria'.[120]

15.29 Both DCI Chandler[121] and Maurice O'Reilly concluded that RL would probably not reach level 3 using current criteria as the risk had not been assessed as imminent. By applying current criteria to the situation as it existed in June 2001, Maurice O'Reilly commented:

> *this case would very clearly come in to the level 2, possibly the level 3 arena.*[122]

15.30 Hilary James thought at the time of the risk revision in June 2001 that:

> *...he would probably have gone to a level 3 MAPPP for people to take a view as to whether he should become a level 3 MAPPP and be followed through that process.*[123]

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118 Maurice O'Reilly page 18
119 Hilary James to Verita 23.1.06
120 David Stevens page 8
121 Norah Chandler page 15
122 Maurice O'Reilly page 12
123 Hilary James page 6

Hilary James told us that this process would now involve health representation.

15.31 We asked DI Hubbard about the purpose of raising RL to high risk after the visits in June 2001:

> *The purpose would have been just to raise his awareness levels... he'd have been recorded on the Genesis information system as high risk.*[124]

15.32 This was also confirmed in the Kent Crime Case Review Team report:

> *The significant impact of this was to heighten the awareness of Police Officers across the county of the potential risk LOUDWELL posed to the public in their future dealings with him. It did not achieve a proactive plan of action for LOUDWELL to be monitored personally by the SOLO, or by his instigation.*[125]

15.33 Maurice O'Reilly told us that if he were now chairing a level 1 risk assessment panel, and information given by police and probation indicated an upgrading of risk, in accordance with the risk matrices:

> *I would expect them to say that we need to set up a multi-agency conference with representatives from the different agencies, and that may be dealt with as a level 2 or put up to level 3.*[126]

He was unsure why this did not happen then, except that it was a new area of work and an evolving process.

15.34 In relation to RL's risk Hilary James told us:

> *If he'd been raised to a high risk at that stage, the practice would be that the case would be discussed at the KMAPPP and the KMAPPP*

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[124] David Stevens/Tony Hubbard page 5

[125] Kent Crime Case Review Team Review of the Agency Involvement with Richard Loudwell 15th February to 2nd December 2002 page 34

[126] Maurice O'Reilly page 13 & 14

may take the view to endorse the high risk status. Or it might take the view that actually he should be reduced to a medium risk[127]

Psychiatric services and MAPPA

15.35 Dr Dunkley (Consultant Forensic Psychiatrist at the Trevor Gibbens Unit) told us that forensic psychiatry services had contact with MAPPA in 2002. From April 2001 there were 17 referrals from the MAPPP for risk assessments and 64 from probation and youth offender teams. This number of referrals should be set alongside an approximate annual figure of some 3900 offenders being supervised by Kent Probation Service.[128]

15.36 Prior to 2002 widespread concerns in relation to an individual patient resulted in the forensic services tasking a consultant to attend weekly the level 3 MAPPP meetings.

15.37 Dr Dunkley suggested that local MAPPA arrangements with non-forensic mental health services were less structured, though they may include consultant or CPN involvement.

15.38 Dr Dunkley also raised doubt that an individual offender would necessarily advise their probation officer that they were seeing a psychiatrist:

> *there is no common data base and there is no way that probation would necessarily be able to guess that somebody was involved, and you can have systems where people are working completely in parallel without realising it.*[129]

15.39 DCI Chandler described, for health, a route into MAPPA through a referral to the public protection officer (PPO) who is a nominated police constable in each area. The PPO is responsible for maintaining VISOR – the Violent and Sex Offenders Register. The PPO would then 'talk to' a detective sergeant, who would 'talk to' a detective inspector and a decision would be made about referral to MAPPA.

15.40 Maurice O'Reilly said health workers seldom came to MAPPA meetings.

[127] Hilary James page 4
[128] Maurice O'Reilly to Verita 2.2.06
[129] Dr Dunkley page 5

David Stevens told us:

> *If health can contribute (to local MAPPA)... it's really important.*[130]

15.41 The MAPPA Annual Report 2002 by Kent County Constabulary and the National Probation Service, records that the NHS has a broad interface with offenders ranging from drug and alcohol treatment through to addressing other physiological and psychological needs. The report goes on to state:

> *It is in the area of mental health where their activity is most prevalent. The need to fully understand risk particularly of the most serious offenders is highly dependent in a number of cases on psychiatric assessment. In this regard the Kent Forensic Psychiatry Service plays a fundamental role in carrying out such assessments and providing a report which will inform any panel discussion. Community Mental Health Services have an equally critical role in ongoing assessment and management plans.*[131][Our underlining]

Comment

15.42 **At the time that RL's case fell within MAPPA, the process was under development. RL's risk assessment throughout his probation order reflected both the experience of Colin Croft and PC McGowan and the use of risk assessment tools available to them at the time.**

15.43 **Increasing RL's level of assessed risk in the summer of 2001 was based more on concerns over his activities than actuarial measures of risk and did not appear significantly to impact on the amount of attention he received from probation or police.**

15.44 **MAPPA was and remains a system led by probation, police and the prison service. In 2001 and 2002, there was health involvement in relation to more serious offenders, but not at a local level.**

15.45 **The management of RL's case in 2001 and 2002 reflected the structural uncertainty that existed at that time in relation to local MAPPA. RL was**

[130] David Stevens page 11
[131] Kent County Constabulary/National Probation Service Kent MAPPA Annual Report 2002 pages 4-5

being managed by probation and police, with no involvement in the MAPP process from mental health services, despite recognition of increased risk and the fact that he was in contact with psychiatric services. Apart from discussion between police and probation services, there was no referral to a multi-disciplinary conference and no contact or communication with his CPA care co-ordinator. RL's case was 'to be reported' at the Sex Offender Panel for the Medway area[132] and there was apparently a discussion with this panel in August 2001.[133] No minutes of these discussions or meetings have been produced.

15.46 It seems likely that an increase in the level of assessed risk would now trigger a meeting, as it should have done then, to assess the appropriate service response. Representatives from health would be invited if it was felt relevant.

15.47 Witnesses from the police and probation service seemed unclear both then and now about the nature and purpose of the CPA. They were also not aware, beyond the superficial, of health involvement in RL's case. Similarly staff working for mental health services (forensic psychiatry services aside) appeared to have little knowledge of MAPPA.

15.48 Colin Croft perceived Liz Finnerty to be the link between mental health services/social services and police/probation. When this link was severed, there was little prospect of police or probation involving mental health services. This would have required recognition of RL's mental health problems and understanding of the significance of the involvement of Liz Finnerty. In the light of Colin Croft's lack of knowledge of the CPA process and the absence, as he saw it, of links between RL's offending behaviour and his mental health difficulties, it is perhaps not surprising that there was no contact between him and RL's care co-ordinator after May 2001.

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[132] Kent Crime Case Review Team Review of the Agency Involvement with Richard Loudwell 15th February to 2nd December 2002 page 18

[133] Kent Crime Case Review Team Review of the Agency Involvement with Richard Loudwell 15th February to 2nd December 2002 page 33

16 RISK ASSESSMENTS / JOINT WORKING

Health Service

16.1 Effective Care Co-ordination in Mental Health Services states:

Risk assessment is an ongoing and essential part of the CPA process. All members of the team, when in contact with service users, have a responsibility to consider risk assessment and risk management as a vital part of their involvement, and to record those considerations.[134]

16.2 In both March and May 2002, while RL was an inpatient, CPA mental health risk assessment forms were completed. We compared the way the forms were completed:

CPA 3A – risk categories	6 March 2002		24 May 2002	
	Past	Present	Past	Present
Risk of suicide or self harm	X	X	X	√
Risk of harm to others	√	X	X	X
Risk of self neglect/exploitation/abuse by others	X	X	√	√
Sexual risks	√	X	√	√

CPA 2A - information contained in form	Source of information	Alternative information
Has had two serious relationships – one lasted for 18 months and the other for 8 months (6.3.01 form)	Self report	Following his arrest for the murder, he gave different accounts to different doctors. He told the probation officer who prepared the report in 2002 for the indecent assault charges that he never had a sexual experience with an adult
..had a very good relationship (with) family who are supportive to him – has got loads of friends CofE actively practicing (6.3.01 form) Does not have a large social network – is socially isolated and lonely. (24.5.02 form)	Self report	He has few friends and has withdrawn from attendance at local church (Tim Craven probation report 8.2.2000)
…nil of note on physical aggression (6.3.01 form, 25.5.02 form silent)	Self report	Aggressive for about 6/52 (Dr Raleraskar 11.3.02)
Sex offence by touching the breast of [adult member of his family] (6.3.01 form) …is on the Sex Offenders Register for inappropriately touching female family member (24.5.02 form)	Self report	RL was also convicted of charges of indecent assault for offences covering the period 1975 to 1980. 'Twenty-five years earlier when [the family member] was living with him and her grandparents at the cottage he had abused her on a number of occasions. (Tim Craven probation report 8.2.2000)

[134] Effective Care Co-ordination in Mental Health Services - Modernisng the Care Programme Approach DofH 2001 page 21 paragraph 74

16.3 In March and May there was no evidence of any systematised risk assessment before RL's discharge from hospital. When Alex Turner completed his re-assessment in August, he asked RL to complete a 'Beck's Depression Inventory, Hopelessness Scale and Suicidal Scale', with which RL complied. This document, which relies on self-report, focused only on the risk of harm to self. Following the June and August community assessments, there was no evidence of proper evaluation of inpatient notes before the assessments. In addition there was a failure to:

a. accurately record risk in the inpatient setting

b. transmit key information from the inpatient assessors to the community assessors (for example the June assessors knew that RL was on the Sex Offenders Register but were not aware of, amongst other things, his behaviour on the ward and the concerns about his behaviour expressed by both his sister and his mother)

c. transmit key information from one inpatient admission to the next.

Comment

16.4 The inpatient assessors recorded some historical risk factors. The inventory, narrative, and nursing care plan covering risk to self and others did not use this information to inform a risk management plan. There was no comprehensive overview of RL's case combining all the different aspects of his problems and diagnosis, and linking this to a management plan. Following the March and May inpatient admissions there was plentiful material on which to base a risk assessment. The information was never properly synthesised and linked with the historical information.

16.5 The completion of a risk inventory is not the same as a risk analysis, and even a risk analysis, no matter how well completed, serves no useful function unless management strategies are adopted in the light of it. The risk assessments completed on RL focused on the risk of self-harm and necessarily relied on self-report. The way the inpatient forms were completed illustrates however, the downgrading of the actual risk that RL presented in 2002. If the information on the two forms had been

combined, and we found no evidence that it had been, RL's risk profile would have been differently evaluated. No other risk pro-formas, or other forms of risk assessment, apart from the Beck's Inventory, were completed in 2001 and 2002. This is particularly noteworthy in relation to RL's assessments in the community in June and August 2002.[135]

Probation Service

16.6 Maurice O'Reilly summarised the probation service's assessment of the risk RL presented:

He was a registered sex offender…he was initially assessed as a low risk but then the risk increased some time during his supervision.[136]

16.7 Certainly the assessment of the risk that he presented varied considerably during his period under supervision.[137] The following table is based on the supervision and case management plans contained in the probation service files:

	Risk of re-offending	Risk of harm to public	Victim awareness	Risk of harm to self	Risk of harm to staff
22.2.00	Medium to low	Medium to low	Low	Medium	Low
6.11.00	Low	Low	Low	Medium	Low
6.2.01	Low	Low	Low	Low	Low
14.5.01	Medium	Medium	Low	Low	Low
7.8.01	High	Medium	Medium	Low	Low
6.11.01	Medium to low	Low	Medium	Low	Low

16.8 We did not see any further plans. We note that the Kent Case Crime Review Team recorded that on 8 January 2002 RL was still considered to be high risk after his supervision ended 'due to his behaviour and attitude.'[138]

135 Clinical and Practice Review into the care of RL – states: 'there is no documented evidence of a formal and systematic risk assessment having been undertaken by mental health staff, either as an inpatient or in the community.'
136 Maurice O'Reilly page 8
137 Probation records – risk assessment: documents
138 Kent Crime Case Review Team Review of the Agency Involvement with Richard Loudwell 15th February to 2nd December 2002 pages 18-20

Police and probation service - joint working

16.9 RL was registered as a sex offender on 15 December 2000 at Rochester Police Station. Following RL's registration, collaborative working between the police and probation services developed. Colin Croft was closely involved with PC McGowan, who was the Sex Offender Liaison Officer for Medway. Colin Croft told us that he developed good relationships with the sex offender liaison officers which were *'a good way of sharing information.'*[139]

16.10 PC McGowan and Colin Croft agreed a joint evaluation of the risk that RL presented. On 13 June 2001, they decided that they should raise his risk assessment from medium to high.

Comment

16.11 The police and probation service variously identified the risk that RL presented. Together they managed the risk that RL presented within the limits, and duration, of the probation order. When the order ended RL remained on the Sex Offenders Register and the police continued to monitor him, Colin Croft also maintained informal contact with RL and his family.

Communication between agencies

16.12 Alongside the failure by the mental health service risk assessors to properly evaluate risk using information available to them, the wider process of risk evaluation, in particular sharing information with other agencies did not take place.

16.13 The probation and police services together evaluated, monitored and managed the perceived risk that RL presented. There was however no communication between these two organisations and the mental health service after Liz Finnerty closed the case. Colin Croft was not aware that Dr Shobha was the care co-ordinator after Liz Finnerty closed RL's case, and he had never worked with Dr Shobha. He felt that Liz Finnerty's

[139] Colin Croft page 6

involvement was essentially to monitor RL's mental health,[140] and his own concerns about RL never related to him having a mental illness. This was reflected in the absence of any communication between Colin Croft and mental health services when the probation order ended.

Comment

16.14 **If there had been contact between the agencies, we consider it likely that police intelligence about RL's problem behaviours would have contributed to RL's continuing risk assessment and management within mental health services. In 2002 RL was on the Sex Offenders Register with a documented history of paedophilic offences, offences against a female adult, inpatient sexual disinhibition, possible memory problems, unusual behavioural disturbances that remained unexplained, a recurrent depressive disorder, a limited social network and increasing reliance on an elderly mother. He was jobless and episodically preoccupied with his sexual functioning. He was discharged from inpatient psychiatric care in March 2002 because of his disinhibited speech and behaviour.**

[140] Colin Croft page 10

17 ORGANISATIONS RESPONSES TO THE HOMICIDE

Health service - Serious Untoward Incident Procedure

17.1 The terms of reference of our inquiry require consideration of the extent to which local operational policies were followed after the homicide committed by RL. We read an outline of the Serious Untoward Incident Procedure. The Clinical and Practice Review was undertaken according to this procedure. The purpose of the Clinical and Practice Review was, according to Nessan Thambiah, the author of the review report, to learn from the incident and identify areas of risk:

> *It identifies issues that the organisation needs to deal with in terms of service delivery, resources, staff training, and for the team to learn through this experience to see what changes they need to make to their own service delivery.*[141]

17.2 The Clinical and Practice Review into the care of RL was undertaken on 13 January 2003. The only participants were from mental health services. The review made various recommendations and developed an action plan.

17.3 The Clinical and Practice Review was inaccurate insofar as it referred to the probation service's risk assessment of RL as of low risk of re-offending. In reality the probation service's evaluation of RL's risk varied: for example in June 2001 he was regarded as high risk by Colin Croft and PC McGowan and when the order ended he was still considered high risk. The Clinical and Practice Review also referred to RL having asked for sex from female patients during the May admission, but this was in fact during the March admission. His demeanour had been very different during May. Aside from these inaccuracies, the Clinical and Practice Review went on to identify some of the concerns that have come to light through our inquiry, namely: poor compliance with CPA processes, inadequate risk assessments in June and August 2002, poor communication within the CMHT and an unclear rationale for not offering RL a service. It is surprising that the reviewers took no account, or maybe were unaware, of the work by Liz Finnerty between 1999 and 2001, when full notes had been maintained which could have helped formulate risk assessments, taking into account the historical

[141] Nessan Thambiah page 9

perspective, particularly as she had detailed her numerous contacts with the probation service.

Action Plan

17.4 The Clinical and Practice Review was accompanied by an action plan to meet its recommendations. The objectives of the action plan were to foster better joint working, communication and shared decision-making within the CMHTs, as well as greater emphasis being placed on risk assessment.

17.5 We have considered the action plan and comment below, in general terms, upon the relevance and sufficiency of the recommendations:

Action Plan recommendations	Our comments
Care co-ordinators supported by team managers must ensure that there is documented evidence that the risk assessment policy is adhered to by all staff.	This recommendation appears to place managerial responsibility on individual care co-ordinators. The managers should ensure that the current CPA policies and procedures are adhered to; and the care co-ordinators have an individual responsibility to manage each case according to existing policies and ensure that a risk assessment is undertaken.
Team managers must ensure that where clients are not offered a service for which they are referred; there is documented evidence of the rationale for rejecting that referral.	The outcome of any assessment will result in a conclusion that either there is no need for a particular service, or that there is a need which can, or cannot, be met within existing service provision. The recommendation does not make this distinction.
Reported incidents of threats or violence towards others must be shared with all members of the CMHT. A risk assessment of the threats should be undertaken.	This recommendation is unnecessarily specific by confining incidents to 'threats or violence' and does not cover, for instance, risk behaviours such as sexual disinhibition.
Copies of the assessment documents must be made available to the referrer.	We agree with this recommendation.
The Team Managers and consultant must ensure that systems are in place to improve joint working and shared decision-making regarding patient care matters.	Our reservation about this recommendation is the use of the phrase 'shared decision making'; the term 'effective decision making' more accurately reflects the work that has to be undertaken in this context to fundamentally improve joint working.
The team undertakes a review of its operation, allocated resources and service utilisation of its resources in order to meet safe service delivery.	Any review of this nature should be instigated outside the team by personnel senior to the team manager/s and should include, as part of the process, comparison with other similar teams.

17.6 Information that was not explicitly contained in the action plan was Nessan Thambiah's concerns about the quality of the community assessments undertaken in 2002. He considered that they were not adequate and therefore did not amount to safe practice. He accepted that there was no follow-up on this point in the action plan and suggested that if a similar type of review were to be undertaken now:

> *We would put them through specific training or supervision systems. There would be more than one action to support the individual*[142]*.*

Comment

17.7 As indicated above, the Clinical and Practice Review contained factual inaccuracies and failed to involve or take account of the work and perspective of the police and probation service. Perhaps more surprisingly, the considerable work by Liz Finnerty was not considered at all. Thus the review could be seen as limited in its scope.

17.8 Nessan Thambiah was not aware of the MAPPA processes at this time. This is not a criticism as few health staff were aware of the nature and purpose of the arrangements. He was given inaccurate information about the probation service's view of RL's risk status. We consider that this reflected a compartmentalised approach to understanding the problems presented by RL's case. We consider that if a representative from the probation service had been invited to participate in the review, further information about RL's behaviour would have been known, which would have contributed to the action plan. Equally, if social services' notes had been studied by the reviewers more relevant information would have been available. This would have highlighted for them the lack of integration of services within the CMHT.

Police and probation service reviews

17.9 The police and probation service conducted a review of the RL case on 22 April 2004 in conjunction with another case (RL & P review). The purpose of the RL & P review was to be 'a learning exercise to improve practice and

[142] Nessan Thambiah page 12

look at reviewing cases.'[143] The minutes of the meeting contained opening statements from Detective Superintendent Greg Barry and Maurice O'Reilly,

> *Within the (RL) case, there were health issues and this should be a consideration of all case reviews.*
>
> *Consideration of health was a big issue. Agencies were not aware of the level that health were involved in the (RL) case. Health was now included in the duty to co-operate, which was not around when this case was ongoing.*[144]

17.10 The minutes of the meeting also refer to the circulation of a review by Hilary James, In the context of this review, Rob Verity, Assistant Chief Officer, Kent Probation area noted:

> *...there was a psychiatric report that was not included and that it had not highlighted medical issues.*[145]

17.11 One of the conclusions of the RL&P review was apparently that Kent Probation Service had no idea of RL's mental health problems. However this does not take account of the communication between Liz Finnerty, Colin Croft and other probation officers.

17.12 Hilary James told us such a review did not exist:

> *That has to be an incorrect minute because if I had conducted a review, it's quite clear from the file that there were many discussion between Colin Croft and the mental health social worker as to Loudwell's health problems, together with a full and detailed psychiatric report which relates his history of depression.*[146]

Comment

17.13 At the outset of the RL&P Review meeting it was minuted that consideration of health was a 'big issue.' Mental health services were

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[143] RL&P Review 22 April 2004 page 1
[144] RL&P Review 22 April 2004 page 1
[145] RL&P Review 22 April 2004 page 2
[146] Hilary James page 7

however not represented at the review in April 2004 and the absence of a representative illustrates the continuing compartmentalised approach to the problems highlighted in RL's case. If a representative from mental health services had been present (perhaps Nessan Thambiah who had chaired the internal case review and therefore had knowledge of the case) then the accuracy of the information recorded might have been improved.

Kent Crime Case Review

17.14 The Review of the Agency Involvement with RL conducted by the Kent Crime Case Review Team (Kent Crime Case Review) included the following terms of reference:

- *Establish and make comments on how the Police worked with other agencies in managing LOUDWELL prior to the murder of Joan Smythe*
- *Involvement of the probation service and relevant health authorities*

17.15 The purpose of the Kent Crime Case Review was to:

learn lessons and identify opportunities to improve systems and processes both in terms of future sex offender management and the review process.

Comment

17.16 We found the Kent Crime Case Review helpful in providing clear and detailed information about the extent of police and involvement with RL. The review drew attention to the quantity of information available to the police service and also to the probation service, because of the close working relationship between Colin Croft and PC McGowan, which would have helped health services in assessing the risk RL presented to the public.

17.17 Nobody from health or social services was interviewed during the Kent Crime Case Review process, or attended the key meeting on 16 May 2003. This is reflected in the conclusions of the review, which contain no reference to health or social services. David Stevens told us that this review was modelled on the Part 8 review process (a multi-agency review undertaken under child protection procedures) and was the first of its type undertaken in Kent for this type of case.

18 SERVICE DEVELOPMENTS SINCE 2002

Introduction

18.1 One of our tasks has been to evaluate how far the organisation and structures surrounding the delivery of psychiatric care and treatment to RL have developed and changed since December 2002.

CPA

18.2 A systematic analysis of all incidents in the first year of existence of West Kent NHS and Social Care Trust (2002) identified poor implementation of CPA and inadequate risk assessment as top of the list of causal factors.[147]

18.3 Key witnesses, including James Sinclair and Kevin Lindsay, in senior managerial positions, all stressed that the delivery of the CPA had changed and improved since December 2002. The weaknesses identified by James Sinclair included: recording on case files, out-of-date risk assessments, care plans not properly used and poor communication and sharing of information.

18.4 Methods to improve individual professional's performance through supervision and appraisal include the provision of joint training on the delivery of CPA. CPA audits conducted by Margaret Vickers, based on random file reviews have indicated improvement. The audit is annual and involves one file per care co-ordinator being randomly selected and reviewed.

18.5 In addition, the managers of the service including Kevin Lindsay, John Hughes and Philippa Macdonald are working to improve CPA delivery through regular management review.

18.6 Claude Pendaries considered that the delivery of the CPA had improved since December 2002:

> *there is a single approach used by health and social care staff… risk assessment is much better… quality of care plans better*[148]

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[147] Claude Pendaries page 3
[148] Claude Pendaries page 2

Carers' Assessments

18.7 We identify elsewhere[149] the failure to provide Mrs Loudwell with the carer's assessment to which she was entitled. James Sinclair told us that there was now an increased capacity within CMHTs to conduct these assessments.[150] The assessments are now being undertaken by dedicated staff, and according to John Hughes the number of assessments being undertaken is growing.[151] The reality of the current situation does seem to be that although the numbers of assessments are increasing as Ann Windiate told us a carer's assessment, in fact:

> *Is only of value if you can provide something in relation to the needs you identify... when we assess carers there is very little to offer them in the way of services at the moment and people are not imaginative enough – or carers are not demanding enough – that they want something additional for themselves.*[152]

Integrated working

18.8 In 1997/8 the Trust mental health teams and social service teams 'started to have joint meetings'.[153] Professional staff are now physically located at the same base. Matters have improved considerably in Medway since mid 2002 when James Sinclair told us that there were:

> *separate groups of staff who were really working in isolation. They were trying to work in partnership in an integrated way but they were still very separate and disparate.*[154]

18.9 James Sinclair considered that this physical change in the location of staff had promoted a parallel cultural change, whereby professionals are working more effectively together.

[149] Chapter 13 Compliance with Statutory Obligations paragraph 13.6
[150] James Sinclair page 5
[151] John Hughes page 10
[152] Ann Windiate page 17
[153] Mike O'Meara page 3
[154] James Sinclair page 9

18.10 Kevin Lindsay considered that in 2002:

> '*every profession could not have been more separate and individual within the organisation.*[155]

The most pressing need was to have all the team members in the CMHT bases.

18.11 Claude Pendaries referred to multi-disciplinary working as having 'progressed in leaps and bounds'[156] and multi-disciplinary training as promoting this process.

18.12 John Hughes felt that the integration, not only within CMHTS, but also between CMHTs and inpatient services, had improved:

> *Having ward managers go out to the CMHTs for their referral meetings, having the community staff coming into the wards, had made big differences. But there are still lots of barriers to be broken down there.*[157]

18.13 Nessan Thambiah considered that the Gillingham Community Mental Health Team had changed:

> *The consultants are now based there, we have changed leadership, we have put the structures in place… Because the team is now together and better integrated, I will be more confident.*[158]

Investment in the Gillingham CMHT

18.14 The action plan prepared following the Clinical and Practice Review[159] stated that, following the review of the Gillingham CMHT where under resourcing had been identified, service reorganisation and developments:

[155] Kevin Lindsay page 3
[156] Claude Pendaries page 7
[157] John Hughes page 6
[158] Nessan Thambiah page 8
[159] Chapter 17 Organisations Responses to the Homicide paragraph 17.4

will involve an effective increase of resources by some 20% through a refocusing of teams work on long term complex cases only. All assessment and intake will be managed by a new CRHT team.[160]

18.15 This service reorganisation was recorded as being implemented by November 2004.

Current investment in mental health services[161]

18.16 Over the last three years Medway Primary Care Trust has invested £1 million above nationally agreed contract uplifts in adult mental health services for the local population. This investment has been used to develop an early intervention service, crisis resolution home treatment service, to improve access to services for people with personality disorders and to increase the capacity to provide carers' assessments. Although bed numbers have reduced, the PCT has maintained its level of investment in inpatient acute mental health services provided by West Kent NHS and Social Care Trust. This continuing investment is to support the Trust in increasing numbers of staff on its acute mental illness wards.

18.17 A report to the PCT Board on 18 January 2006 contained the following information:

- *The Community Mental Health Teams provided by West Kent NHS and Social Care Trust have recently undertaken a service redesign. This has resulted in the creation of 3 fully integrated Community Mental Health Teams across the area. These teams will provide longer-term treatment, recovery and assertive outreach to the seriously mental ill.*

- *The Gillingham CMHT has recently won a Community Care Magazine award.*

- *Acute Mental Health services; consisting of two inpatient units, Brooke and Shelley, and the recently established Crisis*

[160] RL (Medway) 2004 Action Plan, Recommendation 6.
[161] The information in this section of the report was provided to the inquiry by Bill Gillespie, the Chief Executive of the Medway Primary Care Trust

Resolution Home Treatment Team (CRHT); have recently been further developed by introducing a single Inpatient Consultant Psychiatrist and a CRHT Consultant Psychiatrist. These developments have improved the experience of service users who are now able to have individual reviews with the Consultant. This improved patient pathway has resulted in 16 vacant beds and the Trust is confident that this will reduce by a further 8 bringing the total number to 24 as planned for the new unit. This Consultant led model has been recognised by The National Institute for Mental Health in England (NIMHE) as best practice and the South East Development Centre (SEDC) has commended these services to other Mental Health Providers as the preferred model.

Record-keeping

18.18 When asked about the shortcomings that continued to be apparent in the CPA procedures, Philippa Macdonald highlighted the process of communicating information from inpatient to community services. She identified as a particular problem the delay that could occur in locating where an individual known to the team is admitted as an inpatient. This could result in an individual being discharged from an inpatient site without the CMHT being informed.[162]

18.19 Both Philippa Macdonald and James Sinclair identified continuing problems with the flow of information from the inpatient setting to the community teams. Separate records are maintained and there appears to be no quick or established means of transferring information from one setting to another:

> *we have the medical record, the notes on the ward, the community team holds a file for example and it is extremely problematic.*[163]

18.20 In the absence of common electronic record keeping systems, Claude Pendaries identified the solution as all teams being able to achieve:

[162] Philippa Macdonald page 5
[163] James Sinclair page 15

Commonality of clinical notes between members of the same team by using the same care plan, the same CPA documentation including the risk assessments even if they keep their professional notes separately.[164]

18.21 Claude Pendaries also considered that record-keeping had improved, if only because social workers, nurses, psychologists and other professionals work side by side in the same building. He told us, however, that there was no genuinely integrated common record system, although the Gillingham CMHT had volunteered to pilot one.[165]

Supervision

18.22 James Sinclair described a process, which is in development for joint management supervision for all professional staff. Claude Pendaries told us that there was now (operational May/June 2005) a single management supervision framework common to the various members of the same team.[166] Philippa Macdonald told us:

there is a clinical co-ordinator who helps manage the nursing staff and provides clinical supervision and guidance, and... Geoff Turner... who provides the managerial and social care supervision for the social care staff in the team.[167]

Managing risk

18.23 Claude Pendaries described the developments generally across the Trust, namely a strategic and an evidence-based approach to risk management. He regarded his job as 'trying to articulate a corporate and systemic approach'[168] to risk analysis and management across the Trust.

18.24 Claude Pendaries described an analysis of the Serious Untoward Incident Reports, with five identified risks accounting for 85% of serious untoward incidents (SUIs). These risks were: poor risk assessment/management,

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[164] Claude Pendaries page 10
[165] Claude Pendaries page 10
[166] Claude Pendaries pages 8-9
[167] Philippa Macdonald pages 1-2
[168] Claude Pendaries page 6

defective CPA procedures, lack of co-ordination betweens services and /or agencies, poor compliance with Trust policies and poor quality of patient's notes

Comment

18.25 **Objective data about service change is not always easy to identify. It is clear that the Gillingham CMHT is now an integrated service insofar as there is one manager and there are systems common to all team members. The team members are on one site. Cases are allocated according to client need rather than the preference of individual team members. Supervision and management arrangements have been developed and have improved. We discuss the CPA elsewhere [169] but here we highlight one particular and continuing problem: the lack of communication between inpatient and community teams.**

[169] Chapter 14 The Care Programme Approach

19 CONCLUSIONS

Introduction

19.1 In paragraph 2.17 of this report we refer, in outline, to effective work undertaken with RL and his family. If this type of monitoring and support had been provided to RL (as it had on occasions in the past) from March 2002 onwards, inter-agency communication would have been enhanced and the growing risk that RL presented could have been more readily identified and managed. While different management strategies might, however, have reduced the risk of serious sexual offending, we are unable to conclude that the homicide that RL committed was either predictable or preventable. The reasons for this are various and include the fact that RL was particularly difficult to diagnose, treat and manage.

Individual Criticism

19.2 Our principle purpose throughout this inquiry was to establish the facts and identify constructively lessons to inform future practice in the care and treatment of patients such as RL. In doing this, we found it necessary to criticise the work of certain individuals. We informed everyone concerned of the points of potential criticism and we gave them an opportunity to comment. When we criticised individuals, we tried to put the individual failure into context. We have drawn our analysis of the performance of some individuals to the attention of the commissioners of this inquiry, and we have made recommendations for action.

Terms of Reference

The following conclusions are based on the Terms of Reference (see Annex 1) and summarise information contained elsewhere in this report.

Compliance with statutory obligations

The extent to which RL's care corresponded to statutory obligations, particularly the Mental Health Act 1983.

19.3 We considered the use of the Mental Health Act 1983 and the statutory entitlement for carers to be assessed, contained in the Disabled Persons (Services, Consultation and Representation) Act 1986 and the Carers (Recognition and Services) Act 1995.

19.4 Given how RL's risk was understood by all the mental health professionals who provided him with care and treatment, it is not surprising that an assessment under the Mental Health Act was not actively considered. With hindsight, it is unfortunate that such a step was not taken in March 2002. We consider that RL's detention under section 2 of the Mental Health Act 1983 (admission for assessment for 28 days) would have been justified at this time.

19.5 Mrs Loudwell was entitled to a carer's assessment. There were a number of opportunities to assess her, but no formal assessment was offered. We consider that this contributed to the feelings that Mrs Loudwell and her daughter communicated to us, namely that they felt they were not listened to, that their concerns were minimised, and that they were excluded from decision making processes.

Compliance with the Care Programme Approach (CPA)

The extent to which RL's care corresponded to relevant guidance from the Home Office and Department of Health Care Programme Approach (HC(90)23/LASSL(90)11) Supervision Registers (HSG (94)5); Discharge Guidance (HSG) (94) 27; and local operational policies.

19.6 The CPA was introduced in 1990 as the framework for the care of people in England with mental health needs. We were struck by the fact that when we examined the application of the CPA during the critical years of our investigation (2000 to 2002), the responses from professionals seemed to indicate a perception that CPA was somehow a new system. In fact CPA had already been in existence for over a decade.

19.7 We identified poor CPA compliance in a number of key areas including; mis-application of criteria, absence of preparation of comprehensive care plans, absence of formal risk assessment and/or its documentation and failure to record unmet need.

19.8 In 2002, RL should have been placed on enhanced CPA and should not have been discharged from hospital in March until this had been effected. If it had been decided that he was not detainable and that it was necessary to discharge him because of his behaviour, a post-discharge CPA review could have been arranged. If he had been placed on enhanced CPA with an allocated care co-ordinator, there would have been no need for the June and August assessments to have taken place. RL's May inpatient admission and the June and August assessments presented further opportunities to rectify the situation. This did not happen. RL's May discharge was not properly planned and he should have been placed on enhanced CPA before discharge. He should have been re-assessed in September, following the request from a psychiatrist.

Treatment and Care

The appropriateness of RL's treatment, care and supervision in respect of:

- **His actual and assessed health and social and support needs**;
- **His actual and assessed risk of potential harm to himself and others**;
- **His previous psychiatric history and treatment including drug and alcohol misuse.**
- **The documentation recorded relating to the above.**

19.9 The inpatient treatment that RL received, particularly in 2002, lacked direction. We consider that the decision to discharge RL in March 2002 without at the very least an agreement to his being placed on enhanced CPA was the wrong decision on the basis of the information then available.

19.10 We consider the assessments of RL in the community in June and August 2002 inadequate. The rationale for not offering him an enhanced service included the fact that at the time of the assessments his presenting problems did not warrant CPA care co-ordination and furthermore he would not co-operate. Neither of these assessments adequately took into account the diagnoses of recurrent depressive disorder and/or organic disorder. The

analysis of his compliance ignored the fact that he had co-operated with Liz Finnerty, his care co-ordinator from August 1999 to May 2001.

Care Plans

The extent to which care plans were effectively drawn up with RL and how these plans were delivered and complied with.

19.11 We consider the March and May 2002 discharge care plans prepared by those responsible for RL's inpatient psychiatric treatment to have been inadequate. As we have already commented, we contrast this with other clear and accurate records, for example the March and May inpatient nurse care plans.

19.12 The initial care management needs assessment prepared by Liz Finnerty highlighted RL's needs and appeared accurate. Without a subsequent formalised care plan, she tried to help meet those needs. In effect, diligent work by a newly qualified professional did succeed in developing and sustaining a method of working which met RL's needs, and those of his mother.

Joint working

To examine the process and style of collaboration within and between all agencies involved in the care of RL and providing services to him and his family.

19.13 Between 2000 and 2002 joint working between mental health service professionals was hampered by the absence of a properly integrated team. Medical staff occupied different premises from other members of the CMHT and until about March/April 2001, social workers were housed separately from their CPN colleagues. This situation compounded difficulties in communication.

19.14 It was not only physical separation that created difficulties. The attempt by a psychiatrist (who was working in the CMHT) to arrange a re-assessment of RL in September 2002 was met with an entirely inadequate response by the

CMHT manager. We consider that this was likely to have been partially attributable to poor professional relationships within the CMHT. Physical separation reinforced poor inter-disciplinary communication. There was no written referral to the community assessors and the purpose of the community assessment in June was not clarified. Straightforward communication between team members did not appear to be taking place. For example, the contact that Dr Shobha had with Alex Turner following his assessments is disputed and unclear, even though they worked together in the same team.

19.15 The lack of effective transmission of information from the inpatient setting to the CMHT hampered proper assessment of RL's case. We consider that the community assessors did not scrutinise the inpatient notes before conducting their assessments. The June assessment of RL by Alex Turner and Matthew Graham was hampered by all the relevant information not being available to them. We consider that they did not read the social service notes and we also note that other information relevant to RL's case was not as readily available as it rested with police and probation services.

19.16 The police and probation officers who had regular contact with RL did not communicate at all with mental health professionals after 2001. This was in part because they did not regard RL's mental disorder as having any bearing on the risk he presented. Similarly, although the health professionals were aware of RL's forensic history, they did not consider that this history had any bearing on the care and treatment they provided.

19.17 This lack of communication extended to the management of the various services. Two reviews led by the police and probation services were undertaken after the homicide committed by RL with the aim of learning lessons and to improve practice. Both reviews identified RL's history of mental disorder and contact with the mental health service as significant, yet neither review arranged to involve mental health services. The West Kent NHS and Social Care Trust Review also did not involve police or probation services, although reference is made to these issues in their report.

19.18 The process of assessing the risk that RL presented was impeded by the shortcomings in the joint working practices of the agencies responsible for

his care, in particular the lack of communication between probation, police and mental health services. This meant that mental health services were denied critical information that would have allowed them to re-evaluate the risk presented by RL, while police and probation were similarly denied access to information which could have influenced their management of RL's case. The responsibility for this failure is not attributable to one individual. The fault may partially lie in the absence of reliable ways to share information between organisations. In addition professionals both working 'on the ground', and in managerial positions, appeared not to realise that other agencies could make a contribution to their understanding and management of RL.

19.19 We do not know whether concerns about medical confidentiality would have impeded meaningful communication between health and criminal justice agencies. We did not hear or read any evidence that the failure to share information was caused by concerns relating to medical confidentiality.

Risk management

To examine any issues of in-service training in relation to those caring or providing services to RL and to consider the adequacy of risk management and training of all staff involved in RL's care and supervision.

19.20 We identify inadequacies in the risk assessment and management of RL's case. We heard evidence of continuing training, dealing with both the CPA and general risk-management/assessment skills. The inadequacies we identify raise further training needs, especially for inter-agency and inter-professional working.

20 RECOMMENDATIONS

We identify a number of areas where we consider action should be taken. While we have tried to avoid being prescriptive, we recommend that those commissioning this inquiry draw up an action plan to develop these recommendations. Where appropriate, the involvement of police and probation services will need to be considered.

20.1 CPA

Current CPA policy and procedures should be amended to take into account the following:

a. Change of eligibility criteria

The characteristics of people on CPA may change – for example a person on standard CPA may become eligible for enhanced CPA. The policy should explicitly deal with this and should contain guidance about reviewing each patient's status.

b. Dispute resolution

The possibility of dispute between professionals about applying eligibility criteria for CPA and other CPA-related areas, for example the contents of care plans, should be explicitly recognised and the policy should contain procedures to resolve disputes.

c. Multi-agency working and public protection

The policy should contain clear information about MAPPA. There should be specific and explicit references in the CPA documentation to the involvement of other agencies, including both the police and probation services and to MAPPA where appropriate. For example:

CPA 1 screening information should include involvement with other agencies and should specify agencies involved. The tick-box should include reference to MAPPA.

CPA 2 information, under the forensic heading, should again specify agencies involved.

d. **Inpatients**

The use of the phrase 'the transfer of relevant information'[170] from hospital team to community-based staff should be re-evaluated. Consideration should be given to itemising information to be made available where a patient is being discharged from an inpatient setting.

e. **Difficult to engage/out-of-contact, vulnerable, at-risk clients**[171]

Where this part of the policy refers to communication with other agencies, the probation service should be included in the list of agencies to be considered.

f. **Process of risk assessment**[172]

This section of the policy should be amended to refer to MAPPA. It should contain a brief explanatory note about the function of MAPPA and about local routes to the MAPPPs.

g. **Service shortfall**

The need to identify service shortfall[173] should be given greater prominence in the policy and the purpose of completing CPA5 should be clarified.

h. **Change of care co-ordinator – enhanced CPA**

The policy should explicitly deal with the circumstances where there is to be a change of care co-ordinator for a person on enhanced CPA. There should preferably be a face-to-face transfer meeting involving a CPA review. The policy should take into account that when workers leave it is not always possible to re-allocate the case straight away. Sometimes there

[170] Kent and Medway Care Programme Approach Policy and Procedures page 16
[171] Kent and Medway Care Programme Approach Policy and Procedures page 13
[172] Kent and Medway Care Programme Approach Policy and Procedures page 24
[173] Currently referred to in Kent and Medway Care Programme Approach Policy and Procedures page 32

will have to be temporary cover to deal with emergencies regarding a case before a definitive transfer can be made.

i. Training

The training of police and probation officers to enhance their knowledge of the CPA should be considered.

20.2. MAPPA

a. Health involvement in MAPPA

A senior mental health service manager should attend all level 2 meetings. We understand that a consultant forensic psychiatrist attends all level 3 meetings. The attendee should have received appropriate training in the interface between psychiatry and the criminal justice system, and must be senior enough to commit resources. The function of the manager at level 2 is threefold: to screen and identify the appropriate specialism to whom further communication should be directed, for example CAMHS, forensic, general, drugs and alcohol; to liaise with the forensic services attending level 3 meetings and to act as a conduit for all referrals to MAPPA by mental health services.

b. Police

In collaboration with mental health services, the police should promote the role of the Public Protection Officer to mental health services. The purpose of this is to advertise the role of this officer as a resource and conduit into MAPPA.

c. The CPA

The mental health services should review existing CPA guidance and procedures to ensure that:

- All CPA meetings routinely question MAPPA registration.

- CPA documentation, including risk assessment pro-formas, is amended to incorporate MAPPA status.

- CPA policy and procedures is amended to include guidance on those circumstances which might indicate a need to make a referral to the responsible authority (police and probation) in order to prompt a MAPPA review.

d. Training

In conjunction with the responsible authorities for MAPPA, mental health services should devise a programme of multi-disciplinary training for health staff and other agencies. The purpose of this training would include describing the organisation and function of MAPPA and the processes for sharing information between police, probation and health services. All disciplines involved in the delivery of mental health services should be encouraged to participate in this training.

e. MAPPA Reviews

When a person on any level of MAPPA is arrested for a further offence, an urgent review should take place. If the offence is of a violent or sexual nature, a MAPPP meeting should be convened, with full multi-disciplinary involvement, to allow appropriate sharing of information and to enable risk-assessment/management plans to be developed. When an offender is described as high risk, and his/her probation order is to end, a MAPPA review should be initiated.

f. Guidelines

The Trust should develop guidance relating to the duty to cooperate and the circumstances in which information can be shared. Staff should be provided with training relevant to their roles and responsibilities in this area.

g. Procedures and information systems

Mental health services should develop clear policies and procedures relating to their interface with MAPPA. Mental health services may consider

developing systems to ensure that without breaching confidentiality, patients known to both mental health and probation services can be identified and so managed safely.

h. CMHTs

Forensic ASWs or other specialist professionals working with mentally disordered offenders who work with or for CMHTs should have dedicated time allocated in order to deal with and develop links with MAPPA organisers.

20.3. General communication issues

We list below some of the communication issues that have been raised in this report. We recommend that the Mental Health Trust consider gathering data and identifying solutions to the following problems:

a. Primary health care

We were told that it was sometimes difficult for a GP to obtain feedback if his /her patient had been in contact with either community or inpatient psychiatric services.

b. Inpatient teams, the CMHT, and vice versa.

We noted difficulties in communicating information from inpatient to community teams on a patient's admission and discharge. For example a patient taking their own discharge against medical advice could result in a delay in the transfer of relevant information. Likewise, we were told of communication difficulties from the care co-ordinator to hospital based staff in the event of a patient experiencing problems in the community.

c. Probation service

Communication between the probation and mental health services should be clarified, in relation to a person on either standard or enhanced CPA and subject to a probation order.

20.4 Training

Our recommendations, particularly in relation to CPA and MAPPA, contain a number of references to areas where training should be considered.

a. Training programme

A programme to be developed which:

i. Builds on existing risk assessment/management training by including relevant details from our report.

ii. Provides training concerning MAPPA for all agencies, involving key stake holders for MAPPA - police, prison and probation service, and mental health services.

20.5 Post Incident Reviews

We were concerned that mental health services were not involved in either of the police or probation service reviews which took place following the homicide committed by RL, and that mental health services did not include police or probation services in their review.

a. Reviews

Post-incident reviews and/or Serious Untoward Incident reviews/inquiries should include representation from all agencies involved with an individual patient. Current Serious Untoward Incident policies should be amended accordingly.

20.6 The Clinical and Practice Review Action Plan

Given our comments about the sufficiency and relevance of this plan, we recommend that the plan is jointly reviewed and updated in the light of our analysis and these recommendations.

20.7 Supervision

We were told about the development of joint management/supervision arrangements for members of the CMHT and about 'professional' or 'clinical' supervision for various disciplines. We did not discuss arrangements for supervision or support for senior medical staff and we suggest that further consideration is given to developing methods of peer support for this group of professionals.

20.8 Carers assessments

We pointed out on a number of occasions throughout this report that Mrs Loudwell was entitled to receive a carer's assessment. We were told that these assessments are now being regularly undertaken.

a. Audit of carers' assessments

We suggest that the effectiveness of the carers' assessments be audited. In particular we question whether primary health care practitioners are aware that some of their patients may be entitled to such an assessment, and we suggest therefore that an audit may help to publicise the benefits of these assessments to this group.

ANNEX 1

Terms of Reference: Independent Inquiry into the Care and Treatment of RL

General remit	To examine the relevant circumstances surrounding the treatment and care of RL by the NHS, the social service authority and other agencies, both public and private. By initially reviewing the documentation and providing a preliminary report to the Medway Primary Care Trust. (The commissioners) To then consider other matters as the public interest may require, and in a manner to be determined by the inquiry team after consultation with the commissioners.
Treatment and care	The appropriateness of RL's treatment, care and supervision in respect of: • his actual and assessed health and social and support needs; • his actual and assessed risk of potential harm to himself and others; • his previous psychiatric history and treatment including drug and alcohol misuse. • the documentation recorded relating to the above.
Compliance	The extent to which RL's care corresponded to statutory obligations, particularly the Mental Health Act 1983 and relevant other guidance from the Home Office and Department of Health Care Programme Approach (HC(90) 23/LASSL(90)11) HC (9()) 23/LASSL (90) 11) Supervision Registers (HSG (94)5); Discharge Guidance (HSG (94) 27; and local operational policies.
Care plans	The extent to which care plans were effectively drawn up with RL and how these plans were delivered and complied with.
Joint working	To examine the process and style of the collaboration within and between all of the agencies, involved in the care of RL and the provision of services to him and his family.
Risk Management	To examine any issues of in-service training that arise in relation to those caring or providing services to RL and to consider the adequacy of the risk management and training of all staff involved in RL's care and supervision.
Report	To prepare a report and to make recommendations to the commissioners and other relevant agencies.

ANNEX 2

Document retrieval

1. Peter Hasler – Director of Nursing & HR

   West Kent Mental Health & Social Care Trust
   Trust Headquarters
   35 Kings Hill Avenue
   Kings Hill
   West Malling
   Kent, ME19 4AX

   Thames Gateway NHS Trust Notes
   North Kent NHS Trust
   Medway Maritime
   Clinical and Practice Review into the care of RL
   CPA Policies

2. Medway PCT
   GP Notes

3. Keith Yardy – Senior Crown Prosecutor

   CPS
   West Kent Trials Unit
   Priory Gate
   29 Union Street
   Maidstone, ME14 1PT

   Witness statements
   Police MG5 summary of evidence
   Defendant interviews transcripts
   Unused material

4. Rob Verity – Assistant Chief Officer

   Kent Probation Service
   Chaucer House
   25 Knightrider Street
   Maidstone
   Kent
   ME15 6ND

   Probation records
   L and P Review 22.04.04
   MAPPA documentation

5. **DCI Norah Chandler**

   Kent Police
   Special Investigation Unit and Case Review
   Kent County Constabulary
   HQ
   Sutton Road
   Maidstone
   ME15 9B

   Police Records
   Kent Crime Case Review

ANNEX 3

LIST OF WITNESSES

Name of witness	Job Title
West Kent NHS & Social Care Trust	
Dr Sabah Sadiq	Medical Director
Peter Hasler	Director of Nursing and Human Resources
Mike O'Meara	Head of Information
Claude Pendaries	Director of Performance
James Sinclair	Director of Social Care & Mental Health Services (West)
Kevin Lindsay	Director of Social Care & Mental Health Services (East)
John Hughes	Service Manager Mental Health Services
Nessan Thambiah	Clinical Governance Manager
Margaret Vickers	CPA Manager
Lindsay Hasler	Formerly managed Community Psychiatric Nurses (CPN) Gillingham CMHT
Cecilia Wigley	Formerly managed CPN Gillingham CMHT
Philippa Macdonald	Current Team Gillingham CMHT
Liz Finnerty	Social Worker (formerly)Gillingham CMHT
Geoff Turner	Senior Practitioner Gillingham CMHT
Edwina Morris	Team manager (retired) Gillingham CMHT
Matthew Graham	Social Worker (formerly) Gillingham CMHT
Alex Turner	CPN (formerly) Gillingham CMHT
Dr Shobha	Consultant Psychiatrist
Dr Raleraskar	Associate Specialist
General Practitioner	
Dr Bhasme	General Practitioner
Trevor Gibbens Unit	
Dr Dunkley	Consultant Forensic Psychiatrist
Medway Council	
Ann Windiate	Director of Social Services
Broadmoor Hospital	
Dr Petch	Consultant Forensic Psychiatrist
Kent Probation Service	
Colin Croft	Probation Officer
Maurice O'Reilly	Area Manager - Public Protection and Victims, Kent Probation area
Hilary James	Chief Officer, Kent Probation area
Kent Police	
DCI Chandler	Joint Chair Kent MAPPP
DI Hubbard	Kent Crime Case Review Team
David Stevens	Kent Crime Case Review Team