



Report of the independent inquiry into the care and treatment of Michael Stone

September 2006

Published by
South East Coast Strategic Health Authority
Kent County Council
Kent Probation Area

**THE REPORT OF THE INDEPENDENT INQUIRY
INTO THE CARE AND TREATMENT
OF MICHAEL STONE**

*Commissioned by
West Kent Health Authority
Kent County Council Social Services
Kent Probation Service*

Erratum

The final paragraph of section 20.1 (page 106) should read:

"Nevertheless, the Panel do not find that the delays in the receipt of depot Haldol identified during this period in fact had any significant adverse clinical effect upon Mr Stone, either then or later, who had been receiving Haldol for some time."

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Statement concerning the partial anonymisation of this inquiry report

Mental health inquiry reports commissioned under the terms of “*Health service guidance into the discharge of mentally disordered people and their continuing care in the community*” HSG (94)27 are made to the commissioning agencies and it is for the commissioning agencies to determine what if anything is published and when. Often such reports have been published in full, though in recent times a number have been published with names of key witnesses removed and replaced by initials.

In 2001, at a joint meeting of the three agencies that commissioned the inquiry into the care and treatment of Michael Stone, concern was expressed that given the horrific nature of the original crime and Michael Stone’s continued denial of the offence, naming staff in the report might place them at risk. In recognition of the seriousness of this concern, the agencies sought the advice of Kent Police. A detective superintendent who was well acquainted with the case but who had not been part of the criminal investigation was nominated to conduct a formal risk assessment.

The risk assessment was commissioned in April 2001. It concluded there was evidence to suggest that certain individuals would be at risk if named in the report. In July 2002 the Assistant Chief Constable (Central Operations) wrote to the commissioning agencies saying, “the advice from this force is that the report should not be published in a format that identifies any of those named in it.” The risk assessment recommended that all names should be removed from the report prior to any publication.

The commissioning agencies discussed the implications of the risk assessment with their legal advisers and with the authors of the report (Robert Francis QC and his Panel). Robert Francis indicated that the Panel’s role was to conduct the inquiry and present their report to the commissioning agencies and that it was for them to decide what form publication might take. He did, however, indicate that in the Panel’s view, the report should be published in full.

The legal advice was that the commissioning agencies had a duty to satisfy themselves as to the strength of the evidence upon which the police risk assessment was based. Accordingly, in October 2002 representatives of the commissioning agencies met with Kent Police to review the evidence.

As a result of this review, and acting on legal advice, the commissioning agencies determined that the best approach to publication would be to replace the names of all care staff with initials

(though not their own initials). It was the view of the commissioning agencies that in every other respect the report should be published in full.

In deciding to partially anonymise the report the commissioning agencies have had to balance the public interest of protecting care staff and others from potential risk against that of open and transparent publication.

The commissioning agencies and the police believe that the decision to partially anonymise this report by replacing the names of care staff with a code of initials is a reasonable approach to publication and represents a balanced and even-handed way of resolving conflicting public interests. Kent Police confirmed in a letter from the Assistant Chief Constable in July 2002 that in their view this approach reduced the risk to an acceptable level. Kent Police reconfirmed this advice in May 2005 and in August 2006.

Signed:



Candy Morris
Chief Executive
South East Coast Strategic
Health Authority



Oliver Mills
Managing Director of Adult Services
Kent County Council



Hilary James
Chief Officer
Kent Probation Area

We have reviewed the statement above and confirm it represents a true reflection of our views and our involvement in the decision to partially anonymise this report.



Robert Francis QC



Adrian Leppard
Assistant Chief Constable
Kent Police

September 2006

Anonymisation codes

In alphabetical order by employer

Dr AA – Cpsych	Consultant Psychiatrist	Chatham Community Mental Health Trust
Dr P - CD	Clinical Director	Chatham Community Mental Health Trust
Dr BB - Psych	Psychiatrist	Chatham Community Mental Health Trust
Dr ZX - DOH	Department of Health	Department of Health
Ms C - SW	Specialist Mental Health Social Worker	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Mr D - ASW	Approved Social Worker	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Ms E - Man	Corporate Services Manager	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Ms F - Man	Non Executive Director	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Ms G - RMN	Registered Mental Nurse	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Dr H - Psych	Clinical Assistant	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Dr ZA - CPsych	Consultant Psychiatrist	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Mr ZC - CNMan	Clinical Nurse Manager	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Mr N – Man	Services Manager	Invicta NHS Trust
Ms ZO – (F)CPN	Forensic Community Psychiatric Nurse	Invicta NHS Trust
Mr P – RMN	Register Mental Nurse	Invicta NHS Trust
Dr U – CPsych	Medical Director	Invicta NHS Trust
Dr Q – Psych(F)	Forensic Senior Registrar	Trevor Gibbens Unit, Invicta NHS Trust
Dr R – FPsychol	Forensic Psychologist (Chartered Forensic)	Trevor Gibbens Unit Invicta NHS Trust
Ms ZP – CPN	Community Psychiatric Nurse	Trevor Gibbens Unit, Invicta NHS Trust
Dr T – CPsych(F)	Consultant Forensic Psychiatrist	Trevor Gibbens Unit, Invicta NHS Trust
Dr ZK - CPsych(F)	Consultant Forensic Psychiatrist	Trevor Gibbens Unit, Invicta NHS Trust
Ms CC – PO	Probation Officer	Kent Probation Service
Mr DD – PO	Probation Officer	Kent Probation Service
Ms EE – PO	Senior Probation Officer	Kent Probation Service
Ms FF – PO	Probation Officer	Kent Probation Service
Mr GG – PO	Senior Probation Officer	Kent Probation Service
Mr HH – PO	Probation Officer	Kent Probation Service
Mr II – PO	Assistant Chief Probation Officer	Kent Probation Service
Ms JJ – PO	Probation Officer	Kent Probation Service
Ms KK – PO	Probation Officer	Leicestershire Probation Service
Ms LL – PO	Probation Officer	Leicestershire Probation Service
Dr V – CPsych	Consultant Psychiatrist	Medway and Swale Addiction Service
Ms MM – SW	Senior Practitioner	Social Services Kent County Council
Mr NN - SW	Team Leader	Social Services Kent County Council

Mr OO - SW	Social Worker	Social Services Kent County Council
Mr PP - SW	Team Leader	Social Services Kent County Council
Ms QQ - SW	Team Leader – Mental Health	Social Services Kent County Council
Mr RR - SW	Forensic Social Worker	Social Services Kent County Council
Mr SS - SW	Principal Officer – Mental Health & Substance Misuse	Social Services Kent County Council
Ms TT - SW	Team Leader	Social Services Kent County Council
Mr UU - SW	Team Leader	Social Services Kent County Council
Mr VV - SW	Mental Health Social Worker	Social Services Kent County Council
Ms ZJ - SW	Social Worker	Social Services Kent County Council
Dr A - CPsych	Consultant Psychiatrist	Stansfield Unit, Bexley Hospital
Dr B - Psych	Psychiatrist	Stansfield Unit, Bexley Hospital
Dr ZB - CPsych(F)	Consultant Forensic Psychiatrist	Stansfield Unit Bexley Hospital
Dr YA -TMD	Trust Medical Director	Thames Gateway NHS Trust
Dr ZT - TPsych	Trainee Psychiatrist	Thames Gateway NHS Trust
Mr ZY - NGMan	Nurse General Manager	Thames Gateway NHS Trust
Ms YB	Addiction Services Team Leader	Addiction Centre, Manor Road, Thames Gateway NHS Trust
Dr Z – CPsych	Consultant Psychiatrist	Addiction Centre, Manor Road, Thames Gateway NHS Trust
Dr W – Psych	Psychiatrist	Addiction Centre, Manor Road, Thames Gateway NHS Trust
Dr X – Psych	Psychiatrist	Addiction Centre, Manor Road, Thames Gateway NHS Trust
Mr ZM - CPN	Community Psychiatric Nurse	Addiction Centre, Manor Road, Thames Gateway NHS Trust
Mr Y – RMN	Registered Mental Nurse	Addiction Centre, Manor Road, Thames Gateway NHS Trust
Mr Z W - NSUP	Clinical Nurse Supervisor	Throwley House, Thames Gateway NHS Trust
Dr ZH - HMPGP	Prison Doctor	Whitemoor Prison
Dr I - GP	General Practitioner	Self employed
Dr J - GP	General Practitioner	Self employed
Dr K - GP	General Practitioner	Self employed
Dr L - GP	General Practitioner	Self employed
Dr M - GP	General Practitioner	Self employed
Dr ZS - GP	General Practitioner	Self employed
Dr ZR - GP	General Practitioner	Self employed
Dr ZN - CPsych(F)	Consultant Forensic Psychiatrist	
Dr ZE - Psych(F)	Forensic Psychiatrist	
Dr ZD - Psychther	Psychotherapist	
Dr ZI - SR	Specialist Registrar	
Dr ZL – S12	Section 12 Doctor	
Dr BJ - CPsych	Consultant Psychiatrist	
Dr FO - CPsych	Consultant Psychiatrist	

Anonymisation codes

In alphabetical order by code

Dr A - CPsych	Consultant Psychiatrist	Stansfield Unit, Bexley Hospital
Dr AA – CPsych	Consultant Psychiatrist	Chatham Community Mental Health Trust
Dr B - Psych	Psychiatrist	Stansfield Unit, Bexley Hospital
Dr BB - Psych	Psychiatrist	Chatham Community Mental Health Trust
Dr BJ - CPsych	Consultant Psychiatrist	
Dr FO - CPsych	Consultant Psychiatrist	
Dr H - Psych	Clinical Assistant	De La Pole Hospital, Hull & Riding Community Health NHS Trust
Dr I - GP	General Practitioner	Self employed
Dr J - GP	General Practitioner	Self employed
Dr K - GP	General Practitioner	Self employed
Dr L - GP	General Practitioner	Self employed
Dr M - GP	General Practitioner	Self employed
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Dr ZN - CPsych(F)	Consultant Forensic Psychiatrist	
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Dr ZS - GP	General Practitioner	Self employed
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Mr HH – PO	Probation Officer	Kent Probation Service
Mr II – PO	Assistant Chief Probation Officer	Kent Probation Service
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Ms JJ – PO	Probation Officer	Kent Probation Service
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**INDEPENDENT INQUIRY
INTO THE CARE AND TREATMENT OF MICHAEL STONE**

**Commissioned by
West Kent Health Authority
Kent Social Services
Kent Probation Service**

FINAL REPORT

November 2000

To: The Chief Executive, West Kent Health Authority
The Strategic Director of Social Services, Kent County Council Social Services
The Chief Probation Officer, Kent Probation Service

We present this our Final Report in accordance with the Terms of Reference of this Inquiry.



Robert Francis QC



Dr James Higgins



Mr Emlyn Cassam

30th November 2000

TERMS OF REFERENCE

Fact-finding stage

- (1) To report on what care, supervision and services were provided by the Health Service, Social Services and the Probation Service in respect of Michael Stone and what professional judgements were made about his condition, its 'treatability', and his needs in the period 1992-1996 and, in so far as it appears relevant to the inquiry, before that period.
- (2) To report on what information concerning Michael Stone was shared between Health Services, Social Services and the Probation Service and other statutory and non-statutory agencies.

Evaluation stage

- (3) To report on whether the care, supervision and services provided or planned for by the agencies individually and in liaison with each other were suitable and appropriate in the context of Michael Stone's history and needs. With particular reference to the period 1992-1996, to report the extent to which any professional judgement made was in the interests of the public, Michael Stone and staff of the agencies, and on the adequacy of the communications between agencies.
- (4) To report on whether the care, supervision and services provided met statutory obligations, national guidance and local policies and practices.

Policy stage

- (5) To report as the inquiry sees fit on the adequacy of mental health law, national guidance and local policies and practices in the context of the care, supervision and services provided in respect of Michael Stone (including any amendment or reform that may be proposed or made before the inquiry is completed).
- (6) To identify and report on any other matters of relevance that may arise from the above.
- (7) If the inquiry sees fit, to issue an interim report in connection with any of the items 1-4 before reporting on items 5 and 6.

Formatting of the report

The inquiry Panel have adopted the following formatting throughout this report

Narrative and findings of the Panel:	normal Times Roman font
The Panel's comments and recommendations:	<i>italic bold Times Roman font</i>
Quotations from the oral evidence of witnesses:	normal Courier Font
Quotations from written evidence of witnesses:	normal Arial Narrow Font
Quotations from original documents:	normal Arial Narrow Font
Drug names:	<i>italic Times Roman font</i>

EXECUTIVE SUMMARY

1. THE RUSSELL MURDERS

On 9th July 1996 Lin Russell and her two daughters, Megan and Josie, aged six and nine respectively, were walking down a Kent country lane when they and their dog were viciously attacked. Lin and Megan died, Josie was severely injured and left for dead. The incident gave rise to instant and justifiable national horror.

2. THE INQUIRY

Over a year after the Russell murders, Michael Stone was arrested and charged with the crimes. Following his conviction for homicide in October 1998, an inquiry into his treatment, care and supervision was set up in accordance with National Health Service guidelines.

This inquiry has investigated the treatment, care, supervision and services provided to Mr Stone over a long period (September 1992 to his arrest in July 1997) and has not been confined to the time immediately surrounding the Russell murders. The terms of reference of the inquiry are to look into the treatment, supervision and care received by Mr Stone. It is not the purpose of this inquiry to investigate the correctness of Mr Stone's conviction nor to seek to explain the actions of the killer of the Russells. This report was completed before the outcome of Mr Stone's appeal against conviction was known and does not address the issue of his guilt or innocence. Nonetheless, if he did commit these crimes, the inquiry has found no evidence that they would have been prevented if failings in provision of treatment, care, supervision or other services to Mr Stone had not occurred.

3. MR STONE - THE PATIENT AND CLIENT

Michael Stone is one of the group of patients who are among the most difficult and challenging for the health, social and probation services to deal with. He presented with a combination of problems, a severe antisocial personality disorder, multiple drug and alcohol abuse, and occasionally, psychotic symptoms consistent with the adverse effects of drug misuse and/or aspects of his personality disorder. This complex and shifting picture made consistent and accurate diagnosis difficult.

Even after a searching investigation by this inquiry, it is not possible to describe a full picture of the man, his history and his life, for much of it remains unknown. Each of the services dealing with him must have had an even less complete picture. His presentation to the many professionals who attended him during the period in question was for the most part compliant and apparently needing help; less often, he could be frighteningly aggressive. Many people as or more difficult than Mr Stone present to the various services, and his presentation was not unusual for a patient known to forensic mental health services.

4. THE RANGE OF SERVICES PROVIDED

Nonetheless, during the period under review, despite the many difficulties in doing so, Mr Stone received a wide range of services from all the agencies approached. He had regular and frequent contacts with professionals. Although the Panel have occasion to make criticisms of certain of the services provided, it must be recognised that in many other areas it is unlikely he would have received any significant assistance from medical or social services. In this respect services in Kent must be commended. This is emphatically not a case of a man with a dangerous personality disorder being generally ignored by agencies or left at large without supervision.

5. THE PRISON SERVICE

(Contact: Adolescence to September 1992; October 1993-April 1994)

Mr Stone's prison medical records have been lost. Therefore the full nature and extent of treatment he received there is not known. It is of concern that the medical history of a man who has spent a substantial part of his life in prison is missing in this way. It is also of concern that the full details of his prison history were not made available to the authorities responsible for care after his release. There should have been a more systematic sharing of information with outside agencies.

6. THE GENERAL MEDICAL SERVICES

(Contact: October 1992-July 1997)

The first GP practice with which Mr Stone registered on leaving prison in 1992 provided a high standard of care to a difficult patient. The GPs were proactive in identifying his needs and making appropriate referrals. The forensic team was promptly informed when Mr Stone failed to attend for his depot medication. Mr Stone left this practice in January 1995.

The same cannot be said for the second practice with which he registered. The GP altered the patient's prescription without consulting or informing the relevant specialist services. Record keeping was of a poor standard and he did not monitor Mr Stone's attendance for depot medication. The GP did not notify the forensic team of Mr Stone's irregular attendances in 1995, and gave incorrect information to the Community Psychiatric Nurse about his attendance in July 1996. While this was shortly before the Russell murders, it is impossible to say whether the provision of the correct information would have resulted in the admission of Mr Stone to hospital at the time.

7. CHATHAM COMMUNITY MENTAL HEALTH TEAM (CMHT)

(Contact: October 1992: February 1993-December 1994)

Although there was an appropriate initial assessment by the CMHT and referral to the forensic services in 1992, the follow-up, coordination with other agencies, in particular the general medical services and the forensic services, was inadequate for a case of this nature, and led to the risk of Mr Stone being lost to the various services at a time when he was in need of their help. Although this risk did not materialise, neither the Care Programme Approach (CPA) nor its principles were applied.

In November 1994, at a time when Mr Stone was perceived to be in need of compulsory admission to hospital by reason of mental illness and to be a danger to others, he was allowed to remain at liberty for several days without further risk assessment or psychiatric oversight. After a compulsory in-patient assessment indicated that he was not mentally ill and should not be further detained, there was reluctance on the part of the CMHT to acknowledge that they had a role in his continuing care. Indeed, the CMHT's approach to the case of Mr Stone might be characterised as one of reluctance to remain or get involved because of the perceived danger, without any review of that assessment in the light of the findings of others.

8. THE ADDICTION SERVICE

(Contact: February 1993-July 1997)

The initial appraisal of Mr Stone in 1993 was good and led to an appropriate acceptance of his case by the Addiction Service. However, the care subsequently provided at the Manor Road Centre was poor in a number of respects. There was inadequate planning, implementation or review of a care package and requests by Mr Stone for in-patient detoxification were ignored. The principles of the Care Programme Approach should have been applied but were not. As a result, coordination with other agencies was of a poor standard, as was the sharing of information. While considerable resources were devoted to his case, there is little to suggest that the input was as worthwhile as it might have been. This is not to suggest that any different approach to Mr Stone's case would have been more effective. It is possible that any approach would have failed to alleviate his drug abuse on any but a short-term basis.

9. THE FORENSIC PSYCHIATRIC SERVICE

(Contact: October 1992: December 1994-July 1997)

The initial assessment of Mr Stone in 1992 was unsatisfactory. On Mr Stone's re-referral to the forensic service in December 1994, under the new consultant, a high standard of professional attention was given to Mr Stone. The consultant psychiatrist made a clear diagnosis, risk assessment and recommendations. The inappropriateness of Mr Stone's continued detention under the Mental Health Act at De La Pole Hospital was correctly identified. Thereafter, the consultant made the resources of his service available to Mr Stone as best he could, and in some cases, as when he allowed Mr Stone to be voluntarily admitted for detoxification to a medium secure unit, went beyond care that might have been provided elsewhere in the country.

As with other services, inadequate attention was paid to the requirements of the Care Programme Approach, leading to a lack of coordination with other services. However, communication with other agencies was generally good, and appropriate plans put in place and carried through. A high standard of service was provided by the Community Psychiatric Nurses.

Contrary to some suggestions in the media, the forensic service did not at any stage refuse admission to Mr Stone and indeed offered admission for detoxification when other units were not available or willing to do so.

There was no material available to the forensic consultant to justify or require him to have considered admission of Mr Stone to hospital at the time of the Russell murders. It is also

clear that there was no reluctance on the part of the consultant to offer admission had such material been present. Had the consultant psychiatrist been informed that Mr Stone was not attending for his depot medication punctually, he might have considered admission, but it is not possible to determine what his judgment would then have been.

10. THE STANSFIELD CLINIC BEXLEY HOSPITAL

(Contact: November 1994)

The role of this unit was limited to the five-day temporary admission of Mr Stone pending his assessment for transfer to De La Pole Hospital. The staff performed this task without cause for criticism. The management of his care and record-keeping appear to have been of a high standard.

11. DE LA POLE HOSPITAL

(Contact: November 1994-January 1995)

During his seven-week admission to this hospital (which has since closed), the quality of care provided to Mr Stone was good. The decision to detain Mr Stone under Section 3 of the Mental Health Act was inconsistent with the view reached on assessment under Section 2 of the Act that he was not mentally ill and could be cared for in an open ward. Appropriate steps were taken to transfer Mr Stone back to Kent at this time, but when the local Medway CMHT refused to accept Mr Stone back to their care, unjustified reasons for compulsory detention and its continuation were relied on. There was inadequate communication with services in Kent to ensure continuity of care.

12. KENT SOCIAL SERVICES

(Contact: November 1994-July 1997)

Social Services had only a relatively limited role in assisting Mr Stone during the relevant time. A good standard of service was provided by a social worker during Mr Stone's admission to forensic in-patient unit, but in certain respects the service provided by other social workers in the community fell short of what was desirable. In particular there was at times confusion about the identity of the key-worker, and on two occasions considerable delay caused by ineffective steps to transfer the case between teams.

There is, however, no suggestion that this client, who was justifiably perceived as being difficult and potentially dangerous, was deprived of any service which would have made him less of a danger to the public.

13. KENT PROBATION SERVICE

(Contact: April 1994-May 1996)

The supervision of the probation order by the Kent Probation Service was of a high and conscientious standard. Two probation officers in particular were able to formulate clear plans and maintain regular contact with Mr Stone and the other agencies involved in his care. The efforts of one probation officer in liaising with other agencies did much to mitigate the difficulties caused by the failure of the health service agencies to implement the Care Programme Approach. A third probation officer, although only briefly involved in the case in

1994, devoted considerable skill in assisting the mental health service in the process of assessment which led to Mr Stone's admission to hospital at that time.

The only matter for criticism relates to this last officer's handling of certain confidential information regarding Mr Stone and the processing of the resulting complaint. The information concerned is confidential and is not otherwise relevant to the assessment of the care and treatment of Mr Stone at the relevant time.

14. MEDIA INTEREST AND INVOLVEMENT

Quite justifiably, the media have taken a considerable interest in this case. Unfortunately, this has had a negative impact in several ways. First, various reports contained significantly inaccurate versions of Mr Stone's history and events. Second, the attempts of some elements of the media to obtain information amounted to breaches of journalists' codes of conduct and unwarranted intrusion and interference in the lives of professionals and patients. Third, it is apparent that some confidential clinical information which was published came into the hands of the media by unauthorised means, but it has not been possible to identify the source of this information.

The press statement on behalf of the commissioning agencies at the conclusion of the trial was made in good faith and on the advice of professional advisers and the Department of Health. It was also made in the context of unprecedented media pressure. However, it contained a number of assertions which in the opinion of the Panel were not an accurate reflection of the history of the case and included judgments which it was not the place of the agency to make. The responsibility for this was not that of any individual but the result of the collective activity of many. Few agencies have occasion to respond to such media pressure and lessons can be learned at both a national and local level. The Kent experience suggests the need for a comprehensive review of media handling in cases of this nature.

15. CONCLUSION

The inquiry has identified some shortcomings in aspects the care, treatment and supervision provided to Mr Stone. In doing so, the Panel do not seek to suggest that the responsibility for the crime should lie anywhere other than with Mr Stone.

In many previous homicide inquiries there has been a clear explanation of the reasons for the crime either through the court process and/or through the patient's own account of his/her motivation at the time. In the case of the Russell murders, Mr Stone has continued to profess his innocence. The court process did not reveal any clear motivation for the crime and none of the material available to the inquiry has provided an explanation for it.

As stated at the outset of this summary, this is not a case of a man with a dangerous personality disorder being ignored by agencies with responsibilities for supervising and caring for him. He received a considerable degree of attention over the years in question. The challenge presented by a case such as Michael Stone's is that his problems are not easily attributable to a single feature of his condition or to combinations of them. Further, he did not easily fall into the province of one agency or a combination of them. His problems were multi factorial, and constantly changing in their presentation and importance. While at times there

will be things that can be done for such a person to reduce any dangers he may pose to the public and to help him cope, at other times there will be little that can be offered by any of the services.

The Panel are satisfied that the agencies and professionals involved here all did what they perceived at the time to be for the best. The Panel doubt that much more would have been attempted anywhere else in the country. However, at times the medical and social service provision lacked clarity of purpose and coordination. This could have been remedied by closer adherence to the principles of the Care Programme Approach (CPA).

Since the events with which this inquiry has been concerned, much work has been done by the relevant Kent agencies on improving the CPA procedures and practice, and integrating the CPA and Care Management in Kent.

BACKGROUND TO THE INQUIRY

1. THE RUSSELL MURDERS

- 1.1 On 9th July 1996 Lin Russell and her two daughters, Megan and Josie, aged six and nine respectively, were walking home from school down a Kent country lane with their dog when they were viciously attacked. They were all tied up: Lin and Megan were beaten savagely about the head with a hammer or pole, their skulls were fractured and they died from massive injuries. Josie was also severely injured in the attack and left for dead. The incident gave rise to instant and justifiable national horror.
- 1.2 Over a year later, Michael Stone, who was then 38 and lived in Gillingham, was arrested and charged with this crime. He had a history of mental disorder, drug abuse, and violence and he had received treatment and supervision from various agencies. In particular, since his release from prison in 1992, he had been seen by various psychiatric services in Kent, had been detained under the Mental Health Act on one occasion, and had received treatment and supervision from a drug addiction clinic. For two years up to just before the murder he had been the subject of a probation order.
- 1.3 On 2nd October 1998 Michael Stone appeared at Maidstone Crown Court where he pleaded not guilty to two counts of murder and one of attempted murder. The case against him at the trial rested principally on evidence of alleged admissions he was said to have made to fellow prisoners while on remand and circumstantial evidence showing Mr Stone's familiarity with the area concerned, his general whereabouts, his possession of a vehicle and his disposal of clothes. The Crown sought to introduce evidence of his behaviour as witnessed by a community psychiatric nurse and others shortly before and shortly after the murder. Although this evidence was ruled inadmissible, there was a certain degree of discussion in open court in the absence of the jury of Mr Stone's medical and mental health history.
- 1.4 After a lengthy trial, on 23rd October 1998 Mr Stone was convicted on all counts on the indictment and was sentenced to life imprisonment. The Chief Executive of West Kent Health Authority gave a press statement, on behalf of the health, social and probation services, summarising the treatment, care and supervision Mr Stone had received, asserting that he had not been mentally ill, but had suffered from a personality disorder, and that he had received a high level of care from a number of different agencies. The statement asserted that this was not a case of a person needing professional help not receiving it. The question was, it was said, whether he was "mad or bad". The statement concluded by stating that he was certainly not mad.
- 1.5 Predictably, there was wide coverage in the media of these sensational events. Detailed histories of Mr Stone's life, mental state, and treatment appeared. Many of these contradicted each other; some contained detail that could have been derived only from a source with access to medical records. Various concerns were raised, including suggestions that Mr Stone had begged for help, but had been refused it.

1.6 Immediately after his conviction, Mr Stone lodged an appeal. At the date of writing this report his appeal has not been heard.

1.7 Political reaction to the case was immediate. Mr Alan Beith MP put a question to the Home Secretary.

“Does the Home Secretary believe that further measures will be needed to deal with offenders who are deemed to be extremely violent because of mental illness or personality disorder, but whom psychiatrists diagnose as not likely to respond to treatment? Is he aware that this concern has arisen not simply following the conviction of Michael Stone for those two brutal and horrible murders, but because there has been a tendency in recent years for psychiatrists to diagnose a number of violent people as not likely to respond to treatment?”

Mr. Straw replied:¹

“Yes, I entirely agree with the Right Hon. Gentleman that there must be changes in law and practice in that area. We are urgently considering the matter with my right hon. and hon. Friends in the Department of Health. Sir Louis Blom-Cooper, who has a distinguished record in this field, said on the radio on Sunday that one of the problems that has arisen is a change in the practice of the psychiatric profession which, 20 years ago, adopted what I would call a common-sense approach to serious and dangerous persistent offenders, but these days goes for a much narrower interpretation of the law. Quite extraordinarily for a medical profession, the psychiatric profession has said that it will take on only patients whom it regards as treatable. If that philosophy applied anywhere else in medicine, no progress would be made in medicine. It is time that the psychiatric profession seriously examined its own practices and tried to modernise them in a way that it has so far failed to do.”

1.8 Since then the Government has put out for consultation proposals to amend the Mental Health Act law relating to the way in which society should deal with people suffering from psychopathic or antisocial personality disorders.² While the Government deny that the proposals are motivated by the case of Michael Stone, the public perception of the case, as reported in the media has formed part of the discussion about them.

2. INTERNAL REVIEW

2.1 Following the arrest of Mr Stone in July 1997 the West Kent Health Authority, Kent Social Services and Kent Probation Service, in consultation with the NHS Executive Regional Office and the Department of Health, jointly determined that an internal review should be held to identify any matters related to the care of Mr Stone which might require immediate attention by those authorities in advance of the findings of this inquiry.

2.2 The report was commissioned from two independent professionals who did not work for any of the bodies associated with Mr Stone’s care. These were Dr Moodley, a consultant psychiatrist (recommended to the Health Authority by NHS Regional Office), and Ms Hancock, a senior psychiatric social worker who had worked as a Social Services Inspector.

¹ *Hansard* 26th October 2000 column 9.

² *Managing Personality Disorder - Proposals for Policy Development* Home Office July 1999; *Reform of the Mental Health Act 1983 - Proposals for Consultation* Home Office/DoH November 1999; see also *Review of the Mental Health Act 1983 - Report of the Expert Committee* DoH November 1999; *Modernising Mental Health Services* DoH December 1998.

- 2.3 The task set to the authors of the report was to produce a chronology of events in the care of Mr Stone and comment upon the adequacy or otherwise of that care. They were given access to documentary material only and did not interview any persons involved in Mr Stone's care.
- 2.4 The specific material given to Dr Moodley and Ms Hancock comprised the mental health records from the three Kent services (Trevor Gibbens Unit, Manor Road Addictions Centre and Medway CMHT), social services records, the GP records and some probation records. They were not provided with Mr Stone's records from the following services: HM Prison Service; Bexley Hospital and De La Pole Hospital; Lincolnshire Probation Service, nor did they have the Kent Social Services childhood contact file or Kent Probation Service contact files.
- 2.5 The final 36-page report was submitted to the Health Authority and Social Services in May 1998. To some extent it informed the joint agencies' statement made following Mr Stone's conviction, although, as noted in chapter 14 below, there was some incongruity between the findings of the report and the final statement presented at the press conference.
- 2.6 The internal report concluded by identifying both "positives" and "possible criticisms" which are appended at Appendix 3.

COMMENT:

The Panel finds it was wholly appropriate of the Health Authority and Social Services to commission such an internal report.

In a case such as Mr Stone's an internal review enables the agencies to identify quickly and act upon any obvious deficiencies in services and/or be reassured in general terms if it is noted that their staff have acted competently.

Because of the form of such an internal review it will always have limitations. In this case the authors did not have access to all the documents which have been before this inquiry and importantly were unable to consider oral evidence from witnesses. Such an internal review is unlikely to be a substitute for full inquiry in a complicated case such as this. However, where the delay to trial is likely to be lengthy it is appropriate for an interim review to be held.

However, this Panel have discovered several matters which were not noted within the internal report and, where there is to be a full external inquiry, agencies should exercise caution before relying upon any internal review as comprehensive evidence of the facts.

3. APPOINTMENT OF THE INQUIRY PANEL

- 3.1 Circular HSG(94)27, issued by the Department of Health, requires the relevant agencies to commission an independent inquiry wherever a homicide is committed by a person receiving mental health treatment. The inquiry must examine the appropriateness of the care provided, point to any lessons to be learnt and make recommendations.
- 3.2 West Kent Health Authority, Kent Social Services and the Kent Probation Service had resolved before the conclusion of the trial that such an inquiry would be required in the event of a conviction, and an announcement to that effect was included in their joint statement made by the Chief Executive of the Health Authority at the end of the trial.
- 3.3 West Kent Health Authority, with the consent of Kent Social Services and Kent Probation Service, took the lead in making the administrative arrangements for the conduct of the inquiry.
- 3.4 The Chairman of the Inquiry was appointed by letter of 4th December 1998, other members of the Panel were appointed shortly thereafter. Those appointed were:

Robert Francis QC (chairman)

Dr Jim Higgins, consultant forensic psychiatrist, Scott Clinic, Rainhill

Emlyn Cassam, former director of Norfolk Social Services

Professor Ivor Gaber, Emeritus Professor of broadcast journalism, Goldsmith's College

A brief description of the backgrounds of the Panel members appears at Appendix 1.

- 3.5 None of the Panel members had any previous involvement in the case or with any of the commissioning agencies.
- 3.6 On 24th March 2000 Professor Gaber withdrew from the Panel as he was exploring a business relationship with a company which had given media advice to West Kent Health Authority. The remaining members of the Panel were completely satisfied that Professor Gaber's valuable contribution to the inquiry up to that point had been completely independent and impartial. This report, however, reflects the views of, and is the responsibility of, the remaining members of the Panel only.

4. APPOINTMENT OF ADVISERS

- 4.1 The commissioning agencies considered that the Panel would be assisted by the appointment of specialist advisers. They were to make available to the Panel expertise on specialist areas that might lie outside the knowledge of the Panel. How this resource was to be used was to be a matter entirely for the Panel.
- 4.2 The eventual appointments made were:
Psychiatric and drug dependency services: Dr David Forshaw, Consultant Forensic

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Psychiatrist, Broadmoor Hospital.

Probation: Geoffrey Green, retired (former assistant chief probation officer, Hampshire Probation Service)

Nursing: Lezli Boswell, Chief Executive, Mental Health Service of Salford NHS Trust

- 4.3 In addition Bridget Dolan was appointed as independent counsel assisting the inquiry. Melanie Bloomfield acted as secretary to the inquiry.
- 4.4 None of the above advisers had any previous involvement with the case or with any of the commissioning agencies.

COMMENT:

The Panel acknowledges with gratitude the invaluable assistance it has received from the advisers and counsel without whom it would not have been possible to produce this report. They wish to pay special tribute to the efficient and thoughtful assistance received from the inquiry secretary.

- 4.5 Before the appointment of the Panel West Kent Health Authority had approached Dr Johns, consultant forensic psychiatrist at Broadmoor Hospital, with a view to his being appointed specialist psychiatric and drug dependency services adviser to the Panel. On being approached by Mr Marsden on behalf of the Health Authority, Dr Johns disclosed that he had prepared a report on Mr Stone for the court case. The Health Authority believed this was a “one-off mental state examination on behalf of both the prosecution and defence”. In fact, Dr Johns had prepared a report on Mr Stone, following an examination of him, for the police in connection with the prosecution. This information was not communicated to the Panel before the press conference announcing the opening of the inquiry on 22nd January 1999. As soon as the Panel became aware of these facts, it resolved that Dr Johns would be unable to be seen to have the independence required of an adviser to an independent inquiry and resolved not to avail itself of his services. Accordingly, Dr Johns was released as an adviser. He had neither met the Panel nor reported on or discussed any issue with the Panel by this time.

COMMENT:

It is of crucial importance in inquiries such as this that the inquiry process is independent of the commissioning agencies, and, just as importantly, seen to be independent. The public credibility of any findings and recommendations will otherwise be reduced.

5. TERMS OF REFERENCE

- 5.1 The Terms of Reference are set out at the beginning of the report. Paragraph 7 of the Terms of Reference allowed the inquiry to issue a report in relation to the fact-finding and evaluation stages before proceeding to consider the policy stage. The Panel determined at the outset that it would be advantageous to do so.

COMMENT:

The Panel is of the firm view that the policy debate concerning the adequacy of the law, policy and guidance should take place in the context of the actual facts of the case of Michael Stone, as opposed to the incomplete and in some cases inaccurate accounts that have appeared to date.

The decision as to whether this inquiry should be extended to contribute to this debate cannot be made until after publication and further consultation with the commissioning agencies.

6. PROCEDURE

6.1 All inquiries have to consider what procedure is appropriate for the particular issues to be considered. The objectives must be to conduct an inquiry which so far as is practicable:

- investigates the matters within the terms of reference thoroughly;
- ensures objectivity;
- enables all the relevant information is considered;
- is fair to those who are under scrutiny;
- recognises the position and interests of all those concerned with the events which led to the inquiry.

6.2 A particular challenge confronting this inquiry was the fact that Mr Stone appealed against his conviction and has at all times vehemently denied that he committed the crimes of which he was accused. On reviewing the reports of previous homicide inquiries, the Panel found that this was an unusual feature. It was obviously important that the inquiry should not in any way prejudice the continuing criminal proceedings. One possibility would have been to postpone the commencement of the inquiry until the appeal had been concluded. To have done so would have meant running the risk that the recollections of those involved in providing treatment, care and supervision to Mr Stone would have faded. Furthermore, it would have delayed the identification of any problems or defects in the provision of services. Therefore the commissioning agencies were keen that the inquiry should proceed promptly. The Panel agreed that it would be in the public interest to do so. The Panel considered that in any event its task was not to investigate the merit of the criminal allegations against Mr Stone.

6.3 The Panel made no assumptions about Mr Stone's guilt or innocence and avoided considering evidence which related solely to the events surrounding the murder. In this way it put itself as nearly as possible in the position of those who had to provide Mr Stone with treatment, care and supervision, without applying the hindsight that can tempt criticism of professionals for matters about which they were justifiably ignorant at the time in question.

Further, the Panel do not seek to explain what motivated these horrific crimes. In many previous homicide inquiries there has been a clear explanation of the reasons for the crime either through the court process and/or through the patient's own account of

his/her motivation at the time. In the case of the Russell murders, Mr Stone has continued to profess his innocence. The court process did not reveal any clear motivation for the crime and none of the material available to the inquiry has provided an explanation for it. In the circumstances, it would be inappropriate of the Panel to speculate upon the motive for and/or precipitant of the crime.

COMMENT:

In the course of this report various criticisms are made about the care and supervision or services which have been examined in the inquiry. It must be emphasised that no criticism is intended to imply that there was any causative link between the matter criticised and the murders. Any such conclusion would be outside our terms of reference, unfair to the individuals concerned, and in any event could only be speculation.

- 6.4 The decision to proceed in advance of the determination of the appeal did have one unfortunate consequence. Mr Stone was, naturally, central to the inquiry. It was the appropriateness of his care and supervision that the Panel were investigating. It would have been extremely helpful to have been able to obtain a full account of various events from his perspective. While Mr Stone was prepared to see two members of the Panel on an informal basis before the inquiry started, and to consent to the disclosure of his records and medical information for the purposes of our inquiry, he felt unable to meet us as a witness. It may be that there was an understandable and justifiable reluctance to take any step which might have prejudiced his appeal.

COMMENT:

This report has been prepared without a full contribution from Mr Stone or, indeed, members of his family and others close to him who may have had a different perspective on his needs. The comments, criticisms and recommendations must therefore be read with that qualification.

- 6.5 The agencies were able to provide for the inquiry Panel extensive case records relating to Mr Stone's treatment and supervision³ with the exception of:

Probation Contact files: (in respect of attendances in 1994 to 1996) which were misplaced by the probation service and, despite continued efforts on the part of Kent Probation Service to trace them, were not discovered until 1st October 1999 when found in a disused desk drawer.

Bexley Hospital and GP records in the name of Michael "G": (in respect of an admission to Bexley Hospital in 1980; GP care before 1987 and subsequent multiple GP registrations in 1993 and 1994) which were produced at the request of the inquiry when it emerged that Mr Stone had obtained treatment in another name.

³ A list of all documents available to the panel is at Appendix 9.
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Prison Service records: which remain largely unavailable.⁴

COMMENT:

It is of concern that original records relating to a client arrested and charged with murder were insufficiently secure that they could be misplaced by the probation service.

It appears that all services handed original records to the police service without photocopies being kept. Although all records were returned by the police, it would have been prudent for the services to have retained a copy.

6.6 A large number of individuals working in the various agencies which had contact with Mr Stone were invited to provide information in writing and did so. The Panel then determined which of those witnesses they wished to interview. From the outset the Panel determined that it would meet witnesses in private. It was felt that this would encourage those who came to assist the Panel more freely. It was made clear to all witnesses that their evidence would be treated by the Panel as confidential to the inquiry, save to the extent that it was necessary to include that evidence in this report in order to show the basis of the Panel's findings. Witnesses were given the opportunity to be accompanied by a professional or other adviser of their choice. Some chose to come alone, many chose to be accompanied by counsellors appointed by the commissioning agencies for the purpose. Only one witness chose to be accompanied by a legal representative. Each witness was provided with a record of their evidence and invited to submit amendments and further evidence if they wished to do so on further consideration. A total of 24 days was spent in interviewing witnesses. In addition, the Panel visited the Trevor Gibbens Unit, Shelley Ward at Medway Hospital, Manor Road Addictions Centre and Throwley House.

6.7 At the completion of this stage of the investigation, counsel assisting the inquiry was invited to prepare draft findings for the Panel's consideration. Before reaching any conclusion and preparing this report, each of the individuals referred to in the drafts prepared by counsel received the extracts relevant to themselves and were invited to comment on these, whether or not they were the subject of criticism in the draft. Almost all those invited to provide such comments did so. As a result, extensive revisions were made to the draft.

COMMENT:

The Panel would like to express its appreciation to all those who have contributed information to the inquiry. In general the Panel received the fullest cooperation from those it approached, despite the demands in terms of time our requests must have imposed. The Panel fully understands the stress this sort of inquiry can impose on those who are subject to this form of investigation.

⁴ See Prison Service chapter at paragraph 6.

7. CONFIDENTIALITY AND THE PUBLIC INTEREST

7.1 One of the first matters the Panel had to consider was the question of confidentiality. In examining the conduct of the agencies, their staff and the media, the Panel have in mind the position in law regarding treatment information. The Panel found that the staff of all the agencies involved in the provision of care and supervision to Mr Stone understood that information concerning him was confidential. It is likely that this is not so well understood or accepted by journalists, given the commercial pressures and demands for the disclosure of information under which they operate. It is therefore important that the requirements of the law are clearly set out. Inevitably, what follows concentrates on the medical duty of confidentiality, but the same principles apply to information in the possession of the probation service and social services.

The general law⁵

7.2 The law imposes on doctors a duty to keep confidential information about their patients. It is easily expressed:

... in common with other professional men for instance a priest and there are of course others, the doctor is under a duty not to disclose [voluntarily], without the consent of his patient, information which he, the doctor, has gained in his professional capacity, save... in very exceptional circumstances... [for] example... the murderer still manic, who would be a menace to society... The law will enforce that duty.⁶

7.3 Not all information is confidential, even if no consent has been obtained for its disclosure. Information which is already public knowledge is not confidential. Where information has been confidential but has become public knowledge, and no further harm can be done by further publication, such duty of confidence as remains is unlikely to be enforced.⁷

Even where the information is confidential, the duty not to disclose is not absolute:

- There is no right to confidence in information where to conceal it would be to conceal serious wrongdoing.⁸
- Confidential information may be disclosed when disclosure is required by law. Such disclosure may be required by statute,⁹ or in response to an order of the court.
- Confidential information may be disclosed where there is a public interest in its disclosure which outweighs the public interest in preserving the confidentiality.¹⁰

⁵ What follows does not purport to be an exhaustive analysis of the law of confidentiality but a short review of its application to the problems arising in the case of Mr Stone. For a full account see *Principles of Medical Law*, Kennedy and Grubb, 1998 OUP, chapter 9.

⁶ See *Hunter v Mann* [1974] QB 767, 772 Boreham J.

⁷ See *Attorney-General v Guardian Newspapers (No 2)* [1990] 1 AC 109.

⁸ See *Gartside v Outram* [(1856) 26 LJ Ch 113.

⁹ See *Hunter v Mann* (above).

¹⁰ See *W v Egdeell* [1990] Ch 359.

The application of the law to medical information

7.4 There is no doubt that information imparted by a patient to his doctor in the course of seeking or receiving treatment is confidential. This is so whether or not the patient expresses a desire that it should be so treated. The General Medical Council may take the view that unjustified disclosure of medical information by registered medical practitioners is serious professional misconduct.

7.5 Patients may have their own interest in keeping information private, but it is the recognised public interest in maintaining the confidentiality of medical information which gives rise to the duty. The nature of the public interest varies according to the circumstances, but in the context of a patient seeking or receiving mental health or drug dependency treatment it would seem to the Panel that the following public interests can be identified:¹¹

- The proper assessment of the mental state of such patients, and of any drug dependency requires that the patient “should feel free to bare his soul and open his mind without reserve” to those providing treatment and care. He will be unlikely to do so if he fears that the information he imparts may be disclosed to others for purposes other than treatment. In the case of a patient who may be dangerous, this interest is even greater.
- A patient should be free of the fear that he will be harmed by cooperating with his treatment, care and supervision by disclosure of what he has said, unless there is a compelling reason to do so.
- All patients have the same human rights as the rest of society: these include those enshrined in Article 8 of the European Convention on Human Rights, incorporated into English law from October 2000, by the Human Rights Act 1998:

Article 8: Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

7.6 The Convention also qualifies the right to freedom of expression by reference to confidential information:

Article 10(2) provides:

2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.

¹¹ See also *Confidentiality*, General Medical Council October 1995, page 2: “patients may be reluctant to give doctors the information they need to provide good care.”

- 7.7 The public interests that may justify disclosure are somewhat limited. Any disclosure justified by such an interest must be restricted to that necessary for the purpose. Thus disclosure to prevent a serious crime must be made only to those to whom it is reasonably necessary to do so for that purpose. The interests that may allow some degree of disclosure relevant to the present case include the following:
- Disclosure may be justified where it is required to avert a real risk of a danger of death or physical harm to others.
 - Disclosure necessary to protect colleagues or patients from such risks.
 - Disclosure necessary for the prevention or detection of serious crime.
- 7.8 These interests justifying some degree of disclosure can be supported by reference to decided cases, and the guidance of the General Medical Council which has in the past met with approval in the courts as reflecting the law. None of them is likely except in the rarest of circumstances, of which none appears to have been present in this case, to justify disclosure to the press.
- 7.9 The question has to be asked whether there is a public interest following the commission of a very serious crime of violence in the public being given information to allow it to assess whether public bodies charged with patient care and public safety have fulfilled their duties, and whether they can have confidence that proper steps were taken to protect the public.

COMMENT:

It is the considered view of the Panel that in exceptional cases, of which this is one, the level of legitimate public concern is sufficiently great to justify overriding the confidentiality of the patient's information to the extent that it is necessary to enable that assessment to be made. The existence of such a public interest is demonstrated by the circular under which this inquiry is being held and by the duties imposed with a view to the protection of the public on the various agencies in relation to mentally disordered patients and offenders.

- 7.10 It must be noted and accepted that a balancing exercise of the nature required by the law in this area is extremely difficult. There are bound to be reasonable differences of opinion about whether and to what extent disclosure can be justified in any particular case. In what follows the Panel have kept those difficulties well in mind. It must always be remembered, however, that disclosure should be limited to that required for the identified purpose and should never be dictated by the understandable demands of the media for any information of interest to their readers, listeners and viewers. However society views a person such as Mr Stone, a convicted murderer, it must be remembered that in a society respecting human rights, such persons are also entitled to those rights.

8. CONFIDENTIALITY OF RECORDS

- 8.1 Clearly, Mr Stone's medical records and clinical information were confidential to him and remained so despite his conviction. Nonetheless, his complete records were offered to the Panel by the commissioning agencies without his consent.
- 8.2 The Panel considered the guidance on confidentiality of clinical information published by the General Medical Council and decided that it should not proceed to examine the records without first approaching Mr Stone for his consent. The Panel took the view that Mr Stone's conviction of murder, however evil the crime, did not mean that he was stripped of the usual right to confidentiality of his clinical information. The Panel bore in mind that this was not a statutory inquiry with the power of compelling evidence to be produced before it. It was decided to defer consideration of the question of whether the public interest justified the disclosure of clinical information in the absence of consent until after discovering whether Mr Stone's consent was forthcoming.
- 8.3 After preliminary correspondence, the Chairman and the medical member of the Panel met Mr Stone and his legal adviser in prison to explain to him the nature of the inquiry and the issues surrounding the giving of his consent. After due consideration and an opportunity to take legal advice, Mr Stone consented in writing to the disclosure to the Panel of all records and information relating to the provision of services to him by the medical, probation and social services for the purposes of the inquiry.

COMMENT:

The Panel wish to thank Mr Stone for his cooperation in relation to the disclosure of confidential information to them. His written consent allowed the production to the inquiry not only of all the available documentation, but also of written and oral evidence from professional witnesses who might otherwise have felt prevented by ethical obligations from cooperation.

The Panel did not have to consider whether the public interest in holding the inquiry outweighed Mr Stone's confidentiality, if he had asserted it. Such an assessment would have been difficult to undertake before the conclusion of the appeal against conviction. Even if the Panel had taken the view that public interest factors justified the disclosure and use of otherwise confidential information, it is quite possible that some of the professionals who assisted the inquiry with evidence would have taken a different view. The inquiry would then have been less complete or delayed considerably.

The Panel were surprised to note from perusal of previously published inquiry reports, that the issue of confidentiality does not normally¹² appear to be expressly addressed. It may be that in many cases either consent is forthcoming, or the relevant confidential information has entered the public domain in the course of the criminal trial. Nonetheless, particularly after

¹² Some inquiries have sought the patient's consent: eg *Report into Treatment and Care and of Raymond Sinclair*.

the incorporation of the European Convention on Human Rights into English domestic law, it is important that the patient's right to confidentiality is recognised and addressed.

In view of the past reported practice of other inquiries no criticism can be made of the commissioning agencies in this case for not addressing this issue explicitly, but this should be done in any future inquiry.

9. CONFIDENTIALITY - CONTENT AND PUBLICATION OF THE REPORT

9.1 At the outset of the inquiry it was envisaged that the report of the Panel would be published. Indeed, one of the purposes of the policy requiring this type of inquiry is to inform the public whether the treatment, care and supervision provided were appropriate and whether a different approach might have avoided the homicide. Since the promulgation of circular HSG(94)27, many such reports have been published.

9.2 In considering publication it is important to note the precise relationship between the inquiry and those who commission it. This inquiry is required by government policy as laid down in the circular, but the decision and responsibility for setting it up rests with West Kent Health Authority, Kent Social Services and Kent Probation Service each in respect of their own service. The remit of the Panel appointed by them is to report on the terms of reference to those commissioning agencies. The terms of reference do not in themselves contain any authority or instruction to the Panel to decide whether or not its reports should be published. That responsibility rests with the commissioning agencies.

9.3 Despite the fact that such publication is the normal practice, the Panel have noted that the patient, his family, and in some respects the staff of the various services involved have rights to confidentiality which should only be overridden where this is required by the public interest.

9.4 The public interest factors identified by the Panel as justifying publication in this case are:

- At the time of the homicide Mr Stone was under the care of various agencies which had duties to monitor and assist him in order to reduce, so far as was practicable, the risk he might have presented to the public;
- If there has been a failure in those arrangements, the public have a right to know about it and about what steps need to be taken to prevent such a failure occurring in future;
- If there was no such failure, the public have a right to be reassured;
- If there are lessons to be learned from what happened which might reduce the risk to the public in other cases, these should be known to the public;

- Where the events surrounding the care and supervision of a patient or client convicted of homicide have been the subject of widespread and legitimate public debate and criticism, the public have a right to be provided with an accurate version of the facts.

9.5 Unusually, this inquiry has been conducted at a time when the conviction for the murder has been subject to appeal. If Mr Stone's appeal is upheld and the conviction quashed, different considerations might apply. An inquiry and report would no longer be required under the circular. The rationale of the inquiry of investigating whether the homicide could have been avoided with different treatment, care and supervision would no longer apply. The Panel therefore considered what, if any, were the public interests in publishing the report in that eventuality. The Panel sought and received advice from the Department of Health via the Joint Branch Head of Mental Health Services that it would not follow from the quashing of the conviction that there was nothing noteworthy to report. The Department is willing to consider this matter with the commissioning agencies on delivery of the report and completion of the appeal process.

9.6 The Panel, conscious that the decision whether or not to publish is not theirs but that of the commissioning agencies, consider that the following factors might be identified in favour of publication, even if the conviction is quashed:

- The patient was considered at various times to be highly dangerous and therefore of a category where special care for public safety had to be taken;
- There is legitimate public concern that the arrangements for his treatment, care and supervision and the protection of the public were inadequate;
- His history of treatment, care and supervision by and association with the commissioning agencies played a part in his arrest and prosecution for murder;
- The commissioning agencies have already given an account in public of the patient's condition and an assertion that the treatment, care and supervision provided were appropriate; an inquiry having been set up to investigate those issues, the public might be thought to have a right to know of the outcome;
- It is important that the debate on the matters of public concern which have arisen from this case is grounded on an accurate and full account of the facts, which has hitherto been denied to the public. It would be unfair to the public for the debate to be conducted without knowledge of the facts;
- Much of Mr Stone's background and mental and social history is already in the public domain, for better or for worse. In so far as that has been confirmed by the commissioning agencies in public statements, and in so far as reports concerning these matters are inaccurate it would be unfair to him if the record were not put straight. As recorded above, Mr Stone has, after taking legal advice, consented to the disclosure of confidential information for the purposes

of this inquiry. Such consent was given in the knowledge that the report of the inquiry was likely to be made public;

- Various agencies and their employees have been the subject of criticism, much of it uninformed. Fairness to those who have been criticised in public would indicate that, if the Panel find the criticism to be ill-founded, that should be made known; in the case of those where criticism is made by the Panel, there is a public interest in knowing about that criticism, the reasons for it, and what, if any lessons can be learnt in relation to the treatment, care and supervision of certain types of patient or client.

9.7 The factors which might be identified as indicating that publication should be withheld in the event of the convictions being quashed are:

- From Mr Stone's point of view, it might be thought that his privacy has been invaded as a result of his suspected involvement in the murders. If he were to be acquitted, that invasion might arguably be thought to be aggravated by further disclosure of his private life, particularly if he did not want such further disclosure to take place. If he sought to prevent publication it could be justified only by identification of a sufficient public interest in its favour;
- Were the appeal to be successful, the requirement to hold this inquiry under the circular would, in retrospect, have proved not to exist. This would not, of course, invalidate the inquiry, as there is a general power under Section 2 of the National Health Service Act 1977 to hold inquiries in any event.

10. **IDENTIFYING STAFF BY NAME**

10.1 The commissioning agencies have requested that the Panel give consideration as to whether or not the report should identify staff members by name. The concerns expressed by the agencies in respect of naming staff are that:

- Staff identified may fear violence or reprisal from Mr Stone if he is freed on appeal;
- If individuals are at fault, this should be dealt with by their employing agency and they should not run the risk of being pilloried in public;
- Individual staff have no effective means after publication of defending themselves;
- It is becoming more usual for reports not to refer to staff by name;
- Where the report commends individuals, they will be aware of this;
- Where the report is critical of individuals, publication can only lead to the "name and shame" culture which increasingly stigmatises public services;
- Naming individuals adds nothing to the report's value in identifying and commenting upon issues of concern which should be addressed by the agencies involved.

- 10.2 In September 2000, the commissioning agencies sought the views of Kent County Constabulary as to the publication of the report. A Detective Inspector who had not seen the inquiry report, but is understood to have considerable knowledge and experience of Mr Stone, raised his concern that naming of individuals and attribution of direct quotes to them may place them at risk.
- 10.3 It is outwith the remit of this Panel to form a view as to whether staff named in this report would be subject to any increased risk of reprisal from Mr Stone (if one even exists at all) should the report be published. Some staff did tell the inquiry of their own concerns about risks to themselves prior to Mr Stone's conviction. However, the Panel were not made aware of any actual threat by Mr Stone or his associates.
- 10.4 The Department of Health have advised the Panel that they are not aware of any inquiry in which the published report has been anonymised by reason of fears as to staff safety. Names have been withheld where the victim has been related to the perpetrator of the homicide.
- 10.5 The inquiry panel have identified staff in the report which is presented to the commissioning agencies for the following reasons:
- Mr Stone is already well aware of the identity of those professionals with whom he had contact. Anonymisation of the report is unlikely to reduce any risk of reprisal even if such a risk exists;
 - Others within the agencies are aware of the identities of the individual staff members involved;
 - Some names of staff have already appeared in the press and where such names are in the public domain it is important that their role in the case is clarified;
 - Some staff whose actions have been criticised in the press have been commended by this report and this should be openly acknowledged;
 - Where the action(s) of a particular staff member are subject to criticism, it is important that the person is identified so that their actions are not mistakenly attributed to others;
 - It is generally custom and practice for reports such as this to refer to staff by name;
 - Any attempt to conceal identities may be perceived by the public as an attempt to avoid professionals' accountability.
- 10.6 For the reasons above, the Panel recommend that any published report identifies staff by name. Notwithstanding this, the Panel note that it is for those who have commissioned this report to decide whether and in what form it is published. Thus the final decision as to whether staff are identified in any document which is made public must lie with the commissioning agencies.

11. STRUCTURE OF THE REPORT

- 11.1 The inquiry has been obliged to examine the provision of care and services by a wide range of services and individuals over a number of years. In some cases the agencies acted in concert with each other, but on other occasions this was not so, and on some agencies acted in ignorance of each other's involvement. Therefore it will not be possible to analyse what happened merely from a simple chronological account, although this will be necessary as well.
- 11.2 While no structure is ideal in these circumstances, this report will set out an overview of Mr Stone as a patient and client of services, the general standard of the services provided, a chronological history of Mr Stone's background and contact with the services, followed by an analysis and evaluation, service by service, of what was done. An executive summary summarises the main findings of each chapter.

12. RECOMMENDATIONS

Paragraph 4

In preparation for any inquiry of this nature, any candidate for appointment as a member of the Panel, or expert adviser should be asked whether he or she has had any previous professional or other connection with the patient, or any organisation or individual that may be the subject of the inquiry. If such a connection is disclosed, and it is decided nevertheless to appoint the individual concerned, the connection disclosed should be included in the Panel report and announced at the outset of the inquiry.

Paragraph 5

The extent and nature of the policy stage of this inquiry should be considered after publication of this report, in consultation with the commissioning agencies.

Paragraph 6.4

If it is practicable to do so, Mr Stone should be given an opportunity to consider this report on its completion. On conclusion of his appeal he should be given the opportunity to make representations to the Panel about any matter arising from the report. The Panel should then reconsider the report in the light of any comments made to them by Mr Stone and, if appropriate, make a further report to the commissioning agencies.

Paragraph 6.5

In any case where it appears that a patient known to statutory services may be the subject of a homicide investigation the management of the service responsible should immediately recall and secure all records. A photocopy of the records should be made before any originals are provided to the police.

Paragraph 8

When homicide inquiries are set up, the commissioning agencies should automatically consider the confidentiality of the information it is proposed to disclose, and seek the consent of the patient to disclosure of the relevant confidential information for the purposes of the inquiry. If such consent is not forthcoming, the commissioning agencies should consider whether it is in the public interest for such disclosure to be made in spite of the absence of consent. Any decision to disclose information without consent on public interest grounds should be communicated to the patient together with reasons for the decision.

Where such consent is not forthcoming, or it is anticipated that significant evidence can be obtained only by compulsion, commissioning agencies should invite the Secretary of State to consider constituting the inquiry under Section 84 of the National Health Service Act 1977.

Paragraph 9

The commissioning agencies should publish this report after the resolution of the criminal proceedings regardless of the result, subject to the recommendation below.

In the event of Mr Stone's appeal against conviction succeeding, in reaching a decision whether or not to publish the report, the commissioning agencies should seek and have regard to any representations made by or on behalf of Mr Stone.

If the commissioning agencies determine that the report should not be published, copies of the report should nonetheless be given to Mr Stone, any person criticised in it and the Department of Health.

Paragraph 10

Any published report should identify staff involved in Mr Stone's supervision and care by name.

A BRIEF CHRONOLOGY OF EVENTS

DATE	EVENT
7 June 1960	Michael Stone born
5 December 1967	Received into care temporarily (until 25 December 1967)
3 March 1972	First appearance in court: offences of dishonesty Supervision Order 3 years
5 August 1972	Received into voluntary care
2 October 1972	Place of Safety Order
6 October 1972	Care Order; placed at Woodlands Reception Centre
15 March 1973	Placed - Greenacre Community Home
28 March 1974	Placed - Redhill Classifying School
13 June 1974	Placed - North Downs Community Home
29 October 1974	Convicted - offences of dishonesty: 3 months Detention Centre
25 April 1975	Convicted - offences of dishonesty: 3 months Detention Centre
11 August 1975	Convicted - offences of dishonesty: Borstal training
11 March 1977	Convicted - offences of dishonesty: Recalled to Borstal
15 December 1977	Convicted - offences of dishonesty: 18 months imprisonment
23 February 1978	Convicted - offences of dishonesty and arson: 8 months imprisonment
10 October 1979	Convicted - offences of dishonesty: 8 months imprisonment
28 November 1979	Admitted - Alpha House (discharged after a day)
21 May 1980	Admitted - Bexley Hospital Drug Dependency Ward (Self discharged after 4 days)
6 February 1981	Convicted - robbery, malicious wounding: 2 years imprisonment
1 July 1982	Released from prison
20 May 1983	Convicted - robbery, ABH, wounding with intent: 4½ years imprisonment
2 September 1986	Released from prison
10 April 1987	Convicted - Robbery, possession of firearm, burglary, theft: 10 year sentence - reduced to 8½ years on appeal
24 August 1992	Released from prison
8 September 1992	Registered with Dr M - GP, general practitioner
8 October 1992	Assessed by Dr BB - Psych [Throwley House, Chatham Community Health Team (CMHT)]

DATE	EVENT
21 October 1992	Assessed by Dr Q - Psych(F), Senior Registrar [Trevor Gibbens Unit]
22 December 1992	Convicted - offences of dishonesty - fined
12 January 1993	Registered in different name with general practice of Dr I - GP
4 February 1993	Emergency GP referral to Dr V - CPsych, Consultant Psychiatrist [Manor Road Addiction Centre]: accepted for treatment and referred to Dr AA - CPsych, Consultant Psychiatrist [Medway Hospital] for depot medication. Diagnosis: Paranoid psychosis triggered by drugs
5 March 1993	Commenced depot medication
21 July 1993	Discharged from depot clinic for failure to attend
12 August 1993	Offences of dishonesty - conditional discharge
September 1993	Goes to Skegness
October 1993	Arrested in Skegness and remanded in custody in connection with burglary, possession of antique firearm
6 April 1994	Remanded to bail hostel for pre-sentence report [Ms LL - PO, Lincolnshire Probation Service]
29 April 1994	Convicted - Burglary, possession of air weapon whilst prohibited: Probation Order 2 years; 6 monthly reports to be submitted to Judge
3 May 1994	Attended probation officer - Ms CC - PO
21 July 1994	Attended Dr I - GP as temporary patient
6 October 1994	Registered under different name with general practice of Dr K - GP
3 November 1994	Case conference: thought to need compulsory admission to hospital
24 November 1994	Admitted to Bexley Hospital: Section 2 Mental Health Act
29 November 1994	Transferred to De La Pole Hospital, Hull
30 November 1994	Threatened new probation officer
14 December 1994	Settled on medication. Considered suitable for transfer to open ward
20 December 1994	Admission regraded to Section 3 Mental Health Act
27 December 1994	Assessed by Dr T - CPsych(F) for forensic mental health service
16 January 1995	Discharged from De La Pole Hospital; Mr HH - PO, probation officer, allocated as key-worker
18 January 1995	Section 117 discharge planning meeting at TGU
13 February 1995	Ms CC - PO, probation officer allocated as key-worker
28 February 1995	Registered with Dr I - GP as general practitioner
20 April 1995	Case transferred to Gillingham Social Work Team : Mr OO - SW allocated case

DATE	EVENT
22 May 1995	Case conference: Mr OO - SW, social worker, new key-worker. Commenced methadone reduction in community.
15 November 1995	First seen by Ms ZP - CPN, Community Forensic Psychiatric Nurse
15 January 1996	Social Services role allocated to Mr VV - SW unaware of key-worker role
28 April 1996	Probation order ended
4 July 1996	Incident causing concern to Ms ZP - CPN
5 July 1996	Ms ZP - CPN seeks information about depot injections from Dr I - GP
9 July 1996	Russell murders
10 July 1996	Seen by Ms ZP - CPN and Mr VV - SW
23 August 1996	Admitted to TGU for detoxification
12 November 1996	Discharged from TGU
23 January 1997	Briefly re-admitted to TGU (four days)
July 1997	Arrest
May 1998	Internal Inquiry Report completed
23 October 1998	Convicted of murder and attempted murder
January 1999	External Inquiry commenced

SERVICE INVOLVEMENTS

MONTH	GP	CMHT	ADDICT- IONS	FOREN- SIC	SOCIAL SERVICE	PROBAT- ION	DE LA POLE	BEXLEY HOSP	PRISON
Nov 92									
Dec 92									
Jan 1993									
Feb 93									
March 93									
April 93									
May 93									
June 93									
July 93									
Aug 93									
Sept 93									
Oct 93									
Nov 93									
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Oct 95									
Nov 95									
Dec 95									
Jan 1996									
Feb 96									
March 96									
April 96									
May 96									
June 96									
July 96									
Aug to Nov 96									
Dec 96 to Jan 97									
Jan 97 to July 97									

CHAPTER ONE

AN OVERVIEW OF MICHAEL STONE AND THE SERVICE PROVIDED

1. Mr Stone's problems were multi-faceted. He has a severe personality disorder. He has episodically complained of the symptoms thought at the time to be features of mental illness. Above all, he has abused a wide range of illicit and addictive drugs. It has to be emphasised that his condition was not one-dimensional, capable of being given a simple description or diagnosis. There were at any time many factors in his personality, background and mental condition contributing to his presentation and behaviour, or apparent condition and behaviour.
2. The challenge that faced those who had to assist Mr Stone was much the same as that which has faced this inquiry. Much of what was going on in Mr Stone's life could not have been known to those dealing with him. Even with the benefit of collating all the records and interviewing almost all professionals who had contact with him, it is unlikely that this inquiry has been able to identify all relevant matters. Both those charged with providing care and assistance for Mr Stone and the inquiry have been able to make an assessment only on the basis of what is known. The performance of those looking after Michael Stone has to be assessed against the complexity of the problem confronting them. This was never a case in which there were going to be simply found effective solutions.
3. Michael Stone came from a disrupted family and spent all his adolescence in care or in custody. He was a regular offender, eventually being sentenced to borstal training when aged 15. Apart from a few months between sentences, he was in prison from the age of 18 until he was 32. His offences escalated from crimes against property to crimes of violence, and culminated with an eight-year sentence in 1986 for using an air pistol during a robbery. On several occasions whilst in prison, he lost remission for acts of violence. His drug misuse started at the age of 14. After his release from custody in July 1992 until his arrest in July 1997, he kept clear of prison, apart from a short period on remand, but had major problems with his misuse of drugs.
4. On first referral to the Community Mental Health Team in 1992, Mr Stone was thought to suffer with paranoid personality disorder. He was subsequently diagnosed by several consultant psychiatrists as having a mental illness - specifically schizophrenia¹. However, following assessment and acceptance of his care by the forensic psychiatric service in late December 1994, the diagnosis was changed to one of personality disorder².
5. The Michael Stone known to the caring agencies between 1992 and 1996 was a man with multiple and severe problems. The extent of these and the interaction of one with the other made him a particularly difficult person to obtain information about, to assess, treat, manage or even control. While those treating or caring for Mr Stone had

¹ See Glossary.

² See Glossary.

considerable contact with him, the majority of his life was unknown to them. Influences from this hidden part of his life, his illicit drug use, any criminal behaviour and difficult relationships with other family and friends, all undoubtedly coloured, if not sometimes caused, the clinical picture he presented. On the one hand, in seeking what he perceived to be his best interest, Michael Stone variously inaccurately or selectively revealed, denied or even fabricated elements of his history or of events which might have been germane to his mental state at any particular time: he might behave in a particular way to create an impression or achieve a desired result. On the other hand, his behaviour could at times be driven by the combined features of his personality disorder, his substance misuse, and, possibly, by symptoms of mental illness. The significance of any one of these factors would vary.

6. At other times a different picture of Mr Stone is painted: a man whose life in large parts was based on a routine of watching TV and visiting his mother each day for lunch; a man who complied with advice from professionals and attended appointments made for him. The professionals interviewed said that, as far as they were aware, Mr Stone did not have a “street” reputation of being a “hard” or violent person and, except on isolated occasions, they personally did not consider that he posed a physical threat to them in their professional dealings with him. It is not within the Panel’s remit to investigate what local intelligence was held by the Kent police about Mr Stone. It is clear that no concerns about him were raised with health, social service or probation professionals by the police.
7. None of this is surprising in the light of his history. He had a most damaging upbringing. From an early age he was seen as a disturbed and disturbing child and adolescent. His relationships with important figures, family or carers, have always veered between being open and guarded, wanting and declining help, being amenable and uncooperative, pleasant and threatening, dependent and independent, insightful or driven by fantasy, appearing to be a damaged but intelligent and competent individual and then an unintelligent and disorganised person, being incapable of sustaining lasting relationships and being able to sustain some form of them, appearing to some as a violent and potentially very dangerous man, and, even on the same day, to others as a very disabled and compliant individual in genuine need of support from health and social agencies.
8. Besides his personality disorder and virtually persistent substance misuse, there were occasions when Michael Stone was thought to be psychotic. The assessment of the nature of a psychosis depends upon an evaluation the manner in which the abnormal ideas and behaviour are presented, and what abnormal ideas are voiced. In serious psychotic illness, particularly schizophrenia, abnormal ideas are frequently presented in characteristic ways giving confidence that, no matter what is expressed or what action results, a firm diagnosis of a functional psychosis can be made. Even when there is doubt about the diagnosis early on, further experience of the patient and the emerging pattern of his disorder can help to clarify the picture. As most schizophrenic illnesses tend to be chronic, progressive and disabling disorders, influenced in part by medication and the presence or absence of distressing life events, a confident diagnosis can be made over time. This was not the picture presented over a sustained period in Mr Stone’s case. It is highly unlikely that Michael Stone suffered from a typical schizophrenic or psychotic illness.

9. Substance misuse can produce psychological distress and behavioural disturbance. It can even produce features of temporary psychosis, drugs such as amphetamines doing so more convincingly than cannabis. However, both overuse of or withdrawal from other drugs such as heroin, cocaine, and *benzodiazepines* can produce significant alteration of mental state whether or not amounting to psychosis. Intoxication can produce drowsiness, disinhibition or over-reactivity. Withdrawal, actual or imminent, can result in anxiety, anger, demanding behaviour and even aggression and violence. Repeated episodes can be seen in Michael Stone's history of a disturbed mental state which may well have arisen from drug intoxication, drug withdrawal or anxiety to obtain more drugs.

10. An unqualified diagnosis of personality disorder should not be readily made in the presence of episodes of psychosis, even though such a diagnosis is quite compatible with episodes of exogenous psychosis, e.g. psychosis resulting from external influences such as certain forms of substance misuse. There are, however, particularly vulnerable persons with a very fragile personality who, at times of particular and significant stress, can no longer maintain the integrity of their psychological functioning. They can break down and present a mental state quite similar to schizophrenia although the episode is brief and often self-limiting: it lacks the insidious and gradual deterioration seen in schizophrenia. At times there will be psychotic or psychotic-like episodes in which such individuals are over-preoccupied with fantasy or loosen their grip on reality. They express paranoid and delusional ideas, based on their life experiences and fantasy life. However, over time such individuals attract a diagnosis of personality disorder, not mental illness. Sometimes such fragile individuals may benefit from neuroleptic medication. It can diminish feelings of aggression and anxiety in a non-specific way and thus stave off or reduce psychological deterioration and disintegration. However, it is often difficult to distinguish the relatively non-specific effects of medication from beneficial changes in life experiences, such as those derived from being cared for as an out-patient or, if admitted to hospital, being removed from the stress outside. There are some grounds for considering that all these processes may have been at work in Michael Stone's case at certain times.

11. Having reviewed all the available evidence the Panel are inclined to the view that Michael Stone was much more the product of his drug-abusing environment than of any inner consistency, hindsight or foresight. The picture presented to those who had to provide care for him was highly complex and frequently changing, with various combinations of psychosis, occasionally suspected but in retrospect not confirmed, undoubtedly severe and habitual substance misuse, and a number of personality disorders some of which, at times of stress, might have decompensated into fantasy-driven thoughts and behaviour or brief episodes of psychosis. All these occurred in a man who had a life away from the centres, clinics and hospitals he attended, about which the professionals knew, and could have known, little.

12. The task facing those caring for Mr Stone was daunting. No-one could predict with much confidence from one contact to the next what he would say or how he would behave. It is understandable that there were differing views on the nature of Michael Stone's condition and how it should best be managed. The risk he seemed to present similarly fluctuated and the actual long-term risk he presented, to whom and in what circumstances, and what could be done to reduce it would have been impossible to assess with confidence. Therefore any criticism in this report of the services provided to Mr Stone between 1992 and his arrest in 1997 – and there will be criticism – must be seen in this light. There are no easy solutions to dealing with cases like Mr Stone's, and it would be wholly misleading to suggest that there might be. Most importantly, it is not possible, even with hindsight, to judge whether any different course of action would have resulted in his behaviour being modified in a way which would have led him to behave in a more constructive, less threatening and antisocial way.
13. Nonetheless, however complex a case Mr Stone's was, he did present to the various health and other services, and within their resources and skills, there was undoubtedly a constructive role for them to play. It is noteworthy that throughout the period under investigation, Mr Stone *did* receive very considerable input from all the services involved. Whatever else may be said about the care offered to him, his case was never ignored. There were areas of notable good practice, particularly at the Trevor Gibbens Unit (both Health and Social Services staff) and within the probation service. Considerable resources were devoted to him. It has been suggested to the inquiry that in many areas of the country a case such as this would not have been offered much if any contact with the health services. If that is true, and it may well be, it is a matter of concern, but no such criticism could be made of the services in Kent. It is of note that the only significant period which Mr Stone spent out of prison in his adult life was whilst supervised by Kent agencies.
14. What can be done in this sort of case, dominated by a combination of drug misuse, personality disorder, and criminality? As already indicated, there is no simple remedy, but that is not a reason for doing nothing. What has to be done is patiently to take all reasonable steps to reduce or remove the negative influences on the individual's life, build up the positive ones, and assist through medical and social intervention, and where necessary penal sanction, in a return to a style of life and behaviour more consistent with survival in the community as a successfully functioning personality. There will be many reverses, failures and disappointments, but that is so of many conditions, physical, mental and social, which confront the caring agencies.
15. The cancer patient is not abandoned because there is no cure. The irretrievably dysfunctional family is not left entirely to its own devices. The task is long and challenging. The goal is to improve the individual's ability to lead a life integrated into the society in which he lives. How is this to be done when faced with an individual who leads a chaotic lifestyle, is seeking help from multiple agencies, and whose presentation and immediate needs will vary widely almost from day to day?

COMMENT

The Panel believe that at the core of any service to be delivered to such a person must be four principles:

- *Clarity in current diagnosis, objectives, needs, risk assessment and the strategies to clarify and deal with them;*
- *Coordination of the delivery of service, sharing of information and action;*
- *Checking on the outcome of service provision by regular review;*
- *Changing the diagnosis, needs and risk assessments and service provision in the light of the review.*

In considering the adequacy or otherwise of the approach taken by each service the Panel have evaluated each service against these four principles in the relevant service chapters.

16. The more complicated the case, the more important in the interests of the patient/client, the public and the services it must be to follow those principles. There is nothing novel in these concepts: they are enshrined in the Care Programme Approach which has been promoted as government policy for many years. Unhappily they can be lost sight of under the pressures of a busy workload and when confronted by a particularly challenging case such as Mr Stone, when it may appear easier to react to demand, rather than to adopt a coordinated and clear strategy. In the end, a reactive approach will pose greater difficulty, employ more resources, and stand less chance of achieving objectives.
17. The positive aspects of the services provided to Mr Stone have already been stressed. Unfortunately, the following chapters will demonstrate that there have been negative aspects as well. There will be many matters of relatively minor detail, where improvements in practice will be suggested, but there are also broader matters of concern, in particular:
 - a collective lack of application of the principles mentioned above, in particular evidenced by omissions in the application of the Care Programme Approach;
 - a reluctance in some quarters, particularly the Chatham Community Mental Health Team, to become or remain involved because of the perceived danger presented by the patient without any review of that perception in the light of findings of others;
 - a particular lack of clear objectives in the services provided by the drug addiction service;
 - particular examples of poor practice in the drug addiction service, CMHT and in the case of one general practitioner.

It must be emphasised that there is no evidence whatsoever that any different action by any individual or service would have made any difference to Mr Stone's condition at any one time. There is, however, a possibility that psychiatric services were deprived of an opportunity to reassess Mr Stone with a view to admitting him to hospital shortly before the Russell murders. The Panel has no means of determining whether such an opportunity would in fact have resulted in such an admission. However, no professional involved in the care of Mr Stone, or the provision of any service to him had any cause to anticipate either that he would commit murder in the circumstances of the Russell killings, or be accused of such a horrific crime.

CHAPTER 2

THE AGENCIES, THEIR STRUCTURE AND THE CARE PROGRAMME APPROACH

1. MENTAL HEALTH SERVICES

COMMISSIONING

- 1.1 West Kent Health Authority is the commissioning authority for health services in West Kent. This duty includes ensuring the provision of appropriate mental health services in the area.

MENTAL HEALTH SERVICE PROVISION

- 1.2 North Kent Healthcare NHS Trust/Thames Gateway NHS Trust
From April 1994 until April 1998 the North Kent NHS Trust provided general mental health services to Medway, among other locations. Before that period the relevant authority was Medway Health Authority. After that period the responsibility for Medway was assumed by Thames Gateway NHS Trust. To avoid confusion the relevant Trust is referred to throughout this report as the Thames Gateway NHS Trust. The facilities relevant to the care provided to Mr Stone by the local Community Mental Health Team were:
- 1.2.1 Medway Hospital
The hospital provided in-patient and out-patient care to mental health patients and also in-patient drug rehabilitation.
- 1.2.2 Addiction Centre, Manor Road, Chatham
As its name suggests, this centre provided out-patient care for drug users.
- 1.2.3 Throwley House, Chatham
This was an out-patient clinic serving the needs of patients in the community from the Chatham area.
- 1.3 Maidstone Priority Healthcare NHS Trust/Invicta NHS Trust
This Trust provided general mental health services to the population of Maidstone and in addition the forensic in-patient services at the Trevor Gibbens Unit in Maidstone, a medium secure unit serving Kent.
- 1.4 Bexley Community Health NHS Trust/Oxleas NHS Trust
The Bexley Community Health NHS Trust was responsible for the management of Bexley Hospital and the Stansfield Clinic which provided a psychiatric intensive care service for Medway Hospital, among others. Since the period relevant to this inquiry, the Stansfield Clinic premises have been demolished and the service is now provided in the Bracton Centre. Bexley Hospital is now under the management of Oxleas NHS Trust.

2. GENERAL MEDICAL SERVICES

General medical services obtained by Mr Stone during the relevant period were provided by general practitioners on the NHS list managed in the first instance by the West Kent Family Practitioners Committee and latterly by the West Kent Health Authority via the Kent Health Authorities' Support Agency.

3. SOCIAL SERVICES

1994-1996

3.1 Overall responsibility

During the time covered by this inquiry the responsibility for delivering social services throughout Kent rested with Kent County Council. The headquarters based in Maidstone dealt with overall policy, strategy and allocation of resources; operational matters and liaison with local agencies were delegated to five Area Directors, each of whom managed the whole range of services for children and adults in a particular geographical area.

3.2 Medway/Swale Area

Rochester, Gillingham and Chatham were then part of the Medway/Swale Area. Adult Services were controlled by a Commissioner of Adult Services who reported to the Area Director. He was assisted by a Locality Manager, Mr SS - SW, who was responsible - amongst other things - for the delivery of the Social Services mental health operations throughout the whole of the Medway/Swale Area.

3.3 Mental Health Teams

Three Group Leaders managed the day-to-day mental health services. All the post-holders were appropriately qualified and experienced. To a greater or lesser extent all three were involved in the services offered to Mr Stone:

3.3.1 Mr UU - SW was the Group Leader for Rochester. His team comprised one senior practitioner (Ms KJ - SW), eight social workers (one of whom was Ms QQ - SW) and one care management assistant. This team dealt with the application of Mr Stone to be admitted to hospital in November 1994.

3.3.2 Ms TT - SW was the Group Leader for Gillingham. Her team consisted of 6.5 (equivalent) social workers (including Mr OO - SW and Mr VV - SW) and one care manager. This team provided social work contact with Mr Stone from May 1995.

3.3.3 Mr NN - SW was the Group Leader for Swale, with an added responsibility for the Social Services Substance Misuse Team for the whole of the Area. This team dealt with requests for Mr Stone to receive drug rehabilitation services.

3.4 Community Mental Health Teams

In 1994 mental health social workers were structurally part of multi-disciplinary community mental health teams. In practice within Medway/Swale this meant that they liaised closely with their psychiatric colleagues by holding weekly meetings and attending ward rounds at the hospital. They did not share the same premises, nor were they jointly managed. They did, however, share some joint policies and practices.

3.5 Staffing levels in Mental Health Teams

According to the Group Leader of the Rochester Mental Health Team, although there were pressures on the team at the time, they would not have affected the service they offered to Mr Stone. However, the Group Leader of the Gillingham Team showed the Inquiry a memorandum she had written in September 1995 to her line managers seeking additional staff to cope with the work pressures caused by staff training and maternity leave. During late 1995 and 1996 the team was under greater than normal pressure of work.

3.6 The Social Services Substance Misuse Team

During 1994-1996 the service was embryonic and covered assessment of persons who sought to be rehabilitated and finding residential places for them. Community support was given by Manor Road, which was run by Thames Gateway NHS Trust.

3.7 Care Management

Care management was introduced into the Kent mental health services in 1993. The practice was consolidated in 1994/5 by the introduction of the documents *Eligibility Criteria for Adult Services 1994/5*, which sets out very clearly the role and purpose of care managers. All the Social Services witnesses were conversant with this document.

3.8 Supervision and Staff Appraisal

Schemes for supervision and staff appraisal were in place. Only one witness was not satisfied with the support he/she was receiving from a senior colleague, and the Panel were told by the line manager of factors which might have influenced that person's opinion.

3.9 Trevor Gibbens Unit

This Forensic Unit had an establishment for a senior practitioner and two social workers (one of whom was Mr RR - SW). Mr RR - SW provided social work services to Mr Stone following his admission to the Unit in August 1996. The social workers at the Trevor Gibbens Unit were managed by staff from the Mid-Kent Area and not the Medway/Swale Area. This has not been a relevant factor in this inquiry.

1999

- 3.10 In April 1998 the Medway Local Authority, Medway Council, was established. Rochester, Gillingham, and Chatham are now part of this new Council and are therefore no longer the responsibility of Kent County Council.

3.11 Mental Health in Medway

The services in Medway have not changed significantly in structure or personnel. Two Mental Health Teams led by Mr UU - SW and Ms TT - SW report to a Principal Officer for Mental Health and Substance Misuse (Mr SS - SW). He in turn is accountable to the Assistant Director Adult, who previously held the post of Commissioner for Adult Services in the former Medway/Swale Area.

3.12 Mental Health in Kent Social Services

In 1997 mental health services in Kent were centralised. Three mental health areas have been created, and these are coterminous with NHS Trust boundaries. A fourth service manager is responsible for substance misuse throughout the whole county. These four managers report to the Head of County Mental Health Service based in Maidstone. In addition to her operational responsibilities, this post-holder takes a lead in county-wide policy, planning and business management.

4. PROBATION SERVICE

4.1 Kent Probation Service is one of 54 which cover England and Wales. It reports to a county-wide Probation Committee comprising magistrates of every bench in the area, a judge, a co-opted member and local authority representatives. The service is led by a chief probation officer (in 1994 - 96 Mr Whitfield), who is supported at headquarters by a deputy chief and four assistant chief probation officers. Mr II - PO is the assistant chief probation officer responsible for the local probation offices covering the Medway towns.

4.2 At local level services are delivered by teams which cover an area coterminous with that covered by one or more magistrate courts. During the time Mr Stone was on probation (April 1994 to April 1996), there were two teams in the Medway towns;

- one based in Rochester was managed by senior probation officer, Mr GG - PO. Mr Stone was initially supervised by this team, firstly by Ms CC - PO from April 1994 until October 1994 (when she transferred to the Chatham team), and secondly by Mr HH - PO.
- another team covered Chatham and was managed by Ms EE - PO. Mr Stone was supervised by this team following his discharge from hospital in January 1995, initially by Ms CC - PO again and then by Ms FF - PO until the probation order was completed.

4.3 Mr Stone was subject of a probation order for two years. Such an order combines punishment (the requirement to see a probation officer regularly) with supervision, guidance and assistance in relation to offence-related factors in the person's life. Orders can contain additional requirements specified by the court, e.g. to attend a particular group work programme. The purpose of a probation order is to help the offender manage the factors in their life which make them more likely to break the law. The offender's welfare and interests are always subordinate to the need to make sure the court order is implemented and further offending reduced or prevented.

4.4 If probationers do not conform to the requirements of the order, the matter can be referred to a magistrates' court or Crown Court for the original sentence to be reconsidered. In the case of Mr Stone, the Crown Court Judge making the original order required the probation officer to make regular reports to him.

5. SECTION 117 OF THE MENTAL HEALTH ACT 1983 - THE CARE PROGRAMME APPROACH AND CARE MANAGEMENT

5.1 SECTION 117 OF THE MENTAL HEALTH ACT 1983

5.1.1 Section 117(2) of the Mental Health Act 1983 provides:

It shall be the duty of the [Health Authority] and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services...

A duty is laid on the relevant agencies to provide, in co-operation with voluntary organisations, such services for any person who has been compulsorily admitted to hospital under Section 3 (and other sections) of the Act.

5.1.2 The section does not define 'after-care', but makes it clear that the persons to whom it applies have a right to such care.

5.1.3 The Department of Health clarified after-care arrangements in 1991 with its requirements for the Care Programme Approach.

5.2 DEVELOPMENT OF THE CARE PROGRAMME APPROACH BETWEEN 1992 AND 1996

5.2.1 The Care Programme (CPA) was introduced by the Department of Health in 1991¹ to provide a framework for effective mental health care. Its four main elements were:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services
- the formation of a care plan which identifies the health and social care required from a variety of providers
- the appointment of a key-worker to keep in close touch with the service user and to monitor and co-ordinate care
- regular review and, where necessary, agreed changes to the care plan.

5.2.2 The original circular required health authorities by 1st April 1991, in consultation and agreement with social services authorities, to have drawn up and implemented local care programme policies to apply to all in-patients considered for discharge, and all new patients accepted by the specialist psychiatric services they manage from that date.

¹ Health Circular (90)23; Local Authority Social Services Letter (90)11.

5.2.3 Where agreement could be reached between health and social services, a key-worker was to be appointed to keep in close touch with the patient and to monitor that the agreed health and social care is given. The key-worker could come from any discipline, but should be sufficiently experienced to command the confidence of colleagues from other disciplines. A particular responsibility of the key-worker was to maintain sufficient contact with the patient to advise professional colleagues of changes in circumstances which might require review and modification of the care programme.

5.2.4 Further guidance in May 1994² concerning mentally disordered people stressed the importance of systematic recording and of ensuring that the arrangements for communication between members of the care team were clear. The plan should include:

- the first review date;
- information relating to any past violence or assessed risk of violence on the part of the patient;
- the name of the key-worker (prominently identified in, e.g., clinical notes, computer records and the care plans);
- how the key-worker or other service providers can be contacted if problems arise;
- what to do if the patient fails to attend for treatment or to meet other requirements or commitments.

5.2.5 Social Services Departments have duties under the NHS and Community Care Act 1990 to assess people's needs for community care services. Following guidance issued by the Department of Health in 1991, Social Services Departments had to introduce systems for care management from April 1993. The guidance did not mandate a specific model for the organisation of care management, but set out options from which local authorities could decide what was best for them.

5.2.6 Care management is a process which tailors services to individual needs, rather than fitting the needs of people into whatever services might be available.

5.2.7 Department of Health guidelines identify the following ingredients for a care plan:

- overall objectives;
- specific objectives of users, carers and service providers;
- criteria for measuring the achievement of these objectives;
- services to be provided by which personnel/agency;

² HSG(95)8; LAC(95)5; see also the revised Mental Health Act Code of Practice which came into effect in November 1993. A new revision, in which the requirements of the Care Programme Approach were more strongly emphasised came into effect in April 1999.

- cost of the user and contributing agency;
- other options considered;
- any point of difference between user, carer, care planning practitioner or other agency;
- any unmet needs with reasons - to be separately notified to the service planning system;
- the named person(s) responsible for implementing, monitoring and reviewing the care plan;
- the date of the first planned review.

6. APPLICATION OF THE CARE MANAGEMENT AND CARE PROGRAMME APPROACH IN KENT

- 6.1 Kent Social Services produced for 1994-95 a document 'Eligibility Criteria for Adult Services'. Amongst those eligible for care management were those who have been in continuous psychiatric inpatient care for at least one month. Automatically eligible were people with mandatory eligibility under Section 117 of the Mental Health Act 1983.
- 6.2 During 1992-1995, care management and CPA in Kent had been thought through, but it appears that implementation was still patchy. Although health and social care agencies in Kent now have comprehensive policies and procedures for the Care Programme Approach, during the period 1992-1996 it appears that practitioners were free to exercise their discretion in its application. In this respect Kent has been no different from many other areas of the country. There has been a stream of reports indicating that the Care Programme Approach has not been consistently implemented.³

7. SUPERVISION REGISTERS

- 7.1 Supervision Registers (set up in 1994) were a development of the Care Programme Approach in England, and sought to ensure that those patients who posed more risk to themselves and others received special care support and supervision within the community to assist in preventing them from falling through the care network.
- 7.2 The three categories indicated for being placed on the supervision registers were:
- a significant risk of suicide;
 - significant risk of serious violence to others;
 - significant risk of severe self-neglect.

³ For instance: the report of the Clinical Standards Advisory Group on Schizophrenia (HO 1995) Vol 1, paragraph 4.39; *Social Services Departments and the Care Programme Approach: an Inspection* (DoH 1995) the report of the Social Services Inspectorate; *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (HO 1994).

7.3 Such a register was set up in Kent during 1994.

8. **DEVELOPMENTS**

8.1 During the 1990s, many inquiries into homicides have criticised health and social services for failing to implement adequately the Care Programme Approach (e.g. the report concerning Christopher Clunis in 1994).

8.2 The Department of Health has accepted the criticisms of many professionals that the Care Programme Approach and care management are similar processes, and that to have both has led to a burdensome bureaucracy. Accordingly it published in 1999 a policy booklet modernising the Care Programme Approach with the purposes of:

- achieving integration of the CPA and care management;
- achieving consistency in implementation of the CPA nationally;
- achieving a more streamlined process to reduce the burden of bureaucracy;
- achieving a proper focus on the needs of service users.

8.3 Amongst the changes are:

- integrating CPA with care management;
- the key-worker will be known as the care co-ordinator;
- supervision registers will be abolished;
- review and evaluation of care planning should be regarded as ongoing processes;
- local audit will focus on quality rather than numbers;
- responsibility for implementation rests with the Chief Executive of the Mental Health provider Trust in conjunction with their partner Directors of Social Services.

CHAPTER 3

MICHAEL STONE'S EARLY YEARS.

Only one witness was available to give direct evidence as to Mr Stone's early years. Thus the information below is drawn in the main from the documentary evidence before the inquiry. The documents relied upon include the contemporaneous Social Services and Probation Records and Mr Stone's own account(s) of his childhood as recorded by health care staff in his adulthood. The Panel are unable to determine the factual accuracy of all of these accounts, although where corroborative evidence is available this is noted.

Although detailed information is provided in the case files, only a brief account of relevant aspects of Mr Stone's early life is set out below. Wherever possible the anonymity of third parties has been preserved.

1. FAMILY AND EARLY CHILDHOOD

- 1.1 Michael Stone was born on the 7th June 1960, the second of five children. At the time of his birth, his mother (whom the Panel shall refer to in this report as Mrs Stone) was married to a Mr G, although she had already formed a relationship with Mr Stone and subsequently lived with him for many years. Although Social Services documents record Mr Stone as being Michael's father, the identity of his biological father is unclear. As a child, Michael reported his unhappiness about not knowing who his father was and being unclaimed by the man known to him as "Dad" (Mr Stone). Michael was known as Michael "G"¹ throughout his adolescence and early adulthood. Probation records show that he began using the name Stone around 1984 (at age 24).
- 1.2 From the records available to the Inquiry, it is clear that the environment in which Michael Stone grew up was unsettled and that he was exposed to the effects of familial separation, arguments and violence. Mrs Stone is said to have left Mr Stone on several occasions, sometimes taking the children with her.
- 1.3 On 5th December 1967 (when he was seven years old) Michael and another of his siblings were received into the care of Kent County Council under Section 1 of the Children Act 1948 (i.e. voluntary care), and placed in Eastry Children's Home near Sandwich. Mrs Stone had separated from Mr Stone; however, they resumed cohabitation and the children were discharged back to their care on Christmas Eve 1967.
- 1.4 On 10th April 1968, a report for the Court hearing a matrimonial application between Mrs Stone and Mr G says: "The three children seem to be fairly happy with their parents when the parental relationship is normal, and they have not shown signs of being highly disturbed". A supervision order was suggested but was not made by the Court.

¹ The actual name is not necessary for the purposes of this report.

- 1.5 In 1969, Mrs Stone again left Mr Stone. She met and married another man but left him almost immediately. She subsequently divorced and married Mr Stone in 1973.
- 1.6 The case files contain repeated descriptions of Michael being exposed to violence within the home. He is said to have seen Mr Stone attacking another man with an axe in the family kitchen. This event was later confirmed by one of his siblings who gave a graphic account of this incident to Mr Stone's probation officer in 1981, describing how the blood splattered onto the sibling as Michael shrieked, shouted and was terrified. Michael also recounted the incident to Dr V - CPsych at an assessment in 1994. Records also say that Michael Stone witnessed an attempted poisoning of Mr Stone, an event also confirmed to a probation officer by his sibling in adulthood.
- 1.7 Michael is reported as saying in 1974 that Mr Stone used to lock the children outside in the garden, and on occasion would chase them around the house with a big stick. Michael Stone is described as being affectionate towards his mother, but thought that Mr Stone was "nutty".

2. EARLY OFFENDING AND SOCIAL SERVICES CARE: AGED 11 TO 14 YEARS

- 2.1 Early in 1972 (at the age of 11 years), Michael was missing from home for several days during which time it is said he became involved with other boys in committing several offences. In March 1972, Michael was made subject of a supervision order for three years to Kent County Council, having been convicted of theft (of an offertory box) and burglary (with five other offences taken into consideration). Reports to the Court included the following:

- from a social worker:

"Michael is a small, blond-haired boy with a slight speech impediment. He presents as a friendly but unhappy child. He speaks of the week in which the offences were committed in a flat, emotionless way, and maintains that at the time he gave no thought to the consequences of his actions. He talks bitterly of his father and the home situation, and appears to be ambivalent in his feelings towards his mother. He is adamant that he does not wish to return home."

The social worker recommended committal to the care of the County Council.

- from an educational psychologist:

"Michael is a boy who relates inadequately and displayed many anti-social attitudes and ideas. Apart from rather hostile sociopathic responses, his general emotional response was inhibited, his personality rather in turning and non-communicative. Test results show Michael to be of low average ability who is reading satisfactorily. WISC verbal scale 89."

- from his school report:

"About average for the ability range in a Sec. Mod school. Attendance satisfactory up to Xmas 1971; poor this term. Healthy, undisciplined, unreliable, has stolen articles from local shops, appears to give reasonable explanations. Tries on occasion to blame his friends for misdemeanours which are his responsibility. Transferred to this school from one where he had apparently been truanting on occasions and associating with unreliable older boys. Mother says she is at her wits' end and said he would be better taken from home."

Chapter three: Michael Stone's early years

2.2 Despite the supervision order being in force offending continued, and Michael was convicted of theft (with three offences taken into consideration) in May 1972. On this occasion he was given a one-year conditional discharge.

2.3 On 3rd July 1972, Michael was admitted to the West Kent Hospital in a semi-conscious condition following the consumption of a bottle of whisky. Dr FO - CPsych wrote to Social Services:

“I was rather concerned about the depth of the boy’s depression, and I feel that although it was safe to discharge him, I should arrange a follow-up at the Child Guidance Clinic”.

2.4 There are no health records available from childhood to verify whether this referral to Child Guidance ever occurred.

3. CARE ORDER: AGED 12 YEARS

3.1 On 5th August 1972, Michael was received into care at the request of his mother, as Mr Stone had refused to have him in the house because of his offending behaviour and running away. When told that the Social Services Department would seek a formal care order, Mr and Mrs Stone discharged Michael from voluntary care on 24th Sept 1972. Michael was then removed by Social Services to a Place of Safety on 2nd Oct 1972, following his mother leaving home.

3.2 On 6th October 1972, following an application from his supervising officer, the court ordered that Michael’s supervision order be replaced with a Care Order. He was committed to the care of Kent Social Services and placed at Woodlands Reception Centre.

3.3 On 27th November 1972 (at the age of 12 years), a case conference made the following observations:

“Michael needs a lot of control and support and cannot really be trusted to do much sensibly. He does not respect adults and will only comply to non-compromise. He will often physically attack junior members of staff.

Michael manages to live in the group with a happy-go-lucky attitude but frequently abuses the lesser structured situations. On the whole he appears to have few innocent friendships - he is frequently involved in conspiratorial whispering sessions. He has the ability to decide group movements, and when unsettled will disrupt younger boys and often lead in deviant activities e.g. absconding. He is often involved in fights.

Michael is a likeable lad who can show a good sense of humour, but who at present is often depressed and obviously confused by his situation. He is socially and emotionally retarded and presents as rather a pathetic little boy. He is excitable and restless, and when corrected will throw screaming, swearing tantrums, and accuse staff of maltreatment and abuse society in general. He seldom has any long period of calm - but when he does can concentrate for long enough to play chess or work on his stamp collection. In many ways Michael is a likeable, friendly boy. He needs a stimulating environment where adults have more to offer than his delinquent contemporaries.”

“Schoolroom Report Reading - 10 yrs 2 months (Burt Revised), Spelling 9 years 7 months (Shonell). In class discussions his contributions are negative and disruptive. This boy is clearly under- functioning. He has ability but is so emotionally disturbed and anxious that academic progress is being affected”.

3.4 It was recommended by the case conference that Michael should be placed in a community school. On 15th March 1973, he was placed at Green Acre Community Home. He was said to have settled well at Green Acre, appearing less depressed and discussing his feelings about his unhappiness at home with staff. No evidence of deviance was seen by staff and he made no efforts to abscond. His verbal IQ was assessed at 95 (WISC) in March 1973. He commenced normal secondary school in May 1973, but then when his “house-parents” and two other staff at Green Acre left to take up other posts in June 1973, he absconded and began offending.

3.5 On 7th March 1974, when Michael was 13, his social worker sought another placement for him. Her report says:

“Michael’s behaviour has deteriorated, having absconded and committed offences. His cigarette smoking has increased, and he has started pulling out his hair causing a noticeable bald patch. He resents all forms of authority and more recently has struck out at members of staff. A recent fire in the basement is believed to have been his responsibility. He has thrown bottles at a staff car, and together with another boy he has been responsible for bullying the other boys.”

Dr FO - CPsych (a consultant psychiatrist) agreed to Michael being moved.

4. IQ TESTING

4.1 On 28th March 1974 (at age 13 years), Michael went to Redhill Classifying School. Psychological tests performed at this time showed a Verbal IQ of 123, Performance 113, Full Scale 120 (WISC). These indicate superior overall intelligence and were marked improvements from the 1972 results which showed a full-scale IQ of 89². It was suggested that the cathartic effect of a long and emotional interview might have accounted for the improvement from earlier test results. It was noted that he had a speech impediment which worsened with anxiety. Mr Stone has since said to Dr BB - Psych (in 1992) that he was late at talking and first began to speak properly at age 14, having previously had a speech defect.

5. PRESCRIPTION OF PSYCHOTROPIC MEDICATION: AGE 13-14 YEARS

5.1 At a case conference held at Redhill on 22nd May 1974, it was recorded that he had been prescribed *Limbitrol* for depression and was also on *amitriptyline* and *clorampax*. A consultant psychiatrist had assessed him and concluded that:

“Overt mental illness can be excluded at this stage [but]... he is suffering from a severe degree of emotional disturbance which could result in grossly abnormal and irresponsible behaviour. I am of the opinion that his present needs are more in the sphere of psychiatric and psychological help than the conventional community home.”

² See paragraph 2 above.

It was agreed at a subsequent case conference that referral to a psychiatric adolescent service be sought.

- 5.2 On 22nd May 1974 a consultant psychiatrist declined to offer Michael a place in a child psychiatric residential unit because of his negative attitude and his absconding. He went back to North Downs Community Home on 13th June 1974. On 3rd July 1974 Michael was said to have settled well but had surprisingly absconded.
- 5.3 In adulthood Mr Stone reported to several health professionals that his drug abuse began at age 14 with cannabis usage and that he soon moved on to taking LSD, cocaine and morphine.

6. JUVENILE OFFENDING AGED 14 TO 17 YEARS

- 6.1 Michael Stone's offending continued throughout adolescence with several convictions for theft and burglary; by October 1974 (at age 14), his first custodial sentence was imposed, 3 months in a detention centre. On 3rd January 1975, he was again returned to North Downs Community Home, but by February 1975 he had been convicted of further offences of burglary and theft, which on this occasion were punished with a fine.
- 6.2 On 1st April 1975, he was remanded in custody for taking and driving away motor cars. An application was made for him to go to the Secure Unit at Redhill but this was declined by the Department of Health on the grounds that there was no immediate vacancy and because they were concerned about the impact Michael would have in an already explosive situation there. On 28th April 1975, he was sent to a Detention Centre for the second time for a three-month period. When Michael was discharged back to North Downs on 24th June 1975, he was described by the social worker as looking most unwell. He was near to tears the whole journey home and gave the impression that everything was worthless.

7. BORSTAL TRAINING

- 7.1 Convictions for theft, burglary and stealing cars continued throughout Mr Stone's youth, culminating in a period of borstal training being imposed in August 1975 (at age 15). His care order was subsequently discharged. Michael was initially allocated to Dover Borstal but then transferred to Feltham for psychiatric oversight as it was thought that he suffered with depression. No records are available in respect of this episode. Following discharge from Feltham in August 1976, he rapidly re-offended and was returned to borstal from March to July 1977. A borstal training report dated 10th November 1977 suggested that further offending be dealt with by imprisonment. According to Mr Stone's later accounts he first used heroin at age 17.

8. IMPRISONMENT: AGED 17 YEARS

8.1 Mr Stone's offending continued unabated and his first sentence of imprisonment of 18 months for a number of thefts and burglaries (including 11 offences taken into consideration) was imposed by Kent Crown Court in December 1977 (at the age of 17). A further eight months' imprisonment (concurrent) was imposed in February 1978 for a further series of property offences including arson. In his social inquiry (pre-sentence) report at the time his probation officer, Mr DD - PO, wrote that:

"Before he committed his present offences he demanded to be returned to Feltham Borstal because of his inability to cope with the normal stresses of living...I would only hope that he receives some form of treatment whilst serving a sentence which enables him to use his good intelligence in a constructive way for the future."

8.2 Mr Stone was imprisoned at HMP Canterbury. Despite Mr DD - PO's hopes there is no indication that any psychiatric or psychological treatments were considered or made available to Mr Stone. A report by the assistant governor dated May 1979 describes him as an "aggressive, disruptive and truculent young man" and records how he had twelve disciplinary reports during his sentence losing 27 days remission.

8.3 Mr Stone's drug abuse was escalating in this period. In October 1992 he told Dr BB - CPsych that between 1978 and 1980 whilst out of prison he started taking amphetamines and heroin, using 2gm in a weekend. In June 1979 a further probation report by Mr DD - PO, following burglary charges, describes Mr Stone as:

"Above average intelligence with a pleasing personality with some potential. Although he likes to give the impression of being sophisticated and arrogant, beneath the shell he is in reality an immature and highly confused young man. It is largely the result of his early environmental experiences that he has such a damaged personality and has developed poor self image.

[He] has also a very prominent self-destructive nature which is exemplified by heavy involvement in different types of illegal drugs.[he] has enjoyed the experience that drugs provide in blotting out reality for him, and he is, perhaps, unable to cope with life without them."

8.4 At this time, Mr Stone was in employment at a packaging company who were prepared to retain him despite his offending. Mr DD - PO recommended that, rather than further imprisonment, rehabilitation be attempted, and suggested the option of a drug dependency hostel be tried. Although his motivation was not high, Mr Stone had agreed to a trial period. After a guilty plea to burglary charges, sentencing was adjourned whilst a placement at Alpha House, a drug treatment unit, was explored. Social Services agreed to fund this place at Alpha House, but Mr Stone left only a few days after he attended. Despite the failure of the Alpha House placement, an 18 months' suspended sentence was imposed. Mr DD - PO continued to try to persuade Mr Stone to have treatment and on 28th November 1979 he was re-admitted to Alpha House. However, he discharged himself within a day saying "he couldn't handle it".

8.5 Mr DD - PO continued to supervise Mr Stone. Although he remained in contact with probation, his intravenous drug use began to escalate, so that by May 1980 his mother and a sibling attended the probation office expressing concerns about his condition

and withdrawal symptoms. Mr DD - PO recorded that Mr Stone had, of his own volition, attended the West Kent Hospital and the Maudsley Hospital asking for *methadone*, but neither unit was prepared to admit him and his GP was not prepared to prescribe *methadone*. Mr Stone's GP had, however, arranged an assessment for him at St Giles' Hospital.

- 8.6 In the interim Mr DD - PO attempted unsuccessfully to find a drug hostel which would accept Mr Stone. As an alternative he negotiated with Mr Stone's GP for daily *methadone* to be prescribed and to be administered under Mr DD - PO's direct supervision.

9. REFERRAL TO NHS DRUG DEPENDENCY SERVICES: AGED 19 YEARS

- 9.1 Mr Stone's first formal contact with NHS drug dependency services was in 1980 (at the age of 19 years) when he was assessed by Dr BJ - CPsych, consultant psychiatrist, at St Giles' Hospital on 21st May 1980. Following this assessment, Mr Stone was admitted to Bexley Hospital for treatment of his drug dependence under Dr BJ - CPsych's consultant care. He told the registrar that he had started using barbiturates and cannabis at age 14 and had later moved on to LSD, cocaine and morphine. His heroin abuse began at age 17 when he used it occasionally, and he considered himself to have had a habit for the previous seven months using up to 2g a day. He described how his offending had continued since his last release from prison in October 1979. He said that he had burgled chemist shops on three occasions but had not been caught.
- 9.2 It was noted that his actual physical addiction was doubtful and, although no specific diagnosis was recorded, the formulation was that he was "basically a personality problem" with "lots of personality factors in his presentation". There is nothing in the records to suggest that Mr Stone was considered to be a dangerous patient, that he misbehaved on the ward or that he was deemed unsuitable for a non-secure general psychiatric unit at that time.
- 9.3 Dr BJ - CPsych noted her agreement with the registrar's conclusion that Mr Stone's addiction was questionable. She recommended a *methadone* withdrawal program reducing from 15mg/day. It was hoped that by withdrawing Mr Stone from a small dose they may keep him in the in-patient unit long enough to explore his personality difficulties. However, Mr Stone discharged himself from the unit against medical advice on 25th May 1980. It was recorded that his reason given for leaving was that he felt lonely and that he said he would have stayed had his partner been there. No further follow-up was arranged, although this was offered if he should make further contact with the clinic. In fact, Mr Stone had no further contact with drug addiction services until 1993.

10. VIOLENT OFFENDING: AGE 21 YEARS

- 10.1 Mr Stone's first convictions for violence appear in February 1981 (at age 21) when he was sentenced to two years' imprisonment for robbery and grievous bodily harm. (In October 1992 Mr Stone told Dr BB - CPsych that this conviction was for "attacking people with hammers".) On release, he remained in voluntary after-care with the Kent Probation Services, again supervised by Mr DD - PO.

- 10.2 A pattern of rapid re-offending after release followed with further charges (at age 23) of wounding with intent, burglary and assault in 1983. In October 1992 Mr Stone informed to Dr BB - CPsych that this conviction was for "stabbing someone." For apparently the first time the court requested a psychiatric report before sentencing Mr Stone.
- 10.3 In April 1983 Dr ZE - Psych(F), a Forensic Psychiatrist assessed Mr Stone in Canterbury Prison. In a very short report, she stated that she found him to be a "volatile and emotional man who found it difficult to co-operate with a psychiatric interview". Dr ZE - Psych(F)'s report concluded that "It is apparent that he is very unstable, but there is no evidence that he has a mental illness for which treatment in a psychiatric hospital would be advisable... his very deprived and unsatisfactory childhood has led to a severe personality disorder." Dr ZE - Psych(F) recommended that, should Mr Stone receive a sentence of more than one year, he be considered for treatment within the prison system. However, the report gives no indication of the suggested nature or purpose of any such treatment.
- 10.4 Mr DD - PO's probation contact sheets record a phone call with Dr ZE - Psych(F) following her assessment. She told him she could not conduct the interview as Mr Stone was aggressive towards her and that she thought Dr ZK - CPsych(F) (consultant forensic psychiatrist) should see him as "the only decision is whether he should be in prison or hospital as obviously society needs protecting from him." In the forensic psychiatry records there is a handwritten note of a telephone call from Dr ZE - Psych(F) to Dr ZK - CPsych(F) requesting his opinion for the Crown Court which reads "discussed with her - no further action".
- 10.5 In his pre-sentence report, Mr DD - PO, noted how Mr Stone was:
- "increasingly becoming used to the routine and security of institutional establishments which have little effect in producing any change in attitudes and only make it more difficult for him to cope with life on release."
- 10.6 In May 1983 Mr Stone was sentenced to 4½ years imprisonment. There is no documentary evidence to suggest that Dr ZE - Psych(F)'s proposal that he receive treatment in prison was followed up during his sentence.
- 10.7 Mr Stone presented a management problem in prison. He engaged in a "dirty protest" in October 1984, smearing faeces around his cell. A probation case record for December 1984 details how he lost 162 days of remission for assaulting prison staff during his sentence and describes him as "a young man in need of help but not willing or able to receive it."
- 10.8 Mr Stone was released from prison on 2nd September 1986. During his sentence he had completed an "O" level and had obtained a place at Mid Kent College on a business studies course. Mr Stone entered voluntary after-care with Kent Probation Service although not with Mr DD - PO. He commenced his college course but his probation officer was told that he had dropped out after a couple of weeks. By October 1986 his voluntary attendance at probation had also lapsed and thus his case was closed.

11. IMPRISONMENT FOR ARMED ROBBERY: 1987-1992

- 11.1 The most serious offences in Mr Stone's history before 1992 were two robberies of a theatre box office and an armed robbery (with an air pistol) of a building society. These offences were committed in October and November 1986 within two months of leaving prison. In April 1987 (at age 27) Mr Stone pleaded guilty to these offences and was jailed for 10 years.
- 11.2 Probation and press reports of the time record that the sentencing judge described him as "an extremely dangerous man ...[with] an appalling record for dishonesty and violence". The sentence was later reduced to eight and a half years on appeal.
- 11.3 Mr DD - PO moved to a new post in September 1989. Since 1973 he had been Mr Stone's main probation service contact, and indeed was the only professional involved with Mr Stone for any substantial period of time. It is clear from the extensive correspondence on file that Mr Stone valued his relationship with Mr DD - PO and appreciated the efforts he made on his behalf. In evidence to the inquiry Panel, Mr DD - PO stated that he had a good relationship with Mr Stone and that he was able to discuss matters with Mr DD - PO that he found difficult to discuss with others. At Mr Stone's request a new probation officer was not appointed to the case. In June 1991 probation contact resumed when a new supporting officer was assigned the case. However, Mr Stone said he did not want after-care on leaving prison. In a case summary report of September 1991 Mr Stone is described by the probation officer as "the most dangerous man I have dealt with".
- 11.4 Whilst on home leave from prison on 13th March 1991, Mr Stone was arrested and charged with theft from a motor vehicle and taking and driving away a motor vehicle. He was subsequently sentenced to a further four months imprisonment in respect of these charges.
- 11.5 Mr Stone's contact with probation services resumed in June 1991 while he was still in prison when a new supervising officer was appointed to his case. At an initial meeting with his new probation officer at HMP Swaleside in June 1991, he said he did not want probation after-care.
- 11.6 It appears that Mr Stone's mental health difficulties were recognised in the prison, in that he was prescribed psychotropic medication in July 1991 by the prison medical officer. However, no prison medical records are available to clarify what happened to prompt this prescription. Probation records show that a new probation officer was assigned in September 1991. He had some difficulty tracking down Mr Stone who had been moved to HMP Belmarsh. It seemed that Mr Stone planned to live in Chatham on release, so his case was transferred to the Medway probation team. In January 1992 a letter from HMP Parkhurst informed the probation office that Mr Stone had been transferred there. However, before he was seen by anyone from Kent Probation Service, a further letter arrived stating that Mr Stone had been transferred to HMP Whitemoor in May 1992 because of an incident related to alleged drug trafficking at HMP Parkhurst.

- 11.7 In July 1992, Mr Stone wrote to Kent Probation Service stating that he intended to live in Peterborough on release. Any probation after-care at this time would have been on a voluntary basis and although the Kent probation file remained open, it was deemed low priority and no further contact was made with Mr Stone.

COMMENT:

Mr Stone's offending history is confirmed by his Probation Records and information from the criminal records office (CRO). It is notable that Mr Stone gave detailed and accurate accounts of his offending history to those health care professionals who questioned him about it in adulthood. There is no indication that earlier probation records or CRO information were ever requested by or made available to any of those working in the health service who were involved in his care and treatment from 1992 to 1997.

Despite Mr Stone repeatedly reporting his history of having been in social services care as a child, his social services records were neither requested by or made available to any of those working in the health service who were involved in his care and treatment from 1992 to 1997.

The inquiry had great difficulty in tracking down the records of admission to Bexley Hospital in 1980 which were held under the name of Michael G. None of those involved in the treatment, care and supervision of Mr Stone between 1992 and 1997 appear to have been aware of this admission.

CHAPTER 4

SUPERVISION, TREATMENT AND CARE FROM 1992 TO 1997

The following is a summary account of Mr Stone's history drawn from the documentary evidence before the inquiry and the direct evidence of witnesses. Save where otherwise indicated the Inquiry Panel consider that, on the basis of evidence before them, the information set out below is an accurate account of events. Wherever possible the anonymity of third parties has been preserved.

1. RELEASE FROM HMP WHITEMOOR: SEPTEMBER 1992

- 1.1 On 4th September 1992 Mr Stone was released from HMP Whitemoor having served 5 years 5 months of his 8½ year sentence. The prison did not inform Kent Probation Service (KPS) of his release and records show that, although his file remained open, his nominal probation officer remained unaware of his release until a secretary made an inquiry of HMP Whitemoor in October 1993, over one year later.¹
- 1.2 On release from prison, no follow-up mental health care in the community had been arranged. Mr Stone was released with a week's supply of medication and a "to whom it may concern" letter written by Dr ZH - HMPGP the Head of Health Care. This letter gave a brief summary of his mental health problems, described as "long-standing problem of ideas of reference, paranoid thinking and possible auditory hallucinations", and detailed the medication he had been treated with in prison - *trifluoperazine (stelazine)* (a drug used to control schizophrenia and other psychoses) and *procyclidine* (a drug used to control the side effects of *stelazine*).
- 1.3 The letter explained the lack of any follow-up arrangements by saying that "We have been unable to arrange for his ongoing review by Community Mental Health Services, as there is uncertainty as to where he will reside in the long-term." In fact Mr Stone went to live near his mother in Chatham.²

CONTACT WITH MENTAL HEALTH SERVICES 1992-1993

2. GENERAL PRACTITIONER REGISTRATION AND REFERRAL: SEPTEMBER 1992

- 2.1 On September 8th 1992, four days after his release, Mr Stone attended Dr M - GP, GP surgery in Chatham and registered as a new patient presenting Dr ZH - HMPGP's letter. On 16th September 1992 Dr M - GP gave Mr Stone a one-month repeat prescription of *stelazine* and *procyclidine*. Dr M - GP notified the Kent FHSA of Mr Stone's registration with him. He was unknown to Kent FHSA and thus a new NHS Number was allocated centrally.
- 2.2 On 8th October 1992 Mr Stone re-attended Dr M - GP and told him that he felt under pressure and had been taking more *stelazine* than prescribed (25mg rather than 15mg). He told Dr M - GP that when he came out of prison he was walking in the woods and

¹ Prison Service chapter paragraph 2.4.

² Prison Service chapter paragraph 4.1.

felt like killing children. He had increased his *stelazine* of his own accord as he realised “these ideas were not good”. Dr M - GP was sufficiently concerned to make an urgent telephone referral to the local community mental health team (CMHT) at Throwley House, Chatham.³

3. CMHT ASSESSMENT AT THROWLEY HOUSE

- 3.1 Mr Stone was seen as an emergency by Dr BB - Psych, a staff grade psychiatrist under the Consultant charge of Dr AA - CPsych, at Throwley House on 8th October 1992. Dr BB - Psych began taking a history from Mr Stone but he became angry, shouting that he wanted his medication increased. Because of Mr Stone’s agitated behaviour it was not possible to complete the assessment and she asked him to take 30mg *stelazine* and return the next day.
- 3.2 Mr Stone returned on 9th October 1992 in the company of his mother. He was more calm at this second appointment, and Dr BB - Psych was able to take a lengthy and detailed history from both him and his mother. Dr BB - Psych recorded details of Mr Stone’s forensic history, noting his violence and his account of previously attacking people with hammers.
- 3.3 Dr BB - Psych subsequently discussed Mr Stone’s case with her Consultant, Dr AA - CPsych. They concluded that because of his history of violence Mr Stone was not suitable for their service. On 13th October 1992 Dr BB - Psych referred Mr Stone to Dr ZK - CPsych(F)’s Forensic Psychiatry service at Maidstone. The referral letter noted how Mr Stone felt he was heading towards probably stabbing somebody and stated “we thought he may be suffering from paranoid personality disorder and would appreciate your opinion”. The letter did not indicate that Dr AA – CPsych’s view was that Mr Stone was unsuitable for his team and this view was never communicated to either Dr ZK - CPsych(F)’s team or to Dr M - GP.⁴
- 3.4 On 15th October 1992 Mr Stone returned to see his GP Dr M - GP. He told him that Dr BB - CPsych had increased his medication to 30mg Stelazine per day and that he was waiting to see Dr ZK - CPsych(F).

4. ASSESSMENT BY FORENSIC MENTAL HEALTH SERVICES: 1992

- 4.1 On 21st October 1992 Mr Stone attended an out-patient assessment appointment at the Trevor Gibbens Unit in Maidstone with Dr Q - Psych(F), Senior Registrar in Forensic Psychiatry in Dr ZK - CPsych(F)’s team. Following this assessment Dr Q - Psych(F) did not offer any formal diagnosis. He concluded that Mr Stone had a good deal of insight into his difficulties but was not suitable for psychotherapy in view of his disordered childhood and background. Mr Stone said he did not want to come regularly to Maidstone for out-patient appointments (he was living in Chatham), although Dr Q - Psych(F) did offer that he would see Mr Stone again himself at Dr M - GP’s request or if Mr Stone wanted further help. Dr Q - Psych(F) then wrote to Dr

³ General Medical Services chapter paragraph 4.2 to 4.4.

⁴ CMHT chapter paragraph 2.5.

BB - Psych advising that she continue to prescribe *stelazine* for Mr Stone: this letter was copied to Dr M - GP.

- 4.2 Dr Q - Psych(F) remained unaware that Dr BB - Psych and Dr AA - CPsych had already decided not to accept Mr Stone in their team. Dr Q - Psych(F) therefore assumed Dr AA - CPsych's team were continuing with Mr Stone's care. No further request for either Dr Q - Psych(F)'s or Dr ZK - CPsych(F)'s involvement was made and Mr Stone was not re-referred to the Forensic Service for over two years (i.e. until 9th December 1994).⁵

5. REFERRAL TO ADDICTION SERVICES : 1993

- 5.1 From October 1992 to February 1993 Mr Stone had no further contact with psychiatric services. Dr M - GP remained unaware that Mr Stone was not being seen by Dr AA - CPsych's team. Dr BB - Psych was aware that Mr Stone's case was not being managed by forensic services but, having agreed with Dr AA - CPsych that his team would not accept his care, she did not offer him another appointment. Mr Stone did, however, continue to attend his GP regularly for monthly prescriptions of *stelazine*.

- 5.2 On 1st December 1992 Mr Stone told Dr M - GP that he had been taking heroin and cocaine and asked for prescription of *temazepam*.

- 5.3 On 12th January 1993 Mr Stone registered as a new patient with another GP, Dr I - GP, using the name of Michael G.⁶ He told him his wife had died in a car accident and obtained a week's supply of *diazepam* and *temazepam*. He did not see Dr I - GP again until 21st July 1994.⁷

- 5.4 Mr Stone continued to see Dr M - GP regularly and was prescribed more *temazepam* on 28th January and 3rd February 1993. On 3rd February 1993 Mr Stone told Dr M - GP that he was still taking heroin and buying *DF118* on the street. He asked Dr M - GP for help coming off drugs and Dr M - GP immediately made a telephone referral to Dr V - CPsych, Consultant Psychiatrist in charge of the Medway and Swale Addiction Services (based at Manor Road Addiction Clinic, Chatham and Medway Hospital).

- 5.5 Dr V - CPsych saw Mr Stone at a home visit that evening. Mr Stone is recorded as having told him that:

"[A] voice had told him to stab someone....he says heroin controls his paranoia. He feels when he passed by children he feels he'll kill them but when he takes 'smack' it helped. 'Stelazine controls my nervous system'".

- 5.6 Dr V - CPsych's view was that Mr Stone was using street drugs to control his psychotic and aggressive tendencies, and that Mr Stone had a good deal of insight into his condition and was able to accept that he needed *stelazine* to control his psychosis.

⁵ CMHT Chapter paragraph 2.6.

⁶ The actual name is not used as there is no reason to do so.

⁷ General Medical Services Chapter paragraph 5.1.

5.7 Dr V - CPsych planned to take on Mr Stone for out-patient treatment in the Manor Road Addiction Clinic, and contacted Dr AA - CPsych asking that his team oversee prescription of depot anti-psychotic medication. Despite his previous reluctance to be involved in the case, Dr AA - CPsych now agreed to take on responsibility for Mr Stone's depot medication and admitted him to his out-patient depot clinic.

6. **ATTENDANCES AT MANOR ROAD ADDICTION CLINIC: 1993**

6.1 From 18th February 1993 Mr Stone commenced regular attendance at Manor Road Addiction Centre, where he was allocated to the care of Mr Y - RMN, a nurse and drug counsellor. He was placed on a methadone maintenance programme, and by 24th March 1993 he was reported to be more settled having lost his psychotic symptoms.

6.2 Dr AA - CPsych had in the meantime assessed Mr Stone at his depot clinic on 5th March 1993 and, after a test dose, prescribed 25mg *modecate* monthly. Mr Stone accepted depot injections on 26th March and 30th April 1993. However, on 16th June 1993 at an attendance with Dr V - CPsych, it was noted that Mr Stone had stopped taking his depot as he complained of side effects. On 21st July 1993 Mr Stone was discharged from the depot clinic for failure to attend.⁸

6.3 On 27th July 1993 Mr Stone attended the addiction clinic and saw Dr V - CPsych. Dr V - CPsych persuaded him to return to the depot clinic to get his injections. He then accepted two further doses of *modecate* on 27th July and 23rd August 1993.

6.4 Mr Stone attended the addiction clinic on 8th August 1993, when he was said to be feeling much better as a result of the depot injections. It was planned to see him again in two weeks but he did not attend.

6.5 Meanwhile on 3rd August 1993 Mr Stone's solicitors in Chatham contacted Dr V - CPsych requesting a medical report in respect of recent charges of driving without a licence, insurance or test certificate. Dr V - CPsych's report of 11th August 1993 stated that Mr Stone was diagnosed as suffering from paranoid psychosis and drug addiction. He stated he was receiving regular drug counselling and had been stable on medication, although without medication he would relapse and become dangerous.

6.6 A note in the records dated 10th September 1993 states:

"Michael Stone called in moving to Skegness for good. Script to be sent to chemist when he has informed us of which one. Will maintain for 4-5 weeks. Took 7 days medication".

No attempt was made to contact Mr Stone nor did the Manor Road Clinic pass on the information about his moving out of the area either to his GP or the depot clinic.⁹

⁸ CMHT Chapter paragraph 3.10.

⁹ Addiction Services Chapter paragraph 5.13.

6.7 Mr Stone's GP records show that on 13th September and 28th September 1993 he attended GPs in Skegness demanding "sleeping tablets" or *temazepam*; both GPs refused to prescribe these for him.¹⁰

7. PRISON REMAND: October 1993 to April 1994

7.1 On 20th October 1993 Mr Y - RMN received a letter from Mr Stone, who was by then on remand in Lincoln prison. Mr Stone had been arrested in Skegness for burglary and theft after taking an antique shotgun from a shop window.

7.2 In this first letter, Mr Stone described how he had "gone cold turkey" in prison as he could not be given methadone. However, he said he had done some "wheeling and dealing to provide [him]self with smack". He said he had slashed his arms and wrists in the police station; he had lost control and felt he could kill someone. In his letter he asked for detoxification and said he was interested in going into Shelley Ward (the in-patient ward for Dr V - CPsych's addictions team at Medway Hospital) for help to stop himself taking drugs.

7.3 On 25th October 1993 Mr Stone wrote a further letter to Mr Y - RMN again, asking for admission to Shelley Ward to get help coming off drugs. Dr V - CPsych replied on 4th November 1993 informing Mr Stone that he could not be admitted to Medway Hospital from prison but should approach the addiction services once released. He also offered to advise the prison doctors on management of Mr Stone's drug problem if they wanted his advice. This latter offer was not taken up.

7.4 Mr Stone's solicitors also wrote two letters to Mr Y - RMN (on November 3rd and 10th 1993) requesting placement in a drug rehabilitation unit. Mr Y - RMN telephoned saying that Mr Stone could not be admitted direct from prison. The solicitor wrote to Mr Y - RMN once more on 25th November 1993 informing him that a bail application was pending and asking whether, if Mr Stone were given bail, the Manor Road Clinic would agree to treat him. No reply was made to this letter. The Manor Road Clinic did not pass on the information about Mr Stone being in prison to either his GP or the depot clinic.

8. BURGLARY CONVICTION AND SENTENCING: APRIL 1994

8.1 Mr Stone did not obtain bail and spent six months in Lincoln Prison on remand. On 6th April 1994 he was transferred to a bail hostel and was finally sentenced at Leicester Crown Court on 29th April 1994 for possession of a firearm and burglary in respect of the theft of the antique gun.

8.2 Pre-sentence reports were provided by Ms LL - PO (of Lincolnshire Probation Service). At the time of writing her report she had seen the psychiatric report which Dr V - CPsych had written on 11th August 1993 (in relation to earlier motoring offences), which described Mr Stone as a drug addict suffering from paranoid psychosis who would relapse and become dangerous without medication. Her pre-

¹⁰ General Medical Services Chapter paragraph 9.1.

sentence report indicated that Mr Stone had received fortnightly *moderate* during his stay at the bail hostel; the hostel staff said this had been successful in modifying his behaviour.

- 8.3 Before writing the report, Ms LL - PO spoke with Mr Stone and members of his family, and obtained some information from Kent Probation Service. Although Ms LL - PO has said she believed it was extremely important that Mr Stone maintained contact with psychiatric services, she did not attempt to contact either Dr V - CPsych or Dr AA - CPsych's team nor were any psychiatric records requested from Kent services when this pre-sentence report was prepared. Ms LL - PO was thus unaware of Mr Stone's refusal of depot medication in Summer 1993. She considered recommending attachment of a condition of psychiatric treatment to Mr Stone's probation order but recalls being told by a Kent Probation Service colleague that Manor Road would accept only voluntary attendees.¹¹
- 8.4 Judge Bennett sentenced Mr Stone to two years' probation, including the unusual condition that his probation officer make six-monthly reports to the judge on the progress of the order and that any breach of the order be reserved to him.¹²

9. RE-ATTENDANCE AT MANOR ROAD AND THROWLEY HOUSE: MAY 1994

- 9.1 Within four days of being sentenced, Mr Stone had returned to Kent. His supervising probation officer was Ms CC - PO at Kent Probation Service and he attended her as directed on 3rd May 1994. He also re-attended Manor Road Addictions Clinic and his GP (Dr M - GP) that same day. Dr M - GP prescribed *procyclidine* and *melleril* (which Mr Stone had told him he had been given in Lincoln).
- 9.2 The Manor Road team did not make any contact with the Throwley House team at this stage. However, on 12th May 1994 Mr Stone was re-referred to Throwley House by his GP. Dr BB - Psych re-assessed Mr Stone on 16th May 1994. She planned for him to attend for depot *moderate* injections fortnightly and to be reviewed by her once a month. At this time Dr BB - Psych was unaware that Mr Stone was being prescribed *melleril* by Dr M - GP.
- 9.3 On 23rd May 1994 Mr Stone returned to the depot clinic complaining again of side effects from the depot injection. Dr BB - Psych planned to change his medication to *Depixol* 40mg fortnightly to be administered by the CPN, but there is no record of any *Depixol* actually being given to Mr Stone.
- 9.4 Meanwhile Ms CC - PO had been in communication with both Mr Y - RMN and Dr BB - Psych. Ms CC - PO recorded in her notes her view that it was: "vital that all three [agencies] work together as the addiction, mental health problems and offending behaviour were all crucially interlinked."

¹¹ Probation Chapter paragraph 3.8.

¹² Probation Chapter paragraph 4.2.

- 9.5 At Ms CC - PO's instigation a case conference was called on 22nd June 1994 at Manor Road clinic with herself, Mr Stone, Mr Y - RMN and Dr BB - Psych attending. It was agreed that his *melleril* would be reduced and all medication except *methadone* would be prescribed by the Throwley House team.
- 9.6 After this June 1994 case conference, Mr Stone failed to attend Throwley House and Manor Road for the next two months (although he continued to attend at probation weekly). Despite the plan for the Throwley House team to administer his medication, no depot injections were given to him and his non-attendance was not communicated either to Manor Road, his probation officer or his GP.
- 9.7 On 2nd August 1994 Ms CC - PO, having learnt from Mr Stone that he had missed his depot injections, called Dr BB - Psych suggesting a further three-way meeting be set up. This was arranged for 18th August 1994 at Manor Road Clinic and was attended by Mr Stone, Dr BB - Psych, Mr Y - RMN and Dr Z - CPsych (the newly appointed Addiction Consultant replacing Dr V - CPsych).
- 9.8 It was noted that despite lack of depot medication, Mr Stone had no psychotic thoughts or violent fantasies. He said he was abusing *benzodiazepines* and alcohol, and was refusing depot medication because of his concerns about side effects. The treatment plan formulated was; that *methadone* be prescribed on a reducing scale at Manor Road; that the prescription of depot be stopped but that Dr BB - Psych should monitor his mental state monthly and recommence *Depixol* if paranoid symptoms resumed; that he continue in fortnightly counselling with Mr Y - RMN at Manor Road.
- 9.9 Mr Stone was offered appointments with Dr BB - CPsych on 19th and 26th September 1994 but failed to attend these. On 3rd October 1994 a letter was sent by the clinic CPN to his GP (copied to Dr Z - CPsych) discharging him from Throwley House because of his non-attendance on the assumption that this indicated that "all was well at present" (although Dr BB - CPsych has since said this letter was sent in error).
- 9.10 Throughout this period Mr Stone had regularly attended Ms CC - PO as directed under his probation order. From 1st October 1994 the Probation Offices were re-organised and Mr Stone's case was transferred to the Rochester Probation Office under the supervision of Mr HH - PO.

10. DETERIORATION IN MENTAL STATE: OCTOBER 1994

- 10.1 On 5th October 1994 Mr Stone attended his GP, Dr L - GP, saying he could not sleep and requesting *temazepam*: he was given 10 tablets. Unknown to his GP, the next day Mr Stone registered with another GP (Dr ZR - GP) using the name of Michael G. He complained of a shoulder injury and trapped nerve, and was prescribed 28 days supply of *nitrazepam*.
- 10.2 Mr Stone did not attend the two appointments offered with Mr Y - RMN at Manor Road in August and September, but on 17th October 1994 he attended Manor Road

clinic demanding that he be prescribed *benzodiazepines*. This request was refused. On 19th October he attended Dr M - GP's GP surgery demanding sleeping tablets. This request was refused as he had not been attending Throwley House. He was offered re-referral to Throwley House as an alternative, but Mr Stone became abusive.

- 10.3 On 20th October 1994 the GP informed Mr Y - RMN of what had occurred and that he was very concerned. Dr BB - CPsych was in turn informed of these events by Mr Y - RMN, and on November 3rd 1994 a review meeting was called at Manor Road attended by Mr Stone, Dr BB - CPsych, Mr Y - RMN, Dr Z - CPsych and Dr L - GP (Dr M - GP's GP partner).
- 10.4 Mr Stone was aroused and angry. Dr Z - CPsych's opinion was that he was relapsing because of lack of neuroleptics but Mr Stone was unwilling to consider any medication except *benzodiazepines*. Mr Stone said he had been buying 7-8 tablets of *nitrazepam* daily on the streets and that he was stealing to get money for this. He expressed paranoid thoughts and said that he had wired his house to prevent his being attacked in his sleep. He also said he had hit his girlfriend. He threatened that he would rob someone violently if not given *benzodiazepines*. He did, however, agree to continue seeing Mr Y - RMN.¹³
- 10.5 Drs Z - CPsych, BB - CPsych and L - GP discussed his state, and concluded that he was psychotic and that they could detain him under the Mental Health Act 1983 on the ground of threats of violence considering his past history. Dr Z - CPsych was of the opinion that "he could not be coped with in the wards at Medway" and that the forensic team should be contacted.
- 10.6 On being informed of the outcome of this case review meeting, Dr AA - CPsych wrote a memo to Dr Z - CPsych (dated 8th November 1994) which was copied to Ms ZJ - SW (social worker) Mr HH - PO (probation officer) Dr M - GP; (GP) Brooke Ward (Medway Hospital) and two wards at Bexley Hospital.¹⁴ This first memo stated that Mr Stone should be considered dangerous, if not psychotic, and that no attempt should be made to admit him to an ordinary psychiatric ward. Dr AA - CPsych noted that he had contacted Dr T - CPsych(F), (the newly appointed Consultant Forensic Psychiatrist) asking about bed availability in the Trevor Gibbens Unit, the Regional medium secure unit, but there was no vacant bed. Dr AA - CPsych concluded that if there was sufficient cause for concern any admission should be to Bexley Hospital, Stansfield Unit (an intensive care locked ward in the "low security" category). Dr AA - CPsych had not personally seen Mr Stone when he wrote this memo.
- 10.7 On 3rd November 1994 Dr AA - CPsych had contacted Ms ZJ - SW at Kent Social Services Department and requested that an approved social worker (ASW) assess Mr Stone for compulsory admission under the Mental Health Act 1983. He told her that the assessment should not be conducted until appropriate accommodation was found, as Mr Stone was very dangerous and not suitable for Brooke Ward (Dr AA - CPsych's own ward). He also informed her that Mr Stone had paranoid psychosis

¹³ Addiction Service Chapter paragraph 10.3.

¹⁴ CMHT Chapter at paragraph 6.

and had refused medication for four months. Dr AA - CPsych told Ms ZJ - SW that Mr Stone had been discharged from prison via the TGU two years ago (which was incorrect) and that he had a criminal record for armed robbery and attempted murder (the latter of which was incorrect). Ms ZJ - SW was advised that the ASW should not visit Mr Stone at home.¹⁵

- 10.8 Unknown to all other parties, Mr Stone (using the name of Michael G) had also attended ZR - GP's GP surgery on 3rd November 1994, claiming that his previously prescribed *nitrazepam* had been stolen. He was issued with a prescription for *nitrazepam* for a further 14 days.
- 10.9 On 8th November 1994 Mr Stone had his first meeting with Mr HH - PO his new probation officer. Mr HH - PO had already spoken to Dr AA - CPsych before this visit and was aware of his concerns about Mr Stone's mental state.
- 10.10 Mr Stone attended an appointment with Mr Y - RMN on 10th November 1994. He seemed angry with doctors and again demanded medication. Mr Y - RMN recorded that Mr Stone had claimed "he had recently been involved in ABH to an innocent person" and was "making explicit threats about decapitating children and other acts of unprovoked violence". Mr Stone agreed to attend a meeting with Dr Z - CPsych and Dr AA - CPsych the following day to discuss his case.
- 10.11 Dr AA - CPsych and Dr Z - CPsych were unable to see Mr Stone the next day. However, on 10th November Dr AA - CPsych wrote a second memo advising that Dr Z - CPsych was not prepared for Mr Stone to be "sectioned" at Manor Road. Dr AA - CPsych noted that Mr HH - PO (probation officer) had arranged to see Mr Stone on 14th November at the probation office, and planned for Dr Z - CPsych and Dr AA - CPsych to assess him there. Mr Stone was now said to be too dangerous for admission to the Stansfield Unit at Bexley Hospital. Dr AA - CPsych had still not personally seen Mr Stone by this stage.¹⁶
- 10.12 On 14th November Dr AA - CPsych and Dr Z - CPsych met Mr Stone and Mr HH - PO at the probation office. The only contemporaneous record of this meeting appears in the probation notes in which Mr HH - PO noted that a "diagnosis of schizophrenia was made and that it was decided to admit him to a secure unit. In the meantime *stelazine* has been prescribed to him as a replacement for his fortnightly injection. He has been directed to report to me weekly and to accept in-patient treatment" It was noted that Mr Stone's girlfriend had left him as he had assaulted her but that she did not wish to report this to the police.
- 10.13 This meeting was the first occasion on which Dr AA - CPsych had personally seen Mr Stone since assessing him for the depot clinic in March 1993. He had not seen him since 14th November 1994.

¹⁵ Social Services Chapter paragraph 1.

¹⁶ CMHT chapter at paragraphs 8 and 9.

- 10.14 Dr AA - CPsych wrote a third memo after his assessment in which he recorded that he and Dr Z - CPsych “had no doubt this man was suffering from paranoid psychosis... [it was] unlikely that this was drug induced and it is likely this is a paranoid schizophrenia.” He summarised Mr Stone’s condition saying he was “psychotic, dangerous and needed admission to hospital”. However, he noted that Mr Stone had been given a prescription for *stelazine*.
- 10.15 Both Dr AA - CPsych and Mr HH - PO informed the Kent Police pro-active unit of their concerns about Mr Stone, as Dr AA - CPsych considered him a danger to the public. They were told that the police could take no action. On 15th November Dr AA - CPsych and Mr HH - PO investigated bringing proceedings to breach Mr Stone’s probation order, but were told by the Magistrates Clerk that his behaviour did not amount to a breach of conditions.¹⁷
- 10.16 Dr AA - CPsych recorded that he had telephoned Dr T - CPsych(F) at the TGU to ask for advice about obtaining a secure bed but that there was still no bed available in the TGU. Dr T - CPsych(F) had suggested admission to a local psychiatric ward. Dr AA - CPsych had ruled out this option, and he continued to try to find a secure bed for Mr Stone, contacting some 40 secure units across the country including private facilities. On 17th November 1994 a vacancy was found at De La Pole Hospital in Hull, but that unit required Mr Stone to be first assessed in a local hospital before admission.

11. APPLICATION FOR ADMISSION UNDER THE MENTAL HEALTH ACT 1983

- 11.1 On 17th November 1994 in a fifth memo Dr AA - CPsych records that, following discussions with Ms QQ - SW (ASW), there were fears that Mr Stone’s mother (as nearest relative) would not agree to him being detained under s.3 of the Mental Health Act 1983 (admission for treatment). He advised that s.2 (admission for assessment) be used instead.¹⁸ Ms QQ - SW has said that s.3 forms had been completed by the doctors but she asked them to disregard these and complete s.2 forms.¹⁹ The memo also recorded how Mr HH - PO had persuaded Mr Stone to take medication: an injection of *modecate* had been given that day. Dr AA - CPsych and Dr Z - CPsych completed medical recommendation forms for compulsory admission under s.2 Mental Health Act on 17th November 1994 stating that Mr Stone “has refused to accept depot neuroleptic medication in the community”. Neither form mentioned that Mr Stone had accepted both *stelazine* (on 14th November) and a *modecate* injection (on 17th November).
- 11.2 On 18th November 1994 Mr Stone called in at the probation office although he did not have an appointment. He was described in Mr HH - PO’s notes as being “clean and smart in appearance and mentally rational”, but depressed as his girlfriend had left him.
- 11.3 On 23rd November 1994 it was established that Dr A - CPsych at Bexley Hospital was prepared to admit Mr Stone to his intensive care unit on a short-term basis. Mr HH -

¹⁷ Probation chapter paragraph 6.10.

¹⁸ A s.3 application cannot be implemented if the patient’s nearest relative objects.

¹⁹ CMHT chapter at paragraph 12.3 et seq.

PO went to Mr Stone's mother's home to discuss this admission with her and Mr Stone. He noted that "all were agreeable to an admission", and asked Mr Stone to attend the probation office for an assessment by an ASW the following day.

- 11.4 When Ms QQ - SW met Mr Stone and his mother at the probation office on 24th November 1994 she realised that she knew his mother. Her concerns about her objecting to admission proved to be unfounded as Mr Stone's mother was supportive of his proposed admission.
- 11.5 Ms QQ - SW "did not see evidence of psychosis when [she] interviewed Mr Stone". She described him as "a calm focused man who saw hospital as the better alternative to prison and was quite accepting of the position". Mr HH - PO noted that Mr Stone agreed to admission "without hesitation". Despite Mr Stone agreeing to be admitted voluntarily, Ms QQ - SW, however, believed "this was not an option". She believed no hospital would have been prepared to take him on an informal basis because of his history. Ms QQ - SW was unaware that at the time of her assessment Mr Stone had already accepted medication taking both *stelazine* and *modecate*.²⁰

12. COMPULSORY ADMISSION TO BEXLEY HOSPITAL: NOVEMBER 1994

- 12.1 Mr Stone arrived at the Stansfield Ward, Bexley Hospital in an ambulance, accompanied by his mother and Ms QQ - SW. It was noted by Bexley staff that although S.2 of the Mental Health Act 1983 had been instituted, Mr Stone had agreed to come in voluntarily. On admission Mr Stone was calm and co-operative.
- 12.2 Mr Stone did not live up to the reputation that preceded him. On admission he was described as not aggressive with no first-rank symptoms of schizophrenia evident and, save that he said he was thought to be deluded about his source of income, no other psychotic symptoms. There were no reports of disturbed behaviour whilst at the Stansfield Clinic, indeed the discharge summary (which was received by Dr AA - Cpsych on 5th December 1994) specifically noted that there were no aggressive incidents on the ward despite Mr Stone being confronted by other disturbed patients. Mr Stone was compliant with all his medication.
- 12.3 Dr ZA - CPsych, locum consultant psychiatrist at De La Pole hospital, assessed Mr Stone at Bexley Hospital and agreed to admit him to his unit. After five days at Bexley Hospital, Mr Stone was transferred to the De La Pole Hospital on 29th November 1994.

13. TRANSFER TO DE LA POLE HOSPITAL HULL: DECEMBER 1994

- 13.1 The rationale for admission to De La Pole was to stabilise Mr Stone on medication prior to his return to local services. Save for a referral letter no clinical records from Bexley Hospital, Manor Road Clinic or Dr AA - CPsych's team regarding Mr Stone were initially sent to De La Pole, and it appears that none of the Kent services' records were sought or provided during his six-and-a-half week admission there.

²⁰ Social Services Chapter paragraph 2.

13.2 Mr Stone was started on fortnightly depot injections of *haldol decanoate* 100mg. Throughout his stay at De La Pole Hospital Mr Stone presented no management problems. In a nursing summary dated 12th December 1994 Mr Stone was described as a “model patient”.²¹

13.3 On 14th December 1994 Dr ZA - CPsych telephoned Dr AA - CPsych and said he thought Mr Stone was now suitable for transfer back to a local open ward. On 15th December 1994, Dr AA - CPsych wrote to Dr ZA - CPsych saying that he had discussed the proposition for transfer to his open psychiatric ward as an informal patient with his ward manager, but that the nursing staff felt that they could not cope with such a patient. In fact Dr AA - CPsych had already written to Dr T - CPsych(F) on 9th December 1994 asking that the forensic services take over clinical responsibility for Mr Stone’s care when he was discharged from De La Pole. Thereafter Dr AA - CPsych and his team had no clinical involvement in Mr Stone’s case.

14. **DETENTION UNDER S.3 MENTAL HEALTH ACT 1983: DECEMBER 1993-JANUARY 1994**

14.1 Mr Stone’s Section 2 detention (for assessment) was due to expire after 28 days (on 22nd December 1994) and could not lawfully be renewed. A formal application was made for Mr Stone to be detained under Section 3 (for treatment) by Mr D - ASW. In the accompanying social report Mr D - ASW wrote that he supported the Section 3 “*reluctantly*” citing “*lack of planning for discharge*” as a reason for the detention. Despite being of the view that Mr Stone was suitable for discharge, Dr ZA - CPsych wrote a medical recommendation to accompany the application stating that Mr Stone “*has improved but still remains grandiose and deluded and will not take treatments informally although he says so*”. Mr Stone had in fact taken all medication offered to him at both De Le Pole and Bexley Hospitals.

14.2 Mr Stone appealed to Hospital Managers against his detention on 20th December 1994. His appeal hearing was delayed apparently pending a forthcoming assessment by Dr T - CPsych(F), forensic psychiatrist.

14.3 On 27th December 1994 Dr T - CPsych(F) assessed Mr Stone at De La Pole Hospital at Dr AA - CPsych’ request. This was the first time Dr T - CPsych(F) had met Mr Stone. Dr T - CPsych(F)’s impression was that these was “no evidence of mental illness and that Mr Stone was inappropriately detained far away from home”. Dr T - CPsych(F) had noted that Mr Stone wanted “transfer to TGU to be withdrawn from methadone” but went on to say that “Does not appear appropriate to offer a bed. He is no longer mentally ill and is unlikely to respond usefully to a graded package”. Dr T - CPsych(F) did, however, offer to take over Mr Stone’s case as an out-patient, seeing him on a monthly basis.²²

²¹ De La Pole Hospital chapter paragraph 4.6.

²² Forensic Services chapter paragraph 4.

15. APPEAL AGAINST DETENTION AND DISCHARGE FROM DE LA POLE: JANUARY 1995

- 15.1 Mr Stone's appeal to the Hospital Managers was heard on 11th January 1995. A report was provided by Dr ZA - CPsych in which he noted that since Mr Stone had been taking the *haldol decanoate* depot injection, he had been less irritable and grandiose. The appeal was adjourned because of "the non-attendance and lack of information from professionals from Kent", although the only professional from Kent who had been informed of the appeal was Ms ZJ - SW (Social Services) who had provided a detailed report on Mr Stone's social circumstances (dated 9th January 1995) expressing her belief that it was essential that an appropriate care plan be agreed by all agencies before Mr Stone's discharge.
- 15.2 On 16th January a case conference was held at De La Pole. Mr Stone's mother attended as did Mr HH - PO. Mr HH - PO was the only representative from the services in Kent in attendance although Kent Social Services had been informed of the meeting a week earlier. Dr T - CPsych(F) had not been informed of the meeting.
- 15.3 During the meeting Mr HH - PO was told that Mr Stone was ready for discharge but could not be discharged without a key-worker. Mr HH - PO reluctantly agreed to act as Mr Stone's key-worker, and at the conclusion of this meeting Dr ZA - CPsych immediately discharged Mr Stone home with his mother. There was no recorded care plan on discharge and there is no evidence to show that any immediate attempt was made by staff at the De La Pole Hospital to inform either Kent Social Services, Dr T - CPsych(F), Dr AA - CPsych, or Dr M - GP of Mr Stone's discharge.²³

OUTPATIENT TREATMENT: JANUARY 1995 - AUGUST 1996

16. KENT SERVICES' s.117 MEETING AND KEY-WORKER ROLE

- 16.1 On 18th January 1995 a s.117 planning meeting was held at the Trevor Gibbens Unit (TGU) between Dr T - CPsych(F), Mr UU - SW and Ms ZJ - SW (Social Services), all of whom were unaware of Mr Stone's discharge from De La Pole two days earlier.
- 16.2 In Mr HH - PO's absence it was agreed that he would become the key-worker. Ms ZJ - SW noted that Mr HH - PO's appointment as key-worker was to be pending the outcome of his meeting with Mr Stone at De La Pole on 16th January 1995. In the event Mr HH - PO went off sick on 17th January 1995 and the case was transferred back to Ms CC - PO in February 1995. Mr HH - PO had no further professional involvement with Mr Stone.
- 16.3 On 24th January 1995 a supervision register form naming Mr HH - PO as key-worker and Ms ZJ - SW as social worker was completed by Dr T - CPsych(F). In fact, Ms ZJ - SW never met Mr Stone and she transferred his case to Mr OO - SW, a colleague in the Gillingham team, in April 1995 after Mr Stone had moved house.

²³

De la Pole Hospital chapter paragraph 8.5.

Chapter four: Supervision, treatment and care from 1992 to 1997

- 16.4 On 23rd January 1995 Dr T - CPsych(F) met with Mr Stone in his out-patients clinic and saw him on, approximately, a monthly basis thereafter.
- 16.5 On 2nd February 1995 Mr Stone re-attended Dr Z - CPsych at Manor Road Addiction clinic where a plan was made for him to attend Mr Y - RMN every three weeks. Following two further attendances with Mr Y - RMN, Mr Stone was seen on 26th April 1995 by a Dr ZT - TPsych. Dr ZT - TPsych recorded that Mr Stone wanted to come off *methadone*, and planned to reduce his prescription by 5mg fortnightly until he reached 30mg and then to admit him to hospital to stop *methadone* completely.
- 16.6 Ms CC - PO re-commenced her supervision of Mr Stone on 13th February 1995 and fortnightly thereafter. On 17th February she received a letter from Dr T - CPsych(F) asking that the Probation Service continue to provide the key-worker. Ms CC - PO felt that a probation officer acting as key-worker was inappropriate, and after discussing this with her senior informed Dr T - CPsych(F) of her views.
- 16.7 As Mr Stone moved house at this time he could no longer continue with Dr M - GP as his GP, and on 28th February he registered with Dr I -GP. Mr Stone asked (through Ms CC - PO) that Dr I -GP be provided with a letter explaining his medication. Ms CC - PO passed on this request to Dr T - CPsych(F) who wrote to Dr I -GP on 20th March outlining Mr Stone's need for depot medication (100mg *Haldol* fortnightly) and asking that Dr I -GP prescribe it.
- 16.8 On 3rd March 1995 Ms CC - PO contacted Kent Social Services and was told that Ms ZJ - SW was Mr Stone's case manager. Ms ZJ - SW informed Ms CC - PO that at the s.117 meeting held on 18th January at the TGU it had been deemed inappropriate for Mr Stone to have a female case manager. Ms CC - PO insisted a case conference be called to discuss the issue of key-worker, this was arranged for 22nd May 1995.
- 16.9 On 24th April 1995 Mr Stone was accompanied by Ms CC - PO to an appointment with Dr T - CPsych(F). He asked for help with *diazepam* abuse saying that for a long time he had been getting it by giving false names to general practitioners, but that he no longer wished to take *Valium* and had in any event almost run out of local GPs.
- 16.10 Following the case conference on 22nd May 1995, it was agreed that Mr OO - SW (social worker) would accept key-worker status. Dr T - CPsych(F)'s note of the meeting suggested that Mr OO - SW would take over at the end of the probation order, but when he discovered that Ms CC - PO was leaving her post in July he suggested (in a letter dated 18th July 1995) that Mr OO - SW should take over as key-worker when Ms CC - PO left. Mr OO - SW himself has said that he recalls agreeing to take on the key-worker role soon after the May meeting. On 24th July 1995 Ms CC - PO wrote to both Mr OO - SW and Dr T - CPsych(F) notifying them that Mr OO - SW had agreed to take over as key-worker and that the supervision register should be amended accordingly. In fact, the supervision register was never amended and in 1997 still showed Mr HH - PO as Mr Stone's key-worker.

17. METHADONE REDUCTION PROGRAMMES

- 17.1 In May 1995 Mr Stone commenced slow *methadone* withdrawal in the community. Mr Y - RMN recorded in a letter to Dr I -GP that the plan was to reduce by 5mg fortnightly and consider hospital admission at 15mg *methadone*. However, there are no records in the Manor Road notes to suggest that either this proposal to admit him when he reached 15mg or Dr ZT - TPsych's earlier proposal to admit when he reached 30mg *methadone* were acted upon.²⁴
- 17.2 By 21st July Ms CC - PO noted that Mr Stone was down to 25mg *methadone*. She recorded "not sure if Manor Road want him to go to hospital for detox – Mick seems to prefer hospital to doing it himself".
- 17.3 Ms CC - PO left the Kent Probation Service at the end of July 1995 and Mr Stone's case was transferred to Ms FF - PO. At her first meeting on 7th August 1995 Ms FF - PO recorded that Mr Stone was going to Manor Road to discuss hospital or community support and was deciding at that time against hospital.
- 17.4 Over the next weeks Ms FF - PO recorded Mr Stone's reduction in *methadone* to 15mg and noted how difficult he was finding it. On 23rd October Mr Stone had told her that he had begun using heroin again, but that he had arranged an emergency appointment at Manor Road himself and felt he should detoxify in hospital. Again Manor Road responded by offering another *methadone* reduction programme in the community.
- 17.5 On 30th October 1995 Mr Stone and Ms FF - PO met Dr T - CPsych(F); Mr Stone said that he wanted admission to Shelley Ward at Medway Hospital (Dr Z - CPsych's beds) for detoxification.
- 17.6 In the meantime Dr T - CPsych(F) had obtained agreement to have a new forensic Community Psychiatric Nurse post in his service. The first incumbent of this post was Ms ZP - CPN who had previously worked in the in-patient forensic team at TGU. Mr Stone was one of her first patients. On 15th November 1995 Ms ZP - CPN met Mr Stone for the first time; Mr OO - SW (social worker) was also present. She continued to see Mr Stone on (approximately) a fortnightly basis until his arrest in July 1997.
- 17.7 Dr T - CPsych(F) saw Mr Stone with his mother on 18th December 1995. He recorded that his mother described him as being much better, using drugs less, less aggressive and more stable.
- 17.8 On 31st January 1996 a new social worker Mr VV - SW, was allocated to Mr Stone's case. Both Mr VV - SW and his senior Ms TT - SW remained unaware that Mr OO - SW had been the designated key-worker and that Mr VV - SW had inherited this role. Both assumed that Ms ZP - CPN was the key-worker.

²⁴ Addiction Services chapter at paragraph 13.

- 17.9 By 19th January 1996 Mr Stone was down to 20mls *methadone*, but on 1st February he told Ms FF - PO that he had begun using heroin again. On 28th February Mr Stone again spoke with Ms FF - PO about how hard he was finding reducing his drug use and he discussed going into Shelley Ward. On 29th February she spoke with Mr Y - RMN who told her that Mr Stone's *methadone* prescription had been again set at 40mls and that he was now going to test his urine.
- 17.10 On 20th March 1996 at an appointment with Ms ZP - CPN Mr Stone told her he had a gun hidden somewhere, and she felt that he was acting more bizarrely. Ms ZP - CPN informed both Ms FF - PO and Dr T - CPsych(F) of the event and her concerns. Dr T - CPsych(F) suggested to Ms ZP - CPN that Mr Stone's depot medication be increased. Ms ZP - CPN relayed this message to a GP at Dr I -GP's practice on 20th March 1996, although she was unable to speak to Dr I -GP in person. On 29th March Dr I -GP began administering 5mg of *Haldol* to Mr Stone fortnightly in addition to the 100mg of *haldol decanoate* depot injection which he was already receiving.²⁵
- 17.11 Ms FF - PO notified Mr Y - RMN at Manor Road of the concern about the gun and they discussed this with Mr Stone at their next meeting on 25th March 1996. Mr Stone confirmed to her that he had access to a gun, although he said it was not in his possession. He said he had had access to a gun for years and at the moment was fearful of reprisals from an associate in prison. After discussing the matter with her senior, Ms FF - PO assessed Mr Stone's "risk of harm" using a probation "risk of harm management checklist". She concluded Mr Stone was at high risk of offending but that in effect this risk was ever present and was no greater than usual.
- 17.12 Mr Stone's two-year probation order expired on 29th April 1996. He had a final meeting with Ms FF - PO on 7th May 1996, when he told her he had found the probation involvement supportive and wished the order would continue.
- 17.13 On 22nd May 1996 Dr T - CPsych(F), Ms ZP - CPN and Mr VV - SW met with Mr Stone. He informed them that he had disposed of his gun and wanted to get off heroin again.
- 17.14 Mr Stone had a *Haldol* 5mg and *haldol decanoate* 100mg administered to him by Dr I -GP on 29th May 1996. His next injection was due on 12th June but was actually given on 17th June, five days late. Under the fortnightly regime prescribed by Dr T - CPsych(F), his next injection was due on 1st July 1996. However, there is no record of any injection being given until 31st July 1996.²⁶
- 17.15 On 2nd July 1996, Mr Stone attended Manor Road addiction clinic. Mr Y - RMN recorded that Mr Stone looked well and was keen to consider hospital detoxification. He arranged to see him in two weeks, but Mr Stone did not attend that appointment.

²⁵ General Medical Services chapter at paragraph 21.

²⁶ General Medical Services chapter at paragraph 24.

18. AGGRESSIVE OUTBURST: 4TH JULY 1996²⁷

- 18.1 On 4th July 1996 Mr Stone attended an appointment with Ms ZP - CPN accompanied by his mother. During the meeting he became very agitated and complained about his accommodation. He focused his concerns on his previous probation officer Mr HH - PO and made threats to kill him and his family. He repeated his view that Mr HH - PO had breached confidentiality by passing information to his girlfriend and claimed that his had caused their relationship to break up. Ms ZP - CPN was concerned by both Mr Stone's speech and behaviour. Her colleague Mr RR - SW, who was in an adjacent room, was sufficiently concerned when he overheard the outburst, to come into the room in case Ms ZP - CPN needed assistance.
- 18.2 Mr Stone complained that Dr I -GP was injecting him with an additional drug and he did not know what it was. He also complained that Manor Road had failed to offer him inpatient detoxification at Medway Hospital. He said the only way he could get off drugs would be to be admitted and temporarily removed from the drug scene. Mr Stone also made threats to kill prison officers should he receive a future sentence, saying he was too violent for prison and should be in Broadmoor. Although he calmed down somewhat, Mr Stone left the appointment in a "disgruntled mood".
- 18.3 Ms ZP - CPN was concerned about this behaviour and immediately consulted Dr T - CPsych(F). Together they planned that Ms ZP - CPN should:
1. Contact Dr I -GP and elucidate details of Mr Stone's depot medication;
 2. Bring forward his outpatient appointments to weekly until his volatility reduced;
 3. Contact Mr Stone or his mother within 48 hours to establish how he is;
 4. Alert Mr HH - PO to the threats made;
 5. Inform Mr VV - SW of the events;
 6. Inform Mr Y - RMN of the events.

Dr T - CPsych(F) indicated that if there were further problems he would consider an option of admission to the TGU and that, if the need arose, Mr Stone might be willing to be admitted informally.

- 18.4 That afternoon Ms ZP - CPN informed the probation service and Mr VV - SW of what had occurred. She also spoke to Mr Y - RMN the next day. He told her that Mr Stone had been offered detoxification on many occasions but had always declined a bed when one was available. He said that in any event, staff at Medway Hospital did not feel they could cope with him on the detox ward.
- 18.5 On 5th July 1996 Ms ZP - CPN spoke to Dr I -GP and asked about Mr Stone's depot injection. He informed her that he had increased Mr Stone's medication to 105mg *haldol decanoate*. He failed to inform Ms ZP - CPN that Mr Stone's injection was already four days overdue. In fact, Mr Stone did not receive another depot injection from Dr I -GP until 31st July 1996 but Ms ZP - CPN remained unaware of this.²⁸

²⁷ Forensic Services Chapter at paragraph 8.

²⁸ General Medical Services chapter paragraph 25.5.

- 18.6 At 10.30 am on 5th July 1996 Ms ZP - CPN also spoke to Mr Stone by telephone. She found him to be calmer, more reasonable and repentant following his behaviour the previous day, although he still expressed hostility to Mr HH - PO. Mr Stone agreed to attend an appointment with Ms ZP - CPN on 10th July 1996.
- 18.7 It was said in a newspaper article that Mr Stone met a police officer on 5th and 10th July 1996. The Panel have no further information in respect of this allegation. On 9th July 1996 Lin and Megan Russell were attacked and killed and Josie Russell was left seriously injured. There is no record of contact with Mr Stone by any agency on this day.
- 18.8 On 10th July 1996 Mr Stone attended to see both Ms ZP - CPN and Mr VV - SW. They noted that he was much calmer with no evidence of irritable or angry feelings. He appeared subdued and physically unwell with less spontaneous speech than usual. Mr Stone again requested in-patient detoxification, saying this would remove him from the drug scene so that he could withdraw from heroin safely.
- 18.9 Ms ZP - CPN saw Mr Stone again on 18th July and noted that he was much better than in the past two weeks. He told her he had been given a depot injection that week, which he had found beneficial in reducing agitation anxiety and anger. Although Mr Stone had attended Dr I -GP on 15th July, the GP records show only *benzodiazepines* prescribed and not any depot medication being given.²⁹
- 18.10 Mr Stone did not attend his appointment with Dr T - CPsych(F) on 24th July 1996, although it was later learned that this was because he had been arrested for alleged robbery on 23rd July 1996 and was in police custody. Mr Stone also failed to attend his next appointment with Ms ZP - CPN on 8th August 1996. On contacting Manor Road Ms ZP - CPN was told that he had not attended the drug clinic for four weeks.
- 18.11 On 15th August Ms ZP - CPN received a message from Mr Stone's mother expressing concern about his health. Ms ZP - CPN spoke to Mr Stone on the telephone. He told her he was in urgent need of a hospital admission for drug withdrawal. Ms ZP - CPN thought that Manor Road could offer him the best advice on addiction problems, so she contacted Manor Road to try to obtain an appointment for him. Mr Y - RMN was not available, but the staff agreed to arrange an appointment for the next day.

19. ADMISSION FOR DRUG DETOXIFICATION: AUGUST 1996

- 19.1 On 21st August Mr Stone attended Mr Y - RMN at Manor Road with his mother. He said that his mental state had deteriorated recently and that he was distressed. He asked for an informal admission. After a telephone discussion between Dr T - CPsych(F) and Dr Z - CPsych, Dr T - CPsych(F) agreed to admit Mr Stone to the Trevor Gibbens Unit for detoxification. He was admitted on 23rd August 1996.

²⁹ General Medical Services chapter paragraph 26.1.

19.2 Voluntary admission to a regional secure unit for detoxification was a very unusual step, one which Dr T - CPsych(F) and his team had not undertaken before or since Mr Stone's case.³⁰

19.3 Whilst in the Trevor Gibbens Unit Mr Stone successfully completed withdrawal from opiates. His in-patient stay was then extended to attempt *benzodiazepine* withdrawal. Arrangements were made for him to be assessed for a drug rehabilitation placement after leaving the TGU. However, before completing *benzodiazepine* reduction, he chose to discharge himself against medical advice on 12th November 1996.³¹

20. OUTPATIENT FORENSIC CARE: NOVEMBER 1996 – JULY 1997

20.1 Mr Stone returned to the out-patient care of Dr T - CPsych(F) and Ms ZP - CPN, and also attended the Manor Road Clinic. By January 1997 he had returned to using heroin. On 23rd January Mr Stone attended the TGU and described to Ms ZP - CPN's CPN colleague having thoughts of killing someone. She was concerned about this statement and, after consultation, Mr Stone was admitted voluntarily to the TGU until his mental state settled. After a short admission, Mr Stone returned to the community on 27th January.³²

20.2 Mr Stone's heroin use continued to the extent that in May 1997 he told Mr Y - RMN that he had nearly overdosed. He attended Mr Y - RMN with his mother and again asked for detoxification. He was commenced on another programme of *methadone* reduction from 50mg *methadone* reducing by 5mg each week.³³

21. ARREST AND CONVICTION

21.1 In July 1997 on the anniversary of the Russell murders, a Crimewatch TV programme reconstructed the crime. Dr T - CPsych(F) and other staff members saw the programme and independently formed the view that Mr Stone resembled the man sought by police. After discussion with the TGU service manager, this information was passed on to Kent Police.³⁴

21.2 Mr Stone was arrested in late July 1997. On 23rd October 1998 he was convicted of two counts of murder and one of attempted murder in respect of an attack upon Lin Russell and her children on 9th July 1996. He was sentenced to life imprisonment. He has appealed against his conviction, and at the time of writing, this has still not been determined.

³⁰ Forensic Services chapter paragraph 10.2.

³¹ Forensic Services chapter paragraph 15.2.

³² Forensic Services chapter paragraph 17.

³³ Forensic Services chapter paragraph 17.7.

³⁴ Forensic Services chapter paragraph 19.2.

H.M. PRISON SERVICE

OVERALL EVALUATION OF THE PRISON SERVICE

Service involvement in the case

Adolescence to September 1992, October 1993 to April 1994.

Mr Stone served several custodial sentences his last 8½ year sentence ending in September 1992. He was also a remand prisoner for six months from October 1993.

Evaluation against core principles

- **Clarity in current diagnosis, objectives, needs, risk assessment and the strategies to clarify and deal with them.**
- **Checking on the outcome of service provision by regular review.**
- **Changing the diagnosis, needs and risk assessments and service provision in the light of the review.**

Given the absence of prison service records, evaluation of the service against these core principles is not feasible.

- **Coordination of the delivery of service, sharing of information and action.**

It is of concern that the prison medical records of a repeat offender with an identified mental health problem can go missing, particularly given the extant prison policy of retention of such records for 20 years.

It is clear that information sharing between the prison service and other agencies was almost non-existent when it should have been systematic. It is of particular concern that no arrangements were in place to ensure the continuing psychiatric care of a dangerous long-term offender with a recognised psychiatric illness. Given the significant amounts of time that Mr Stone spent under the care and supervision of prison authorities, an opportunity to provide potentially useful information about the management of a complex and challenging man was lost.

H.M. PRISON SERVICE

1. EARLIER CONTACT WITH THE PRISON SERVICE

Before the period with which this inquiry is immediately concerned, Mr Stone spent considerable time in prison. He received custodial sentences as set out in the brief chronology above.

2. REFERENCES TO MENTAL HEALTH ISSUES DURING JUVENILE DETENTION

- 2.1 The earliest reference within Mr Stone's available records which pertains to any mental health issue is found within a court report by the Deputy Governor at Send Detention Centre in 1975 (aged 14 years). This report reflects how:

"during his first stay at Send Detention centre I felt this boy was in need of a good mental check up. He is a good case of split personality, one minute calm and co-operative and the next a handful of trouble."

- 2.2 On 17th January 1976 (aged 15 years) a report from borstal training describes an 'attempted suicide' when Mr Stone made a shallow cut on the inner surface of his right wrist. This is described by the Medical Officer as a "*stupid gesture*" and no further action appears to have been taken.

- 2.3 On 15th March 1976 (aged 15 years) Mr Stone was transferred from Dover Borstal to Feltham Borstal, a specialist facility for trainees with psychological problems, "because of depression which he suffered". The assistant governor's report describes how Mr Stone came from "a problem family and it is largely the result of his early environmental experiences that he is as bewildered and mixed up in his feelings as he is." There are no records available to indicate what type of treatment if any was offered at Feltham.

- 2.4 By 28th June 1977 (aged 17 years) Mr Stone was in HMP Longport, Canterbury where a "release write up" report indicates that he did see a visiting psychotherapist for 10 weekly sessions between April and June 1977. The summary report by Dr ZD - Psychther describes how:

"He asked to see me, the reason being that he felt people talked about him and that he thought he was 'going mad'. He has used the word "paranoid" several times spontaneously... he said he was worried about 'going insane'. In the last but one talk he badgered me repeatedly to put him in the hospital to give him 'treatment' by which he meant injections for his mental state. If I didn't he would 'kill someone' etc..."

- 2.5 No recommendations were made for continued therapy or support in the community on leaving borstal.

3. PSYCHIATRIC CONDITION, CARE AND TREATMENT IN ADULT PRISON

3.1 No records have come to light in respect of Mr Stone's first four periods of adult imprisonment between 1977 and 1980. The majority of subsequent records refer to a range of behavioural problems rather than any psychological or psychiatric distress. A segregation form from HMP Camphill dated 22nd September 1981 records that while serving a two-year sentence for robbery and GBH, Mr Stone attacked another inmate with a chair. It was stated on the form that:

"Stone has remained a control problem throughout his present sentence. An extremely volatile and unbalanced individual who now poses a serious threat to staff and other prisoners if not tightly controlled. Has made threats and there is little doubt he will carry them out."

3.2 On 13th January 1983 at HMP Canterbury (when remanded pending trial for wounding with intent and ABH) the "*Inmate Medical Record*" describes his state of health as "good" and under "*Past Medical History*" the medical officer has written "nil serious". That same record sheet was initialled by a medical officer at HMP Exeter on 18th June 1983 (where he commenced his 4½ year sentence) with no additional information added.

3.3 In April 1983 Dr ZE - Psych(F), a Forensic Psychiatrist assessed Mr Stone in Canterbury Prison. In a very short report, she stated that she found him to be a "volatile and emotional man who found it difficult to co-operate with a psychiatric interview". Dr ZE - Psych(F)'s report concludes that "It is apparent that he is very unstable, but there is no evidence that he has a mental illness for which treatment in a psychiatric hospital would be advisable... his very deprived and unsatisfactory childhood has led to a severe personality disorder." Dr ZE - Psych(F) recommended that, should he receive a sentence of more than one year, he be considered for treatment within the prison system. However, the report gives no indication of the suggested nature or purpose of such treatment.

3.4 A classification form dated 17th June 1983 also describes control problems. It states that he has an:

"extremely aggressive nature ...only a matter of time before this quick tempered hot head is in trouble with prison authorities...he has a very short fuse and will use weapons to attack whatever or whoever is upsetting him. He violently stabbed a female on his current charge and shows no remorse at all. He attacked two police officers at court and will do the same to prison staff should things not go his way. Should be watched carefully by staff at all times extremely dangerous. Will be allocated to high security because of his offence recommend Cat B Albany".

3.5 Mr Stone was eventually transferred to HMP Albany where a 'summary of progress' report form dated 10th June 1985 notes that Mr Stone had 14 reports against prison discipline including 3 assaults on staff. As a result he had forfeited 235 days remission from his sentence.

3.6 Whilst at HMP Albany the prison chaplain became concerned about Mr Stone's mental health. The chaplain wrote "I was concerned when I observed a deterioration in his

appearance which prompted me to refer him to caring agencies...he obviously has many problems and seems reluctant to seek help from any agencies" . It appears that this concern was passed on to the health care team; a psychologist and doctor attempted to see Mr Stone. However, Mr Stone then complained about these visits to the Home Office writing "I am not insane I feel no need to see doctors or psychiatrist. I resent the vicar harassing me by sending these people". There is no evidence that any further investigation of his mental health was made at this time.

4. PRISON MEDICAL SERVICES: SEPTEMBER 1992

4.1 During his last period in custody (10th April 1987 to 4th September 1992) there is no doubt that Mr Stone received attention from the psychiatric and other medical services. On his release on 4th September 1992 Mr Stone was handed a letter by Dr ZH - HMPGP, Head of Health Care Service at HMP Whitemoor dated 24th August 1992 addressed to "The Doctor Responsible for the Care of [Michael Stone]". The relevant part of the letter reads¹:

"He has a long standing problem of ideas of reference, paranoid thinking and possible auditory hallucinations. He does have a history of drug abuse, including amphetamines. He was started on Perphenazine, 4mg tds, in July 1991, and responded well. In July of this year, when Glaxo had difficulty in supplying Perphenazine, we changed him over to Trifluoperazine. His current treatment is:

Trifluoperazine 5mg am, 10mg pm
Procyclidine 5mg b.d

We have been unable to arrange for his on-going review by Community Mental Health Services, as there is uncertainty as to where he will reside in the long-term. He has been discharged from the prison with a one week supply of his medication, to allow him to register with a General Practitioner.

If you would like any further information regarding this patient, please do not hesitate to write or to telephone me at the above number."

4.2 On 8th September 1992 Mr Stone attended the surgery of Dr M - GP and applied to join his general practice list. He was seen on 9th September when the contents of this prison letter were noted. On 9th September 1992 Dr M - GP wrote to Dr ZH - HMPGP at HMP Whitemoor asking for the results of a physical examination which had taken place at the prison the week before. Dr ZH - HMPGP replied on 15th September 1992 stating that she was glad Mr Stone had registered so promptly with a doctor and gave the information requested

COMMENT:

The Panel are concerned to note that it was left to chance whether or not a man with a long prison history of mental ill health problems, deemed

¹ The letter was available to the inquiry as it was retained within the general practice records. The Prison Service were unable to provide a copy.

sufficient to require ongoing psychotropic medication, contacted a general practitioner within a short time after his release and, having done so, whether he gave the prison discharge letter to the doctor. We consider that, subject to obtaining the prisoner's consent, arrangements should be in place to ensure that discharged prisoners are registered with a general practitioner to whom appropriate medical information is then communicated. There are obvious difficulties in the case of prisoners who are uncertain where they are going to live, but it ought to be possible in such cases to utilise the requirements of release on license to achieve this end.

In default of any other arrangement being possible, medical records in relation to a period of custody should be transferred to at least the GP with whom the prisoner was previously registered.

5. LIAISON BETWEEN PRISON AND PROBATION SERVICES

- 5.1 At the time of Mr Stone's release in 1992, there were no statutory provisions for compulsory probation supervision or aftercare. The Criminal Justice Act 1992, which made such provision, did not come into force until 1st October 1992. Following this Act, the Prison Service has implemented a system of discharge reports which are sent to the supervising probation office containing relevant information from the prison service about the released prisoner's address, discharge employment or training, community and family links etc. Before such provisions were introduced prisoners were offered after-care by the probation service on a voluntary basis.
- 5.2 The Kent Probation Service (KPS) records reveal that in November 1991 Mr Stone was in HMP Parkhurst and was reported as not being interested in contact with KPS. In March 1992 it was learnt that Mr Stone had been transferred to HMP Whitemoor, allegedly because of his throwing scalding water over another man in a quarrel. In July 1992 KPS received a letter from Mr Stone stating that he intended to go to Peterborough on his release and had made contact with the probation office there. In August 1992 the Kent file was marked as a low priority case because Mr Stone was apparently not intending to reside in Kent on release.
- 5.3 In November 1992, February 1993 and May 1993 the Kent probation officer assigned to Mr Stone at the time noted that he should contact HMP Whitemoor during the following quarter to assess Mr Stone's position, but never actually did so, apparently because of pressure of work. It was not until November 1993, when that officer was in the process of closing the case, on the ground that he had not heard from Mr Stone, that his secretary found out that Mr Stone had been released from HMP Whitemoor in September 1992, over a year earlier. By the time KPS learnt of Mr Stone's release from HMP Whitemoor he was already back in custody: he was on remand at Lincoln following his arrest in Skegness². There is no evidence that the prison service informed the probation service of the release from HMP Whitemoor.

² See Probation chapter at paragraph 3.1 and Addiction Services chapter at 6.1.

COMMENT:

The Panel appreciate that the discharge system will now have changed following the implementation of the Criminal Justice Act 1991. In the absence of the prison records, the Panel cannot determine whether the prison service notified any probation service of Mr Stone's release; they certainly did not notify Kent Probation service. It is essential that the intended release of any prisoner still subject to the pre-1992 procedures is communicated clearly to any probation service which may become responsible for offering after-care.

6. PRISON MEDICAL RECORDS

6.1 In order to establish whether the information contained in Dr ZH - HMPGP's letter was an adequate summary of Mr Stone's medical history while in prison, with Mr Stone's consent the inquiry approached the Prison Service for disclosure of his prison medical records.

6.2 A request was made for access to his prison records to HM Prison Service Directorate of High Security Prisons. Despite what we have been assured have been extensive searches, the Panel have been told that no such records have been located. No authoritative explanation as to what may have become of them has been forthcoming. The inquiry Panel was informed that:

“the prison service does not normally hold its records for any length of time following the discharge of a prisoner at the end of his sentence... A period of six years is the usual period that records are held.”

6.3 Neither the main prison registry, the Home Office Parole Unit, HMP Whitemoor (where Mr Stone served his last sentence until September 1992) HMP Lincoln (where Mr Stone was a remand prisoner in 1993) nor HMP Frankland (where Mr Stone was detained at the time of the inquiry) had prison medical records for the relevant period in their possession.

6.4 The Prison Service Health Policy Unit have informed the inquiry that the extant policy since 1990³ is that medical records of prisoners who display signs of or have a history of mental disturbance should be retained in central stores for a period of 20 years. Special notification from the prison medical officer is required for this 20-year period to be imposed. In the absence of records, it is impossible to tell whether Mr Stone's records were ever returned to the central store and whether or not the 20-year retention policy was implemented. The Prison Service Health Policy Unit in correspondence with the Panel have assumed that records were lost in 1993 after re-issue from the prison service central store to HMP Lincoln.

³ As stated in Prison Service Circular 23/90 and DDL (90)21.

- 6.5 Some limited papers relating to Mr Stone's periods in custody were made available by the Directorate of High Security Prisons. The Panel were informed that these had been held at Prison Headquarters where a separate policy of document retention exists. These papers consisted of reports from periods of Borstal training in 1970s, limited documents relating to disciplinary offences, complaints and requests for transfer in the 1980's-90's and remand forms from Lincoln Prison covering the period 1993-1994. These documents provide very limited and incomplete details of Mr Stone's mental health in the prison system and any psychiatric/psychological treatment and care provided to him.
- 6.6 Between October 1993 and April 1994 Mr Stone was detained as a remand prisoner in HMP Lincoln. Although a few papers related to his time in custody were obtained these related, in the main, to arrangements for his transfer from prison to court in connection with the charges against him. No medical papers were available and it was suggested by the prison service that this was because he either did not seek medical treatment or the papers no longer existed. However, correspondence in health service records indicates that Mr Stone was prescribed psychotropic medication whilst at HMP Lincoln⁴.

COMMENT:

By September 1992 Mr Stone had spent many years of his life in prison. During his detention he received psychotropic medication for symptoms of mental illness about which no more is now known.

In order for appropriate care to be provided it is, in our view, essential that full and accurate medical information is recorded and kept available by the Prison Service. Few people, let alone a long-term prisoner with mental health problems, can be expected or relied upon to give an entirely accurate account of their medical or psychiatric history. The inevitable difficulties caused by the frequent transfer of prisoners from one establishment to another should not be allowed to stand in the way of a proper record keeping and storage system. It is not within our remit to consider how such a system should be set up, but we are concerned that, despite longstanding criticism of current practice, and an extant policy of retaining records for 20 years, an effective system does not seem to have been in place in Mr Stone's case.

The absence of such information will have made the already challenging task of caring for and supervising Mr Stone in the community after his release even more difficult.

⁴ See Addiction Services section at paragraph 6.3.

RECOMMENDATIONS

Paragraph 4

There should be a review of current systems by the prison health care service to ensure that the medical and psychiatric care of prisoners with medical and psychiatric needs is transferred to appropriate practitioners in the community.

Paragraph 6

The Prison Service should review its medical record-making and storage arrangements, and issue a policy designed to ensure that:

- (1) records showing an accurate medical history of every prisoner are made and kept to the same standard as those kept by general practitioners in the National Health Service;*
- (2) such records, if the patient consents, are made available to medical practitioners requiring information for treatment purposes after the prisoner's discharge.*

The implementation of the current policy of retention of records of prisoners with mental health difficulties for 20 years should be reviewed to establish whether the loss of Mr Stone's records represents an isolated case or a wider failing in storage and retention procedures.

GENERAL MEDICAL SERVICES

OVERALL EVALUATION OF THE GENERAL MEDICAL SERVICES

DR M - GP AND PARTNERS

Involvement in the case

October 1992 to January 1995

Evaluation against core principles

- **Clarity in current diagnosis, objectives, needs, risk assessment and the strategies to clarify and deal with them**

Dr M - GP and his partners are to be commended on their practice. Dr M - GP correctly identified and acted upon the risks and needs of Mr Stone and made appropriate and timely referrals to specialist services. He was proactive in pursuing those specialist services when he felt his patient required further input.

- **Coordination of the delivery of service, sharing of information and action**
- **Checking on the outcome of service provision by regular review**
- **Changing the diagnosis, needs and risk assessments and service provision in the light of the review.**

The communication between this practice and secondary and tertiary services was of good standard. Mr Stone's condition was regularly reviewed and matters of concern promptly reported to others involved in his care.

DR I - GP

Involvement in the case

February 1995 to July 1997

Evaluation against core principles

- **Clarity in current diagnosis, objectives, needs, risk assessment and the strategies to clarify and deal with them.**
- **Coordination of the delivery of service, sharing of information and action.**

Dr I - GP remained unaware that his view of Mr Stone's diagnosis differed from that of the forensic service.

His record-keeping and his communication with specialist services was of a poor standard. He altered the prescribing of both *benzodiazepines* and anti-psychotic medication without either reference to specialist services overseeing the case or at least informing them of what he had done. He lacked sufficient understanding of the nature and effects of the anti-psychotic medication which he was administering.

He did not notify the forensic team of Mr Stone's irregular attendances for depot medication and when specifically asked about the matter in July 1996 provided incorrect information. While these lapses deprived the consultant forensic psychiatrist of an opportunity to reassess Mr Stone's treatment with the benefit of accurate information, it cannot be established whether this would have altered Mr Stone's behaviour in any way.

- **Checking on the outcome of service provision by regular review.**
- **Changing the diagnosis, needs and risk assessments and service provision in the light of the review.**

Dr I - GP did not monitor the attendance of Mr Stone for depot medication but was prompted to administer medication only by his patient attending and requesting the same.

FAMILY KENT HEALTH AUTHORITIES SUPPORT AGENCY

- Mr Stone was simultaneously registered with two GP practices using different names but his correct date of birth. It is of concern that the current GP registration the system does not automatically question and investigate a lack of previous GP registration of a 32-year-old man resident in this country since birth.

GENERAL MEDICAL SERVICES

1. GP Records Before 1992

- 1.1 Before the period of the Inquiry's terms of reference Mr Stone had been registered with general practitioners under the name Michael John G., or G..¹ The Panel have seen records in this name going back to the 1970's. These include information relevant to Mr Stone's history of substance misuse, including correspondence relating to his short admission to Bexley Hospital in 1980 for withdrawal from drugs². In 1982 he was re-referred by his GP to drug addiction services. Dr BJ – Cpsych offered an appointment and in a letter dated 10th August 1982 stated:

“I remember that when Michael was with us before he tried to present himself as a long-term addict but it was in fact highly unlikely that he was physically addicted to opiates at all: it seems that this behaviour is continuing, and I would strongly advise against any prescribing for opiate drugs for someone just out of prison...”

- 1.2 In 1992 the registration for Michael John G. was held by a Dr ZS -GP. As far as the Panel can ascertain, there was no GP registration in the name of Michael Stone before Mr Stone's release from prison in 1992, and therefore no general practitioner records in that name until that time. There were, or are likely to have been, prison medical records, but these are now unavailable.³

2. GP REGISTRATION 1992: DR J - GP AND PARTNERS

- 2.1 Drs J - GP, M - GP and L - GP are partners in a long established general practice in Walderslade, Chatham. This is a fund-holding practice staffed by a practice manager, a deputy, three practice nurses, each with special training in particular areas, and six administrative staff. Consultations are by appointment, but there is provision for patients to be seen without appointments in emergency. Dr M - GP told the Panel that the staff had a good understanding of the problems posed by a disturbed patient and were in a position to arrange for such a patient to be seen promptly without an appointment.
- 2.2 The practice has a list of approximately 6,500 patients. Only a small percentage of these would have mental health or drug problems. Dr M - GP had between 12 and 17 patients with such problems on his own list, which totalled about 2,500. Most of these would be cared for by a hospital for most of the time and were stable.
- 2.3 Dr J - GP is the senior partner and has been in this practice since 1972. He has experience in the management of patients with mental illness, personality disorder, and substance and alcohol abuse problems, but so far as the Panel can tell, no specific training.

¹ The actual names used are irrelevant to the purpose of this report and are therefore not used.

² See Early Years chapter at paragraph 9.

³ See Prison Service chapter at paragraph 6.

- 2.4 Dr M - GP joined the practice in 1990. He had spent six months training in psychiatry as a Senior House Officer, and a short period as a Registrar in the field. He has attended lectures on addiction.
- 2.5 Dr L - GP has been with the practice since 1993. His training included six months as a Senior House Officer in general psychiatry, but had no formal training in forensic psychiatry or substance and alcohol abuse. He has attended occasional lectures and meetings on alcohol and drug addiction at the local postgraduate centre.
- 2.6 Mr Stone registered with the practice on 8th September 1992, following his release from prison. He presented the letter from Dr ZH - HMPGP, Head of Health Care Service at HMP Whitemoor dated 24th August 1992. This stated that in prison he had received psychiatric care for “long standing ideas of reference, paranoid thinking and possibly auditory hallucinations”. His medication on discharge was *Trifluoperazine (stelazine)* and *procyclidine (kemadrin)*⁴.
- 2.7 Mr Stone saw Dr M - GP the following day. As noted by the doctor, his principal concern at the time was his physical health. Dr M - GP considered he was stable, not showing any psychotic symptoms, and, despite the suggestion implicit in the prison letter, not in need of help from the community mental health services or of a psychiatric referral of any type. Mr Stone was offered no medication as he still had a supply from the prison, but Dr M - GP wrote to Dr K - GP asking for the result of a physical investigation made in prison. Dr K - GP replied on 15th September 1992 stating that she was glad Mr Stone had registered so promptly with a doctor.

COMMENT:

The Panel formed the impression that this was a well-run, forward-looking practice, more than usually well equipped to care for patients with psychiatric disorders and substance abuse problems.

Dr M - GP's initial reception and assessment of Mr Stone were undertaken competently and conscientiously. He did everything that was necessary to ensure that the patient would be followed up by himself, so that if he did require more extensive help the general practitioner would be in a position to refer him for it.

3. THE REGISTRATION PROCESS

- 3.1 In his answers for the surgery's new patient questionnaire, Mr Stone did not provide information concerning his previous doctor, or an NHS number. When the GP registration form was received by the Kent Health Authorities' Support Agency (“the Agency”) a new NHS number was issued to Mr Stone.
- 3.2 Where there is no trace of a previous registration within the relevant area, an application is made to the Office for National Statistics (“ONS” - to the NHS Central Register function) for the patient's number. The type of number allocated in his case indicates that the ONS were unable to trace the patient's number and had issued a new

⁴ The full text of this letter is set out in the Prison Service chapter at paragraph 4.

one. The Agency were unable to establish from their records whether the ONS had asked the GP, as it on occasion does, to provide any further information about Mr Stone such as whether he had used any other names.

- 3.3 Accordingly, Dr M - GP was not offered any previous general practice records for Mr Stone. In fact, as described above, Mr Stone had been previously registered with general practitioners under a different name.

COMMENT:

It seems that Mr Stone gave Dr M - GP his correct date of birth, but did not disclose any previous name(s). In fairness to Mr Stone, we have seen no evidence that he was asked. Dr M - GP had a new patient questionnaire which sought details of the previous medical practitioner and medical history, but this had not been fully completed by Mr Stone. One might expect that a patient of 32 years of age who had been resident in this country since birth would have previous GP records. Despite no previous medical records being received from the Kent Health Authorities' Support Agency, Dr M - GP did not seek any further explanation for the lack of records, nor was he asked to do so by the Agency.

The Panel are concerned at the apparent ease with which a patient may register under a new name and, as a result, not have his previous medical records transferred to the new general practitioner, even though both registrations were held by the same Authority. While this may be understandable if the patient actually refuses to consent to his records being transferred, we have no reason to believe that Mr Stone would necessarily have wished to keep his past records away from his current general practitioner. As will be seen, the existence of separate sets of records under different identities led to the potentially hazardous situation of him being registered with two separate GP practices, which were in ignorance of each other's involvement. Clearly this is highly undesirable in the case of a patient with a history of substance misuse, who is likely to seek drugs from his doctors.

4. REFERRAL TO GENERAL PSYCHIATRIC SERVICES

- 4.1 On 16th September 1992 Mr Stone attended Dr M - GP who prescribed further *stelazine* and *procyclidine*. There was no cause for concern at that time about Mr Stone's condition.
- 4.2 On 8th October 1992 Mr Stone presented again at the surgery and caused a rather different reaction. He told Dr M - GP that he had been taking double the prescribed dose of *stelazine* because he was "under pressure". Dr M - GP recorded that Mr Stone said to him:

"When he came out of prison and was walking through the woods felt like killing children.
↑(increased) *stelazine* and these ideas are not good."

4.3 Dr M - GP described to the Panel his general impression of Mr Stone at this time in the following terms:

"I knew that he is now dangerous, very dangerous, because he himself had some insight and he was able to increase his medication and he found himself very disturbed. I knew with his past history, what I could gather from him, that he was dangerous and I thought that he should immediately get specialist care. So I phoned up the psychiatrist locally and then made an appointment straight away."

4.4 Dr M - GP immediately wrote a letter of referral to Dr BB - Psych, a staff grade general psychiatrist at Chatham Community Mental Health Team (CMHT), based at Throwley House under the Consultant charge of Dr AA - CPsych. Dr M - GP set out a history and requested that she see Mr Stone urgently, which she did.⁵

4.5 On 15th October 1992 Mr Stone saw Dr M - GP again and reported that Dr BB - Psych had increased the *stelazine* dose and that he had been referred to Dr ZK - CPsych(F), the Consultant Forensic Psychiatrist. Some time later Dr M - GP received a copy of Dr BB - Psych's letter of referral to Dr ZK - CPsych(F) (dated 13th October 1992). This recorded her assessment including a description of paranoid symptoms whilst in prison, and a report that, since coming out of prison:

"he has been feeling tense and nervous and feels that he is heading into probably stabbing and murdering somebody"

4.6 In due course Dr M - GP received a copy of a letter to Dr BB - Psych dated 21st October 1992 from Dr Q - Psych(F), Senior Registrar in Forensic Psychiatry at the Maidstone Hospital. He had assessed Mr Stone⁶ and gave further graphic details of Mr Stone's problems:

"He describes how he was walking in though woods about one week ago when he realised that someone was walking behind him and he felt the urge to attack them and possibly kill them. He was able to resist this urge and consulted his GP the following day. He also describes fantasies of torture, dismembering and killing people."

4.7 Dr Q - Psych(F) reported that Mr Stone felt that *stelazine* helped to control his fantasies and urges to attack people. The letter to Dr BB - Psych continued:

"I would suggest that you continue to prescribe Stelazine for him... In view of his extremely disordered childhood and background, I do not think a psychotherapy approach would be of benefit and he did not want this. His action when he had violent urges recently was appropriate and sensible in that he consulted you and asked for an increase in his medication. He has a good deal of insight into his difficulties. I have warned him of the dangers of taking illicit drugs.... which may increase his paranoid ideas. He did not want to be seen regularly in outpatients but I explained to him that I would be prepared to see him at his GP's request should he feel he was becoming out of control or if he wants further help."

⁵ See Chatham CMHT chapter at paragraph 2.

⁶ See Forensic Services chapter at paragraph 2.

- 4.8 As is noted elsewhere⁷ Dr Q - Psych(F) considered that his role in the case was discharged by this letter, and that he had returned to care of the patient to Dr BB - Psych. In contrast Dr BB - Psych had in fact determined not to accept the care of Mr Stone but did not inform the general practitioner of this decision. Dr M - GP understood that the care had been referred back to Dr BB - Psych and Dr AA - CPsych's psychiatric team with himself as part of the team. Dr M - GP regarded the general practitioner's role as essentially a passive one.
- 4.9 Dr M - GP assumed that Mr Stone had been given appointments by Dr AA - CPsych's Community Mental Health Team (CMHT) and told the Panel he would have been concerned to learn - as was in fact the case - that no appointment was in fact offered for the rest of 1992.
- 4.10 Mr Stone saw Dr J - GP at the surgery on 17th November and was prescribed *stelazine* and *kemadrin*.
- 4.11 On 1st December 1992 Mr Stone is recorded as having told Dr J - GP that he had been taking heroin and cocaine. He was given a further prescription for his anti-psychotic medication and, also *temazepam* 10mg (6 tablets). Dr M - GP told the Panel that during this period there was no special concern about Mr Stone, because he was stable on the medication, was willing to attend the surgery, and they had struck up a good rapport.
- 4.12 Unknown to any health service personnel, Mr Stone was convicted of theft on 22nd December 1992 and was fined.

COMMENT:

The Panel consider Dr M - GP's interpretation of Dr Q - Psych(F)'s letter and of Mr Stone's subsequent behaviour to have been a perfectly sensible one. However, the difference in understanding between the general psychiatric team and the general practitioner about who was resuming the care of this patient's psychiatric problems could have been significant, bearing in mind the potentially dangerous nature of the fantasies and urges Mr Stone was reporting. If he had stopped attending the general practice surgery, he might have been lost from medical supervision and assistance. Fortunately the risk was minimised because Mr Stone in fact continued to attend the general practitioners on a fairly regular basis, and was carefully monitored by them.

In December 1992 it might have been preferable for Dr J - GP to seek specialist advice or treatment for Mr Stone rather than initiate the prescribing of temazepam to a patient who was, on his own admission, misusing drugs. However, only a limited number of tablets were given (6) and many GPs would have done the same in such circumstances.

⁷ See Forensic Services chapter at paragraph 2.12 and CMHT chapter at paragraphs 2.4 to 2.9.

5. FIRST REGISTRATION WITH DR I - GP: JANUARY 1993

- 5.1 Unknown to the practice of Dr M - GP, on 12th January 1993 Mr Stone had registered with Dr I - GP, in Gillingham, under his original name of Michael John G.. (spelt G..d in the records). It seems unlikely that Dr I - GP had access on that occasion to the original "G.." GP notes, which to that date had been in the custody of Dr ZS -GP. Dr I - GP's note of the appointment records weight, height, blood pressure, pulse, heart and respiration rates, and various other examinations. He also records a history of physical illness in the 1980's, that Mr Stone was a smoking 40 a day, took no alcohol, and that he had been on *diazepam* and *temazepam* since June 1991. Mr Stone had told him that this had been when his wife died in a road traffic accident in Maidstone.

Dr I - GP prescribed *diazepam* 10mg 1 tds (three times a day) and *temazepam* 20 mg, 1 at night, 1 week's supply. This appears to be the only occasion on which Mr Stone saw Dr I - GP using the name G..⁸. The registration in the name of G.. was transferred to Dr ZR - GP on 20th October 1994.⁹

COMMENT:

It would have been helpful for Mr Stone's regular general practitioner, Dr M - GP, to have known that his patient was recorded as giving a different history with regard to his reasons for needing drugs to other doctors.

It is well known that drug-dependent patients will seek to obtain drugs by giving false histories to a series of doctors. In this case this information was not passed on because of the apparent inability of the registration system to connect the two identities being adopted by this patient. Dr I - GP cannot be criticised for accepting the story he was given by the patient on this occasion and providing treatment appropriate to that history.

6. CONTINUED CARE AT THE PRACTICE OF DR M - GP

- 6.1 On 28th January 1993 Mr Stone saw Dr J - GP and requested a supply of *temazepam*. Mr Stone is recorded as saying that he was waiting for an appointment at the Manor Road Addictions Centre, Chatham. He was given a prescription for 10 tablets. We could find no record in any other set of records that Mr Stone had by this date been referred to Manor Road or had himself sought an appointment there.

COMMENT:

Dr J - GP knew that the patient had a history of drug abuse, although he knew nothing of the appointment with Dr I - GP. Unfortunately Dr J - GP did not record any reasons for the prescription, but in view of his belief that the patient was about to go to Manor Road he might have been better advised to refer the question of prescribing to them. However, what he did is understandable.

⁸ Mr Stone next saw Dr I - GP in July 1994 at which time he used the name "Stone". See paragraph 11 below.

⁹ See paragraph 13 below.

7. REFERRAL TO MANOR ROAD ADDICTIONS CENTRE: FEBRUARY 1993

- 7.1 On 3rd February 1993 Mr Stone saw Dr M - GP again and was given a further prescription for 10 *temazepam* tablets as Mr Stone claimed he could not obtain them from the Manor Road Addictions Centre. Dr M - GP told the Panel that he thought he had been told that Mr Stone had gone to Manor Road of his own accord and they had not given him an appointment. Later the same day, Mr Stone saw Dr M - GP again and is recorded as having reported that he had now gone back onto heroin for the past four weeks and wanted to come off it. He was buying DF118 on the street and is recorded as saying that if he was not given it he would steal or rob.
- 7.2 Dr M - GP's reaction was to seek an urgent referral to the Manor Road Addictions Centre. He spoke to Dr W - Psych, a staff grade psychiatrist there, in an attempt to obtain an immediate consultation, but was unsuccessful. Dr M - GP was not prepared to be put off or delayed, and therefore approached the consultant psychiatrist, Dr V - CPsych, directly.
- 7.3 Dr M - GP told the Panel he did this because he knew there was a danger and Mr Stone had asked him to put him in Broadmoor. Dr M - GP thought Mr Stone should be dealt with straight away as, given his previous history, there might otherwise have been a lot of problems.
- 7.4 As a result of this request Dr V - CPsych undertook a domiciliary visit to Mr Stone the same evening and reported his findings to Dr M - GP in a letter dated 4th February 1993.¹⁰ This added to the previously recorded accounts of Mr Stone's current problems by noting that:

"He feels there is a lot of anger inside him and sometimes he makes a list of people in his mind who have done him wrong and he feels he should kill them."

- 7.5 Dr V - CPsych's diagnosis was of paranoid psychosis, triggered at times by drugs. He thought, however, that Mr Stone took drugs to control some of his aggressive behaviour. There was possibly a diminution in the effectiveness of the *stelazine* because it made him sick. Dr V - CPsych reported that he had arranged with Dr AA - CPsych, consultant in charge of the Chatham Community Mental Health Team (CMHT), to put Mr Stone on *moderate* depot injections,¹¹ and himself had agreed to prescribe *methadone*. He also stated that liaison between the Addiction Team, the Mental Health Team and the general practitioner would be needed. Dr V - CPsych concluded his letter:

"Liaison between us, them and you, is the best strategy forward to help this unfortunate man and contain his aggression."

COMMENT:

Dr M - GP acted in an appropriate way to overcome an initially negative reaction at Manor Road Addictions Centre to his urgent request for assessment. His action resulted in a domiciliary visit by an appropriate

¹⁰ See Addiction Services chapter at paragraph 3.3.

¹¹ "Depot" medication refers to the process of administering a psychoactive substance in an oil based medium by deep intramuscular injection so that it releases slowly into the patient's blood stream over the following days, thus having a long acting effect.

consultant for a patient who, at least in theory, could have presented a danger to himself and others if not offered speedy assistance. His actions here show the value of an interactive professional approach between various services in a case of a patient with complex needs for the services of multiple agencies, as opposed to the passive acceptance of the judgment of others without critical analysis.

8. SUPERVISION OF DEPOT MEDICATION

8.1 The treatment regime prescribed by Dr V - CPsych included the administration of depot injections at Dr AA - CPsych's clinic. Despite the observation in Dr V - CPsych's letter of 4th February 1993 referred to above, that liaison would be needed between the various agencies treating Mr Stone, it does not appear that any specific role was assigned to the general practitioner. Again, Dr M - GP regarded his role as monitoring progress and responding to requests for help.

8.2 On 21st June 1993 Dr V - CPsych wrote to Dr M - GP reporting that Mr Stone had decided to stop taking the depot and tablets such as *stelazine*, because of unpleasant side effects and because the injection site could be painful. Dr M - GP was asked to encourage him to go back to Dr AA - CPsych to discuss the issue:

“... because of the risk of relapse and the risk of dangerousness in someone like him.”

Dr V - CPsych told the Panel that he took a serious view of this development, but no attempt appears to have been made by the practice to communicate with Mr Stone as a result of this letter. Dr M - GP's explanation was that as a copy of the letter had been sent to Dr AA - CPsych any required action would be taken by his team.

8.3 On 21st July 1993 Dr X - Psych wrote to Dr M - GP from the depot clinic to report that Mr Stone had not attended a further appointment; they had heard that he did not want to continue the injections and thus he would not be sent further appointments for the depot clinic.

8.4 Following receipt of these two letters, Mr Stone was not seen again at Dr M - GP's practice until late August.

8.5 On 31st August 1993 Dr L - GP, Dr M - GP's partner, saw Mr Stone for the first time. Mr Stone was recorded as having asked for sleeping tablets and was offered a referral to Manor Road. In fact by this time Mr Stone had been seen at Manor Road on 27th July and 3rd August and had also been given a depot at Medway Hospital on 27th July and 29th August although none of this had been reported to the GPs.

COMMENT:

No criticism can be made of the general practitioners for not seeking to encourage Mr Stone to return to the depot clinic as requested in the letter of 21st June; Mr Stone did not attend the GP practice, so no opportunity arose. While some doctors might have written to the patient, it was not unreasonable for Dr M - GP to leave this to the psychiatrists at the depot clinic. Any such action was rendered unnecessary by the decision by Dr AA - CPsych to discharge the patient from the clinic. In any event, the practice was hampered by the absence of up to date information from either the Depot Clinic or the Manor Road Centre.

9. A GAP IN ATTENDANCE: AUGUST 1993 TO MAY 1994

- 9.1 From 31st August 1993 to 3rd May 1994 nothing was heard of Mr Stone at Dr M - GP's practice. The reason was that he had moved to Skegness where he was seen as a temporary patient on 13th and 28th September 1993 by two general practitioners from whom he attempted, unsuccessfully, to obtain a prescription for *methadone*. Mr Stone was later detained in custody in connection with criminal offences which led to his eventually being sentenced to two years' probation on 29th April 1994¹².

COMMENT:

Dr M - GP's practice obviously had no idea where Mr Stone had gone. Staff at the Manor Road Centre were aware of Mr Stone's move to Skegness and his remand in prison from October 1993. The depot clinic staff learnt of this in December 1993, but neither of these psychiatric services communicated their knowledge to the GP. Had Mr Stone been made subject to the Care Programme Approach it might be expected that this information would have been passed between agencies. However implementation of the CPA is not the responsibility of General Practitioners.

10. GP ATTENDANCES: MAY TO AUGUST 1994

- 10.1 Mr Stone re-presented at the GP practice on 3rd May 1994 when he was seen by Dr L - GP. He was given a prescription for *procyclidine* 5mg tds and *melleril* 50mg tds (90 tablets of each). He told the doctor he was just out of prison and was receiving *moderate* injections. When he returned on 10th May 1994 with a physical complaint, he was noted to be drunk. Mr Stone came back to the surgery again the following day to explain that he had been receiving *moderate* in prison and had been to Medway Hospital where he had been told that he needed a GP referral letter for further treatment. This was provided the following day.
- 10.2 Mr Stone also re-attended the Manor Road Addictions Centre. Dr V - CPsych wrote to Dr M - GP on 17th May 1994 to report that Mr Stone was now being given *moderate* 25mg fortnightly at Throwley House, and *methadone* 70mg daily at Manor Road. Mr Stone seemed to have settled down, but was complaining of physical problems which Dr V - CPsych associated with the neuroleptic drugs and probably other illicit drugs as well. Dr BB - Psych had agreed to review him at Throwley House with a view to

¹² See Probation chapter at paragraph 3.1 and Addiction Services chapter at 6.1.

reducing the dosage of *moderate* or changing to *Depixol*. Mr Stone had been advised to take *melleril* only when necessary.

- 10.3 On 23rd May 1994 Dr BB - Psych reported that she had reviewed Mr Stone. She had stopped the *moderate* and put him on an equivalent dose of *Depixol* (40mg)¹³. Dr BB - Psych said she would keep the GP informed. On 2nd June 1994 Dr M - GP saw Mr Stone and prescribed *thioridazine* and *procyclidine*.
- 10.4 Nothing more was heard at Dr M - GP's surgery from Mr Stone or from the Manor Road Centre until August 1994.

COMMENT:

The general practitioners were not informed of the case conference concerning Mr Stone which had taken place on 22nd June 1994.¹⁴ It would obviously have been helpful if they had been informed of the decisions taken then, and of Mr Stone's subsequent failure to attend either Throwley House or Manor Road Addictions Centre for the two succeeding months.

11. SECOND CONTACT WITH DR I - GP: JULY 1994

- 11.1 On 21st July 1994 Mr Stone saw Dr I - GP for a second time as a temporary patient. On this occasion he was using the name "Michael Stone". He was prescribed *kemadrin* and *melleril* 50mg, one week's supply. The name of Dr M - GP appears on the record of treatment form as the "home" doctor, but the name of Dr I - GP is written over it.

COMMENT:

Dr I - GP did not recognise the patient he had previously registered as a patient of his practice under a different name, but as the previous attendance had been some time previously (12th January 1993) it is understandable that he had forgotten him.

12. GP ATTENDANCES: AUGUST TO NOVEMBER 1994

- 12.1 On 8th August 1994, Mr Stone attended Dr M - GP's practice with a minor complaint and was given a course of antibiotics.
- 12.2 On 22nd August 1994 Dr BB - Psych wrote to Dr M - GP to report that Mr Stone had failed to attend at Throwley House and had missed his last three depot injections. It was also reported that Mr Stone was abusing *diazepam* and *mogadon* which he was buying on the street. Dr Z - CPsych¹⁵ and Dr BB - Psych had met the patient at Manor Road on 18th August 1994. A plan had been agreed that Mr Stone should not use any drugs except *methadone* as prescribed by Manor Road, and that it was very important that he should not be prescribed any psychotropic medication without liaison with the psychiatrists. He was to continue to attend Throwley House once a month for mental state assessment. If at any time he showed psychotic symptoms he was to be put back on depot *Depixol* injections.

¹³ See Chatham CMHT chapter at paragraph 4.

¹⁴ See Addiction Services chapter at paragraph 7.5 and Chatham CMHT chapter at paragraph 4.4.

¹⁵ The newly appointed Addiction Service consultant psychiatrist (replacing Dr V - CPsych).

12.3 On 3rd October 1994 Mr ZW - NSUP, clinical nurse supervisor at Throwley House, reported to Dr M - GP that Mr Stone had not attended the offered appointment or responded to letters. The letter went on:

“I can therefore only assume that all is well at the present time and that he no longer wishes to be seen at Throwley House.

If at any time in the future he does wish to re-refer, please do not hesitate to contact the above centre.”

Dr BB - Psych has since told the Panel that this discharge letter was sent by Throwley House in error.¹⁶

12.4 Mr Stone was seen by Dr L - GP at the surgery on 5th October 1994 requesting *temazepam* because he said he could not sleep. It was recorded that he was drunk. He is recorded as claiming that he had been to Throwley House and had been sent to the surgery to be given *temazepam*. A prescription of 10 tablets was given.

12.5 Dr L - GP replied to the Throwley House letter on 12th October pointing out that in their letter an address was given which was not the one recorded at the GP surgery and suggesting that this might account for the patient not responding to their correspondence.

12.6 On 19th October Mr Stone saw Dr L - GP, again requesting sleeping tablets. The GP refused to do so on this occasion on the basis that Mr Stone had not been attending Throwley House. Dr L - GP offered to make him another appointment there. Mr Stone became offensive and verbally abusive, and walked out of the surgery shouting at other patients and staff.

12.7 The following day Dr L - GP discussed the case with his partners Dr M - GP and Dr J - GP and then telephoned Dr BB - Psych. She told them that Mr Stone had not attended Throwley House for his injections during the last few months, but about two weeks previously he had been there and demanded *temazepam*. She advised the general practitioners to contact the Manor Road Centre. Dr L - GP did so, speaking to Mr Y - RMN (Mr Stone's drug counsellor) in the consultant's absence. Mr Y - RMN promised to try to see Mr Stone the following day to assess his mental state. Dr L - GP telephoned Manor Road again the next day (21st October 1994) and spoke to Dr W - Psych who told him they were taking steps to have Mr Stone assessed.

12.8 On 3rd November 1994 Dr L - GP attended a case conference at Manor Road where he saw Mr Stone together with Dr BB - Psych, Dr Z - CPsych, and Mr Y - RMN. During the meeting Mr Stone was hostile and angry. He refused further treatment at Throwley House and was insistent that he would take no more depot injections because of the side effects¹⁷.

12.9 Dr L - GP recalls that it was agreed at this meeting that it was unnecessary and unwise to “section” (compulsorily detain) Mr Stone without having arranged a bed in a

¹⁶ See CMHT chapter at paragraph 4.12 to 4.14.

¹⁷ See CMHT chapter at paragraph 5 and Addiction Services chapter at paragraph 10 for a fuller account of this meeting.

suitable secure unit. He telephoned Dr BB - Psych the following day and was told that Dr AA - CPsych and an approved social worker (ASW) would be attempting to “section” the patient so that he could be admitted to the Trevor Gibbens Unit. The practice subsequently received copies of Dr AA - CPsych’s five memoranda¹⁸ and in this way was kept in touch with events.

COMMENT:

Drs M - GP, L - GP and J - GP did not accept Throwley House’s proposed discharge of a patient in clear need of continuing care. They followed up the need for a mental state assessment when this became apparent. In doing so they acted entirely appropriately.

13. CONCURRENT INVOLVEMENT OF OTHER GENERAL PRACTITIONERS

- 13.1 Unknown to Dr M - GP and his partners, Mr Stone had again been visiting other GPs using the name Michael G..(d).
- 13.2 On 6th October he attended the surgery of Dr K - GP in Chatham and registered as a new patient. The local address given by Mr Stone was different from that given to the practice of Dr M - GP. The history he gave, as recorded by Dr K - GP, was also rather different from that which he had given to the other doctors. Mr Stone told Dr K - GP that he was a weight-lifter and had served eight years for armed robbery. He said that whilst he had been in prison several members of his family had died, which had led to him suffering from depression; as a result he was on tranquillisers and sleeping tablets. He stated that he had since had a trapped nerve for which he had taken a double dose of *nitrazepam*. He said he had suffered an injury one week previously while bench pressing and trampolining. He stated he had come out of prison on 3rd October 1994.
- 13.3 Dr K - GP recorded that he examined the patient and found pain at the root of the neck on turning the head to the left and tilting it in the same direction. There was no pain on resisted shoulder movement and there was good power at the shoulder. He was unable to elevate the arm. True abduction was limited to about 10 degrees. Dr K - GP diagnosed cervical root lesion and prescribed *diclofen*, *solpadol* and *nitrazepam* (5 mg x 4 at night). The Panel infer from the evidence that the prescription was for either two weeks or 28 days’ supply. Dr K - GP ended his note by recording that the patient might need physiotherapy and that when the arm pain was resolving Mr Stone would need a drug reduction programme.
- 13.4 Dr K - GP informed the Panel that if he had known that the patient was under the care of the Manor Road Addictions Centre he would have contacted them to coordinate management of the patient, although not necessarily the same day, as it was not uncommon for information from the clinic to take a few days to be supplied.
- 13.5 Dr K - GP was asked to comment on his prescription of *benzodiazepines* and stated:

“Looking at my written records, it would appear that I accepted the patient’s story on 6th October 1994 that he had been treated with sleeping tablets (*nitrazepam*) previously and decided to continue these. In retrospect

¹⁸ See CMHT chapter at paragraph 6.

I would say that I was over-generous with the amount of nitrazepam I prescribed and concurrently (*sic*) I am likely to prescribe a smaller amount, or not to prescribe them at all."

- 13.6 Dr K - GP informed the Panel that from time to time his practice received notification from the Health Authority that patients were using aliases and such information was kept in reception. However, the receptionist would refer to this only if suspicious. In this case, there was no such information available.
- 13.7 On 20th October 1994 Mr Stone saw Dr K - GP again. By this time he had been formally registered as a patient with Dr K - GP's partner, Dr ZR - GP. He is recorded as complaining of a strained muscle at the gym, which was improving. He was advised to avoid chest exercise and was supplied with a further prescription of *benzodiazepines*, with a supply designed to last 28 days.
- 13.8 On 3rd November Mr Stone was back at this surgery and being seen by Dr K - GP once more. It was recorded that he "needs renewal of *nitrazepam*" and he claimed to have used 14 days of the previous 28-day supply before someone stole the remaining tablets. Dr K - GP entered a comment in the record: "?Convincing". Despite his suspicions Dr K - GP issued a further prescription for 56 days *nitrazepam*.
- 13.9 Dr K - GP could not recall this consultation, but having looked at his records, had no reason to believe that Mr Stone was suffering from any psychotic symptoms or that he was threatened by the patient at the time. On this same day, Mr Stone was seen at Manor Road Clinic where he was demanding *benzodiazepines* and three doctors felt his mental state was so disturbed that he was in need of immediate compulsory detention¹⁹. It is not now possible to ascertain the order of these attendances that day.
- 13.10 Following 3rd November 1994 Mr Stone was not seen again at Dr K - GP's surgery. His registration on the list of Dr ZR - GP was cancelled on 10th May 1995 on the grounds that his whereabouts were unknown.

COMMENT:

The Panel agrees with Dr K - GP's view that his prescription of benzodiazepines on 6th October 1994 was generous in relation to a patient to whose records he had not by then had access. The dilemma which faces any general practitioner must be recognised in that it is natural s/he will wish to believe the patient's history and Dr K - GP did elicit apparent physical symptoms on carrying out his examination. Nonetheless it would perhaps have been prudent to prescribe, if at all, a more limited supply, pending receipt of the patient's records. In this case, of course, the system did not supply Dr K - GP with Mr Stone's full records and gave him no opportunity of knowing of the involvement of Dr M - GP's practice or the Manor Road Centre.

By 20th October 1994 Dr K - GP's practice may have received the records in the name of Mr G. Nothing in them would have necessarily contraindicated

¹⁹ As described in the Addictions Services chapter at paragraph 10.3 and CMHT chapter at paragraph 5 et seq.

this form of treatment, and the obvious gap in the records could have been explained by the prison sentence from which the patient claimed just to have been released. However, once again the supply was generous, and, if the previous prescription had also been for 28 days, suspicions should have been aroused as to the use to which the tablets were being put, particularly as Dr K - GP had already flagged up the need for a drug-reduction programme.

By 3rd November Dr K - GP was faced with a patient who was suspected of having no convincing reason for receiving benzodiazepines without any other therapeutic intervention being considered. While the Panel appreciate the difficult position in which this general practitioner was placed by not being given the full information on this patient, the Panel consider that by this time he should have been seeking the assistance of the specialist services or at least attempting to address the real reasons why the patient was seeking this form of medication.

The Panel accept that there was nothing in Mr Stone's behaviour on 3rd November 1994 to suggest to Dr K - GP that he required urgent psychiatric attention. The picture of this patient's presentation in this surgery is in marked contrast to the description given of Mr Stone on the same day at Manor Road Clinic as recorded in Dr AA - CPsych's memorandum of 8th November.²⁰ Such rapid changes can be a feature of this type of case, and demonstrate the difficulty in any one practitioner or team gaining a full picture of the patient's condition.

It would obviously have been of benefit to Mr Stone and to those other professionals seeking to provide him with treatment and care if they had been able to have information concerning the medication he was receiving from this practice. The fact this was not disseminated is in no way the responsibility of Dr K - GP or his partners, but the Panel are bound to express concern that, yet again in the history of this patient, he was able to obtain simultaneous treatment from a range of different professionals without them knowing of each other's involvement.

14. GP ATTENDANCES: JANUARY 1995

- 14.1 Between 24th November 1994 and 16th January 1995 Mr Stone was detained in Bexley and De La Pole hospitals under the Mental Health Act 1983.²¹
- 14.2 Following his discharge, Mr Stone came under the consultant care of Dr T - CPsych(F), forensic psychiatrist at the Trevor Gibbens Unit, Maidstone. On 23rd January 1995 Dr T - CPsych(F) saw Mr Stone whose prescribed medication at that time was *Haldol* 100mg (depot injection fortnightly), *Perphenazine* 4mg (tds), and *nitrazepam* 10mg (at night). He was also receiving *methadone* 60mg (daily) from Manor Road.
- 14.3 Mr Stone told Dr T - CPsych(F) he was due a *Haldol* injection the next Monday. It transpired that Dr M - GP's GP surgery in Chatham was more convenient for Mr Stone

²⁰ See Chatham CMHT chapter at paragraph 6.

²¹ See De La Pole Hospital and Bexley Hospital chapters below.

to visit than the TGU: Dr T - CPsych(F) telephoned the surgery and arranged for the depot injection to be given there. In his subsequent letter to Dr M - GP (which was copied to Dr AA - CPsych, Social Services, Probation, and the Manor Road Clinic) Dr T - CPsych(F) recorded his assessment of Mr Stone and confirmed the above information.

- 14.4 On 27th January 1995 Dr M - GP informed Dr T - CPsych(F) by fax that he had written to Mr Stone on 24th January asking him to attend to pick up his *Haldol* prescription and make an appointment for its administration on 30th January, but had to date received no response. A file note also shows that Dr M - GP asked his staff to also alert the probation officer of this non-response.
- 14.5 In fact, on 30th January 1995 Mr Stone did attend Dr M - GP who administered the depot injection as instructed. A further injection was given on 13th February 1995. On 27th February 1995 Mr Stone did not attend for the next depot injection, and Dr M - GP again contacted Dr T - CPsych(F) by telephone to alert him to this matter.
- 14.6 Mr Stone had moved house by this time. On 28th February 1995 he attended Dr I - GP's surgery and subsequently he permanently registered with him. Dr M - GP and his partners had no further involvement in Mr Stone's treatment and care.

COMMENT:

The Panel note that Dr M - GP conscientiously recorded and complied with Dr T - CPsych(F)'s instructions in respect of the depot medication and appropriately alerted both the consultant psychiatrist and the probation office when Mr Stone failed to attend for an injection on its due day.

15. REGISTRATION WITH DR I - GP: FEBRUARY 1995

Dr I - GP's professional background and practice

- 15.1 Dr I - GP has been in general practice since 1991. He obtained his primary medical qualification in 1969 and started practising in this country in 1974. His initial training was in various posts in general surgery, orthopaedics, general medicine, anaesthesia, obstetrics and gynaecology. He then undertook 12 months' training in general practice. He received no specific training in psychiatry, but in this is no different from many general practitioners, particularly at that time.
- 15.2 Dr I - GP has a single-handed practice in Gillingham. He employs three receptionists, a practice nurse who works three days a week, and has access to the services of district nurses and midwives. He has over 1,900 patients on his list. Patients are encouraged to make appointments, but will be seen if possible if they drop in. Dr I - GP undertakes his own visits to patients' homes during working hours and up to 7.00 pm, and thereafter delegates visiting to a locum service. Dr I - GP thought his list might include about 30 patients suffering from some of mental illness or disorder, of whom about 10 could be described as having a serious illness. He might have 12 to 15 patients suffering from substance misuse problems.

Introduction to Mr Stone

- 15.3 On 28th February 1995 Mr Stone registered, in that name, as a temporary patient with Dr I - GP, shortly after his discharge from De La Pole Hospital. At first Dr I - GP was unwilling to accept him onto his list, but, after intercession by Ms CC - PO, Mr Stone's probation officer, Dr I - GP agreed to accept Mr Stone as a permanent patient.
- 15.4 Mr Stone was given a letter by Ms CC - PO which described the medication he required. On 28th February 1995 a practice nurse took and recorded a short history from Mr Stone and an injection of *Haldol* 100mg was administered. Dr I - GP thinks he may have telephoned Dr T - CPsych(F) to obtain details of the case.
- 15.5 It is unclear whether Dr I - GP actually saw Mr Stone on 28th February 1995. The first *Haldol* injection administered on that day may have been given by the practice nurse. It is possible that Dr I - GP did not see him: there is no record that he did so. Dr I - GP did see Mr Stone on 10th March 1995 when he personally administered a *Haldol* injection 100mg.

COMMENT:

By March 1995 Dr I - GP had seen Mr Stone on two previous occasions: in January 1993 (using the name Michael G) and July 1994 (using the name Michael Stone). Understandably Dr I - GP did not recognise him as being someone who had previously registered with him in a different name. The Panel do not attribute any responsibility for this to Dr I - GP given the absence of any acknowledged system for the cross-checking of applications for registration from new patients.²²

16. DR I - GP'S UNDERSTANDING OF MR STONE'S DIAGNOSIS

- 16.1 Dr I - GP informed the Panel that he understood that Mr Stone was being prescribed *Haldol* because he was suffering from paranoid schizophrenia. On frequent occasions Dr I - GP issued sick certificates for Mr Stone giving the diagnosis as "schizophrenia". It is likely that he acquired this understanding from the medical correspondence in the GP records. This would have included the letter of Dr ZA - CPsych of 19th January 1995 and the short discharge summary from De La Pole Hospital dated 16th January 1995. The latter gave the psychiatric diagnosis as "paranoid schizophrenia/personality disorder", and the former referred to a "history of chronic schizophrenic illness".
- 16.2 The general practitioner's file does not contain a copy of Dr T - CPsych(F)'s letter of 5th January 1995 describing his examination of Mr Stone at De La Pole in December. This gave a diagnosis of antisocial personality disorder with a possible paranoid mental illness which was said to be "largely remitted".

COMMENT:

While Dr I - GP's understanding of the diagnosis was not in accordance with the actual basis on which Dr T - CPsych(F) was working, it was in accordance with the correspondence from De La Pole Hospital. It is regrettable that Dr T - CPsych(F)'s letter of 5th January was not sent to the general practitioner.

²²

See paragraph 3 above.

17. INITIAL ARRANGEMENTS FOR DEPOT INJECTION

- 17.1 While the first injection may have been given on an *ad hoc* basis, Dr T - CPsych(F) soon sent Dr I - GP a copy of his earlier letter to Ms CC - PO (dated 20th February, copy received by Dr I - GP 7th March 1995) in which he stated that *Haldol* depot 100mg should be given fortnightly. On 20th March 1995 Dr T - CPsych(F) wrote formally to Dr I - GP asking him to administer *Haldol* 100mg once every two weeks, and to prescribe *Perphenazine* 4mg three times a day, *nitrazepam* 10mg at night, and *procyclidine* 5mg twice daily
- 17.2 Dr I - GP said that Mr Stone is the only patient for whom he has ever had to supply depot neuroleptic medication. He told the Panel that he understood that the medication was necessary to control Mr Stone's behaviour and that it was important that it was administered regularly. He believed that the patient might become violent and have paranoid thoughts if he missed his injection. He said he would have attempted to trace Mr Stone via Social Services if he failed to attend for an injection.
- 17.3 Dr I - GP explained to the inquiry Panel the system he set up. He would write a prescription for 5 ampoules of 100mg *Haldol* at a time, and present it personally to the pharmacist next door to the surgery. He would record the prescription on the record cards. The pharmacist would then deliver the ampoules personally to the surgery. Mr Stone would present himself for the injection which would usually be administered by Dr I - GP personally, although this may have been done by a practice nurse on about three occasions. Dr I - GP was adamant that every injection administered was recorded in the record cards on the day of the injection, and that there was no question of a record being made of an injection which had not in fact been given. He would renew the stock of ampoules when necessary in the manner described.

18. MANAGEMENT OF BENZODIAZEPINE PRESCRIPTION REGIME: 1995 THROUGH TO AUGUST 1996

- 18.1 On 25th April 1995 Dr T - CPsych(F) wrote again to Dr I - GP informing him that, on extracting an undertaking from Mr Stone not to obtain illicit supplies of *benzodiazepines*, he had "reluctantly" agreed to prescribe *diazepam* 5 mg three times daily and 10mg at night. He asked Dr I - GP to add this to the list of current medications. Dr T - CPsych(F) also invited Dr I - GP to the case conference to be held on 22nd May 1995.
- 18.2 This letter was received by Dr I - GP on 29th April 1995. On 1st May 1995 he received a letter from Mr Y - RMN at the Manor Road Centre, dated 26th April 1995, which stated that Mr Stone had attributed his drowsiness to his use of *benzodiazepines*. On 1st May 1995 Mr Y - RMN wrote again recording that Mr Stone was very pleased to have been prescribed *diazepam* by Dr T - CPsych(F) and had agreed to a programme of reduction of his *methadone*.
- 18.3 Dr I - GP did not attend the case conference on 22nd May 1995, but he did receive a note of its outcome from Dr T - CPsych(F) on 1st June 1995. Dr I - GP told the Panel that he did not attend such meetings as, in common with many general practitioners, he did not have the time to do so.

- 18.4 On 20th July 1995 Dr I - GP received a letter dated 12th July 1995 from Mr Y - RMN expressing concern about the extreme lethargy exhibited by Mr Stone, and wondering whether this was due to excessive use of *benzodiazepines*. The following day he received a letter from Dr T - CPsych(F) which reported Mr Stone's complaints of stiffness, but no other extra-pyramidal symptoms. Dr T - CPsych(F) told Dr I - GP that Mr Stone might come to see him if the stiffness continued, as Mr Stone was concerned he might have some rheumatic condition. The letter also reported that Mr Stone appeared intoxicated and requested Dr I - GP to change the benzodiazepine prescription to ensure that it was dispensed daily.
- 18.5 Dr I - GP recorded giving a *Haldol* injection to Mr Stone on 1st August 1995, but there is no record of his having examined his patient or of any findings made on that occasion. On 9th August he gave a further prescription of *benzodiazepines*. Again there is no record of the patient's condition.

COMMENT:

There are very few entries in Dr I - GP's notes recording anything other than the prescription or administration of medication and none that the Panel could find specifically relating to the effect of the medication.

A general practitioner retains responsibility to check his patients' physical condition and should undertake regular assessments of a drug dependant patient's physical condition, unless he knows this is being undertaken by a specialist addictions clinic and is aware of their findings.

- 18.6 On 19th September Dr T - CPsych(F) wrote to Dr I - GP stating that he had seen Mr Stone that day. He noted that his *benzodiazepine* prescription was now *nitrazepam* (10mg at night) and *diazepam* (25mg - ie 5mg x five per day) He noted that Mr Stone was no longer taking *perphenazine* or *procyclidine*.
- 18.7 On 26th October 1995 Dr I - GP received a letter (dated 24th October 1995) from the Manor Road clinic informing him that Mr Stone had "confessed to using illicit heroin, *benzodiazepines* and *methadone*." Manor Road were "not able to comply with his request for prescribed *benzodiazepines*." This letter gave no instructions or advice to Dr I - GP about what he should do with regard to the *benzodiazepine* regime he was currently prescribing at the request of Dr T - CPsych(F). The letter is initialled by Dr I - GP indicating that he read it on 26th October 1995. That same day Dr I - GP recorded a 15-day prescription for *nitrazepam* (10mg at night) and *diazepam* (25mg). He told the Panel he may have issued this prescription before he saw the Manor Road letter.
- 18.8 On 3rd November 1995 Dr I - GP received a letter dated 30th October from Dr T - CPsych(F) which gave information apparently in conflict with that from Manor Road, namely that Mr Stone had been taking heroin, but denied using any other illicit substance, apart from cannabis and tobacco. Dr T - CPsych(F) gave no advice on any changes to the existing *benzodiazepine* regime and certainly no explicit written advice to stop the prescription.
- 18.9 Dr I - GP suggested to the Panel that he stopped the *benzodiazepine* prescription on 9th November 1995 and that this was in response the Manor Road letter. However, his

records show only a week's gap in *benzodiazepine* prescribing before entries on 16th November and 1st December 1995 for repeat fortnightly prescriptions of *nitrazepam* (10mg a day) and *diazepam* (25mg a day)

18.10 On 18th December a record by Dr I - GP indicates that he saw Mr Stone and discussed a reduction in the supply of *diazepam* and *nitrazepam*. Thereafter, a reduced *diazepam* prescription (by 5mg per day - now at 20mg a day) was given along with a prescription for *nitrazepam* (10mg a day) for the next 15 days.

18.11 On 27th December Dr I - GP received a letter from Dr T - CPsych(F), dated 18th December 1995, reporting that Mr Stone had explained recent difficulties at his general practitioner's surgery as being due to another patient "pestering him to sell on his *benzodiazepines*". He went on:

"Michael asked me to ask Dr I - GP on his behalf to continue the *benzodiazepines* prescription as before and not to reduce it at the present time. On the assumption that the patient is not obtaining other *benzodiazepines* from elsewhere, this would appear to be reasonable. However, when Mr Stone manages to be abstinent from opiates in the near future, it would then be appropriate to discuss *benzodiazepine* dosage reduction."

Dr I - GP could not recall any particular difficulty experienced at this surgery at this time which led to a reduction in the prescription.

18.12 On 27th December 1995 Mr Stone appears to have been seen at the GP surgery by a doctor other than Dr I - GP. He was complaining of a chest infection but also requested *benzodiazepines*. The prescription given was back at the original level suggested by Dr T - CPsych(F): *nitrazepam* (10mg a day) and *diazepam* (25mg a day). However, at the attendance on 12th January 1996 Dr I - GP provided a further "reduced" *diazepam* prescription of 20mg per day.

18.13 On 15th January 1996 Dr I - GP received a copy of a letter to Dr T - CPsych(F) from Manor Road reporting that Mr Stone had appeared in a very intoxicated state and confessed to having taken...

"a cocktail which included alcohol, illicit heroin, prescribed *methadone* and prescribed *benzodiazepines*".

The letter suggested Mr Stone should stabilise on the present prescribed medication.

18.14 On 31st January 1996 further *benzodiazepines* were prescribed by Dr I - GP, the *diazepam* prescription was now returned to the suggested 25mg per day. However, on 15th February 1996 Dr I - GP once more prescribed a lesser amount of *diazepam*, the prescription now being 15mg per day (i.e. 10mg less).

18.15 On 19th February Dr I - GP received a letter from Dr T - CPsych(F) (dated 14th February and copied to Manor Road) reporting that Mr Stone admitted to the continuing use of heroin, but denied using any other illicit drug. Mr Stone had consistently explained that the prescribed *benzodiazepines* allowed him to desist from obtaining illicit supplies. Dr T - CPsych(F) stated that his current understanding was that Mr Stone was being prescribed 25mg *diazepam* and 10mg *nitrazepam* daily. Dr I - GP did not notify Dr T - CPsych(F) that this understanding was not correct.

- 18.16 On 21st February 1996 Mr Stone returned early to see Dr I - GP and demanded an increase in his *diazepam*. Dr I - GP explained to him that on the contrary he should be slowly reducing the dosage. Mr Stone said he wanted to change his doctor and was given a form to enable him to do so, but he does not appear to have taken any further action in this respect.
- 18.17 Despite Dr T - CPsych(F)'s letter of 14th February 1996 Dr I - GP thereafter continued to prescribe a reduced level of *diazepam* (15mg daily) from 29th February 1996 onwards. Dr I - GP suggested to the Panel that this was because the specialist wanted him to reduce the dose but the Panel are unable to find any evidence to support this assertion.
- 18.18 On 22nd May 1996 Dr T - CPsych(F) wrote again to Dr I - GP (copied to Manor Road) suggesting that *diazepam* 25mg per day should be prescribed to Mr Stone, but Dr I - GP continued to prescribe only 15mg a day through to August 1996. There is no evidence that Dr I - GP informed Dr T - CPsych(F) or the Manor Road Centre of these altered dosages of *diazepam*.
- 18.19 When Dr I - GP's attention was drawn to the above fluctuations in *diazepam* prescription he explained that he was concerned that Mr Stone was selling his *benzodiazepines* and thought he might overdose one day or would sell them and make others become addicted. He said he later prescribed according to Dr T - CPsych(F)'s advice.
- 18.20 Dr T - CPsych(F) learnt for the first time of the changing *benzodiazepine* prescriptions from the inquiry Panel. He responded that, in his view, Dr I - GP acted reasonably in taking every opportunity to persuade Mr Stone to accept a lesser dose while allowing a slippage back to previous doses in crises.

COMMENT:

The Panel has examined in detail the changing prescription of benzodiazepines in order to examine the effect of the letters from Dr T - CPsych(F) and Manor Road in September and October 1995. These suggest a conflict of opinion between those services about the desirability of prescribing benzodiazepines. Dr I - GP, however, did not think so, and told the Panel that he knew they informed each other what they were doing. The Panel believe this is unlikely, as there is no indication in any records of any discussion to resolve the apparent difference of opinion between the two specialist centres.

While a general practitioner must to a large extent rely on the advice and treatment plans of specialists to whom his patient has quite properly been referred, he will still wish to exercise his own independent clinical judgement. Where there is an apparent conflict of approach between specialists, the general practitioner would be wise to draw this to the attention of the specialists and to ensure that he, as the prescribing doctor, is given clear and unequivocal guidance. This was not done in this case. Dr I - GP apparently on his own initiative altered the dispensing pattern for the benzodiazepines. Although Dr T - CPsych(F) would have agreed in

principle with reduction of dose had he known, there was no consistency in the altered prescriptions and there is no evidence to suggest increases were in response to crises as postulated by Dr T - CPsych(F). On two occasions in December 1995 and January 1996 Mr Stone appears to have been prescribed reduced levels of diazepam one fortnight only to return to the original prescription the following fortnight with no reason for doing so being recorded.

The further reduction to 15mgs diazepam in February 1996 was not indicated by either of the specialist centres. Despite receiving Dr T - CPsych(F)'s letter of 14th February which endorsed continuing with the original benzodiazepine regime (of 25mgs diazepam) Dr I - GP continued to prescribe less diazepam to Mr Stone and refused his request for more. The Panel are therefore unable to accept his explanation (at paragraph 18.19 above) that he was following Dr T - CPsych(F)'s advice.

Given the dangers of benzodiazepines and benzodiazepine withdrawal and abusers' well known propensity to "shop around" for additional supplies, the Panel consider that Dr I - GP ought to have consulted Manor Road and Dr T - CPsych(F) before making any changes in the regime and at the very least inform those specialists that he had changed the prescription.

19. DR T - CPsych(F)'S REGIME FOR HALDOL PRESCRIPTION

- 19.1 Dr T - CPsych(F)'s original request to Dr I - GP was to administer, among other things, an injection of depot *Haldol* 100mg every two weeks. He has told the Panel that his rationale for this regime was primarily the treatment of aggression in personality disorder, although acknowledging that the research evidence in favour of this is extremely limited. Dr T - CPsych(F) has also made clear to the Panel that he was pleased by the willingness of Dr I - GP to become involved in the care of Mr Stone, which he felt presented some contrast to the attitude of some other agencies.
- 19.2 The purpose of a depot regime of medication is to provide a known level of compliance, to deliver the therapeutic effect of the drug over a relatively long period of time, and to reduce the number of times an injection has to be administered. A feature which attracted Dr T - CPsych(F) to the use of *Haldol* was that research had demonstrated its stability in blood levels, which was in marked contrast to the more rapid rise and fall seen in other depot neuroleptics. A slow-acting drug of this nature takes some time to reach its peak level, but it also takes time for the level to reduce. Accordingly the time intervals between injections are not critical in the sense that the clinical effect is unlikely to be reduced markedly if there is a slightly longer period than planned between injections. The Panel received evidence confirming these features of *Haldol* from the manufacturers.

COMMENT:

The Panel agree that it was perfectly reasonable to prescribe depot neuroleptics to Mr Stone and that Haldol had the merits outlined above. It is also accepted that it is now, and would have been at the time, difficult to distinguish between the relative effects of the neuroleptics and other influences on Mr Stone's behaviour and presentation, such as prescribed

and illicit benzodiazepines, any other illicit drugs he was obtaining, alcohol and his underlying disorder. Not for the first time it is necessary to emphasise that neither then nor now has it been possible to obtain a full picture of Mr Stone's lifestyle, consumption of drugs, alcohol and exposure to other influences. Nonetheless, the Panel note that the purpose of the Haldol prescription was to assist in modifying Mr Stone's anti-social tendencies and behaviour. The best chance of achieving that aim and monitoring its effectiveness with the regime was to ensure that Haldol was administered as regularly as possible and that any difficulties in achieving this were shared with all involved.

20. COMPLIANCE WITH DR T - CPSYCH(F)'S HALDOL REGIME: JANUARY 1995 - MARCH 1996

- 20.1 The administration of *Haldol* by Dr I - GP from the time he took over the patient until March 1996, as recorded by him in the GP notes, is shown in the table in Appendix 4. It will be seen that on frequent occasions a period of more than two weeks elapsed between depot injections. The intervals exceeded 20 days on a number of occasions, although one of those may be explained by an omission to record the administration.

COMMENT:

The Panel appreciates that it might have been difficult on occasion to persuade Mr Stone to attend the GP surgery on a regular basis, even though no witness has reported to the Panel any such difficulty. If Dr I - GP did have problems securing patient compliance with the regime he did not report this to Dr T - CPsych(F). The position can be explained only by one of the following possibilities:

- (1) Dr I - GP may not have recorded the administration of depot Haldol injections accurately;*
- (2) Mr Stone may have failed to attend when he was asked to, in which case Dr I - GP did not report the non-attendance to Dr T - CPsych(F) or have any system for recording non-attendance.*

As appears in paragraph 23.3 below, while it is clear that Dr I - GP's record-keeping was poor, supporting evidence persuades us that depot Haldol injections were given as recorded. Therefore we consider that the second is the most likely explanation. Whichever of these explanations is the case, they indicate substandard practice on the part of Dr I - GP, given his knowledge that it was important that Mr Stone receive his medication on a regular basis and his belief that the patient might become violent and have paranoid thoughts if he missed his injection. This contrasts with Dr M - GP having immediately informed Dr T - CPsych(F) when Mr Stone missed an injection in January and February 1995 (see paragraphs 14.4 and 14.5 above).

Nevertheless, the Panel do not find that the delays in the receipt of depot Haldol identified during this period in fact had any significant adverse clinical effect upon Mr Stone, who had been receiving Haldol for some time.

21. INCREASE IN HALDOL PRESCRIPTION

21.1 On 29th March 1996 Dr I - GP recorded in the margin of the record card²³ the following note.

“His carer wants his *Haldol* to increase.”

The dose administered on that day was recorded as being 100mg *Haldol* but Dr I - GP then recorded a prescription ordering 5 ampoules of *Haldol* 100mg and 5 ampoules of *Haldol* 5mg. Although Dr I - GP told the Panel he gave an increased dose of 105mg that day, in fact the records suggest that an increased dosage was started on 12th April 1996. The Panel will return to the manner of delivering this increased dosage.

21.2 Dr I - GP had no helpful memory of the identity of the carer who was noted as wanting the increase in *Haldol*, or as to any of the surrounding circumstances. He suggested he had increased the dose because Dr T - CPsych(F) or another specialist wanted him to do this.

21.3 The TGU records show that Ms ZP - CPN (Community Psychiatric Nurse) had raised concerns about Mr Stone's behaviour with Dr T - CPsych(F) on 15th March 1996 and Dr T - CPsych(F) considered that Mr Stone's depot may need to be increased. Dr T - CPsych(F) suggested she ring Dr I - GP to discuss this. On 20th March 1996 Ms ZP - CPN recorded that she spoke to another (unidentified) GP at Dr I - GP's surgery as Dr I - GP was not available, she explained her concerns and passed on Dr T - CPsych(F)'s suggestion to increase the depot medication.²⁴

21.4 The TGU records do not specify the new dosage of *Haldol* suggested by Dr T - CPsych(F) or Ms ZP - CPN. However, in evidence to the Panel both stated that they had suggested 150mg as the appropriate new dose.

21.5 Dr I - GP's notes do not record that any specific dose was suggested to him. When asked by the Panel why he increased the dosage to 105mg, he stated that he thought a 5mg increase would be all right. He did not refer back to Dr T - CPsych(F) about the increase and having increased the *Haldol* dose to 105mg he did not report back to Dr T - CPsych(F) what he had done.

COMMENT:

It is unfortunate that Dr T - CPsych(F) did not explicitly set out in a letter the new medication regime which he was advising to Dr I - GP.

While the Panel have some sympathy with Dr I - GP for the difficult position in which he accordingly found himself, it was nonetheless unacceptable practice on his part to increase the dose of a drug with which he was unfamiliar without discussing this with the consultant. The potential dangers of this course of action are demonstrated by the matters the Panel consider in the following paragraphs.

²³ A copy of this record, 'GP 34' is appended. See Appendix 5.

²⁴ See Forensic Services chapter at paragraph 7.21.

- 21.6 Dr I - GP accepted that in psychiatric practice, it was usual to increase the a dose of *Haldol* by 25mg increments, but, he told the Panel, he was reluctant to increase the dose by that much as he wanted the dose to go up slowly.
- 21.7 Dr I - GP said he made up the dose of 105mg using a stock of 100mg and 5mg ampoules of *Haldol* obtained by means of prescriptions. This is confirmed by inspection of the records, by way of example, for 17th June 1996.²⁵ Dr I - GP told the Panel that although on the first occasion he used two syringes and had given two separate injections, subsequently he put both preparations into the same syringe and administered them by deep intra-muscular injection. His rationale for doing this was to give Mr Stone less suffering by giving one injection rather than two.
- 21.8 The increased dose came to light only when Ms ZP - CPN asked him whether Mr Stone was receiving his *Haldol* on 5th July 1996.²⁶ Until informed by Ms ZP - CPN in July that Dr I - GP had increased the *Haldol* from 100 to 105mg, Dr T - CPsych(F) had no knowledge of what Dr I - GP had done.
- 21.9 Dr T - CPsych(F)'s first reaction before the inquiry Panel when his attention was drawn to Ms ZP - CPN's memorandum of 5th July 1996²⁷ which documented an increase in *Haldol* to 105mg was to assume this was a misprint for 150mg. When informed that the entry was in fact correct Dr T - CPsych(F) remarked that he thought it was "very odd".

COMMENT:

Dr T - CPsych(F)'s reaction was shared by the medical member of the Panel and the Panel's specialist medical adviser. Such a small increase in a dosage of depot Haldol would have no demonstrable therapeutic effect. Initially the Panel could not understand why such a small change was made when there would have been no justification for it. Therefore the Panel made further inquiries of Dr I - GP as to the substances he administered.

22. HALDOL DECANOATE ADMINISTRATION

- 22.1 In describing the depot drug administered, this account has been referring so far to the terminology used by Dr I - GP in his records and his evidence. Neither the documentary records nor Dr I - GP's oral evidence indicated that Dr I - GP clearly distinguished between the different nature and purpose of the two injectable preparations of *Haldol*. The Panel therefore drew Dr I - GP's attention to the different preparations of *Haldol* as recorded in the British National Formulary (BNF)²⁸.
- 22.2 "*Haldol*" is the trade name for the drug *haloperidol*. *Haloperidol* comes in a number of different forms:
- *Haloperidol Decanoate* is the form of the drug specified for depot injections, and it was this which Dr I - GP was prescribing and administering when the dose was the 100mg specified by Dr T - CPsych(F). It is this formulation

²⁵ See Appendix 5.

²⁶ See below at paragraph 25.

²⁷ See Appendix 6.

²⁸ British National Formulary published by BMA and Royal Pharmaceutical Society of Great Britain.

which provides the long acting effect required for the control of the behaviour of those suffering from the symptoms of paranoid schizophrenia - or, as intended by Dr T - CPsych(F) in the case of Mr Stone, the modification of disordered behaviour whether or not caused by a mental illness. It is produced in an oily compound to delay the uptake of the drug and produce the long-term effect. It is supplied in ampoules of either 50mg or 100mg doses. The recommended maximum dose is 300mg every 4 weeks or 150mg per fortnight, although it is recognised that higher doses may be used in patients with severe symptomatology.

- *Haloperidol* is produced in tablet and injection form and is a short-acting drug for the treatment of acute psychosis. It has a prompt effect lasting a few hours. The tablet form is used for the management of psychosis in those patients who can be relied on to take tablets regularly. The injectable form is used to bring acute episodes of psychosis under rapid control and is supplied in ampoules with a concentration of 5mg per ml in a water-based solution. The data sheet recommends a dose of between 2mg and 10mg intra-muscularly every four to eight hours until sufficient symptom control is achieved, up to a maximum of 60mg a day.

- 22.3 Dr I - GP was clear that his intention was to increase the depot *Haldol* injection by 5mg to 105mg. The Panel noted that 5mg ampoules of *haloperidol decanoate* did not exist, although *haloperidol* did come in that size of dose. Therefore the Panel wondered whether in fact these two different *Haldol* preparations had been given to Mr Stone.
- 22.4 Having been shown by the Panel the two entries for *haloperidol* in the BNF, Dr I - GP, after a period of considerable thought, confirmed that he had actually given 5mg *haloperidol* in addition to 100mg *haloperidol decanoate*. Dr I - GP then said that he wanted to give a drug to reduce the acute symptoms followed by the longer-acting depot. He said he had not misunderstood the nature of the two preparations that he had given.
- 22.5 Dr I - GP was therefore asked whether it was wise to mix, as he had done, two different forms of the same drug in the same injection, when one was in an oily solution and one in a watery solution. He replied that in his view the chemistry of the compounds was the same as they were from the same group of drugs. He thought that if he administered the injection slowly the effect of mixing the compounds would be that the water based compound would be absorbed quickly followed by the oily one.
- 22.6 Although Dr I - GP has subsequently informed the Panel that he now accepts he should not have mixed them in the same syringe, he has reiterated that his intention was to reduce the number of injections which Mr Stone required.
- 22.7 On Dr I - GP's account, the two substances were administered on every occasion in the same injection. However, he thought there may have been one occasion, when the nurse gave the injection when the two substances were administered separately. Mr Stone appears to have been aware that he was receiving an additional drug, but did not know precisely what it was. In his contact with Ms ZP - CPN on 4th July 1996 he was recorded as complaining that:

“he had received an additional dose of an unspecified drug with his original depot and could not understand what this is.”

- 22.8 Information was sought from the manufacturers of *Haldol* regarding the likelihood of any adverse effects from mixing *Haldol* and *haldol decanoate* injections in the same syringe. Their advice was that there are unlikely to be any adverse effects of so doing save that, as *haldol decanoate* is oil based, mixing it with *Haldol* might have the effect of diluting the latter. It may make it more difficult to ensure that the entirety of the *decanoate* was being given, making it less effective and not so long-lasting. The drug company, however, stressed that there are no clinical indications for mixing the two substances as described.

COMMENT:

In making the criticisms which follow the Panel must emphasise that there is no evidence that there was any adverse physical effect on Mr Stone in this particular case or that there was any apparent deterioration in his mental state or behaviour as a result of the dose or type of medication he received.

The Panel is satisfied that Dr I - GP's intention was to increase the dose of depot Haldol. He chose to give an additional 5mgs following the oral communication of Dr T - CPsych(F)'s wishes. However an increase of 5mg in a depot Haldol injection would be unlikely to have any therapeutic effect and would therefore be pointless.

The Panel's view is that Dr I - GP was unaware that he was administering two differently acting preparations of the same chemical until this possibility was drawn to his attention by the inquiry Panel whilst he was giving evidence. Such ignorance is potentially hazardous to a patient.

Even if Dr I - GP had been aware of what he was doing:

- *it is unacceptable practice to administer two different preparations of a drug in this way without having obtained explicit advice that it was safe to do so and in the absence of specific knowledge of the potential physical or chemical interactions between them.*
- *any effect that Dr I - GP might have honestly but mistakenly believed the 5mgs of Haldol was having would have been of very short duration and there was no current clinical indication for such medication in Mr Stone's case.*
- *Mr Stone was caused unnecessary anxiety by being given to his knowledge an additional dose of a drug in circumstances which he did not understand. This may have increased his apparent reluctance to be treated with a depot injection, and made it more likely that he would not attend for it.*

The overall result was that despite Dr T - CPsych(F), Ms ZP - CPN and Dr I - GP all believing that Mr Stone's depot injection had been increased, to a varying degree, this had not actually occurred.

23. **THE RECORDING OF THE DEPOT ADMINISTRATION BETWEEN MAY AND AUGUST 1996**

- 23.1 The Panel felt that the public would be particularly concerned to know whether Mr Stone was receiving appropriate treatment in the months leading up to 9th July 1996. It therefore analysed the records of depot administration in detail. Examination of Dr I - GP's records gives information about depot administration which is best shown in the tabular form which follows.²⁹ In order to follow the Panel's findings of this issue, reference should be made to the copies of the GP record cards.³⁰ It will be seen that entries recording the administration of *Haldol* are often squeezed into the margin of the card or are on cards which do not appear to follow a logical sequence. The Panel questioned Dr I - GP in detail about these apparent discrepancies. He assured the Panel that he had recorded injections contemporaneously as and when they were given, and that such discrepancies were due to him not having the relevant record card at the time.
- 23.2 There is a record of a depot injection being given on 29th May 1996.³¹ There follow two entries on the same card for unrelated matters, dated 14th and 15th June. The rest of the card is blank, but scored through. The next record of an injection is dated 17th June and appears on a different card.³² The note recording the prescription for the next batch of ampoules appears within the space on the card designed for entry of records, after a note about an unrelated condition attended to on the same day. The actual record of the administration of the injection appears above the margin of the record card written over the heading of the form. When asked why he had not written the record on the same card as the entries for the previous two days, as there was room to do so, Dr I - GP suggested that he did not have the notes with him at the time and had started a new card. When asked why, in that case, the record had not been started in the box for entry of records, he said that such things happened at busy times, when they could be done too quickly.
- 23.3 Dr I - GP agreed that the next recorded injection was dated 31st July.³³ There was a further entry purporting to record an injection on this date at the top of another record card.³⁴ This has been deleted, together with an entry for the same date of a prescription for *nitrazepam* 5mg. The latter prescription is not repeated in the note which has not been deleted. Dr I - GP said that most probably he had written it thinking he had not already done so, and deleting the entry when he discovered that he had already made a record. He thought he had probably made both entries on the same day and possibly while he was with the patient. He had deleted the reference to *nitrazepam* because that had been a mistaken entry. That had been prescribed the previous day, as recorded. The next record on the card containing the deleted entry for

²⁹ See Table 1 below.

³⁰ See Appendix 5.

³¹ See Appendix 5.

³² See Appendix 5.

³³ See Appendix 5.

³⁴ See Appendix 5.

31st July is dated 24th December 1996.³⁵ An entry for 20th August 1996 appears overlapping the bottom margin of the card containing the un-deleted entry for 31st July,³⁶ and a further entry for 26th November 1996 appears on an entirely separate card.³⁷ When asked why a card with one erroneous entry on it had been kept for so long, Dr I - GP suggested it could have been by mistake. He said he was sure that he had administered an injection on 31st July.

COMMENT:

The standard of Dr I - GP's record-keeping was poor. There are examples of records squeezed into margins of cards, of an incomplete card, of cards not being completely filled before a new one was started, of repetition of an entry on two different cards and of a deleted entry. The entries which caused the Panel the most concern were those for 17th June and 31st July 1996. However, the administration of an injection on these days was consistent with the records of ordering the supply of Haldol (which all fall within the body of the record cards). Further, the Panel were given access to the surgery's appointments book which confirmed an attendance by Mr Stone on the two dates in question. (The book was produced to the inquiry within hours of it being requested and without there having been an opportunity to alter it.)

Therefore the Panel feel it reasonable to conclude that the Haldol injections were administered as now recorded. However, although the Panel accept that the injections were given, they are satisfied that at least some of the actual records of administration were not contemporaneous, without that fact having been made clear.

³⁵ See Appendix 5.

³⁶ See Appendix 5.

³⁷ See Appendix 5.

TABLE 1

Analysis of Dr I - GP's Records of Depot Injections: March 1996 to August 1996

DATE AND PAGE	RECORDED PRESCRIPTION	RECORDED ADMINISTRATION	DAYS SINCE LAST INJECTION	COMMENT
29-3-96 GP34	Injection <i>Haldol</i> 100mg/amp/ml 5 ampoules Injection <i>Haldol</i> 5mg/amp/ml	Injection <i>Haldol</i> 100mg ampoule given intra-muscularly (deep) "His carer wants his <i>Haldol</i> to increase"	15	This indicates that 5 ampoules each of <i>haloperidol decanoate</i> 100mg and <i>haloperidol</i> 5mg were ordered: enough for the 5 injections due for 10 weeks if they were to be given every 14 days <i>Appointment confirmed in surgery diary</i>
12-4-96 GP34		Injection <i>Haldol</i> 105mg given deep intramuscularly left hip	15	<i>Appointment confirmed in surgery diary</i>
29-4-96 GP34		Injection <i>Haldol</i> 105mg given deep intramuscularly right hip	17	<i>Appointment confirmed in surgery diary</i>
13-5-96 GP34		Intra-muscular injection <i>Haldol</i> 105mg left hip	14	<i>Appointment confirmed in surgery diary</i>
29-5-96 GP35		Injection <i>Haldol</i> 105mg/ml deep intra-muscular given	16	This record is on a different page from a record of a repeat prescription for <i>benzodiazepines</i> on the same date, which is written in the margins of the card. GP34 <i>Appointment confirmed in surgery diary</i>
17-6-96 GP36	Injection <i>Haldol</i> decanoate 100mg/ml 5 ampoules Injection <i>Haldol</i> 5mg/ml 5 ampoules	105mg <i>Haldol</i> given deep intramuscularly	19	The record of the administration is entered in the upper margin of the card and separate from and above the entry for the prescription, which follows an entry recording treatment for eczema. Both entries appear on a different card from the previous card GP35 which contains entries for 29 th May, and 14 th and 15 th June and on which there would have been space to continue entries for the rest of June. <i>Appointment confirmed in surgery diary</i>
31-7-96		Injection <i>Haldol</i> 105mg intra-muscular	44	A deleted record of an intra-muscular

DATE AND PAGE	RECORDED PRESCRIPTION	RECORDED ADMINISTRATION	DAYS SINCE LAST INJECTION	COMMENT
GP 36		given		injection of <i>Haldol</i> 105mg on 31-7-96 also appears on another page GP38, on which the next recorded entry is for December 1996. The injection entry is scored through as is an entry for the same date of a prescription of <i>Nitrazepam</i> 5mg, which is not repeated elsewhere. <i>Appointment confirmed in surgery diary</i>
20-8-96 GP36		Injection <i>Haldol</i> 105mg intra-muscular given.	20	The record is entered in the lower margin of the card, and in an apparently different handwriting to an entry for the same date for a repeat prescription of <i>benzodiazepines</i> . <i>Appointment confirmed in surgery diary</i>
24-12-96 GP 38		Injection <i>Haldol</i> 150mg		This was the first administration after the discharge from the Trevor Gibbens Unit following admission for detoxification. <i>Appointment confirmed in surgery diary</i>

24. **COMPLIANCE WITH DR T - CPSYCH(F)'S PRESCRIPTION: MARCH TO AUGUST 1996**

- 24.1 Dr I - GP was questioned about the gap in administration of depot injections, but was unable to give any explanation. He accepted that this should have been handled better, although he could not say why the injections were not given or why Mr Stone did not attend.
- 24.2 The Panel note that on 18th July 1996 Mr Stone is recorded as telling Ms ZP - CPN (at the TGU) that he had received his depot *Haldol* that week which he found beneficial. There is no record in either the GP records or the GP surgery appointments diary to indicate that any such injection was actually administered). Mr Stone is reported to have said that he was more anxious and agitated just before receiving his depot.

COMMENT:

Having accepted as a matter of fact that the injections recorded, albeit unsatisfactorily, as having been administered had in fact been given, nonetheless the following matters of concern are apparent:

- *From an examination of Table 1 it is clear that the 14 day interval between injections as prescribed by Dr T - CPsych(F) was frequently exceeded;*
- *In particular, the injection on 17th June 1996 was 5 days late, and there was then no further injection, on Dr I - GP's account, until 31st July, a period of 44 days. That means that between 29th May and 31st July Mr Stone only received one injection when Dr T - CPsych(F)'s regime required him to be given four injections.*
- *Even if Mr Stone's account to Ms ZP - CPN of receiving an injection on or about 18th July is accurate, this injection would already have been a fortnight late and he would have been without depot injection for a month since 17th June 1996.*
- *The omission to administer injections cannot be explained by Mr Stone failing to attend the surgery between the dates just mentioned. The records indicate attendance for other purposes on 15th June, and 26th June 1996. Repeat prescriptions for benzodiazepines were made out on 14th June, 15th July and 30th July 1996; it can be presumed Mr Stone would have attended the surgery to collect these.*

The Panel accept that relatively short delays in the administration of regular depot Haldol are unlikely to adversely affect the blood level of the drug given the stability referred to above. Nonetheless, depot medication ought to be given in accordance with a regular schedule and steps taken to avoid irregularity. The Panel are obliged to conclude that between March and August 1996 Dr I - GP took inadequate steps to ensure that Mr Stone complied with the depot regime prescribed by Dr T - CPsych(F). There is no indication that Mr Stone was refusing medication which was offered to him

during this period. Dr I - GP could have, but did not:

- *Make appointments for Mr Stone to attend earlier than he did;*
- *Contact the key-worker, the community psychiatric nurse, or Dr T - CPsych(F), if Mr Stone was not attending;*
- *Offer to administer the injection when Mr Stone attended the surgery for other reasons.*

25. RESPONSE TO Ms ZP - CPN'S INQUIRY ON 5TH JULY 1996

25.1 On 4th July Ms ZP - CPN, the forensic community psychiatric nurse from the Trevor Gibbens Unit, had cause for concern about Mr Stone's behaviour as is considered in detail elsewhere.¹ When she advised Dr T - CPsych(F) of this he asked her to do a number of things, the first being to contact Dr I - GP and find out details of Mr Stone's depot medication. This she did on 5th July. Her note reads²:

"I later spoke with Dr I - GP who confirmed an increase in Michael's *haldol* decanoate from 100mg to 105mg fortnightly. Dr I - GP says he is willing to receive further advice from Dr T - CPsych(F) regarding Michael's depot."

25.2 Dr I - GP agreed that this was probably a fair summary of what he said to Ms ZP - CPN although he had understandable difficulty in recalling the detail of the conversation. He was asked why he did not tell her that Mr Stone was late for his injection; he thought he may not have remembered that this was so at the time of the conversation, and that he may not have looked at the notes.

COMMENT:

The Panel are satisfied that Dr I - GP did not give Ms ZP - CPN an accurate account of the medication that Mr Stone was actually receiving: he did not tell her that he was late for the current injection, or that between 29th May and 5th July he had only received one injection rather than the two which he should have had. He also failed to tell her that the increase in dosage had been achieved by mixing short acting haloperidol with haloperidol decanoate. Given the specific nature of the inquiry made by Ms ZP - CPN who was seeking to confirm the details of the medication being received, the Panel consider that this was information which a competent general practitioner should have provided. It is possible that the quality of Dr I - GP's record-keeping explains why he was unable to do so.

25.3 The Panel asked Dr T - CPsych(F) what his perception of the circumstances would have been if he had been told that Mr Stone had missed one, or more injections. Dr T - CPsych(F) was deliberately asked about this without informing him what the general practitioner records showed and to ensure that it could not be suggested that his answers would be affected by that knowledge.

¹ See Forensic Services chapter at paragraph 8 et seq.

² See Appendix 4.

- 25.4 Dr T - CPsych(F) explained to the Panel that had he been told at the time that Mr Stone had missed one, two or three injections it would have changed his view as to the significance of his disturbed behaviour on 4th July 1996. One possibility which he would have considered was that *Haldol* was controlling some underlying mental illness and that Dr. AA - CPsych's diagnosis had been correct or secondly that *Haldol* was controlling impulsiveness or aggression in personality disorder.
- 25.5 In either case, he would have been of the view that at the time there was an increased risk which was reversible and he would have wanted to get Mr Stone back on *Haldol*. Although he understood the situation to be hypothetical, he stated that had he been aware that Mr Stone had missed his depot and that there were clear mental illness symptoms which had just emerged, then he may have considered using the Mental Health Act to detain him for reasons of mental illness. In the second scenario, where the *Haldol* was controlling aggression and volatility in personality disorder, Dr T - CPsych(F) would have felt that a lack of *Haldol* might provide grounds for considering compulsory admission for treatment of personality disorder in that the "treatability" criterion under the Mental Health Act may have been met, at least in the short-term, by the need to administer *Haldol*.
- 25.6 Had he been told that Mr Stone had missed his Haldol Dr T - CPsych(F) stated that he would have seen him rather more quickly than he actually did (i.e. on 24th July 1996). He stated that on listening to Ms ZP - CPN's account on 4th July 1996 he was looking for any indication that something could usefully be done for Mr Stone or for a reason to take a particular course of action. If Ms ZP - CPN had said to him on 4th July that Mr Stone's condition had got worse recently, that he was more paranoid than he used to be and that he was not taking his Haldol, then a way forward would have emerged. There would have been a picture of a temporary deterioration which might be regarded as an element of mental illness or at least a treatable component of personality disorder. However, Dr T - CPsych(F) pointed out that as far as he was made aware there was nothing like that present.

COMMENT:

It is clear that Dr T - CPsych(F) was looking for an explanation for the deterioration in Mr Stone's behaviour in early July 1996 and some indication for an admission to hospital for treatment. The Panel are satisfied that if Dr T - CPsych(F) had known that Mr Stone had not been receiving the prescribed dosage of haloperidol decanoate at the prescribed intervals he would have wanted to investigate whether that provided an explanation for the behavioural deterioration. He would also have considered assessing Mr Stone personally with a view to arranging his compulsory admission to hospital to restore the depot regime to the prescribed level in order to see whether that resulted in an improvement in his behaviour, regardless of whether he suffered from mental illness, personality disorder, or both. The Panel wish to emphasise that they have no means of knowing whether an admission would have resulted from any assessment by Dr T - CPsych(F). All that can be said is that an opportunity for re-assessment of the patient was missed.

- 25.7 Having given this evidence to the inquiry, Dr T - CPsych(F) was subsequently made aware by the Panel that Ms ZP - CPN had been misinformed about the administration of depot *Haldol* by Dr I - GP. Mr Stone was in fact four days overdue his *Haldol* injection on 4th July 1996 and over the preceding three months he had been given 100mg of the depot *Haldol* fortnightly and not 150mg as Dr T - CPsych(F) thought.
- 25.8 Dr T - CPsych(F) then commented that in his view the timing of *Haldol* injections was not likely to be of direct relevance to Mr Stone's condition given its known stability in blood level and that there was no necessary causal link between *Haldol* levels and deterioration in behaviour. He felt that equal prominence should be given to the "reverse explanation", that Mr Stone's failure to attend for depot injections was a consequence of a period of disturbance due to other factors in his life. His aggression may have been related to heroin withdrawal and the use illicit drugs to calm himself down. He felt that changes in *Haldol* levels were not of themselves explanatory of Mr Stone's mental state and that prominence should also be given to the effects of illicit drug taking and drug withdrawal, *benzodiazepine* taking and withdrawal and alcohol intoxication as well as the frustrations of everyday interactions.

COMMENT:

The Panel agrees with Dr T - CPsych(F) that a wide range of factors influenced Mr Stone's behaviour at any one time and that their exact nature and relative importance are and will remain unknown. Therefore the Panel wish to emphasise that they have no means of knowing whether the deterioration in Mr Stone's behaviour as reported by Ms ZP - CPN was caused by a reduction in the blood level of haloperidol or whether there would have been any improvement if haloperidol levels had been restored earlier than they were.

On 9th July 1996 the depot was eight days overdue, a period of time which, although undesirable, will not necessarily result in major deleterious effects on the mental state. It is impossible to know whether the delay in administration and the use of a dosage less than that advised by the Consultant had any adverse effect on Mr Stone's mental state or behaviour at that time.

Nevertheless, there remains a possibility that had Dr T - CPsych(F) been aware of the facts as found by the inquiry, he would have seen and assessed Mr Stone urgently. Unfortunately he was not in possession of the full facts, because Dr I - GP had not informed Ms ZP-CPN of the correct position concerning Mr Stone's medication.

The Panel are satisfied that, if he had been given this information, Mr T - CPsych(F) would have considered whether Mr Stone's clinical condition warranted detention, but it is impossible to know whether he would have concluded detention was necessary.

The Panel's conclusion that Dr I – GP fell below the standard of a competent general practitioner in the provision of information to Dr T - CPsych(F) should not be interpreted as, and is not intended to be, a finding that he is in any way responsible for the Russell murders. The Panel refer to paragraph 15 of the Executive Summary.

The Panel wish to emphasise that during this period there was no cause for Dr I - GP to act upon any disturbed behaviour exhibited by Mr Stone. Dr I - GP had not observed any such behaviour when he last saw Mr Stone on 17th June 1996. In the interim period Mr Stone was seen by Mr Y - RMN (at the Addiction Centre) on 2nd July 1996 who also noted no worrying behaviour. Even after the outburst on 4th July Ms ZP - CPN found Mr Stone to have calmed down the following day. There has also been a suggestion in the Guardian newspaper (which the Panel are not in a position to investigate) that Mr Stone was seen by a police officer on 6th July 1996.

26. FURTHER ATTENDANCES

- 26.1 Following 5th July 1996 Mr Stone next attended Dr I - GP's surgery on 15th and 30th July 1996 for prescriptions of *benzodiazepines*. It does not appear that any offer of a depot injection was made. However, on 31st July a depot was given. Further such injections were given on 20th August, 24th December 1996, and then regularly on various dates in 1997 until Mr Stone's arrest.

COMMENT:

The provision of depot medication in the latter half of 1996 was spasmodic, with no indication evident from the records that Dr I - GP was concerned, or that opportunities were taken to offer depots on days when Mr Stone attended his the surgery for other purposes. The pattern appears to have been more satisfactory in 1997.

RECOMMENDATIONS

Paragraph 3

The Kent Health Authorities' Support Agency should review its procedures for confirming the identities of patients where no NHS number is known. These should include a routine request for details of any previous names used, and, possibly, for evidence of identity. If this is difficult to implement because the system is national, then we recommend that the Authority makes local general practitioners aware of this problem and of the need to make thorough inquiries to establish a patient's previous medical history, where there is an unaccountable lack of records.

Paragraph 22

The Panel is concerned at the level of knowledge displayed by Dr I - GP in relation to the prescription of neuroleptic medication. The Panel is unable to comment from the evidence it has received whether this is a general problem or specific to this

practitioner. In the circumstances West Kent Health Authority's Director of Public Health should review local continuous training to ensure that general practitioners are able to acquire and maintain the appropriate knowledge and skills.

Paragraph 23 et seq

Steps should be taken through the West Kent Health Authority's Director of Public Health to review the practice of Dr I - GP and to assist him in remedying any systemic difficulties in his practice with particular regard to note-keeping and communication with specialist services.

CHAPTER 7

CHATHAM COMMUNITY MENTAL HEALTH TEAM

OVERALL EVALUATION OF THE CHATHAM CMHT

Service involvement in the case

October 1992 to December 1994

Although Mr Stone's care was initially not accepted by the service in October 1992, he was subsequently accepted as a depot clinic patient in February 1993. Between then and August 1993, he was seen six times. He was seen a further seven times between May 1994 and November 1994.

Evaluation against core principles

- **Clarity in current diagnosis, objectives, needs, risk assessment and the strategies to clarify and deal with them.**
On his initial presentation to the CMHT in October 1992 a thorough assessment of Mr Stone was made. His condition was accurately diagnosed, risks were identified and an appropriate referral for a specialist forensic opinion was made.

During Mr Stone's further contacts with this service, the objectives of treatment were not clearly specified and there was little assessment of his needs beyond administration of depot medication. There was less clarity of diagnosis and little further risk assessment was undertaken.
- **Coordination of the delivery of service, sharing of information and action.**
The quality of co-ordination of service delivery by the CMHT with other services was variable. Salient matters were not communicated to other services and CPA principles were not applied.
- **Checking on the outcome of service provision by regular review**
Agreed plans for medical review were not carried through and no system was in place to follow up non-attendance of patients deemed a risk to the community. When, in November 1994, Mr Stone was deemed of sufficient danger in the community to require secure admission he was left at large for several days without further risk assessment or direct psychiatric oversight.
- **Changing the diagnosis, needs and risk assessments and service provision in the light of the review.**
On three occasions there was reluctance to accept Mr Stone as a patient demonstrated by the consultant psychiatrist. On none of these occasions had that consultant personally seen or assessed Mr Stone before arriving at this view.

CHATHAM COMMUNITY MENTAL HEALTH TEAM
THROWLEY HOUSE AND MEDWAY HOSPITAL

1. CHATHAM COMMUNITY MENTAL HEALTH TEAM: THROWLEY HOUSE

- 1.1 The Thames Gateway NHS Trust via the Chatham Community Mental Health Team (CMHT) provided mental health services (in-patient, out-patient and community services) for a population of about 53,000 aged between 17-65 living in the Chatham sector of the Medway Towns (whole population about 66,000). This population generated around 12 new referrals a week. The Royal College of Psychiatrists norm was that in an area of above average psychiatric morbidity the population per consultant psychiatrist should not exceed 21,000. At the present time, the Panel was informed, the all-age catchment population of Chatham is estimated to be 73,000.
- 1.2 The Chatham CMHT was led by Dr AA - CPsych, consultant psychiatrist. Dr AA - CPsych had been a consultant psychiatrist since 1977 following completion of his training in Birmingham and Cardiff. He had been appointed to his post in Medway in 1986, becoming clinical director for mental health in 1996. At the time of events which concern this inquiry he was the only Consultant Psychiatrist in that sector and was coping with a population more than twice of that recommended by the Royal College of Psychiatrists. There are now two funded full-time Consultant Posts.
- 1.3 In 1992, as now, the team's out-patient service was based in Chatham at Throwley House, a self-contained residential property a considerable distance from the base hospital unit. The main psychiatrist at Throwley House was Dr BB - Psych, a staff grade psychiatrist. Dr AA - CPsych attended on a sessional basis on Monday afternoons and all day Wednesday; a psychiatric registrar also attended sessionally. In addition there were community psychiatric nurses and two part time psychologists in the team.
- 1.4 Throwley House was established for patients with short to medium term mental health problems, which Dr BB - Psych described as mostly emotional problems. The initial policy was not to see people with chronic, long-term mental health problems, but later this policy changed. A depot¹ clinic was set up in 1994, and all Chatham community patients, including those with long-term mental health problems, attended out-patient appointments at Throwley House, although arrangements could be made to see particular patients at the day hospital in Medway Hospital.
- 1.5 Dr BB - Psych qualified in 1972. After general medical training she came to England in 1979 and trained in psychiatry until she was appointed to the post of Staff Grade Psychiatrist at Throwley House, working under the consultant supervision of Dr AA -

¹ "Depot" medication refers to the process of administering a psychoactive substance in an oil-based medium by deep intramuscular injection so that it releases slowly into the patient's blood stream over the following days, thus having a long-acting effect.

CPsych. She had no specialist training in working with drug abuse or with personality disorder.

- 1.6 In 1992 her case load was 40 patients. This doubled to 80 patients in 1994 with the opening of the depot clinic.

2. **ASSESSMENT AT THROWLEY HOUSE: 8TH OCTOBER 1992**

- 2.1 On 8th October 1992 Mr Stone was referred directly to Dr BB - Psych by his GP, Dr M - GP, who requested an emergency assessment after Mr Stone reported having violent feelings². Prior to seeing Mr Stone Dr BB - Psych was provided with a brief referral letter from Dr M - GP. She also was sent a copy of the letter from Dr ZH - HMPGP at Whitemoor prison describing Mr Stone's psychotropic medication in prison and briefly describing his symptoms as "ideas of reference, paranoid thinking and possible auditory hallucinations".

- 2.2 Mr Stone gave Dr BB - Psych a brief account of his drug and criminal history and his paranoid ideas in custody. He began to describe having stabbed another man in prison, but at this point he became restless and angry, demanding an increase in his medication. He declined to remain to enable Dr BB - Psych to take a full history; she therefore asked Mr Stone to increase his current dose of *trifluoperazine (stelazine)* to 10mg tds (three times daily) and asked him to return the following day.

- 2.3 Mr Stone returned as requested on 9th October 1992 in the company of his mother. He was calm and co-operative. Dr BB - Psych took a formal psychiatric history eliciting from both Mr Stone and his mother details of his family history and a disturbed early personal history. His extensive criminal history with convictions for violence was also reviewed. A drug history revealed earlier use of cannabis, heroin and amphetamine, and use of heroin and cocaine the previous weekend. Mr Stone described paranoid thoughts, possible auditory hallucinations in prison and the subsequent carrying of a knife, but he reported that these features had responded well to the prescription of *Perphenazine* and the *Trifluoperazine* in prison. However, he said that since his release he had been feeling tense and nervous and felt he was heading towards stabbing and murdering someone. Dr BB - Psych found no definite evidence of delusions or hallucinations and did not consider him depressed. Mr Stone was insistent that if prescribed further *Trifluoperazine* he would be all right. Dr BB - Psych prescribed *Trifluoperazine* at 10mg tds and *procyclidine* to 5mg tds.

- 2.4 Because of Mr Stone's history and presentation, Dr BB - Psych discussed his case with Dr AA - CPsych. Dr AA - CPsych recalled this conversation in evidence to the Panel when he said:

"[I was] told about a person, an ex-prisoner, who had been a violent offender, and there was a hint of drugs about it, and I said, "No, we shouldn't see him here. He can go directly to forensic," and she went ahead and did that and referred to the Trevor Gibbens team."

² See General Medical Services chapter at paragraph 4.2.

- 2.5 Dr BB - Psych recorded Dr AA - CPsych's view in the notes as being that Mr Stone was "not suitable to be seen at Throwley House". Dr BB - Psych has stated that she did not regard Dr AA - CPsych's decision to have been communicated clearly to her and she was ambivalent about it. Dr AA - CPsych has explained to the Panel that he had meant that Mr Stone should not have a full assessment in his sector service because of the strong forensic history and suggestions of escalating violence.
- 2.6 On 13th October 1992, acting on Dr AA - CPsych's advice, Dr BB - Psych wrote a detailed letter to Dr ZK - CPsych(F), the then consultant forensic psychiatrist at the Trevor Gibbens Unit, which she copied to Dr M - GP. The letter explicitly asked Dr ZK - CPsych(F) for an assessment and his opinion and stated:
- "I gave him a prescription of *stelazine* 10mg tds and *procyclidine* 5mg tds and discussed the case with Dr AA - CPsych, Consultant Psychiatrist. We thought he may be suffering from paranoid personality disorder and that with this kind of history we would appreciate your opinion".
- 2.7 On 21st October 1992 Mr Stone was assessed by Dr Q - Psych(F), Senior Registrar to Dr ZK - CPsych(F)³. In his letter of reply addressed to Dr BB - Psych and dated that same day, Dr Q - Psych(F) suggested that Dr BB - Psych continue to prescribe neuroleptic medication for Mr Stone at the further increased dose of *Trifluoperazine* 10mg qds (four times daily). He noted that Mr Stone did not want a further out-patient appointment at the TGU but offered to see Mr Stone again at the request of his GP, should it be felt that Mr Stone was getting out of control, or if Mr Stone wanted further help. This letter to Dr BB - Psych was copied to Dr M - GP.
- 2.8 Dr Q - Psych(F) told the inquiry that his expectation was that Mr Stone would remain under the care of Dr BB - Psych. Unknown to Dr Q - Psych(F) Dr BB - Psych did not offer Mr Stone any further appointments nor did she prescribe any further medication for him. Mr Stone continued in the sole care of Dr M - GP who remained unaware that Mr Stone was not being seen by Dr AA - CPsych's team.
- 2.9 Dr BB - Psych confirmed to the inquiry Panel that her appreciation at the time was that Dr Q - Psych(F) was sending Mr Stone back to her care, but nevertheless she did not offer him any follow-up at Throwley House. Her explanation for this was that as she and Dr AA - CPsych had agreed that she would not see Mr Stone she did not send him another appointment. Dr BB - Psych has since added that she knew the patient was under the care of his general practitioner, who was prescribing appropriately. She did not accept that there was a danger of the patient "falling between two stools" because communication should have continued between the GP and the forensic team as suggested by Dr Q - Psych(F) in his letter. Dr AA - CPsych has said that Mr Stone was not offered a further appointment because Dr Q - Psych(F) had said in his letter that the patient could be cared for by the GP. Dr AA - CPsych accepted that, in retrospect and on re-reading the letter, he was concerned by the apparent reliance on the general practitioner for the care and supervision of such a patient.

³ See Forensic Services chapter at paragraph 2

- 2.10 Dr AA - CPsych, however, was not aware of Dr Q - Psych(F)'s letter at the relevant time. When he was asked by the inquiry Panel about his team's response to the letter, Dr AA - CPsych agreed that the letter showed there was no intention on the part of the forensic service to do anything more unless asked by the GP. He also stated that he would not have thought that his clinic would have been able to care for a patient of this type and that such a patient was more appropriately dealt with by the forensic unit.
- 2.11 It was suggested to Dr AA - CPsych that, given that he did not communicate his team's decision that Mr Stone's was unsuitable for their service either to Dr Q - Psych(F) or the GP, there was some danger of Mr Stone's care falling between two stools, Dr AA - CPsych said he agreed "absolutely" and that it was a concern to him when he re-read the letter afterwards.

COMMENT:

Dr BB - Psych's initial assessment of Mr Stone was thorough. When he became agitated she appropriately asked Mr Stone to come back the following day and, when he did, she took a full history. Her decision to discuss his case with Dr AA - CPsych then was also appropriate.

A referral to forensic services for an opinion was justified at this stage, but it was premature for Dr AA - CPsych to have told Dr BB - Psych that Mr Stone was not suitable for their service before the results of this forensic assessment were available, particularly when he had not assessed Mr Stone himself.

Dr AA - CPsych has since said to the Panel that he did not predetermine that Mr Stone should be excluded from his service. However from the written record and the oral statements by Dr AA - CPsych and Dr BB - Psych (at paras 2.4 and 2.10 above) there was room for the impression that there was a difference of opinion between the general psychiatric services and the forensic service about the category of patient each was prepared to deal with. If allowed to persist, that could lead to a patient not receiving the relevant care from the appropriate service.

Dr BB - Psych's referral letter failed to inform Dr Q - Psych(F) that Dr AA - CPsych considered the patient unsuitable for his service and the grounds for this decision. Therefore it did not alert Dr Q - Psych(F) or the GP to the possibility that Mr Stone would not be under secondary psychiatric care in the future.

Dr AA - CPsych has expressed the view that Mr Stone was not returned to his team by Dr Q - Psych(F) and that the forensic opinion was that he could be looked after by his GP. The Panel cannot accept this given the wording of Dr Q - Psych(F)'s letter. Further, not only did Dr Q - Psych(F) inform the Panel that his intention was that the case be returned to Dr AA - CPsych's team, but this was also how Dr M - GP read the letter. Indeed, where a difficult and complex case has been referred for an opinion by a secondary service to a tertiary service, it would be unusual for it to be returned directly to the exclusive care of a GP.

Although Mr Stone was temporarily lost to psychiatric supervision, in fact this sequence of events did not impact on Mr Stone's continued contact with medical services. In the event, his GP continued to remain in contact with him and prescribe stelazine. The GP was also able to refer Mr Stone to substance abuse services when his condition deteriorated in early 1993.

3. REFERRAL TO DR AA - CPSYCH'S TEAM: FEBRUARY 1993

- 3.1 On 3rd February 1993 Mr Stone told Dr M - GP that he was taking heroin and buying *DF118* on the street. He asked Dr M - GP for help with coming off drugs; Dr M - GP immediately made a telephone referral to Dr V - CPsych, Consultant Psychiatrist in charge of the Medway and Swale Addiction Services. Dr V - CPsych conducted an emergency home visit.⁴ Dr V - CPsych was of the opinion that Mr Stone was suffering from a paranoid psychosis triggered at times by drugs. He offered Mr Stone out-patient treatment in the Manor Road Addiction Centre.
- 3.2 Dr V - CPsych believed that Mr Stone was already under the care of the local community mental health team and he believed that the responsibility for managing his psychosis lay with it. However, because of concern over possibly poor compliance with *stelazine*, Dr V - CPsych thought that an intra-muscular depot injection was a preferable option for keeping Mr Stone's psychotic illness under control. He contacted Dr AA - CPsych asking that his team oversee the prescription and monitoring of depot anti-psychotic medication.
- 3.3 Following a conversation with Dr V - CPsych, Dr AA - CPsych now agreed to take on responsibility for Mr Stone's depot medication and to assess him in his out-patient depot clinic.
- 3.4 On 26th February 1993 Mr Stone attended the depot clinic accompanied by his mother and met Dr AA - CPsych for the first time. Dr AA - CPsych noted that he was well and symptomless with a normal mental state. He recorded that Mr Stone was "insightful" and was agreeing that he needed to come off heroin and to receive the proposed *modecate* injections. A test dose of *modecate* 12.5mg was administered with a view to increasing the dose of *modecate* slowly, then reducing the dose of *trifluoperazine (stelazine)*.
- 3.5 On 5th March 1993 Dr AA - CPsych reviewed Mr Stone's response to the test dose of *modecate* and, as all was well, then prescribed depot *modecate* 25mg at three-weekly intervals.

COMMENT

In the Panel's opinion Mr Stone's presentation in early 1993 was such that he ought to have been made subject to the Care Programme Approach (CPA)⁵ and would have benefited from it. Despite it having been a

⁴ See Addiction Services chapter at paragraph 3.3

⁵ See Agencies chapter above for a description of the CPA and its requirements.

requirement since April 1991 that CPA be implemented for people referred to the specialist psychiatric services,⁶ the CPA does not appear to have been implemented in the Medway services at this time.

Dr AA - CPsych has confirmed that CPA was not in operation in Medway Health Authority until 1993 when they began to plan a pilot scheme in Rochester. He has informed the Panel that it was not introduced fully until January 1996 when in his capacity as Medical Director he began to formalise what was still a patchy CPA system in his service.

The Panel is aware of delays in implementing CPA policies nationally. Failure to implement CPA appears to be a notable failure nationally, commented on by various previous inquiry reports

The absence of any CPA led to a subsequent lack of clarity over who was responsible for overseeing and coordinating the totality of Mr Stone's treatment and care. In February 1993 both Dr V - CPsych and Dr M - GP were unaware that Mr Stone was not under the active care of the CMHT. In a complex case such as this where there was now dual service involvement, it would have been advisable to formalise CPA arrangements from the outset and set up regular reviews of his management. The lack of effective local CPA arrangements made it inevitable that this was not done.

- 3.6 Mr Stone was next reviewed in the depot clinic on 26th March 1993 by a Dr X - Psych, a trainee psychiatrist. Mr Stone reported the absence of paranoid feelings and hallucinations and a reasonable mood. He was attending Manor Road Addiction Centre weekly where he was being prescribed *methadone* 50mg per day. Mr Stone said that he had used heroin only once in the preceding six weeks. Because Mr Stone was experiencing characteristic side effects of neuroleptic medication Dr X - Psych, assuming that Mr Stone was still taking *Trifluoperazine*, suggested reducing this by 5mg per day with the intention of reducing it by a further 5mg on his next appointment, provided Mr Stone's paranoid feelings remained at bay.
- 3.7 Mr Stone did not keep an appointment on 16th April 1993, but attended the next one on 30th April 1993. He explained his previous missed appointment to be the result of finding the *moderate* injection painful and the emergence of side effects. He said he had reduced *Trifluoperazine* to 10mg at night which he found helped him to sleep. He reported the absence of any paranoid feelings. His dose of *moderate* was therefore reduced to 25mg every four weeks. Although a letter recounting this attendance was sent to the GP it was not copied to the addictions team.
- 3.8 Mr Stone did not attend the depot clinic in May or June 1993. On the 16th June Dr V - CPsych at the addictions service saw Mr Stone and was "alarmed" to discover from Mr Stone that he had stopped taking his depot medication six weeks previously. The CMHT had not informed the addictions team that Mr Stone had failed to attend for his depot since 30th April 1993, or that his dose of *moderate* had been reduced at his last

⁶ See the Department of Health Circular: HC(90)23 / LASSL(90)11.

attendance. Dr V - CPsych encouraged Mr Stone to re-attend the depot clinic suggesting that his *modecate* be changed to *Depixol*. He then wrote a letter to Mr Stone's GP on 21st June informing him of these developments adding:

"I am sending a copy of this letter to Dr AA - CPsych to see if he can make sure that this psychotic man continues to have his medication because of the risk of relapse and the risk of dangerousness in someone like him"

- 3.9 The letter was received by the CMHT and appears in the Medway notes, but there is no evidence that any immediate action was taken in response. Mr Stone missed his next scheduled appointments on 22nd June 1993 and 13th July 1993. A report was then received from a friend that Mr Stone was no longer interested in attending the depot clinic. Dr X - Psych asked the clinic community psychiatric nurse (CPN) to visit Mr Stone at home. Mr ZM - CPN, the CPN, tried visiting Mr Stone once without finding him at home. He left a message that he would return the next week but then took (and recorded) the view that he should not visit Mr Stone at home because of his history of violence.
- 3.10 On 21st July 1993 Dr X - Psych wrote to Dr M - GP stating that Mr Stone had not attended since 30th April 1993 and thus would not be sent further appointments for the depot clinic. Despite being discharged from the depot clinic, following persuasion by Dr V - CPsych, Mr Stone did re-attend the depot clinic on two further occasions, on 27th July and 23rd August 1993. On each visit he was given further doses of 25mg *modecate* by the CPN but he was not reviewed by a doctor on either occasion.
- 3.11 Dr AA - CPsych informed the Panel that depot clinic patients were not reviewed by a doctor after every injection but a minimum every three months, unless there were complications or concerns. However, by this time Mr Stone had last been seen by a doctor at the depot clinic more than three months previously (on 30th April), and there were ongoing concerns about his mental state and compliance as raised by Dr V - CPsych in his letter of 21st July 1993.
- 3.12 On 27th August 1993 Mr Stone turned up at the depot clinic complaining of a stiff neck. He had not been taking *procyclidine* because he felt it gave him side effects but agreed to take it that day. Two days later Mr Stone presented himself at Brooke Ward, Medway Hospital⁷, complaining of continuing stiffness. He was seen by a junior doctor who did a physical examination and noted that he was suffering from neuroleptic induced rigidity. Mr Stone was given an intra-muscular dose of 10mg of *procyclidine* to counteract the side effects of his *modecate* and advised to continue to take oral *procyclidine*, but at the increased dose of 5mg qds (four times daily).
- 3.13 Mr Stone did not reappear at the depot clinic and his medication records were marked "transferred to Manor Road". In fact, no such transfer had taken place. Mr Stone had gone to live in Skegness where he was subsequently remanded to prison on a charge of burglary.⁸ Dr AA - CPsych's depot clinic team did not inform either the Manor Road team or Mr Stone's GP of his failure to attend since August.

⁷ Dr AA - CPsych's in-patient ward.

⁸ See Probation Service chapter at paragraph 3.1.

- 3.14 Meanwhile, Mr Y - RMN and Dr V - CPsych at Manor Road Clinic had been aware since 10th September 1993 that Mr Stone was intending to moving to Skegness but they did not pass on this information to Dr AA - CPsych's team.⁹
- 3.15 Eventually, a note dated 29th December 1993 was written on the depot clinic chart which shows that an unidentified depot clinic staff member had telephoned Manor Road Clinic that day and discovered that the Manor Road team had also not seen Mr Stone for some time and believed he was in prison.
- 3.16 Dr AA - CPsych explained to the Panel that his team did not make enquiries about Mr Stone's whereabouts until this time because it was assumed that Mr Stone had attended Manor Road.

COMMENT:

There is no evidence that either the Care Programme Approach or the principles underlying it had been adopted in respect of Mr Stone's case in 1993. Dr AA - CPsych has told the Panel that to the best of his recollection he did liaise with Dr V - CPsych. However, there is no documentary record of any such discussions or their outcome.

Even without the formality of the CPA, given what the CMHT knew of Mr Stone's past history with his propensity for violence and their view that he required depot neuroleptic medication, there ought to have been effective communication between the CMHT, the Manor Road team and his GP to address Mr Stone's failure to receive depot medication.

In July 1993 it was inappropriate for the CMHT to discharge from the depot clinic a patient who was believed to require medication without review of his mental state or any discussion of this with either Dr AA - CPsych or any of the other professionals involved in his care. Furthermore, once Mr Stone had returned for two subsequent injections in July and August 1993, it was inappropriate of the CMHT to fail to ensure there was a medical review of the patient, particularly given the team's stated policy that patients would be reviewed when there were complications or concerns.

The CMHT further failed to inform either Dr V - CPsych or Mr Stone's GP of his subsequent failure to attend the clinic from September.

No inquiry into Mr Stone's whereabouts was made for over four months despite very simple measures being available such as contacting Mr Stone's mother, Manor Road Clinic or his GP. It is unacceptable that the assumption was made that he was attending Manor Road without this being checked. No system or procedure for following up non-attending patients seems to have been in place, particularly for those thought to possibly present a risk to the community.

⁹ See Addiction Service chapter at paragraph 6.1.

4. REFERRAL TO DR AA - CPSYCH'S TEAM: MAY 1994

- 4.1 On 16th May 1994, having been released from custody, Mr Stone was re-referred to Dr BB - Psych at Throwley House by his GP, Dr M - GP. Dr BB - Psych wrote to Dr M - GP the following day reporting the consultation and agreeing that an injection of *modecate* 25mg would be given fortnightly with a medical review monthly. At this point Mr Stone reported feeling relaxed, denied paranoid ideas or that he was taking drugs.
- 4.2 On 18th May 1994 Dr BB - Psych received a telephone call from Dr V - CPsych reporting that Mr Stone had unwanted side effects since taking *modecate* and suggesting that the neuroleptic be changed to *Depixol*. When Mr Stone was next seen on 23rd May 1994, he reported that he was keeping well apart from the side effects. *Depixol* 40mg fortnightly was prescribed by Dr BB - Psych.
- 4.3 At a review appointment on 6th June 1994, Dr BB - Psych noted there was no improvement in Mr Stone's side effects but his mental state remained stable.
- 4.4 On 22nd June 1994 the first multi-agency review of Mr Stone's case was held. This took place at Manor Road at the instigation of Ms CC - PO, his probation officer.¹⁰ It was attended by Mr Y - RMN (nurse counsellor at Manor Road), Dr BB - Psych, Ms CC - PO and Mr Stone. Dr BB - Psych recorded that the purpose of the meeting was to co-ordinate the activities of the various agencies involved with Mr Stone in order to minimise his ability to manipulate those dealing with him and to devise a plan to help him.
- 4.5 Dr BB - Psych's record of this meeting describes the medication which Mr Stone was taking, both prescribed and non-prescribed. She records he was receiving 40mg of *Depixol* fortnightly and 70mg of *methadone* per day. She was surprised to discover that he was also receiving another anti-psychotic drug *thioridazine (melleril)* 50mg tds from Dr M - GP.
- 4.6 In the Throwley House notes, Dr BB - Psych recorded the care plan:
- (1) *Thioridazine* should be reduced and his dose of depot be reviewed at the time it was next due;
 - (2) Ms CC - PO would arrange for referral to a meditation group;
 - (3) Mr Stone would be advised to be open and honest with Mr Y - RMN and "say no to drugs";
 - (4) There was doubt about the wisdom of two doctors being involved in his medical review because of the danger of confusion and over-prescribing. This was to be discussed with the new consultant in the substance misuse services (Dr Z - CPsych);
 - (5) The depot neuroleptic was to be given at Throwley House while medical review was to remain with Manor Road.

No agreed record of this meeting was circulated between those attending and Dr BB - Psych did not convey the outcome of this review to Dr M - GP. No date was set for a further multi-agency review of the case.

¹⁰ See Probation Service chapter at paragraph 5.6.

- 4.7 After this meeting, Mr Stone failed to attend Throwley House for the next two months. Despite the plan for the Throwley House team to administer his medication, no further depot injections were given and this non-attendance was not communicated to the Manor Road team, his GP, or his probation officer.
- 4.8 On 2nd August 1994 Ms CC - PO learnt from Mr Stone that he had missed his depot injections and she telephoned Dr BB - Psych suggesting that a further three-way meeting be set up. This was arranged for 18th August 1994.
- 4.9 On 16th August 1994 a CPN recorded in the notes that Mr Stone had missed recent depot injections and that, in a telephone discussion with Mr Y - RMN, he had been told that a sudden relapse was inevitable, especially as, when last seen by Mr Y - RMN, Mr Stone had appeared preoccupied with thought-blocking.

COMMENT:

The two multi-agency meetings in June and August were both called at the instigation of a probation officer rather than the health care professionals who might have been expected to take such steps.

After attending the first case review Dr BB - Psych took no action to inform the other agencies of Mr Stone's failure to attend for depot injections. If Mr Stone had not himself informed Ms CC - PO of this all would have remained ignorant of it.

The Throwley House team did not react to Mr Stone's non-attendance for depot medication until they were contacted by Ms CC - PO. They should have notified the other agencies sooner and/or convened the case conference. In the event, a potentially dangerous situation was averted in part because of commendable reaction of a probation officer.

By now, Mr Stone should have been made subject to the CPA. However, this still did not occur. No key-worker was appointed to his case. At the time Dr AA - CPsych believed that it was social service policy not to appoint a social worker as key-worker for a client on probation, but there was no evidence that Social Services had such a policy. No clear understanding had been arrived at about who was the responsible medical officer (RMO). Dr AA - CPsych thought that the arrangement with regard to RMO was that both Dr Z - CPsych and himself would be RMO within their own clinical fields, something which was formalised later on in respect of dual diagnosis patients.

No formal date was set at the June meeting for reviewing Mr Stone's progress. The report of the June case conference was not sent to the GP (who was not there), and no agreed minute of the meeting was taken and circulated. Each of the agencies thus relied upon its own note of what was agreed rather than ensuring that the same understanding was held by all.

As such, the June case conference did not resolve the admitted confusion in the roles of the various doctors involved in Mr Stone's care.

These omissions contributed to the lack of information sharing and coordination between agencies in respect of his non-attendance for depot medication and their joint failure to ensure that a potentially dangerous patient was monitored in the community.

The Panel consider that these deficiencies highlight the value of CPA in providing clarity in the management of a difficult patient, particularly one involved with various agencies.

- 4.10 On 18th August 1994 a second multi-agency review meeting was held at Manor Road, attended by Dr Z - CPsych (the newly appointed addiction consultant), Mr Y - RMN, Dr BB - Psych and Mr Stone. Mr Stone confirmed that he was misusing illicit *benzodiazepines*, *nitrazepam* and *diazepam*, and alcohol. He denied abusing hard drugs. He had said he had stopped taking *Depixol* and *melleril* because of the side effects with beneficial results. He was still taking 70mg of *methadone* per day.
- 4.11 No psychotic features or violent thoughts or fantasies were noted. The treatment plan devised was:
- (1) to stop abusing *benzodiazepines*;
 - (2) to continue only with *methadone* at 70mg a day but to start to reduce it from 1st October 1994;
 - (3) to see Mr Y - RMN at Manor Road every two weeks for counselling;
 - (4) to attend Throwley House monthly for mental state examination and, should paranoid symptoms reappear, *Depixol* should again be prescribed.

Dr BB - Psych then relayed the outcome of this case conference to Dr M - GP by letter dated 22nd August 1994. In the letter she emphasised that the plan was for Mr Stone not to use any drugs except *methadone* and that he should not be prescribed any psychotropic medication. She stated she would assess Mr Stone monthly and if at any time he showed psychotic symptoms he would be put back on a depot injection. She told the Panel that she recorded the decision to stop *benzodiazepines* and assumed that the addictions team would know how to stop them properly.

- 4.12 Mr Stone was offered appointments with Dr BB - Psych on 19th and 26th September 1994 but failed to attend. On 3rd October 1994 a letter was sent by the CPN to Mr Stone's GP¹¹ discharging him from Throwley House because of his non-attendance stating that:

"This gentleman has failed to attend the appointment offered and not responded to communications...I can therefore only assume that all is well at the present time and that he no longer wishes to be seen at Throwley House".

¹¹ A note on the bottom indicates that this letter was copied to Dr Z – CPsych. However, it does not appear to have arrived, as it is not found in the Manor Road notes.

- 4.13 On 12th October Mr Stone's GP replied to the letter pointing out that he had an address for Mr Stone different from that quoted and querying whether his non-attendance was thus due to him not having received the appointments offered. There is no indication that any further action was taken on receipt of this letter at Throwley House.
- 4.14 When questioned about the rationale for discharging Mr Stone from the Throwley House clinic at that stage, Dr BB - Psych informed the Panel that if a patient with short-term emotional problems was not giving cause for concern at his last attendance and he missed two appointments he would be discharged. However, she would not have expected this to happen with someone like Mr Stone. She thought that the letter of 3rd October was likely to have been a misunderstanding on the part of the secretary. (Mr ZM - CPN, the CMHT coordinator with responsibility for following up non-attendance, was not interviewed by the Panel).

COMMENT:

The treatment plan formulated on 18th August was acceptable save for the unqualified decision that Mr Stone should immediately stop taking benzodiazepines. It should have been considered at this point whether or not Mr Stone was addicted to benzodiazepines as abrupt benzodiazepine withdrawal can be harmful by producing psychosis and convulsions amongst other symptoms. There had been no investigation of the extent of his current and past benzodiazepine use by such means as urine sampling or profiles of use.

Dr BB - Psych was entitled to assume that the addictions team would be aware of the correct procedure for withdrawing a patient from benzodiazepines, but it might have been wise to spell out the requirements in a letter to a general practitioner who might not have been expected to have this degree of specialist knowledge.

The Panel note with concern that, following the second multi-agency meeting in August, the pattern was repeated of neither the depot clinic team nor the addictions team informing the other that Mr Stone had again failed to attend for treatment for almost two months.

Mr Stone should by now have been made subject to the CPA. However, as this had still not occurred, there was still no key-worker appointed to his case, and no clear provision had been made for a responsible medical officer (RMO). This continued to contribute to the lack of information sharing between agencies in respect of his non-attendance and to their joint failure to ensure that a potentially dangerous patient was properly monitored in the community.

As with the June meeting no agreed minute of the August meeting was taken and circulated. Each of the agencies thus relied upon their own note of what was agreed rather than ensuring the same understanding was held by all.

Given the concerns that Mr Stone's mental state might be deteriorating (which had led to the August 1994 case conference being called), his subsequent failure to attend Throwley House for review and possible reinstatement of depot should have been more assertively investigated and the care plan reviewed. The Panel has not been able to determine precisely why the discharge letter was sent, but clearly it should not have been, and a more proactive approach to securing Mr Stone's return to the clinic might have been expected.

It is particularly unfortunate that the loss of contact with the Throwley House team coincided with the beginning of the period of deteriorating behaviour which led to Mr Stone's compulsory detention, but it is not possible to say whether there was any causal relationship between these events.

5. DETERIORATION IN MENTAL STATE: 3RD NOVEMBER 1994

- 5.1 On November 3rd 1994 following reports of disturbed behaviour on the part of Mr Stone, including demanding *benzodiazepines* at his GP's surgery, Dr BB - Psych called a review meeting at Manor Road attended by herself, Mr Stone, Mr Y - RMN, Dr Z - CPsych and Dr L - GP (Dr M - GP's partner at the practice). Dr BB - Psych's note of this meeting records Mr Stone's continuing non attendance at Throwley House, apart from one unheralded (and unrecorded) visit asking for *nitrazepam*, which was refused, and after which he was said to have become angry and threatened to commit robbery.
- 5.2 At the meeting Mr Stone appeared thin and pale; he complained of insomnia which he felt should have been relieved by *benzodiazepines*. He admitted that he was purchasing these daily on the streets (7-8 tablets of *nitrazepam*). He said he was stealing to fund this and to buy food. Mr Stone was described as hostile and angry, verbally abusive and threatening. He denied auditory hallucinations, but expressed thoughts that people would kill him in his sleep and consequently had alarmed his house and had protected it with an electric wire. He also revealed that he had been involved in serious domestic violence. Mr Stone was offered further treatment at Throwley House but became angry, shouted abuse and banged a door. He was insistent that he would take no more depot injections because of the side effects.
- 5.3 Dr BB - Psych recorded that the opinion of those present was that Mr Stone was definitely psychotic, had no insight into his condition and would not accept treatment voluntarily. Because of his background it was felt that he could be a danger to himself and probably to others. It was felt that he needed to be detained under the Mental Health Act 1983 and admitted to a secure unit. Dr BB - Psych, gave evidence to the Panel that during this meeting the possibility of being admitted to hospital, whether voluntarily or compulsorily, was not raised with Mr Stone.
- 5.4 That same day Dr Z - CPsych contacted Dr AA - CPsych and discussed the content of this 3rd November meeting. Dr BB - Psych informed the inquiry Panel that she may also have had a discussion with Dr AA - CPsych that day. After this Dr AA - CPsych assumed clinical charge of the case as he considered it was time for the case to be taken over by a consultant.

5.5 On 3rd November 1994 Dr AA - CPsych telephoned Ms ZJ - SW at Kent Social Services and requested that an approved social worker (ASW) assess Mr Stone for compulsory admission under the Mental Health Act. Dr AA - CPsych asked that any assessment be delayed until a bed was found and she records that he advised her:

- “1. Do not visit at home without police;
2. If picked up on s.136 by police Mr Stone must be admitted to Bexley Hospital and not Brooke Ward (Dr AA - CPsych’s ward).”

DR AA - CPSYCH’S MEMORANDA

6. FIRST MEMORANDUM: 8TH NOVEMBER 1994

6.1 On 8th November 1994 Dr AA - CPsych wrote a memorandum which he addressed to Dr Z - CPsych. He stated that the purpose of the memo was to update everyone likely to be concerned with Mr Stone, whose recent presentation had caused some anxieties. Dr AA - CPsych described Mr Stone’s recent psychiatric supervision and his involvement with Manor Road Clinic. He stated that Dr V - CPsych, Dr Z - CPsych’s predecessor, had thought Mr Stone a paranoid schizophrenic, that he had paranoid ideation - probably delusional ideation - and had been on depot neuroleptics at Throwley House. Dr AA - CPsych recounted how Mr Stone had not attended the depot clinic since August and stated that Mr Stone had “missed three months depot neuroleptic”. Dr AA - CPsych’s memo did not inform the recipients that the doctors’ agreed decision at the case conference in August had been to stop the depot injection (albeit whilst continuing to monitor Mr Stone’s mental state).

6.2 Dr AA - CPsych then gave an account of Mr Stone’s criminal history which he felt indicated:

“escalation towards increasing violence’, having moved from petty property offences, through burglary to attacks on people with hammers, and came to our notice two years ago after completing a ten year sentence for armed robbery”.

6.3 Dr AA - CPsych described Mr Stone’s behaviour at Throwley House on 3rd November 1994, his demands for *benzodiazepines*, his paranoid and threatening ideation, his claims of being persecuted, the barricading and wiring up of his house and his aggression to Dr Z - CPsych and Dr M - GP in the street. Dr AA - CPsych added that he believed that Mr Stone claimed that he was carrying a gun and had been regularly assaulting his partner.

6.4 Dr AA - CPsych’s conclusion was that Mr Stone could be:

“breaking down into frank paranoid schizophrenia, having missed three months depot neuroleptic. In the context of his escalating criminal violence he must be presumed to be dangerous, if not psychotic.”

6.5 Dr AA - CPsych then formulated the following provisional plan:

- “(1) No attempt should be made to admit him to an ordinary psychiatric ward, as it is likely he could not be contained there safely.

- (2) Thus the hospital should not be used as a place of safety under Section 136 in this man's case: the Police Station should be used.
 - (3) Further enquiries should be made regarding others concerned about his recent behaviour:
 - a. Ms QQ - SW, [social worker] has offered to visit his mother for this purpose.
 - b. Mr HH - PO, Rochester Probation, has kindly agreed to check probation files about recent concerns and enquire of the Police, as to whether they are concerned.
 - (4) Dr T - CPsych(F) (new) Consultant Psychiatrist at Trevor Gibbens Unit, regrets that no facilities exist for acute admission of someone like this, owing to blocking of the unit with Section 41 patients. If Mr Stone were admitted to another unit he would be glad to see him there and offer an opinion.
 - (5) The only facility for admission would thus be Bexley Hospital, Stansfield Unit, where we still have a contracted bed. This is often not available and it would need to be secured in advance. Fortuitously, the Bexley Addiction Unit, Brunswell, is opposite Stansfield Unit and have offered to help the addiction problem, should Mr Stone be admitted to Stansfield Unit.
 - (6) If there is sufficient cause for concern about the safety of others, Mr Stone should be admitted compulsorily to Stansfield Unit. This should be carefully planned with adequate Police attendance, preferably one plain clothes officer attending with social worker and Psychiatrist and others held in reserve very near by. Approach should be non confrontational. This could occur at the patient's home, but alternatively at the Addiction Centre, 4 Manor Road.
 - (7) ASW should be a Chatham social worker, as addiction team social worker is not an ASW.
 - (8) All parties should remain in contact about Mr Stone, as long as there is cause of continued anxiety."
- 6.6 This memorandum was circulated widely. It was sent to Ms ZJ - SW (social worker), Dr M - GP (GP), Mr HH - PO (new probation officer), the charge nurse of Brooke Ward, Medway Hospital, and the Stansfield and Brunswell Wards at Bexley Hospital. It was not copied to Dr T - CPsych(F) although he had by this stage been informed of the case.
- 6.7 Dr AA - CPsych had not personally assessed Mr Stone when he wrote this memo although he had been briefed by Dr BB - Psych. Indeed Dr AA - CPsych had met Mr Stone on only two previous occasions, the most recent being over 20 months earlier in March 1993 at the depot clinic.
- 6.8 Dr Z - CPsych in evidence informed the inquiry that in his view the image that is painted in Dr AA - CPsych's first memo of the gun and the police, and concluding that there should be no admission to a general ward under any circumstances, was "*a little bit much*" of an over the top description compared to how he personally viewed Mr Stone at the time. He said that although Mr Stone had said to him that he had a gun, he could not see one and did not believe this assertion to be true. He attributed Dr AA - CPsych's account to the fact that he was working on information he had received rather than having been present. Dr Z - CPsych would not have been as certain about it. Dr AA - CPsych told the Panel that factual information in these community crises, where the patient was not present and information was second or third hand, was often

inaccurate. Although he noted that an accurate description of violence and threats was now regarded as essential for risk assessment, he stated that in his service they were not used to guns and their mere mention produced immediate severe anxiety. He considered that it was better to be overcautious than to dismiss this type of allegation, and would act in the same way today on this type of information.

COMMENT:

The Panel accept that Dr AA - CPsych's actions were motivated by the laudable desire to protect staff, and fully accept the force of his comments with regard to the need for caution. Nonetheless, the greater the need for caution, the greater is the need for accuracy in the information conveyed, and this ought, where practicable, to include checking the accuracy of the information with available sources.

7. SECOND MEMORANDUM: 10TH NOVEMBER 1994

- 7.1 A second memorandum by Dr AA - CPsych was written on 10th November 1994 distributed to all those mentioned above, except Ms ZJ - SW at Social Services, plus Dr T - CPsych(F), consultant forensic psychiatrist. Dr AA - CPsych had still not personally seen Mr Stone.
- 7.2 This memorandum described a visit by Mr Stone that day to Manor Road demanding *benzodiazepines* in a threatening way. It stated that Dr Z - CPsych, who had been consulted by Dr AA - CPsych, was not prepared to section a patient at Manor Road (for policy reasons because of the effect on other service users). Dr AA - CPsych had discussed with Dr A - CPsych the possibility of Mr Stone's admission to Stansfield Unit at Bexley Hospital. Dr A - CPsych in turn had consulted the nursing staff of that unit and Dr ZB - CPsych(F), the local consultant forensic psychiatrist, and had concluded that, on the evidence available, Mr Stone was too dangerous for admission to the Stansfield Unit, Dr ZB - CPsych(F)'s advice was that Mr Stone should be seen only in police custody.
- 7.3 Neither Dr AA - CPsych, Dr A - CPsych, nor Dr ZB - CPsych(F) had personally seen Mr Stone and it was now one week since the initial Manor Road incident.
- 7.4 Dr AA - CPsych then recounted a conversation with Mr HH - PO (probation officer) who that day had seen Mr Stone and had found him quite disturbed, threatening to harm children and shouting inappropriately at passers-by in the street. Mr HH - PO was said to be concerned at his state and was prepared to take him to see a psychiatrist.
- 7.5 Dr AA - CPsych's memo then gave further details of Mr Stone's criminal record, reporting that Mr Stone was currently on probation for carrying a gun and stating that Mr HH - PO had arranged to see Mr Stone on 14th November 1994 at the probation office and that he, Dr AA - CPsych, intended to be present to assess Mr Stone's mental state.
- 7.6 Regarding the continuing search for a bed, Dr AA - CPsych had again spoken to Dr T - CPsych(F) and been told that no beds were available in the Trevor Gibbens Unit

although Dr T - CPsych(F) had again indicated that he would be prepared to see Mr Stone either in police custody or as an out-patient.

7.7 Dr AA - CPsych had informed the duty police officer at Chatham Police Station that he had advised “the proprietors of Medway Hospital” not to allow the hospital to be used as a “Place of Safety” under Section 136 of the Mental Health Act because Mr Stone was potentially dangerous and could not be contained in hospital. Chatham Social Services had also informed the out of hours ASW services about this. The Chatham social worker had not yet visited Mr Stone’s mother.

7.8 Dr AA - CPsych said that the bed occupancy on his own ward was always between about 85% and 90%, and it was not grossly overloaded. He made it clear that his decision not to admit Mr Stone to an open ward at Medway was not based on bed availability.

7.9 When further asked whether Mr Stone would have been less of a risk if admitted to his own ward on a temporary basis, albeit with increased staffing, rather than to leave him in the community, Dr AA - CPsych replied:

“He might, but I am sure the others would not. Maybe I am cynical, but I know then I would still have a nasty feeling that once he was in hospital everyone would walk away, and that was it, and my view was at the time that he would simply walk straight out again... I certainly felt that at the time, that because a person is an in-patient I am undoubtedly then the responsible medical officer, and it is my responsibility as to what happens with this patient's behaviour, and I just was not prepared to do that.”

7.10 As to the possibility of admitting potentially violent patients with some increased security measures in place Dr AA - CPsych volunteered that:

“There have been one or two others where a patient has been quite dangerously violent and we have had confrontations with the police, saying that, “We cannot admit this patient.” I think the last time was when threatened with publicity for not admitting someone we reached an arrangement whereby we would admit immediately to a seclusion room and the police would stay with the patient until all was well and that seemed to work very well. They were quite helpful on that occasion.”

Dr AA - CPsych told the Panel that it remained an absolute hospital rule that issues arising out of the use of weapons and homicidal behaviour are handled only by the police. He maintained that it could be accurately predicted that such issues would arise in Mr Stone’s case and that it would have been...

“foolhardy to admit a dangerous patient to an open ward, without the slightest security on the premises... Our unit could not have contained this determined and dangerous man.”

He pointed out that the most secure area was the seclusion room, which, as a matter of policy, could only be used for a few hours, and that he was not prepared to risk the lives of staff and patients.

COMMENT:

Dr AA - CPsych would have been wholly justified in not admitting to his open ward a patient presenting the risks and dangers he described. It is a matter of great concern that he was placed in the position of not having rapid access to a bed in a local secure facility for such a patient. The absence of a bed in these circumstances could have placed the community at a considerable risk.

Nonetheless, the Panel considers that in these admittedly very difficult circumstances it would have been prudent for Dr AA - CPsych to have assessed the patient personally by this time, or at least taken steps to confirm whether the evidence supported the impression he had obtained of this patient and the degree of risk he presented. Dr AA - CPsych could have then decided whether the better or "least bad" option was to admit Mr Stone to his ward with the best precautions available in place. Dr AA - CPsych's judgment seems to have been influenced more by anticipated future difficulties rather than the immediately pressing ones.

8. MENTAL HEALTH ACT ASSESSMENT: 14TH NOVEMBER 1994

- 8.1 On 14th November 1994 Dr AA - CPsych and Dr Z - CPsych in the company of Mr HH - PO met with Mr Stone at Rochester Probation Office to assess him for a compulsory admission under the Mental Health Act.
- 8.2 When asked why he did not assess Mr Stone personally until 14th November, some 11 days after first being alerted to his condition, Dr AA - CPsych replied that he could not explain the gap. As far as he could remember, he had had to make a number of inquiries to discover where and how he could see the patient. He had believed that he would only get one bite of the cherry in that he believed there would be no opportunity to see Mr Stone after the assessment in order to complete the sectioning process. Therefore, he considered it important to have a bed available before he went to see Mr Stone. He thought that Mr Stone's disturbance was such that the police would be required to help in that process, and once they were involved it was not practical to return on another day. He has pointed out that he had to continue the work of his catchment area at the same time as attending to the problems caused by this case.
- 8.3 In the event, having been persuaded by Mr HH - PO that Mr Stone would be more likely to remain for assessment if this was done in familiar surroundings, Dr AA - CPsych's only meeting with Mr Stone in this period was held in the probation office with neither an ASW nor the police present, and before a bed had been found. The application to admit Mr Stone was not made until he was assessed by the ASW on 24th November 1994.
- 8.4 On assessing Mr Stone on 14th November 1994 both Dr AA - CPsych and Dr Z - CPsych agreed that Mr Stone was suffering from a paranoid psychosis and the likely diagnosis was paranoid schizophrenia. Their view was that Mr Stone was psychotic, dangerous and needed admission to hospital, although Dr AA - CPsych still felt it was not safe to admit Mr Stone to an open ward.

- 8.5 Mr Stone was still refusing to take depot medication because of side effects but Mr Stone himself then suggested that he be given *stelazine* as before. Dr AA - CPsych then prescribed a one-week supply of 15mg *stelazine* daily and *procyclidine* 15mg daily.
- 8.6 The Panel were informed that, although a bed had not yet been found, following meeting with Mr Stone on 14th November 1994, both Dr AA - CPsych and Dr Z - CPsych completed medical recommendations for Mr Stone to be compulsorily admitted for treatment under s.3 of the Mental Health Act 1983. However, these forms were discarded on 17th November on the advice of the ASW and alternative recommendations under s.2 (for assessment) were completed. The eventual application for compulsory admission was later made under s.2 of the Act.

9. THIRD MEMORANDUM: 14TH NOVEMBER 1994

- 9.1 On 14th November 1994 Dr AA - CPsych wrote a third memorandum, which was again widely circulated to all recipients of the earlier memo except Social Services. It recounted how he and Dr Z - CPsych had met with Mr Stone earlier that day at Rochester. Dr AA - CPsych described Mr Stone's presentation at the psychiatric assessment:

"He was shabbily dressed and quite withdrawn, sitting with head bowed and eyes averted. He spoke in a curious, "creaky" voice, very reminiscent of many chronic schizophrenics. His manner was tense and irritable, also frequently rubbing and scratching himself. Initially he was insistent that he wanted nothing but valium and would not speak to me as I could not provide it. On a number of occasions he got up angrily and made as though to leave, but was persuaded to stay. He denied any suggestion of schizophrenia, but ultimately when asked about other problems he suddenly began to tell a delusional story that he was ..., paid twenty thousand pounds a week,... and lived in fear that he would be murdered. He was very indignant when he sensed our disbelief, showed suspiciousness of our motives when we wanted to discuss him alone, but ultimately was persuaded to leave quietly."

- 9.2 Dr AA - CPsych then stated that he and Dr Z - CPsych "had no doubt this man was suffering from a paranoid psychosis..[it was] unlikely that this was drug induced and it is likely this is paranoid schizophrenia." He summarised Mr Stone's condition saying he was "psychotic, dangerous and needed admission to hospital". He confirmed that Mr Stone had requested and accepted a prescription for *stelazine*.
- 9.3 Further contact with Dr T - CPsych(F) had confirmed the continuing unavailability of a bed in Trevor Gibbens Unit; Dr T - CPsych(F) had suggested admission to a local ward instead. Further enquiries about a bed in Runwell Hospital had revealed that a Regional Secure Unit bed there would not be available for six weeks and further information about an intensive care unit bed in that hospital was still awaited. Discussion had taken place about the funding of a place outside the local catchment area and it had been agreed that, if necessary, West Kent Health Authority would fund this.

- 9.4 On 15th November 1994 Dr AA - CPsych wrote to the Duty Officer of the Proactive Unit, Chatham Police Station, copied to the Medical Defence Union. This was to confirm an earlier telephone conversation with the police about the danger of Mr Stone to the public. Dr AA - CPsych wrote:

“He is sectionable under the Mental Health Act, but our advice must be that he is a potential danger to others which is clearly unacceptable. Immediate action to contain him is unavoidable.”

10. FOURTH MEMORANDUM: 16TH NOVEMBER 1994

- 10.1 On 16th November 1994 Dr AA - CPsych wrote and circulated a fourth memorandum. Again it was not copied to Social Services. In this he confirmed that a bed would not be available in the Dudley Venables Unit, Canterbury. He gave further information about a conversation with Dr ZN - CPsych(F), Regional Forensic Psychiatrist, who had expressed the view that Mr Stone’s probation order should be breached on the grounds that he was a danger to the public. The Police Proactive Unit, having listened to the details, was of the view that Mr Stone could not be arrested but promised assistance if he were to be detained under the Mental Health Act.
- 10.2 Dr AA - CPsych had contacted Dr ZX - DOH at the Department of Health asking for information on secure beds nationally, but had been told there was no central record of secure units and thus Dr ZX - DOH was unable to indicate where a bed might be found. Dr ZX - DOH advised that Mr Stone be seen by a forensic psychiatrist. This advice was not taken up by Dr AA - CPsych despite Dr T - CPsych(F) having already offered to see Mr Stone. When asked by the inquiry Panel why he did not ask Dr T - CPsych(F) to assess Mr Stone Dr AA - CPsych replied that he was quite happy that they were discussing the matter by telephone.
- 10.3 Dr AA - CPsych had discussed with Mr GG - PO, senior probation officer, the possibility of breaching of Mr Stone's probation order. Further information from the probation office revealed that Mr Stone had “taken a hammer to his flat and done some damage”. Although Mr GG - PO had been helpful, it was later reported that local Magistrates had said that they were unable to breach Mr Stone’s probation order.¹²

¹² This had in fact been the advice of the Magistrate’s Clerk. See Probation Services chapter paragraph 6.9 to 6.12.

11. 17TH NOVEMBER 1994

- 11.1 On 17th November 1994, Dr AA - CPsych wrote a memorandum to Dr P - CD, his clinical director which was a summary of the views already expressed and action he had taken.
- 11.2 That same day Mr ZY -NGMan, Nurse General Manager, Mental Health Directorate, sent a memorandum to Mr Mangan, Chief Executive of North Kent Health Care Trust, on the topic of Secure Facilities. He reported that as a result of the search for a bed it had now been confirmed that a vacancy existed at De La Pole Hospital, Hull, and that further contact would indicate whether Mr Stone could be offered a bed. Mr Stone had been placed on the Supervision Register by Dr AA - CPsych. Mr ZY -NGMan emphasised that since the previous day 40 units throughout the country (both NHS and the private sector) had been contacted but none had a vacant bed, indicating a severe and unacceptable shortage of secure facilities locally and nationally, an issue which he understood Mr Mangan would be taking up with West Kent Health Authority.
- 11.3 Also on 17th November 1994 Dr AA - CPsych wrote to Mr Iles, Clerk to Chatham Magistrates, following the advice that Mr Stone's probation order could not be breached. He expressed concern about Mr Stone's dangerousness, partly ensuing from mental illness, his criminal record of violence and his recent serious assaults. He reported that Mr Stone needed treatment in hospital but that this should be provided only in a regional secure unit, though, despite much endeavour, no such bed had yet been found. Dr AA - CPsych informed Mr Iles he was anxious about the safety of the public as Mr Stone continued to be at large.
- 11.4 On the same date Mr HH - PO, probation officer, had made a home visit to Mr Stone during which he persuaded Mr Stone of the benefits of depot medication. Mr Stone agreed to accept the treatment and then went to Throwley House with his mother and asked for a depot injection. Dr BB - Psych was present and administered a dose of 25mg of *modecate*. When she told Dr AA - CPsych she felt he had not been very happy about this, because of safety considerations. Dr AA - CPsych explained to the Panel that it was a rule at Throwley House that aggressive or violent patients should not be assessed there. However, Dr BB - Psych had felt safe because Mr Stone's mother had accompanied him.

12. FIFTH MEMORANDUM: 17TH NOVEMBER 1994

- 12.1 On 17th November 1994 Dr AA - CPsych wrote his fifth and final memorandum, again widely circulated to all but Social Services. He described a consultation with Dr YA -TMD, Trust Medical Director, about the possibility of admitting Mr Stone to an ordinary ward if no other facility became available, but said that Dr YA -TMD was emphatic that they did not have the facilities.
- 12.2 When asked whether, bearing in mind his level of concern, it was not possible at this point to revisit his original decision, and look to his own unit again as at least a temporary placement which was safer than the street. Dr AA - CPsych replied:

"Yes, I did, I went to both the clinical director [Dr P - CD] at the time and the medical director [Dr YA -TMD], and both of them said "No" basically... it was a question of saying, "Look, I have this awful problem. We can't get him in anywhere. Can we consider admitting him to an acute bed here?" And their view, independently, was vehemently no."

COMMENT:

The Panel note that Dr AA - CPsych's written advice to clinical director on 17th November was that "because of the dangerousness of this man he should not be admitted to an open psychiatric ward". Given this information both Dr P - CD and Dr YA -TMD would have had no option but to agree with Dr AA - CPsych that Mr Stone should not be admitted to Dr AA - CPsych' ward.

- 12.3 Dr AA - CPsych had been in discussion with Ms QQ - SW, duty approved social worker, about the nature of the proposed compulsory detention. Dr AA - CPsych recorded that:

"Social Services are strongly of the opinion that the patient's mother, nearest relative, would not consent to a Section 3 and advised that Section 2 would be more likely to be implemented. In the circumstances the County Solicitor agrees this is proper."

- 12.4 Although Ms QQ - SW had consulted with the County Solicitor, the Social Services records show that Dr AA - CPsych had agreed with Ms QQ - SW that he would change his recommendation from s.3 to s.2 before the solicitor had been consulted, and that the solicitor had been involved initially because of Dr Z - CPsych's concern about himself and Dr AA - CPsych working for the same Trust.¹³
- 12.5 When asked whether the predicted reluctance of the patient's mother was the reason for changing from Section 3 to Section 2, Dr AA - CPsych agreed that it had been, and that such a ground had been "frowned upon" since then in the Mental Health Act Code of Practice.
- 12.6 Dr AA - CPsych's fifth memorandum also reported that a bed had been found at De La Pole Hospital in Hull and, although the consultant in charge, Dr ZA - CPsych, was not a forensic psychiatrist, preliminary discussions with a charge nurse suggested that the unit could cope with Mr Stone. Dr AA - CPsych had therefore sent a letter of referral to Dr ZA - CPsych, who had indicated that if Mr Stone was not already known to him a nursing assessment would be required, a course which he deemed impractical whilst Mr Stone was still in the community.
- 12.7 When asked by the Panel what information he had about the De La Pole unit at that time, Dr AA - CPsych informed the Panel that he had visited the unit for an approval inspection about five years previously. He was aware that it was not a forensic unit, but was for intensive care, although it was prepared to take forensic patients.

¹³ See Social Services chapter at paragraph 1.12 to 1.14.

- 12.8 Dr AA - CPsych's memorandum also recorded that Mr HH - PO had managed to persuade Mr Stone to go to Throwley House where he had accepted *modecate* 25mg. Dr AA - CPsych noted he had spoken to the CPN who felt 25mg was unlikely to help Mr Stone's mental state very quickly. Dr AA - CPsych had therefore decided to continue with compulsory admission if a bed was still available.
- 12.9 Dr AA - CPsych told the Panel that he had not seen the patient again himself as he felt that if they definitely had a bed, they should use it and "play safe", given the difficulties experienced in getting as far as they had.
- 12.10 Dr AA - CPsych completed a medical recommendation form for compulsory admission under s.2 Mental Health Act on 17th November 1994 in which he set out his reasons why informal admission was not appropriate including:
- "Mr Stone is known to suffer from paranoid psychosis and has refused to accept depot neuroleptic medication in the community."
- The recommendation form did not mention that Mr Stone had accepted both *stelazine* (on 14th November) and a *modecate* injection (on 17th November).
- 12.11 When asked whether the statement on the form about refusal of medication was accurate at the time he wrote it on 17th November, Dr AA - CPsych replied that he was not sure, but believed it to be so at the time he wrote it. However, he would have written the form in the same terms in any event, as the patient had refused to accept medication, and could not be relied upon to accept it in the future, even if he had accepted one injection.
- 12.12 Ms QQ - SW (the ASW who subsequently made the compulsory admission application) said in evidence that despite almost daily contact with Dr AA - CPsych she was unaware that at the time of her assessment of Mr Stone on 24th November 1994 that he had already accepted medication, both *stelazine* and *modecate*.
- 12.13 Social services had not been copied on either of the two memoranda which recorded that Mr Stone had taken *stelazine* and *modecate*. Dr AA - CPsych was unaware whether the approved social worker had known this, and accepted that the responsibility for updating her had been his.
- 12.14 On 17th November Dr Z - CPsych had also been unaware that Mr Stone had accepted *modecate* when he signed the second medical recommendation for Section 2 admission. Dr Z - CPsych informed the Panel that, had he been aware of this, it would have affected what he wrote on the form, and whether to make the recommendation at that time.¹⁴ (Although Dr AA - CPsych did refer to Mr Stone's acceptance of depot medication in his memo dated 17th November which was copied to Dr Z - CPsych, this was sent by post and not received at Manor Road until 24th November, by which time Mr Stone's admission had been effected).

¹⁴ See Addiction Services chapter paragraph 11.3.

12.15 On 17th November Dr AA - CPsych also completed a form placing Mr Stone on the supervision register. Dr AA - CPsych and Dr Z - CPsych were said to be joint RMOs and Dr BB - Psych was recorded as Mr Stone's key-worker. When asked what provoked the decision to register Mr Stone that day, Dr AA - CPsych informed the Panel that the supervision register was a relatively new concept at the time, and that Mr Stone was an obvious person to go on it, following the Clunis report.¹⁵ He thought that his name was probably entered then because the perception of his dangerousness had come more to the fore.

COMMENT:

Given what he believed to be the position on 3rd November Dr AA - CPsych was faced with the very real challenge of a patient he believed to be highly dangerous, refusing medication with no suitably secure facilities available to admit him. On what he believed it was perfectly reasonable to anticipate that a secure placement would be required. His desire to protect his staff was commendable. Unhappily such a situation will be familiar to many consultant psychiatrists up and down the country given the limited availability of intensive care beds and secure accommodation.

Unfortunately the lack of such resources may have led to a lack of clarity and focus in the management of the problem presented by Mr Stone, leading to a failure to obtain appropriate information about the patient's condition or to take account of changing circumstances. The result was that a patient initially, and with justification, feared to be dangerous to the public, was allowed to remain at large for 21 days, before eventually being compulsorily admitted to hospital without regard to changes in his presentation.

On 3rd November the view of four doctors was that Mr Stone was mentally ill, dangerous, and required compulsory detention. The expectation would be that compulsory admission could be effected within a short time and certainly within 24 hours.

When it was discovered that secure accommodation was not immediately available, the Panel consider that there should have been immediate reconsideration of alternative arrangements for accommodating Mr Stone in Dr AA - CPsych's own ward, which had vacant beds or otherwise monitoring and attempting to treat him in the community. While the need to ensure staff safety was obviously important, so was the need to consider the safety of the public.

Dr AA - CPsych should have arranged an assessment of the patient by a consultant, once it became clear that there were difficulties in finding appropriate accommodation. To have done so would have enabled Dr AA - CPsych to establish the condition of the patient, identify any changes in his condition, and most importantly assess the degree of danger actually present.

¹⁵ "The report of the inquiry into the treatment and care of Christopher Clunis" - published February 1994.

Such an assessment could have been undertaken either by Dr AA - CPsych himself or by Dr T - CPsych(F), who had offered to do so.

Instead Mr Stone was left at liberty unseen by any agency for five days (until 8th November when seen by Mr HH - PO, his new probation officer) and without any system for monitoring him being in place.

On 14th November the MHA assessment by Dr Z - CPsych and Dr AA - CPsych made at the probation office resulted in Section 3 admission being recommended by both of them. The records show that these recommendations were later changed to Section 2. There were good reasons for making that change in that the patient was properly thought to be in need of assessment before treatment. However, the reason given by Dr AA - CPsych, namely a fear that the nearest relative would not agree to a Section 3, is unacceptable, even if it had any foundation in fact, which it had not. To use Section 2 in this way deprives the patient and the relative of rights enshrined in the Act, and is, as was acknowledged by Dr AA - CPsych to us, in breach of the Mental Health Act Code of Practice [para 5.4a]. This should not be dismissed as a mere theoretical point, as non-compliance with statutory requirements can lead to successful legal challenge and the inappropriate discharge of patients in genuine need of treatment.

The Section 2 recommendation signed by Dr AA - CPsych was unintentionally misleading in asserting that Mr Stone had refused to accept depot medication, without recording that on 14th November he had accepted a prescription of stelazine, and on 17th November a depot modecate injection. These events required a re-assessment of the case for admission and a review of the impact of this medication on his mental state. Further, the absence of this information in the written recommendation resulted in the ASW undertaking her assessment of the patient in ignorance of these material facts.

It might still have been reasonable for Mr Stone to have been admitted to hospital, compulsorily or voluntarily, but the fact remains that by 24th November Mr Stone had manifested a willingness to accept medication and compliance with requests to attend assessments. These factors might have led to a reconsideration of whether he needed to be admitted to hospital, and, if so, the type of unit to which it was appropriate to admit him.

Finally, the delays in arranging admission or treatment for a patient believed, whether rightly or wrongly, by Dr AA - CPsych, to be a serious danger to the public resulted in his being left at large in the community for a period of 21 days. Dr AA - CPsych himself told the Panel that “I was alarmed at leaving the patient “in the streets” for this length of time. Because the location of the patient was not known for most of this period it was just not possible to put in place community monitoring. We had to fall back on what we heard about the patient, from probation and information from other sources”.

Even if this belief had been correct, and despite his wish to have the patient removed to a place of safety and approaches to the criminal justice system, the public were being exposed to the risk of the very “Clunis” situation of which Dr AA - CPsych warned in his memoranda. Whatever the difficulties, the Panel are unable to accept that there was not more that could and should have been done in this situation by the mental health services. It would have been possible to put in place at least some monitoring, whether directly or via the probation service.

The Panel find it strange that the final plan was to send Mr Stone to a distant hospital which, to the knowledge of Dr AA - CPsych, was no more secure than the intensive care ward at Bexley Hospital.

13. BEDS AT DE LA POLE (HULL) & BEXLEY HOSPITALS: 18TH NOVEMBER 1994:

- 13.1 On 18th November Dr ZA - CPsych, locum consultant psychiatrist at De La Pole Hospital, faxed confirmation that he and a nursing colleague would visit to assess Mr Stone the following week. Dr AA - CPsych then telephoned Dr A - CPsych at Bexley Hospital asking if he would admit him to his ward for a few days to allow assessment by the De La Pole team.
- 13.2 On 22nd November 1994 Dr A - CPsych replied seeking further clarification about matters such as Mr Stone’s offences with a gun and whether his criminal associates were still in contact with him. If he could be reassured on these matters, Dr A - CPsych agreed to admit Mr Stone briefly for the assessment to take place, provided that funding for two additional nurses would be provided, and that if the De La Pole admission did not materialise, North Kent Health Trust would make other suitable arrangements for placing Mr Stone.
- 13.3 On 24th November 1994 Dr AA - CPsych wrote to Dr A - CPsych giving the necessary information and assurances and the Chief Executive of North Kent Health Trust also gave assurances about funding to his counterpart at Bexley Community Health NHS Trust.
- 13.4 On 24th November Ms QQ - SW, ASW, assessed Mr Stone for admission under s.2 of the Mental Health Act at the probation office. She described him as “a calm focused man who saw hospital as the better alternative to prison and was quite accepting of the position”. Mr Stone agreed to admission “without hesitation”.¹⁶

14. ADMISSION TO BEXLEY AND DE LA POLE HOSPITALS: 24TH NOVEMBER 1994:

- 14.1 On 24th November 1994 Mr Stone was admitted to Bexley Hospital under s.2 of the Mental Health Act.¹⁷ Mr Stone presented no management problems in the unit and complied with all aspects of the regime without any attempts to abscond. Dr AA - CPsych had no involvement with his care whilst in Bexley Hospital.

¹⁶ See Social Services chapter at paragraph 2.

¹⁷ See Bexley Hospital chapter.

15. ADMISSION TO DE LA POLE HOSPITAL, HULL: 29TH NOVEMBER 1994:

- 15.1 On 29th November 1994 Mr Stone was transferred to the De La Pole Hospital, under the consultant care of Dr ZA - CPsych. Mr Stone again presented no management problems in the unit. He complied with his medication regime and made no attempts to abscond, indeed he was described as “a model patient” by a nurse at De La Pole.¹⁸
- 15.2 On 9th December 1994 Dr AA - CPsych wrote to Dr T - CPsych(F) asking that the forensic services take over clinical responsibility for Mr Stone’s care when he was discharged from De La Pole Hospital, because he did not think that his own psychiatric service, operating from a Community Mental Health Centre, was equipped to deal with Mr Stone, particularly if he again refused to take depot neuroleptic medication. Dr T - CPsych(F) agreed to assess Mr Stone at De La Pole Hospital.
- 15.3 On 14th December Dr ZA - CPsych telephoned Dr AA - CPsych and said he thought Mr Stone was now suitable for transfer back to a local open ward. On 15th December 1994, Dr AA - CPsych wrote to Dr. ZA - CPsych saying that he had discussed the proposition for transfer to his open psychiatric ward as an informal patient with his ward manager, but the nursing staff had felt that they could not cope with such a patient. Dr AA - CPsych suggested to Dr ZA - CPsych that Mr Stone should be detained under s.3 of the Mental Health Act 1983 to allow for assessment by Dr T - CPsych(F) later in December (Dr T - CPsych(F) first saw Mr Stone on 27th December 1994).
- 15.4 On 29th December 1994 Dr AA - CPsych telephoned Ms QQ - SW at Social Services whose note of the conversation records that he told her that Dr ZA - CPsych was trying to transfer Mr Stone to his ward at Medway Hospital, but that as Dr T - CPsych(F) was willing to accept Mr Stone in his team, he should stay on Section 3 detention at Hull until a bed was available at the Trevor Gibbens Unit, Regional Secure Unit.
- 15.5 Thereafter Dr AA - CPsych and his team had no further clinical involvement in Mr Stone’s case.
- 15.6 Dr AA - CPsych’s view was that, having concluded that Mr Stone was a dangerous individual, and that his dangerousness was based on his personality, background and drug habit, and not on mental illness, it was even more clear that he could not be helped in the open acute psychiatric ward, and that, given his escalating criminal history, he could best be treated in the medium secure unit. This view was shared by the nursing staff and not contested by Dr T - CPsych(F), whose team accepted the care of the patient.

COMMENT:

The Panel are unable to accept Dr AA - CPsych’s view in its entirety. In December 1994 he had decided Mr Stone was unsuitable for admission to his open ward without yet having had the benefit of Dr T - CPsych(F)’s opinion. The indications from Mr Stone’s admissions to both Bexley and De

¹⁸ See De La Pole Hospital chapter at paragraph 4.6.

La Pole Hospitals, and Dr T - CPsych(F)'s assessment, were that this patient had not presented any discernible safety problems whilst an in-patient and was generally compliant. There were aspects of his condition which required treatment as appears to be acknowledged by Dr AA - CPsych.

Dr AA - CPsych's refusal to accept Mr Stone's transfer from De La Pole Hospital to his own ward in December 1994, despite reports of a settled mental state and full compliance with medication and the hospital regimes at both Bexley and De La Pole Hospitals, contributed to Mr Stone's further (and inappropriate) compulsory detention under s.3 of the Mental Health Act at De La Pole Hospital.

RECOMMENDATIONS

Paragraph 1

West Kent Health Authority and Thames Gateway NHS Trust should together review arrangements by which the CMHT's accept new patients and satisfy themselves that these are such that when the CMHT concludes that a patient who is in need of treatment does not fit their eligibility criteria:

- (a) this is made clear to the General Practitioner;*
- (b) this is made clear to any subsequent service to whom the patient is referred;*
- (c) the CMHT should assure themselves that the patient has been accepted by another service before relinquishing their responsibility for the patient.*

Paragraph 3

Patients with the most complex needs who require the intervention of psychiatric and social services, and particularly those involved in a number of different psychiatric services, should be placed on the highest level of CPA. In such cases it is essential that one of the psychiatric services assumes a lead role and that an appropriate key-worker is appointed from these services, preferably the service with the most regular contact with the patient.

Paragraph 3

The West Kent Health Authority should ensure that Thames Gateway NHS Trust reviews the standards of the application of CPA in services which they commission and ensure that this review is a continuing process.

The Panel note however that considerable changes have already taken place in CPA procedures and documentation since the events with which this inquiry is concerned.

Paragraphs 6-12

The West Kent Health Authority in discussion with the Thames Gateway NHS Trust should ensure that the Trust can provide psychiatric intensive care in order to:

- (1) Foster the skills and confidence of non-forensic staff in the locality in dealing with difficult and offender patients;*
- (2) Prevent unnecessary referrals to the medium secure service.*

When a patient in the community is deemed too dangerous to be admitted to a non-secure bed and no secure bed is available, the consultant psychiatrist must ensure that:

- (3) Regular and frequent reviews of mental state are carried out by a psychiatrist;*
- (4) A full risk assessment is carried out and recorded;*
- (5) Emergency staffing arrangements are made to ensure that, should the need arise, the patient can be admitted to a non-secure ward until a secure place becomes available.*

When an ASW has been requested to assess a patient in the community for admission under the Mental Health Act the consultant psychiatrist must ensure that:

- (1) As far as possible that assessment takes place with a s.12 approved doctor present;*
- (2) The ASW is informed of any significant clinical changes including the prescription and acceptance of medication.*

Paragraph 15

When a consultant in a tertiary service recommends that a patient is suitable for return to the care of his/her CMHT, the consultant in charge of the CMHT should not refuse to re-accept the care of that patient without a re-assessment of the case by his/her team.

OVERALL EVALUATION OF THE ADDICTION SERVICES

Service involvement in the case

February 1993 to July 1997

The Addiction team provided a large amount of out-patient resources to Mr Stone. In addition to medical oversight he was allocated a nurse counsellor/key-worker who saw him on (approximately) a six-weekly basis from March 1993.

Evaluation against core principles

- **Clarity in current diagnosis, objectives, needs, risk assessment and the strategies to clarify and deal with them**

In February 1993 the Addiction Consultant offered a rapid and appropriate response to a request for an emergency assessment of Mr Stone. He identified Mr Stone's "dual diagnosis" needs (drug addiction and mental illness) at the time and successfully organised a dual response to this by involving the Community Mental Health Team.

The standard of care subsequently offered to Mr Stone by the Manor Road Clinic staff was poor. No systematic or comprehensive addictions assessment was carried out and no full substance abuse history was taken. No clear goals of treatment were identified and notes of attendances at counselling sessions were brief and uninformative.

- **Coordination of the delivery of service, sharing of information and action**

Given the multi-team involvement the CPA or at least its principles should have been applied to this case from the outset, but they were not. The amount and quality of communication with other services were poor.

- **Checking on the outcome of service provision by regular review**

There was no regular review of the effectiveness of the treatment package being offered. No review of diagnosis was carried out. Mr Stone's drug use was not systematically monitored nor was any systematic risk assessment completed. There were no regular physical examinations or urine screenings.

- **Changing the diagnosis, needs and risk assessments and service provision in the light of the review**

Mr Stone made several requests for in-patient detoxification treatment, and on one occasion a plan for in-patient admission following community detoxification was formulated. None of these resulted in an admission. No offer of a bed was ever made to Mr Stone by the Addictions team. In-patient detoxification was not actively or clearly encouraged even when he reached his pre-determined target for admission. The reasons for this are not recorded.

ADDICTION SERVICES
MANOR ROAD ADDICTION CENTRE, CHATHAM

1. THE SERVICE

1.1 In 1993 the Addiction Services were under the clinical leadership of Dr V - CPsych, Consultant Psychiatrist. In 1994 Dr Z - CPsych took over from Dr V - CPsych, initially as a locum Consultant but, after some months, he was appointed in a substantive capacity in April 1995. The service was part of North Kent NHS Trust and is now part of Thames Gateway NHS Trust.

1.2 The team provided healthcare to those with substance abuse problems and their carers in the Medway, Swale and West Kent area, a population of some 350,000. Dr V - CPsych had a split post with five sessions in the addiction service and six sessions as the catchment area psychiatrist for the Rainham area (pop 35,000).

1.3 Manor Road Centre

The Out-Patient Addiction Centre was based in a converted terraced house in Manor Road in Chatham. The Panel visited the Manor Road Centre. It is conveniently situated just off the main shopping and downtown area. The clinic is able to accommodate three or four clinicians, each seeing clients, in a clinic at a time. An extension to the rear of the property accommodates a small activities and occupational therapy style area which can be used during the day by patients for therapeutic activities. Equipment for drug screening urine samples is located on an upper floor. One of the large interview rooms is equipped with a two-way mirror and video recording equipment.

1.4 In addition to a consultant psychiatrist and a staff grade doctor, the multi-disciplinary team consisted of three nurses, a social worker and, at times, various other professionals such as a clinical psychologist.

1.5 At the time of Mr Stone's first contact with the clinic, it was open between 9am and 5pm, Monday to Friday. The team operated a "key-worker" system in that each client was allocated a particular member of the multidisciplinary team who then became the client's main contact with the service. The drug team "key-worker" was the principal addictions professional involved in routinely providing drug counselling and general support.

1.6 Shelley Ward

The Addictions Service had eight inpatient beds in the local hospital, Medway Hospital. These beds were used mainly for opiate or alcohol inpatient detoxifications. They were located on a general psychiatry acute ward, Shelley Ward, the remaining beds on the ward also being under the consultant charge of Dr V - CPsych/Z - CPsych but were used for general psychiatric patients.

1.7 The Panel visited Shelley Ward. The ward was fairly typical in layout and structure. It was an open ward of 16 beds. A seclusion room and medications area were situated next to the nursing station. Patients stayed in small dormitories. The open ward policy contributed to at least one difficulty: the nursing staff on duty at the time of the visit to the ward commented that in the past several addicts staying on the ward had secreted

illicit substances or alcoholic beverages on the ward. Although the staff on duty indicated a preference for a dedicated addictions unit for the addictions patients, they suggested that the ward functioned reasonably well.

- 1.8 The ward had a full multi-disciplinary team. Some of the nurses had addictions experience. A range of general and addiction orientated education and group activities, either on the ward or in the day hospital on the floor below, were available for the patients to attend. Although Dr Z - CPsych held an encounter group on the ward, the addiction interventions were largely delivered in individual sessions.
- 1.9 Addiction patients admitted to the ward received a nursing and psychiatric admission assessment which included an addictions history and physical examination. Drug urine screening was available on the ward. The community drug team workers retained contact and involvement with the patient on the ward. When addiction patients were admitted they remained the clinical responsibility of the addictions consultant at Manor Road.

2. THE ADDICTION SERVICE'S PHILOSOPHY

- 2.1 The Panel were informed that whilst Dr V - CPsych was the Consultant in charge (to July 1994) the philosophy of the addiction service was to focus on minimising the harm to the addict and society associated with the substance misuse. "Harm minimisation" strategies included educating patients about safer use of drugs and maintaining them on a regular prescription of a safe alternative or replacement drug, such as *methadone* in the case of heroin addicts. The aims of "*methadone* maintenance" included reducing the addict's perceived need to offend in order to obtain a regular supply of expensive illicit opiates and introducing stability into the addict's life by ensuring a daily supply. Dr V - CPsych offered maintenance and counselling to addicts and then attempted to persuade them to become abstinent. Patients were in effect offered maintenance for an indefinite period. Patients who subsequently decided that they wished to become drug-free were detoxified by reducing the daily dosage of the prescribed replacement medication in gradual steps until abstinence was achieved. Those patients requesting detoxification from the start of their contact with the addiction services were initially stabilised for a short period of time on the appropriate replacement medication and then detoxified.
- 2.2 In July 1994, when Dr Z - CPsych took over as Consultant for the Addictions Service, the core philosophy of the unit changed. Dr Z - CPsych considered that abstinence should be the main focus for therapeutic interventions from the start for all addicts. Patients may be prescribed appropriate replacement medications, such as *methadone*, but the aim was to detoxify the patient. Some patients could be detoxified more slowly than others, in so called longer-term detoxifications, but the impetus and focus of counselling and therapy remained abstinence. Under Dr Z - CPsych's regime, maintenance was not formally offered as it suggested a state of no change and acceptance of the drug-using state.
- 2.3 When the core philosophy of a unit changes in this way it is understandable that some addicts previously receiving long-term maintenance may become anxious about the future of their prescription. In his interview with the Panel, Dr Z - CPsych indicated that he did anticipate at the time that the change of philosophy in the unit might lead to

problems for the old-established “maintenance patients”, of which he estimated the clinic had around 40. He felt these patients handled the transition well. Indeed, he considered, in retrospect, that there had been no significant problems.

COMMENT:

In 1991 the Department of Health guidelines to doctors on the management and treatment of substance misuse were short, vague and generally unspecific with respect to the wisdom of “methadone maintenance”.¹ This reflected a long and unresolved debate within the addictions field about methadone maintenance. The theory and practice of Drs V - CPsych and Z - CPsych represented the two main strands of legitimate argument in the field. The differences in their practice reflected a legitimate divergence of professional opinions rather than good or bad practices. Indeed, during their interviews with the Panel, both Dr W - Psych and Mr Y - RMN, who had worked with both consultants, considered that the difference between the two approaches, in practice, was more one of emphasis. The recent Department of Health guidelines summarise some recent findings from clinical research on the subject and give clearer guidelines. They make a clear statement of support for methadone maintenance in selected cases though favour the longer-term detoxification².

MR STONE’S INVOLVEMENT WITH THE ADDICTION SERVICE

3. EMERGENCY REFERRAL: 3RD FEBRUARY 1993

- 3.1 On 2nd February 1993 Mr Stone attended the Manor Road Centre on the advice of his GP, Dr M - GP. The case notes record how he was seen by Dr W - Psych, the Staff Psychiatrist. Mr Stone was asking for *methadone* but was told that as the unit was not a drop-in centre he would first need to attend for an assessment.
- 3.2 On 3rd February 1993, Dr M - GP remained concerned about Mr Stone’s drug use and thus rang and left a message for Dr V - CPsych requesting a Domiciliary Visit. A note of this telephone message shows that Dr M - GP emphasised that Mr Stone had a “long history of drug abuse” and “bizarre fantasies and urges to attack people”. He reported how Mr Stone had been seen by the General and Forensic Psychiatric teams in the past and was currently prescribed *stelazine*. Dr M - GP also reported that he felt Mr Stone was “very paranoid and a threat to children and people outside” and that “Mr Stone also feels he is a threat and expressed a wish to be locked up - possibly Broadmoor”.
- 3.3 Dr V - CPsych visited Mr Stone and his mother at their home on the evening of the 3rd February 1993. Dr V - CPsych did not complete the standardised clinic “Client Information Sheet” and assessment form at this visit. On 4th February Dr V - CPsych wrote to Dr M - GP summarising his findings and outlining his treatment plan. Dr V - CPsych’s letter stated that Mr Stone complained:

¹ Drug Misuse and Dependence: Guidelines on Clinical Management, 1991, Department of Health, HO (page 22).

² Drug Misuse and Dependence: Guidelines on Clinical Management, 1999, Department of Health, Stationery Office (pages 52-54).

“He had been using heroin and cocaine and has been stealing to finance his habit. He also uses amphetamines on occasions but his favourite drug is heroin or *methadone* because they calm him down and stop him from being aggressive”

Mr Stone had said that he had been introduced to drugs immediately after his release from prison five months earlier. Cocaine and amphetamines excited him and made him paranoid, but that heroin acted in the opposite way.

3.4 The letter also detailed Mr Stone's own reported concerns:

"He said that he has been very frightened recently that he might harm others or kill somebody. He said that he will kill himself if he was sent back to prison...there is a lot of anger inside him and sometimes he makes a list of people in his mind who have done him wrong and he feels that he should kill them."

3.5 Dr V - CPsych briefly noted the salient features of Mr Stone's background including: his "very violent upbringing"; "childhood physical abuse"; "speech defect as a child" and that he had been in prison. Dr V - CPsych commented on the difficulty experienced by the authorities when managing Mr Stone in prison "he spent a lot of time in solitary confinement because of his aggressive behaviour towards the prison officers".

3.6 On the basis of Mr Stone's description of having "experienced hallucinations and heard voices telling him to stab people and he acted on these instructions", Dr V - CPsych concluded that he had had a "schizophrenia type of psychosis" at the time of these abnormal experiences. Mr Stone had indicated that the *stelazine* helped him greatly and that he needed to take it to control his "psychosis". However, Dr V - CPsych was concerned that it tended to make him vomit at times and so it might have been vomited before being sufficiently absorbed to have had a therapeutic effect. A depot injection of a suitable alternative medication, *moderate*, was suggested.

3.7 Dr V - CPsych's letter to the GP concluded:

"In my opinion this man suffers from Paranoid Psychosis which seems to be triggered at times by drugs. However, I think that he takes drugs in order to control some of his aggressive behaviour, especially the downers such as heroin or the opiate type substances... I feel that this man should be controlled with tranquillizers in the long-term and should also be maintained on *methadone* on a long-term basis also in order to contain his aggression and stop his violent fantasies....Certainly a liaison between the Addiction Team, the Chatham Mental Health Team and yourself will be needed."

3.8 The letter indicated that Dr V - CPsych had discussed the case already with Dr AA - CPsych in the Medway Community Health Team and had obtained his agreement to prescribe and supervise the *moderate* injections from his depot clinic. In evidence to the Panel Dr V - CPsych stated that at the time he believed that Mr Stone was already under the care of Dr AA - CPsych team and his view was that the responsibility for managing his psychosis lay with that team. However, because of concern that there may be poor compliance with *stelazine* and that it was not sufficient to stop his psychotic disorder Dr V - CPsych thought that an intra-muscular depot injection was a preferable option for keeping Mr Stone's psychotic illness under control.

- 3.9 As to his diagnosis of Mr Stone Dr V - CPsych has since told the Panel in evidence that most of his addict patients have personality disorder and that he avoids the diagnosis in order to prevent people rejecting them. His view was that such patients should be treated regardless of whether they have a personality disorder or not. In Mr Stone's case he believed that he had a paranoid psychosis and probably a personality disorder as well.

COMMENT:

Dr V - CPsych offered a quick and effective response to a concerned GP's emergency request for a domiciliary visit.

Dr V - CPsych's approach and treatment plan as expressed in his letter was reasonable for what he deemed to be a "dual diagnosis" (substance misusing and mentally ill) patient and he successfully organised a dual team (Addictions and General Psychiatric) response for Mr Stone at this time.

Mr Stone was seen speedily at Manor Road to put its part of plan into action. Through Dr V - CPsych's intervention the agreement of Dr AA - CPsych was obtained to take on a patient who had previously been thought to be inappropriate for his service.

In the Panel's opinion Mr Stone's presentation in early 1993 was such that he ought to have been made subject to the Care Programme Approach (CPA)³. Although CPA ought to have been in operation since April 1991, it does not appear to have been implemented in the Medway services at this time. This led to subsequent lack of clarity over who was responsible for overseeing Mr Stone's treatment and care. Particularly in a case such as Mr Stone's with dual service involvement it would have been advisable to formalise CPA arrangements for his case from the outset and set up regular reviews of his management.

4. INITIAL ATTENDANCES AT MANOR ROAD: 5TH FEBRUARY TO 9TH MARCH 1993

- 4.1 On 5th February 1993, Mr Stone attended Manor Road where he was seen by Dr V - CPsych as an out-patient and immediately started a prescription of *methadone* 50mg daily. The case-note entry for the attendance noted that Mr Stone had been assessed at home and recorded some of the main points from Dr V - CPsych's letter to the General Practitioner.
- 4.2 Mr Stone was allocated to Mr Y - RMN, nurse counsellor and team leader, as his addictions "key-worker". Mr Y - RMN was the Community Nurse (Addictions) and Nurse Coordinator of the addiction team. He qualified as a Registered General Nurse in 1982 and as a Registered Mental Nurse in 1985. He had worked for the Trust since 1990 and obtained a diploma in counselling in 1991.
- 4.3 Mr Y - RMN described his role as key-worker to the Panel as:

"...joining with the client, trying to understand their problems and their perspective, trying to motivate change all the time from

³ See Chapter 2 for description of the CPA and its requirements.

both my nursing and my counselling background, believing that people can change... and motivating them with my own belief that anyone can change given the right sort of circumstances, given the right sort of encouragement. So joining with them, helping them within the confines of the agency to look at making achievable targets of change, which may or may not be assisted with a prescription or going into hospital for detoxification, or a controlled drinking problem, some sort of programme with the ethos of harmonisation, trying to reduce the amount of harm they were doing by their addictive practice, and then moving eventually towards a drug free state. ...I would start with any client looking at the most dangerous behaviour and helping them reduce that, but moving all the time towards positive change, towards eventually trying to achieve a drug free state, which I believe is the best state for every individual."

He stated that as an adjunct to Dr V - CPsych's medical responsibility he would be seeing Mr Stone for key-working or counselling.

- 4.4 On 18th February 1993 Mr Stone attended Manor Road and had his first meeting with Mr Y - RMN. The brief case note entry for the visit recorded that Mr Stone felt much more settled. He said he had not used any illicit drugs and his thoughts were less destructive. Mr Stone was said to be "requesting continued support". No nursing/counselling assessment or care plan is recorded, save to see him again in ten days.
- 4.5 On 18th February Mr Stone was also seen by Dr W - Psych, Staff Psychiatrist, at Manor Road who prescribed a night sedative *surmontil* 50mg.
- 4.6 On 9th March 1993 Mr Stone again attended and saw Dr W - Psych who prescribed further *surmontil* 50mg at night. Dr W - Psych also completed a "Notification of Drug Addiction form" as required under the provisions of the then current Misuse of Drugs Act, 1973. Dr W - Psych wrote on that form that Mr Stone had first used heroin, *amphetamine* and *codeine* at the age of 18 years and that he was using half a gram of heroin daily which he was taking by mouth. Mr Stone had injected his drugs in the past, although the form indicated that he had not done so during the past month; he still occasionally took *codeine*.
- 4.7 Mr Y - RMN told the Panel that he never saw Mr Stone in a state which was a risk to either staff or other patients and he never felt intimidated by him. His first impression was of a man who at times had some very strange thought processes and ideas. On occasions he suspected he had been taking illicit drugs. For these reasons he was aware from the outset that his relationship with Mr Stone was going to be a very difficult one and that he could be a danger to himself or other people. Mr Y - RMN said he realised he would have to inform other people very quickly if things became unstable.
- 4.8 Dr W - Psych described Mr Stone always very pleasant and very co-operative when he met him.
- 4.9 Similarly, Dr V - CPsych stated Mr Stone was not disruptive and that he was a very nice man. He said that Mr Stone always complied with appointments, and lost his psychotic and aggressive fantasies when he was prescribed anti-psychotic medication.

4.10 **Clinic assessment form**

Mr Stone's records contain a ten-page standardised clinic "*Client Information Sheet*" and assessment form which includes sections for collecting information about the client's:

- presenting problems;
- substance misuse history (frequency/pattern/amount/routes);
- specific details of types of substances currently abused;
- reasons for taking drugs;
- withdrawal symptoms;
- social history;
- negative experiences due to substance misuse;
- present physical state;
- present psychological state;
- formulation;
- care plan (detox/maintenance/counselling/group therapy/family therapy etc)
- short-term goals;
- long-term goals;
- cumulative record of care and interventions at Manor Road (to be continually updated with details of assessment, detoxification, follow-up, counselling, group therapy etc.)

Save for the first page, with details of addresses, next of kin, GP etc and the "presenting problems" section, this form was not completed in Mr Stone's notes.

- 4.11 Mr Y - RMN confirmed that it was common practice as part of the assessment for each patient to have such a form and could offer no explanation for why the form was incomplete. He stated that he could only conclude that the information was not recorded on that form because it was available elsewhere. It would have been normal practice to have completed that form. He stated that practice at the time did not involve the sort of detailed care planning that is undertaken now. The form was a way of summarising interventions and making some sort of conclusion about what was being done in a particular case. Most clients would have had a form completed.
- 4.12 Dr V - CPsych indicated in his evidence to the Panel that he had not completed the form at night at the domiciliary visit as he was dealing with an emergency. He said he thought Dr W - Psych should have probably assessed him when he came to Manor Road, but noted it was a very busy centre with a large clientele.
- 4.13 Dr W - Psych informed the Panel that the normal practice for admitting a new patient to the clinic involved taking a full history, particularly in relation to drug taking behaviour, identifying the drugs, and quantities consumed, their effects, and the motivation for seeking treatment. It would include the psychiatric, family, and social background, forensic history. He said that it was considered important to administer a urine test: a prescription was only issued if the test was positive for the drug in question.
- 4.14 All workers in the drug service informed the Panel that the Manor Road policy was to screen urine (although not necessarily every time a client attended). However, there is no record of any urine screen being conducted on Mr Stone save for two tests in June 1997, and there is no report in the Manor Road notes referring to the results of such tests. Dr Z - CPsych could not recall seeing any urine results after his arrival. Mr Y - RMN said that he believed there was occasional urine screening of Mr Stone

throughout his time in treatment at the clinic, but he could not explain why no reference to such tests or any results slips appeared in the notes.

COMMENT:

There is no evidence that the Manor Road Centre's own procedure for assessing the amount and degree of substance abuse behaviour (as outlined by Dr W - Psych) was carried out in respect of Mr Stone. The clinic staff should have organised a drug screen, taken a detailed drug taking history and monitored the effects of each drug abused: they did not do so.

It is of concern that at no stage during Mr Stone's contact with addictions services was a systematic and comprehensive addictions assessment conducted which pulled together all the relevant information about his substance abuse history and practices together in one place in the case notes. This is despite clear Department of Health guidelines⁴ which suggest a full diagnostic interview and physical examination be used and outline a checklist of items to be covered when assessing a drug-user.

In particular there was no evidence of:

- *any detailed analysis of present and past patterns of drug use with descriptions of any situations precipitating drug use;*
- *an account of specific risks of harm through his drug abuse techniques;*
- *an assessment of risks to his physical health;*
- *review of injection sites;*
- *urine testing;*
- *ongoing analysis of the extent and severity of Mr Stone's dependency;*
- *any systematic record of any triggers to his drug use;*
- *any systematic appraisal of relationship between his drug use and psychiatric morbidity;*
- *any systematic analysis of the relationship between drug use and his behaviour.*

It has not been suggested by any witness that this lack of history taking was because of Mr Stone's failure to co-operate with clinic staff in their endeavours.

Given the absence of any documentary record of urine testing and Dr Z - CPsych's response that he could not recall ever seeing such test results, the Panel conclude that no urine screen drug test was ever performed on Mr Stone prior to June 1997.

Because of this lack of assessment information no clear baseline of Mr Stone's substance misusing history and his pattern of use was ever established. This is particularly relevant given Dr W - Psych's evidence to the Panel that he did not think Mr Stone was seriously addicted, but was more of an opportunist.

⁴ Drugs Misuse and Dependence: Guidelines on Clinical Management, 1991 Department of Health, HO (pages 14-16).

In the absence of such an assessment there was little justification for continued prescribing of any form of medication. Indeed to prescribe medication without such a work-up can be harmful for the following reasons:

- *There is a danger of prescribing to a patient who was not truly dependent;*
- *Such a patient may become dependent or take an overdose, or increase the supply of drugs on the street;*
- *It is difficult for any clinician to recognise worsening or improvement in Mr Stone's drug use, behaviours and related mental or physical condition;*
- *It is difficult to assess the interplay between substance abuse, prescribed medication and changes in a patient's mental state.*

5. ADDICTION CENTRE ATTENDANCES: MARCH TO AUGUST 1993

- 5.1 On 23rd March 1993 Mr Stone was seen for the second time by Mr Y - RMN, his "key-worker". He recorded that "All is going well...Looks very well & has managed to resist temptations to become involved with criminal activities." However, insomnia was a problem and an appointment was made for Mr Stone to see a doctor the next day. It was also planned that he would meet Mr Y - RMN again in two weeks.
- 5.2 On 24th March 1993 Dr V - CPsych reviewed Mr Stone. He noted he was "much more settled and has lost his psychotic symptoms. He also has become more relaxed and is not mixing with drug users anymore" Mr Stone asked Dr V - CPsych to prescribe *temazepam* which he said he was currently buying on the street to help him sleep. Dr V - CPsych refused to do so and instead suggested he continue with *surmontil*. Dr V - CPsych wrote to Dr M - GP reporting this appointment and repeating this advice.
- 5.3 Despite Mr Y - RMN's plan to see Mr Stone fortnightly, he did not attend Mr Y - RMN from 23rd March until 27th May, a gap of some nine weeks. Mr Stone then did not attend a further appointment with Mr Y - RMN until 3rd August 1993 (ten weeks later).
- 5.4 When asked in evidence about non-attendances at the clinic, Mr Y - RMN told the Panel that the process was that if people missed appointments they were chased up fairly quickly and given encouragement to come. He was asked whether it was particularly important in Michael Stone's case because of the need to monitor him. He replied:
- "Vital; vital. I was aware I did not want to go long periods with Michael, and so I did everything I could to get him into the centre."
- 5.5 However, although letters offering further appointments to Mr Stone following his non-attendance were sent on 29th April, 16th July and 20th July 1993, on no occasion did Mr Y - RMN alert either Dr AA - CPsych's team or Mr Stone's GP to Mr Stone's failure to attend regularly for drug counselling with him.
- 5.6 In the interim, Dr V - CPsych had conducted medical reviews of Mr Stone in his out-patient clinic. On 12th May 1993 Mr Stone had complained "I'm not getting full satisfaction from Methadone - I'm buying gear from the street." Dr V - CPsych had increased the *methadone* maintenance dose from 50mg to 75mg daily.

- 5.7 On 16th June 1993 Dr V - CPsych saw Mr Stone again and was "alarmed" to discover that Mr Stone had stopped taking his depot medication six weeks previously because it made him feel stiff and the injection site was painful. The CMHT had not informed the Addictions Team that Mr Stone had failed to attend for his depot since 30th April 1993 and the Addictions Team had not been made aware that Mr Stone's dose of *moderate* had also been reduced at his last attendance.
- 5.8 Dr V - CPsych encouraged Mr Stone to re-attend the depot clinic, suggesting that his *moderate* be changed to *Depixol*. He then wrote to the GP informing him of these developments adding:
- "I am sending a copy of this letter to Dr AA - CPsych to see if he can make sure that this psychotic man continues to have his medication because of the risk of relapse and the risk of dangerousness in someone like him."
- 5.9 Mr Stone did not re-attend the Manor Road until 27th July 1993 when he told Dr V - CPsych he felt terrible, was in debt and using street drugs such as heroin. Concern was expressed that he may also have been dealing in drugs. Dr V - CPsych prescribed *melleril* 100mg at night and urged Mr Stone to attend the depot clinic again. In fact on 21st July (then unknown to Dr V - CPsych) Mr Stone had been discharged from the depot clinic due to his non-attendance.⁵ Mr Stone nevertheless took up Dr V - CPsych's advice and attended the depot clinic that day for an injection.
- 5.10 On 3rd August Dr V - CPsych received a letter from Mr Stone's solicitors indicating that they were acting on behalf of Mr Stone in connection with traffic offences (no insurance, no licence, and no test certificate). Dr V - CPsych was asked to provide a report clarifying Mr Stone's psychiatric history, the effects of any prescribed medication and "whether his mental disorder and drug problem, or both, would have an affect on his ability to follow proceedings in Court". Dr V - CPsych wrote a brief report, dated the 11th August 1993, in which he outlined: Mr Stone's "paranoid and agitated" behaviour in February 1993; his use of street drugs to control aggressive feelings; his diagnosis as suffering with "paranoid psychosis"; his current stability on anti-psychotic medication. Dr V - CPsych concluded his report:
- "Mr Stone is a drug addict and suffers from Paranoid Psychosis. Without medication as described above he would relapse and become dangerous. He is quite pleasant and in control when he is taking his medication. He is generally speaking a very vulnerable man and needs a lot of support. He is fit to plead..."
- 5.11 Mr Stone's final attendance at Manor Road during this period was on 3rd August 1993 when he saw Mr Y - RMN. He said he was feeling better as a result of the depot injection and had not used illicit drugs for five days. Mr Y - RMN arranged to see him again in two weeks, but Mr Stone did not attend.
- 5.12 There are no records to indicate that any further appointment was sent to Mr Stone, and Mr Y - RMN did not inform either the GP nor Dr AA - CPsych depot clinic team of Mr Stone's non-attendance.

⁵ See CMHT chapter at paragraph 3.10

- 5.13 The next entry in the Manor Road records is a note dated 10th September 1993 which states:
- “Michael Stone called in. Moving to Skegness for good. Script to be sent to chemist when he has informed us of which one. Will maintain for 4-5 weeks. Took 7 days medication.”
- 5.14 The case notes also contain a prescription which indicated that Mr Stone had been on daily pick up of his *methadone* from a local dispensing pharmacy but, at the time of his move to Skegness, he was dispensed a week’s supply to allow him time to make the appropriate arrangements for continuing his maintenance once in Skegness.
- 5.15 No attempt was made to contact Mr Stone, nor did the Manor Road Centre pass on the information about his moving out of the area to either his GP or to the team at the depot clinic.

COMMENT:

There is no evidence that the issues of drug detoxification, drug rehabilitation programmes and harm reduction were systematically addressed with Mr Stone during this period of contact with the Addiction Service.

The Panel note that Dr V - CPsych made a positive contribution to Mr Stone’s care in June and July 1993 by alerting Mr Stone’s GP to his failure to attend for depot injection, asking the depot clinic team to attend to this and later persuading Mr Stone to recommence his depot injections. In the absence of any formal CPA (or even any adherence to the philosophy of the CPA) Dr V - CPsych was in this respect left to fill a gap which should have been the responsibility of the CMHT.

During this period Mr Stone had been allocated to Mr Y - RMN as a key-worker and drug counsellor. The Panel are concerned to note that there is no evidence within the clinical records of either the purpose or effectiveness of this counselling. In 1993 it might be expected that there would have been an initial nursing/counselling assessment with a nursing/counselling plan formulated and recorded which was then subject to regular reviews.

Mr Y - RMN had been allocated the role of key-worker (albeit within his service and not in CPA terms) and had a separate professional responsibility as a community nurse (addictions) to arrange the above, regardless of “culture” around him. He failed to do so.

Despite an initial plan to see Mr Stone on a fortnightly basis, Mr Y - RMN saw him on only three occasions between February and August 1993. Mr Y - RMN told the Panel it was very much left to the individuals to make regular appointments. However, Mr Y - RMN also believed that the monitoring of Mr Stone was “vital”, yet there is nothing in the records to suggest that he was concerned by his lack of contact with Mr Stone, and he had no personal communication with Mr Stone’s GP or the CMHT during this period. He did not write any letters to other professionals

summarising his interventions with Mr Stone. In the circumstances Mr Y - RMN was not adequately fulfilling the role he had accepted in respect of Mr Stone's treatment and care.

When Mr Stone told the Addictions Team he was moving to Skegness this information was not communicated to either the CMHT or the GP. Mr Y - RMN told the Panel that it was not the policy of the clinic to inform other professionals until a definite change of address had been received. This is surprising and is contrary to CPA requirements.

6. CORRESPONDENCE FROM PRISON: OCTOBER 1993-NOVEMBER 1994

6.1 On 25th October 1993 Mr Y - RMN received a letter from Mr Stone indicating that he was detained in prison in Lincoln on remand for burglary.

6.2 Mr Stone wrote that he had done a "cold turkey" as the prison did not provide *methadone*. His letter stated he had "slashed his arms and wrists in the police station and nearly lost control completely". He said he had been given 25mg *moderate* but it was ineffective. He then wrote:

"Do you think that through yourself and the Manor Road team I can be helped? Please let me know I am at a crossroads of my life. I could just get out of here and go on a murderous spree killing as many as I can and kill coppers in a shootout until they get me then all my worries would be over. But I think (hope) that I have got the strength of mind not to do that only as a last resort... Can I be helped by going into a detox or something. I am very interested in going into Shelley Ward for help. It is possible for me to wait at this prison if a place can be sorted out and then I could ask for bail and get it. I am only up on a £250 burglary which I don't think they have very much evidence on anyway... If it were possible to arrange I would prefer to go to a detox for help to sort my head out and get me thinking properly... I know it is important for me to get off heavy drugs and I need that help".

COMMENT:

The explicit threat expressed in this letter was not taken literally by those who received it, and the Panel accept that such an approach was justified. From the style, content and context, it could be seen as part of a pattern of a patient making extravagant threats and claims to support his demands for a particular type of treatment or benefit.

6.3 On 1st November 1993 Mr Y - RMN received another letter from prison in which Mr Stone wrote:

"You haven't replied...is it possible for me to go to Medway hospital to get help coming of drugs because I really need this help, as at the moment I am going through hell...I don't want to go to detox just to get out of prison, I want to go there to receive the proper help I should be getting...

At the moment I am on moderate 25mg per fortnight with *kemadrin* to take the side effects away and I am on *melleril* and *temazepam*. None of this does a lot of good for me so I have to get the other stuff on the wings in prison which is very very expensive. I know the only way I will ever be able to get off smack and *methadone* is by receiving medical help so please could you if possible talk to Dr V - CPsych and find out if it is possible for me to be admitted into the Shelley ward or something".

- 6.4 Mr Y - RMN did not reply to either of these letters. He explained to the Panel that it was Dr V - CPsych's strict policy at the time to reply to such letters in person. Dr V - CPsych did so on 4th November 1993 when he wrote to Mr Stone expressing his sorrow on discovering that he was in prison and stating that it was not possible to admit him direct to Medway Hospital from prison. Dr V - CPsych said he would be happy to advise the prison doctors on Mr Stone's management if required and asked him to visit Manor Road upon his release.
- 6.5 On 11th November 1993 Mr Y - RMN received a further letter from Mr Stone's solicitor asking whether the clinic could arrange a placement for Mr Stone at a Drug Rehabilitation Unit. A handwritten note on the bottom of one of the letters indicated that Mr Y - RMN telephoned the solicitor on 18th November 1993.
- 6.6 On 25th November 1993 the solicitor wrote again to Mr Y - RMN saying he understood that Mr Stone could not be admitted for treatment direct from prison but proposing that Mr Stone lived with his mother in Chatham and attended the addictions clinic from there if they would agree to treat him. The solicitor asked for an acknowledgement and views on this proposal so that he could put them before the court when considering bail. The case notes do not contain any reply to this letter.
- 6.7 When asked about his response to these letters, Mr Y - RMN told the inquiry Panel that Mr Stone probably saw going to Shelley Ward as more attractive than being in prison. It was difficult to offer him help while he was in prison. He told the Panel:
- "To the best of my recollection I can recall saying to Dr. V - CPsych, "These are the two letters I have had from Michael. He is obviously in a dreadful state. Can we do anything for him now?" to which Dr. V - CPsych said, "No, but if he is released from prison we will do something." To the best of my memory, we were quite clear that this was the sort of time when a hospital admission for detoxification might have been appropriate, especially as Michael mentioned that in his letter."
- 6.8 As to the possibility of offering drug rehabilitation, Mr Y - RMN said that if the client was going to residential rehabilitation, which required a stay of about six months, then funding would have to be arranged with social services.

COMMENT:

The Panel accept that where prisoner patients required short-term detoxification this would often take place in prison; it would not be usual to transfer to a hospital unit for this. Indeed, by the time arrangements were in place with a Court to allow a prisoner to be remanded to hospital, the inmate will often have "cold-turkeyed" or completed a prison detoxification. Although the Addictions Team had in-patient detoxification beds in Shelley Ward, this was not a drug rehabilitation unit, and rehabilitation would require further referral to a different service. Clients could be referred to such units by the Addictions Team after a successful in-patient detoxification or they could self-refer.

These matters should have been made explicitly clear to both Mr Stone and his solicitor when they wrote to Mr Y - RMN. In particular the Panel find that the

failure to reply to the solicitor's letter of 25th November 1993 requesting information to put before the court was regrettable.

The Panel acknowledge that a patient may at times request treatment as a means of avoiding detention in prison. Nevertheless, through the failure to provide the requested information for the court, Mr Stone was possibly deprived of an opportunity to be considered for access to appropriate substance abuse treatment at a time when he was clearly indicating some motivation to change.

7. RE-ATTENDANCE AT MANOR ROAD CENTRE: MAY 1994

- 7.1 On 3rd May 1994 Mr Stone re-attended the Manor Road Centre having been recently convicted of burglary and sentenced to two years' probation. He was seen by Dr V - CPsych whose very brief case note entry documents that he had been released from prison on probation, was taking heroin and had *moderate* from a general psychiatrist. Dr V - CPsych re-started *methadone* maintenance at 50mg daily and indicated that there should be follow-up and liaison with the probation officer.
- 7.2 Mr Stone did not attend his next appointment offered on 11th May 1994. On 18th May 1994 Dr V - CPsych saw Mr Stone again and increased his *methadone* to 70mg. Mr Stone was complaining of side effects of *moderate* and thus Dr V - CPsych advised him to see Dr BB - Psych (Staff Psychiatrist in Dr AA - CPsych's team at Throwley House) and ask for monthly *Depixol* instead. Dr V - CPsych wrote to Dr M - GP to inform him of the increase in dose of the *methadone*. He indicated that he had already spoken with Dr BB - Psych from the General Psychiatric team and he copied the letter to her.
- 7.3 Mr Y - RMN saw Mr Stone on 26th May 1994 and recorded in the case notes that he was more stable on *Depixol* and the increased *methadone*. At his next attendance on 9th June Mr Y - RMN recorded only "all is going very well, remains stable on *methadone*".
- 7.4 However, in early June 1994 Mr Stone's probation officer, Ms CC - PO, learnt that Mr Stone was spending his "giro" on street drugs and she contacted other services and arranged for a case conference to be held to discuss his case.
- 7.5 On 22nd June 1994 the first multi-agency case conference to be held in Mr Stone's case took place at Manor Road at the instigation of Mr Stone's probation officer. Dr BB - Psych recorded that the purpose of the meeting was to co-ordinate the activities of the various agencies involved with Mr Stone in order to minimise his ability to manipulate those dealing with him and to devise a plan to help him. Although records of other services show there were several matters discussed and a number of treatment plans made⁶, Mr Y - RMN made only a four-line note of the meeting. This stated:

"Case conference with Dr BB - Psych and probation.
Agreed to reduce melleril to 25mg nocte.
Medication (except *methadone*) to be prescribed by Dr BB - Psych's team
For Medical Review in 1/12 [a month]"

⁶ See CMHT chapter at paragraph 4.6.

- 7.6 By July 1994 Dr V - CPsych had left the Addictions Service which then came under the consultant charge of Dr Z - CPsych.

COMMENT:

On re-attending the Manor Road Centre there was no further assessment of Mr Stone nor any analysis of his drug taking habits or their effect despite him being out of clinical contact for the previous eight months.

On release from remand prison in 1994 Mr Stone should have been made subject to CPA. However neither of the two clinical teams working with him gave any consideration to this. As a result no agreed treatment or care plan was formulated and there was little joint management of his case by the health agencies. Indeed, the first ever multi-agency case conference had to be called in June 1994 at the instigation of his probation officer.

Mr Y - RMN's record of that case conference was very poor and in comparison to the records of other services (eg the three-page note written by Dr BB - Psych) was an extremely inadequate reflection of what transpired and was agreed at the meeting. Mr Y - RMN told the Panel this was because it was normal to receive a full summary of the proceedings from the person who called the meeting.

No formal date was set at the June meeting for reviewing Mr Stone's progress. The report of the June case conference was not sent to the GP (who was not there) nor was any agreed minute of the meeting taken and circulated. Each of the agencies thus relied upon their own note of what was agreed rather than ensuring the same understanding was held by all. As such, the June case conference did not resolve the admitted confusion in the roles of the various clinicians involved in Mr Stone's care.

8. THE ADDICTION SERVICE'S RESPONSE TO MR STONE'S REQUESTS FOR DETOXIFICATION FROM PRISON

- 8.1 Although the Manor Road Centre records contain two letters from Mr Stone in prison requesting detoxification (and two subsequent letters making similar enquiries from his solicitor), there is no record in the clinical notes to indicate that this issue was ever discussed either between staff members or with Mr Stone himself on his release from prison. Nor is there any communication of this request to any of the other professionals or agencies involved in his care.
- 8.2 The inquiry Panel asked Dr V - CPsych what if any action was taken in regard to Mr Stone's previous requests for detoxification made whilst in prison on his return to the addiction service. Dr V - CPsych replied that he had asked for detoxification in prison, but did not want it when he came out. He told the Panel that it was routine to offer patients detoxification and rehabilitation, but he presumed that Mr Stone was not interested in these at the time. He said that the team could only offer the facilities and seek to persuade the patient to accept them. He was certain that Mr Stone could have been admitted to the detoxification beds at Medway if he had wanted to go there; there

had been a more difficult patient than him before. The Panel asked Dr V - CPsych where Mr Stone was ever actually offered a bed. He replied:

"I am only telling you what is the normal practice. Had Michael Stone wanted to be admitted for detox, he would have been admitted immediately. I do not think he ever asked for it. I or [Mr Y - RMN] or any of the staff would routinely offer people the possibility of at least trying detox, "And if it does not work, you can always have your prescription back." This would have been offered to him, but I cannot swear I have done it because it is not in the notes."

8.3 The inquiry Panel asked Mr Y - RMN whether, once contact was resumed in May 1994, any consideration was given to Mr Stone's earlier requests for in-patient detoxification. He replied that Mr Stone would have been aware that detoxification was on offer, but his priority at the time appeared to be getting *methadone* rather than trying to get himself into hospital. He asserted that if Mr Stone had asked to go into hospital it would have been arranged within 48 hours. He said he would have discussed with Mr Stone the letters he had written, and recalled that:

"things had changed dramatically from the obvious desperation reflected in those letters from prison."

COMMENT:

If an explicit offer of detoxification had been made to Mr Stone after his release from prison and this had indeed been turned down, or even if merely the possibility of an admission had been raised with him, the Panel would have expected this to be documented in the clinical notes. Apart from the letters from Mr Stone and his solicitor there is, however, no documented indication that the issue of in-patient detoxification was raised with or by Mr Stone still less that any offer of detoxification was rejected by him at any time. The matter does not appear to have been discussed at the multi-disciplinary case review meeting in June 1994.

On his re-attending the addictions service in 1994, Mr Stone's previous requests for in-patient detoxification were either overlooked or disregarded by both Dr V - CPsych and Mr Y - RMN. It is, of course, impossible to say whether Mr Stone would have taken up any offer of in-patient de-toxification in May 1994, but this does represent a missed opportunity to explore Mr Stone's potential for change at this time.

In response to these criticisms, Mr Y - RMN has said Mr Stone was at all times aware of the options of help available, including in-patient admission, which was regularly discussed with him. Such a course of action would have been wholly appropriate, but regrettably there is not one documented record of any such discussion, still less of any response, negative or otherwise, from Mr Stone in the latter's clinical records. Therefore the Panel maintain the view that there was an inadequate response to Mr Stone's recorded desire for detoxification.

9. ADDICTION SERVICE'S INVOLVEMENT: AUGUST TO NOVEMBER 1994

- 9.1 Following the multi-agency case conference on 22nd June 1994, Mr Stone did not attend either of the next two appointments offered at Manor Road on 25th July and 4th August 1994. (It may however be that Mr Stone was unaware of the appointments as the copy letter on file offering the appointment of 25th of July was incorrectly addressed).
- 9.2 Mr Stone's non-attendance was not reported either to his GP, the CMHT or to Ms CC - PO his probation officer. Unknown to Mr Y - RMN Mr Stone had also failed to attend for his depot injection since the 22nd June meeting.
- 9.3 In early August Mr Stone told his probation officer Ms CC - PO that he had missed his *Depixol* injections and was not taking *melleril*. She immediately telephoned both Dr BB - Psych and Mr Y - RMN to raise concern over this and as a result a further meeting between the agencies was planned which took place on 18th August 1994.
- 9.4 On 18th August Dr Z - CPsych, Mr Y - RMN, Dr BB - Psych and Mr Stone attended the second case review meeting. Mr Stone's recent substance use was documented. He said he had last used heroin nine months ago and cannabis three months ago. He had abused alcohol a week ago but planned to stop. In addition to the prescribed *methadone*, it was recorded that Mr Stone was using *benzodiazepines* (*nitrazepam* 150mg once a month and *diazepam* 50mg weekly). Mr Stone had stopped taking his anti-psychotics (depot *Depixol* and *melleril*) six weeks ago.
- 9.5 Dr Z - CPsych's notes document a treatment plan which included:
- "Stop benzos;
 - Continue on the Methadone 70 mls for two and a half months then begin a reduction at the start of November;
 - No amphetamines/cocaine
 - See Dr BB - Psych and Mr Y - RMN regularly
 - Any violent ideas speak to us and get help."
- 9.6 The outcome of this meeting and the agreed care plan were not formally recorded in a common circulated minute and Mr Stone's probation officer was not informed of what had occurred.
- 9.7 Thereafter, Mr Stone failed to attend his next two appointments at the Addiction Centre on 25th August and 29th September 1994. Yet again Mr Stone's non-attendance at Manor Road was not reported to either his GP, the CMHT or to his probation officer.
- 9.8 Unknown to the Manor Road staff, Mr Stone had also failed to attend Dr BB - Psych since the 18th August meeting. On 3rd October 1994 Dr Z - CPsych received a letter from Throwley House stating that Mr Stone had been discharged from the depot clinic on the assumption that "all was well".⁷

⁷ See CMHT chapter at paragraph 4.12.

COMMENT:

Despite having attended a multi-agency case conference in June, neither the Manor Road Addictions Team nor the depot clinic informed other services of Mr Stone's subsequent non-attendance over the following two months. Both teams had a responsibility to follow up his care and communicate with each other and both failed to do so. A potentially dangerous situation was averted only because of commendable reaction of a probation officer who instigated a further multi-agency meeting in August.

The Panel note with concern that, following the second meeting in August, the same situation again arose with neither the Addictions Team nor the depot clinic team informing the other that Mr Stone had again failed to attend for treatment for almost two months.

Mr Stone should by now have been made subject to the CPA. However, as this did not occur, no key-worker was appointed to his case nor was any provision made for a responsible medical officer (RMO). This contributed to the lack of information sharing between agencies in respect of his non-attendance and to their joint failure to ensure that a potentially dangerous patient was properly monitored in the community. Dr Z - CPsych told the Panel that he was not convinced that being made subject to the CPA would necessarily increase communication. The Panel cannot agree that properly managed and coordinated CPA would be ineffective in ensuring appropriate communication. Mr Y - RMN commented that some telephone conversations may not have been recorded. It is appreciated that busy practitioners cannot be expected to record every event, but a benefit of CPA is that it provides a framework for ensuring that important information is recorded and shared between those who need to know it.

As with the June meeting, no agreed minute of the August meeting was taken and circulated. Each of the agencies thus relied upon their own note of what was agreed, rather than ensuring that the same understanding was held by all.

10. DETERIORATION IN MENTAL STATE: OCTOBER TO NOVEMBER 1994

- 10.1 On 17th October 1994 Mr Stone attended the Addiction Centre where he saw Mr Y - RMN. Mr Stone was "demanding benzodiazepines" which were refused. Mr Y - RMN recorded that he felt Mr Stone's thinking was "unclear" with a "delusive content". Mr Y - RMN noted a plan to arrange a meeting with all concerned as soon as possible: he does not appear to have acted on this immediately but then events overtook him.
- 10.2 On 20th October 1994 Mr Y - RMN recorded that he had received a message from Mr Stone's GP stating that he was concerned that Mr Stone "has been abusive, demanding benzodiazepines". Mr Y - RMN informed Dr BB - Psych of this communication, and on 24th October 1994 Mr Stone was sent a letter asking him to attend a review appointment on 3rd November 1994.
- 10.3 As requested, on 3rd November 1994 Mr Stone attended a meeting in the Addiction Centre with Mr Y - RMN, the General Practitioner and Drs Z - CPsych and BB -

CPsych. In the course of a long note in the clinical records, Dr Z - CPsych made the following observations:

"Difficult to get any rapport. He says he is anxious but appears angry. ?delusions. Ideas that he is at harm in his bed but has put in place various measures to stop people getting into his home.

I think he is probably relapsing because of lack of neuroleptic medication. He is unwilling to consider any help that is not *benzodiazepines*. Definitely against depot or other medication to calm him.

Scruffily dressed, scratches to the back of his wrists and hands.

Little spontaneous speech except when angered.

Poor rapport

Sat with eyes closed and hand on forehead

Mood appeared aroused and angry suspicious not depressed

Speech lots of abusive ideas and violence in thoughts.

No specific delusions but very angry

Denies hallucinations but I am NOT SURE IF THIS IS CORRECT

Cognitively appears intact

Insight poor.

He knew I would not be prescribing benzos before he came and felt it was worthless talking to us. When he left he threatened the next person he robbed he would attack more violently"

- 10.4 The case notes then indicate that, after Mr Stone had left, a discussion between the General Practitioner and Drs BB - CPsych and Z - CPsych concluded:

"Probably we could section him on grounds of threats of violence and past history with his ideas of being vulnerable to being killed while asleep, etc. I do not think he could be coped with on the wards at Medway Hospital and suggest that the forensic team be contacted again (he was seen in October 1992) with a view to admission to Trevor Gibbens Unit."

It was noted that Mr Stone had agreed to continue to see Mr Y - RMN and that Dr BB - Psych would discuss the issues with Dr AA - CPsych. In fact, that same day Dr Z - CPsych contacted Dr AA - CPsych himself and discussed the content of this 3rd November meeting. Thereafter, Dr AA - CPsych took over the lead role in Mr Stone's care for the next month.

- 10.5 Unknown to any of the clinicians present at the meeting, Mr Stone that same day had obtained a prescription for *benzodiazepines* from a local GP with whom he had registered in another name.⁸ He presented to this GP with no apparent abnormality in his mental state. Later in November 1994 when Mr Stone was admitted to Bexley Hospital⁹ he told the admitting doctor at Bexley that he had been prescribed *methadone* 70mg daily at Manor Road but was taking only 40mg and giving the rest away. He also told the Bexley staff that he had started abusing *benzodiazepines* six weeks previously and felt he had got worse since that time.
- 10.6 In evidence to the Panel, Dr Z - CPsych said he could remember little of the meeting of 3rd November other than what was recorded in the notes. He inferred from the notes that he thought that Mr Stone might be suffering from a psychotic illness rather

⁸ See General Medical Services chapter at paragraph 13.8.

⁹ See Bexley Hospital chapter at paragraph 4.5.

than a drug related condition. At the time he did not think that Mr Stone's symptoms were those of *benzodiazepine* withdrawal.

- 10.7 Dr Z - CPsych was asked by the Panel why he wrote that Mr Stone could not be coped with on the wards at Medway Hospital at this time. He stated that there were two reasons. Firstly, that there was, so far as he could remember, a history of his having assaulted somebody which had concerned the nursing staff. Secondly, that, given his lack of insight, Mr Stone would constantly have been wanting to leave the ward.

"He was volatile and, as I say, he was not talking, except when he got angry and started shouting at us. So obviously his behaviour would have caused some problems in any setting. Obviously it can be quite disruptive if people suddenly become angry and shouting for no real reason that could be discerned, as I say, and the history that they had had some problems with him in the wards before was something also that needed to be considered."

COMMENT:

Under the circumstances as they appeared to Dr Z - CPsych on 3rd November 1994, it was reasonable to consider that Mr Stone was mentally ill and in need of compulsory treatment. It was appropriate to involve Dr AA - CPsych as it was preferable that he (as sector consultant) and not Dr Z - CPsych should lead the process of admission.

Dr Z - CPsych's concern that the nurses would be reluctant to admit Mr Stone to the ward at Medway Hospital appears to be unfounded. There is no evidence that the nurses were ever consulted about his possible admission and in any event Mr Stone was unknown to the in-patient nursing team as he had never previously been admitted to Medway Hospital. There is no foundation for the assertion that there was a problem in the past involving Mr Stone assaulting someone. Mr Stone has no history of assaulting either staff or patients in a healthcare setting.

As to the explanation for the symptoms displayed by Mr Stone at this time, Dr Z - CPsych's preferred diagnosis was of a psychotic mental illness. However, an acute psychotic-like illness associated with benzodiazepine withdrawal or a drug induced paranoid psychosis associated with stimulant misuse would have been difficult to exclude definitively.

Although the clinical judgment can be difficult, the clinical management, in terms of dealing with the paranoid psychotic presentation, would be generally the same. A vigilance for the other complications of drug withdrawal states, such as monitoring for withdrawal fits, would be natural in in-patient settings. Of course, if there had been sufficient evidence to indicate a diagnosis of benzodiazepine withdrawal then the instigation of a stabilising, and then slowly reducing, benzodiazepine prescription would have been central to his clinical management.

It was clear from the interview with the Panel that Dr Z - CPsych had considered the issue of an abnormal state of mind associated with benzodiazepine withdrawals and he had, on reasonable grounds, discounted it

as unlikely as a working diagnosis. The issue of whether the paranoid and agitated state constituted a drug-induced paranoid illness or a process illness such as schizophrenia would have become clearer with time after admission.

10.8 On 10th November Mr Stone attended Manor Road and saw Mr Y - RMN. Mr Y - RMN recorded that he was "very angry especially with doctors" and "demanding medication". Whether the type of medication he was demanding was a neuroleptic, *benzodiazepine* or other psychoactive drug was not recorded. The case note entry did record that Mr Stone "claimed that he had recently been involved in causing actual bodily harm to an innocent person." It also documented that he was "Making explicit threats about decapitating children and other acts of unprovoked violence." Mr Y - RMN discussed the case with both Drs Z - CPsych and Dr AA - CPsych and noted that Mr Stone was agreeable to a further review meeting the next morning.

11. MENTAL HEALTH ACT ASSESSMENT: 14TH NOVEMBER 1994

11.1 Dr Z - CPsych's next personal contact with Mr Stone was on 14th November 1994 when in the company of Dr AA - CPsych he assessed Mr Stone for compulsory admission under the Mental Health Act at the probation office. Having assessed Mr Stone, Dr Z - CPsych completed a "medical recommendation for admission" under s.3 of the Act. By this stage Dr AA - CPsych was taking the lead in Mr Stone's management, and Dr Z - CPsych made no notes of the assessment save for what he recorded on the Mental Health Act recommendation form. By the time he gave evidence to the inquiry Dr Z - CPsych could recall little of these events.

11.2 On 17th November 1994 Dr Z - CPsych completed a new "medical recommendation for admission" form, this time under s.2 of the Act, in which he stated that informal admission was not appropriate as:

"He denies there being any problem and is refusing relevant medication. He is becoming more bizarre and disturbed threatening violence to people and property. He is very unpredictable and needs to be in a secure environment"

11.3 In fact, both the probation notes and Dr AA - CPsych's notes record how at the assessment on 14th November Mr Stone had himself suggested that he be given the anti-psychotic drug *stelazine* which Dr AA - CPsych then prescribed (a one-week supply of 15mg *stelazine* daily and *procyclidine* 15mg daily). On 17th November Mr Stone also accepted an injection of *modecate* 25mg. Dr Z - CPsych told the Panel that he could not recall being aware of this. He said that if he had known that Mr Stone had taken a *modecate* injection he could not have written what he had on the medical recommendation. He agreed that it would have been more difficult to recommend compulsory admission when the patient has accepted treatment, even if only temporarily, particularly when this is long-lasting medication. In this case, however, he would not have been convinced that Mr Stone would have continued to accept the medication.

11.4 Dr Z - CPsych could not recall the process which led to him to agree to changing the recommendation from one under Section 3 (for treatment) to Section 2 (for assessment).¹⁰ His reasons for initially recommending a Section 3 admission were that

¹⁰ See also CMHT chapter at paragraph 12.3.

the patient had been known to the services and had been treated previously. When made aware of the suggestion that Dr AA - CPsych's reason for the change had been a concern that the nearest relative might not agree to an admission, Dr Z - CPsych made written observations to the Panel:

"The paramount need in this situation was perceived to be to remove Mr Stone from the general community to the safety of a hospital setting as soon as appropriately possible. ...What occurred was a practical response to a difficult situation working within the Mental Health Act. If formal admission is required then it is required and should be expedited in the patient's and the community's best interests."

COMMENT:

On 14th November the MHA assessment by Dr Z - CPsych and Dr AA - CPsych made at the probation office resulted in Section 3 admission being recommended by both psychiatrists. The records show that these recommendations were later changed to Section 2. There were good reasons for making that change in that the patient was properly thought to be in need of assessment before treatment. The reason for this change given by Dr AA - CPsych is considered elsewhere.¹¹ While the Panel appreciate the force of Dr Z - CPsych's comments as a general statement, they do not consider, and Dr Z - CPsych does not argue, that a perceived need for admission justifies the use of grounds which are contrary to the requirements of the Mental Health Act. There is, however, no evidence that Dr Z - CPsych was personally aware of the process of reasoning which led Dr AA - CPsych to change his recommendation.

The Panel accept that, when signing his Section 2 recommendation for admission on 17th November Dr Z - CPsych was unaware that Mr Stone had agreed to and been given a moderate injection that same day. Although the matter was recorded in a memo by Dr AA - CPsych dated 17th November, which was copied to Dr Z - CPsych, a clinic date stamp indicates that the memo was not received at Manor Road until 24th November. The responsibility for informing Dr Z - CPsych of Mr Stone's changed attitude to depot medication lay with Dr AA - CPsych.

Nevertheless, Dr Z - CPsych was aware that Mr Stone had requested and agreed to take stelazine on 14th November 1994 and best practice would have been for him to acknowledge this on the compulsory admission medical recommendation form.

12. RE-ATTENDANCE AT MANOR ROAD: FEBRUARY 1995

- 12.1 Mr Stone was subsequently compulsorily admitted to Bexley Hospital and then transferred to De La Pole Hospital in Hull. Dr AA - CPsych withdrew from the case in December 1994 and Mr Stone's treatment was thereafter under the consultant care of Dr T - CPsych(F), forensic psychiatrist. On 16th January 1995 Mr Stone was discharged from De La Pole Hospital back to Kent.

¹¹ See CMHT chapter at paragraph 12.5 et seq.

- 12.2 A note in the De La Pole records gives details of a telephone conversation between a De La Pole nurse and Dr Z - CPsych on 16th January 1995. It is recorded that Dr Z - CPsych was informed of Mr Stone's discharge that day and asked that he be given his prescribed *methadone* the following morning at the addictions clinic. Dr Z - CPsych's agreement to this plan is recorded in the Hull notes but no reference to this telephone call or plan appears in the Addiction Service records.
- 12.3 Dr Z - CPsych was sent a discharge summary from De La Pole Hospital, dated 24th January 1995, which stated that Mr Stone's medication on discharge was: *methadone* 60mg daily; *nitrazepam* 10mg at night, depot *haldol decanoate* 100mg fortnightly; *Perphenazine* 4mg tds and *procyclidine* 5mg b.d.
- 12.4 Following his discharge from De La Pole Hospital, Mr Stone first re-attended the Manor Road Addiction Centre on 2nd February 1995 where he saw Dr Z - CPsych. A brief note of his consultation records that Mr Stone was "ok" but that "lots of things worrying him, personal things, finding it hard not to use". Dr Z - CPsych indicated in the notes that the treatment plan was to continue on *methadone* 60mg daily, continue on the *Haldol* depot fortnightly and receive counselling from Mr Y - RMN at three weekly intervals.
- 12.5 Mr Stone next attended Manor Road on 2nd March 1995, when he saw Mr Y - RMN. He recorded that Mr Stone seemed much more stable and that he was not mixing with other drug users. However, he was drinking heavily, up to a bottle of vodka a day. Mr Y - RMN arranged to see him in a fortnight.
- 12.6 Mr Stone did not attend his next appointment but he was seen on 13th April 1995. Mr Y - RMN wrote an account of this attendance to the GP (copied to Dr AA - CPsych but not to Dr T - CPsych(F)) in which he recorded that he "seemed slightly drowsy which he put down to his use of *benzodiazepines*" but he was "mentioning ideas of taking responsibility for himself and increasing his self-determination". A further fortnightly appointment was arranged.

COMMENT:

There is no indication in the notes that, on re-attending the addictions clinic, Dr Z - CPsych or Mr Y - RMN discussed with Mr Stone the events of the previous November, his abusive demands for benzodiazepines at his GP's surgery, Throwley House and Manor Road or what had transpired during his compulsory admission. Mr Y - RMN, however, told the Panel that such discussions had taken place, but had not been recorded in the notes. If this is so, it is an example of poor record-keeping.

13. FIRST METHADONE REDUCTION PROGRAMME

- 13.1 On 26th April 1995 Mr Stone attended Manor Road, where he was seen by Dr ZT - TPsych, a trainee psychiatrist. The case notes indicate that Dr ZT - TPsych discussed with Mr Stone his use of *benzodiazepines*. He recorded that Mr Stone had been using *diazepam* for five years and that he had seen Dr T - CPsych(F) the previous day who had prescribed *diazepam* 25mg daily. Mr Stone told Dr ZT - TPsych that he wanted to be maintained on *diazepam* but wished to come off the *methadone*. Dr ZT - TPsych

discussed a detoxification programme with Mr Stone, and the notes record a proposed plan to commence with a progressively reducing dose of *methadone* in 5mg steps every fortnight until it was down to 30mg daily and then to admit Mr Stone to hospital to complete the detoxification from the remaining amount.

- 13.2 On 1st May 1995 Manor Road received a copy of a letter written by Dr T - CPsych(F) and addressed to Mr Stone's GP, Dr I - GP. The letter confirmed that Dr T - CPsych(F) "reluctantly" had agreed on 25th April to prescribe him *diazepam* 5mg three times during the day and 10mg at night "on the strict understanding that he would not obtain illicit diazepam." The letter noted that Mr Stone had described "his long-term habit of obtaining large quantities of diazepam, by giving false names to General Practitioners or sometimes by buying it on the street." Dr T - CPsych(F) asked Dr I - GP to add the *diazepam* to his current list of medications.
- 13.3 Mr Y - RMN wrote to Dr I - GP on 1st May and reported the proposed *methadone* detoxification programme as described in the case notes by Dr ZT - TPsych, save that the target threshold for the reduction in the community before admission to hospital was said in the letter to be 15mg daily instead of the 30mg planned by the psychiatrist (and as recorded in the case notes). Mr Y - RMN noted how Mr Stone was pleased to have been prescribed *diazepam* by Dr T - CPsych(F).
- 13.4 On 5th May 1995 Mr Stone attended an appointment with Mr Y - RMN and confirmed again that he wished to proceed with the proposed *methadone* detoxification programme, which was instigated.
- 13.5 Mr Y - RMN attended a Case Review meeting at the Trevor Gibbens Unit on 22nd May 1995. Dr Z - CPsych was also invited, but was unable to attend. Mr Y - RMN took no notes of the meeting, but a memo taken and later circulated by Dr T - CPsych(F) (received at Manor Road on 1st June 1995) notes that "Mr Y - RMN will continue with three weekly counselling and support, and oversee reduction of methadone of 5mg per fortnight."
- 13.6 By 1st June 1995 Mr Y - RMN recorded that Mr Stone's *methadone* dose had been reduced to 50mg daily and that he looked "very well... if somewhat lethargic". He was much the same when seen again on 21st June. A case note entry for 14th July notes how Mr Stone "continues with detox".
- 13.7 On 21st July 1995 Mr Stone attended his probation officer who noted he was now down to 25mg *methadone*.¹² She recorded in her contact sheets that Mr Stone was "not sure if Manor Road want him to go to hospital for detox - Mick seems to prefer hospital to doing it himself".
- 13.8 Following a meeting with his probation officer on 7th August 1995, it is recorded in her contact sheets that Mr Stone was due to go to Manor Road that day to discuss hospital or community support and was deciding at that time against hospital. However, the relevant entry by Mr Y - RMN in the Manor Road records for 7th August 1995 states only:

¹² Manor Road clinic were unable to supply details of Mr Stone's *methadone* prescription to the panel. These were not routinely recorded in the Manor Road notes. Thus the records of other services have been relied upon to establish the progression of the *methadone* reduction programme.

“Attended
seems much less anxious.
Continues to reduce
c/o loose bowels after reduction
To see again in 2 week”.

There is no indication that the possibility of admission to hospital was discussed or discounted.

13.9 Mr Stone did not attend an appointment on 21st August 1995. Over the next weeks the probation notes record Mr Stone’s reduction in *methadone* to 15mg and noted how difficult he was finding it. On 22nd September Mr Y - RMN received a copy of a letter from Dr T - CPsych(F) to the GP in which it was noted that Mr Stone was now down to 5mg *methadone* per day.

13.10 The next Manor Road case note entry (by Mr Y - RMN) is dated 12th October 1995 states only:

“Attended
Looks well,
Now has reduced to 5mg and is keen to become drug free
Advised
Is seeing Dr T - CPsych(F) on 30/10/95
To see again in 2 weeks”.

13.11 On 23rd October 1995 Mr Stone told his probation officer that he had begun using heroin again but that he had arranged an emergency appointment at Manor Road himself and felt he should detox in hospital.

13.12 Mr Y - RMN was asked in evidence why the admission which had been planned as part of the reduction programme did not occur. He told the Panel that admission would have been discussed as an option, but that if patients manage without in-patient admission it was not something the team would have insisted on. He stated that:

“Balancing options and giving the patient choice gives them more ownership of the process rather than something they are being told to do by medical staff.”

He said that all the patients knew that if they wanted to consider hospital detoxification there might be a short waiting list, but it was available. If they found the going tough having got down to small doses they would ask to come in, but otherwise they would continue in the community.

13.13 Dr Z - CPsych was also asked about the lack of adherence to the initial plan. He said that generally he would have expected Mr Stone to have discussed the planned admission with his key-worker and that he, Mr Stone, would have felt that he was succeeding in the community and did not require in-patient care at that time, although this was not recorded in Mr Stone’s notes. Dr Z - CPsych had been aware that at times Mr Stone was unwilling to go into hospital for detoxification, because he would have suggested that if he was coming in for this, it would mean he would have to stop all his medication. Dr Z - CPsych was asked whether he would expect the rejection of an offer of a bed or to go on the waiting list to be recorded in the notes. He told the Panel:

"Possibly, but not necessarily and obviously depending where this was in the treatment. If there were big discussions about in-patient treatment and that is what some of them were saying and then they were offered a bed and then they refused it, obviously that should have been recorded in the notes. If they were just mumbling about going into the ward and not being keen and we had not really got anywhere that would be a different matter... Generally speaking, yes, if someone is offered a bed and they refuse it I would expect that to be noted somewhere."

COMMENT:

This was Mr Stone's first attempt at a detoxification programme which had from the outset been planned as a two-stage process. Firstly, there was to be an initial period of methadone reduction whilst in the community down to a target threshold of either 30mg (as recorded by Dr ZT - TPsych on 26th April) or 15mg (as recorded in Mr Y - RMN's letter to the GP of 1st May). This was to be followed by a period of in-patient detoxification to become drug-free.

It is clear that this planned programme was not followed, but there is no record in the case notes of any reason for this or of whether Mr Stone agreed or whether a unilateral decision had been made by Mr Y - RMN and/or the clinical team.

There is no record to suggest that Mr Stone was ever offered an in-patient admission which he declined, or any record to show that the issue of admission was discussed with him when he reached the planned admission threshold.

Mr Y - RMN told the Panel that no changes in the treatment plan would have been made on a unilateral basis, but would have been discussed and explained in full. Any reduction would have been discussed with his consultant, but a search by him through his supervision records has not brought to light any record of this. In any event, the place for recording changes of treatment plan and the patient's views about proposed treatment is in his clinical records, and it is part of the professional duty of any nurse to ensure that such records are maintained.

The absence of such records leads the Panel to conclude that Mr Y - RMN and the Manor Road team did not actively and clearly encourage Mr Stone to enter in-patient detoxification when he reached the required target for admission. Indeed it appears that obstacles were placed in the way of his admission: the admission target of 30mg (set by Dr ZT - TPsych) was changed to 15 mg. It is not clear to the Panel that this was discussed with a medical practitioner as there is no clinical record that it was. There is no evidence of a considered response to Mr Stone's considerable achievement of reducing his methadone in the community. Further the impression which Mr Stone appears to have gained, as reported to his probation officer on 21st July 1995, was that the Manor Road team were not keen for him to be admitted.

If the change of plan was a reasoned decision, Mr Y - RMN failed to record this in the clinical notes or communicate the changed plan to any other professional team involved in Mr Stone's care.

Mr Y - RMN had earlier informed the inquiry Panel:

"...when we saw a patient, wrote in the clinical notes a summary of our interventions, how it affected the care and any concerns we had and if there had been any significant change in the care plan or in the care we were providing we would write to the GP at that time."

It is clear that Mr Y - RMN's own procedures were not followed in Mr Stone's case.

The Panel accept that patients are often unwilling to be admitted for detoxification, when actually offered a bed, however enthusiastic they may have claimed to be previously. Therefore it is obviously not possible to say whether a more positive and clear approach to this reduction programme might have persuaded Mr Stone to agree to in-patient detoxification. However, the Panel consider there is a danger of it being assumed that patients will not agree to admission, and of such an assumption leading to a somewhat half-hearted approach to this type of case.

14. SECOND METHADONE REDUCTION PROGRAMME: OCTOBER 1995

- 14.1 On 24th October 1995 Mr Y - RMN and Dr W - Psych met with Mr Stone who told them he had relapsed to using "street drugs". The case notes recorded that he wanted to undergo a *methadone* detoxification in the community. Dr W - Psych prescribed *methadone* 50mg daily with a view to decreasing the dose by 5mg steps each fortnight until the detoxification was completed. The case notes give no indication that any strategies for avoiding relapse during this second attempt at detoxification were discussed.
- 14.2 Mr Stone was seen by Dr W - Psych again two days later on 26th October 1995 when he again noted that Mr Stone was willing to come off *methadone*.
- 14.3 On 30th October 1995 Mr Stone and his probation officer met Dr T - CPsych(F). Dr T - CPsych(F)'s note records Mr Stone saying that he was keen to be admitted to Shelley Ward at Medway Hospital (Dr Z - CPsych's detoxification beds) for detoxification, but the possibility of an in-patient admission is not referred to within the Manor Road notes for this period.
- 14.4 The Manor Road case notes recorded that Dr W - Psych continued to see Mr Stone on 9th and 23rd November and 7th December 1995. The detoxification apparently proceeded fairly well. Dr W - Psych wrote to Dr M - GP¹³ on 12th December and noted "He is still taking *methadone* on a reducing scale and also said he was using *Diazepam* on a reducing scale prescribed by you". The level of *methadone* is not recorded in the Addiction Service case notes, but from the record of a meeting with Dr T - CPsych(F) on 18th December it appears Mr Stone was now taking 35mg daily.
- 14.5 On 4th January 1996 Dr W - Psych saw Mr Stone in the Addiction Centre with Mr Y - RMN. Mr Stone was described as "intoxicated". It was noted that he had relapsed to using street drugs and had used heroin the previous night. A clinic "*prescription*

¹³ Although by this time Dr I - GP had become Mr Stone's general practitioner.

alteration form” dated 11th January 1996 records an instruction from Mr Y - RMN to stop reducing Mr Stone’s *methadone* prescription which was set at 25mg until further notice.

- 14.6 On 17th January 1996 Mr Stone attended an appointment with Mr Y - RMN. He noted that Mr Stone seemed alert and not intoxicated; he had used heroin only once since his last visit.
- 14.7 On 8th February 1996 Mr Stone was seen by Dr W - Psych and Mr Y - RMN. Mr Y - RMN noted that Mr Stone was injecting heroin intravenously twice per week, and, in addition to his 25mg of prescribed *methadone*, was buying extra to make up a total daily dosage of 100mg. It was decided not to change Mr Stone's prescription but to stabilise him on the current dose.
- 14.8 On 29th February 1996 Mr Stone was seen urgently by both Dr W - Psych and Mr Y - RMN at the request of his probation officer. Mr Stone had told his probation officer, Ms FF - PO, that he was taking heroin most days along with his *methadone*. Mr Stone was talking about wanting to go into Shelley Ward for detoxification; Ms FF - PO had called Manor Road clinic to inform them of this and make an appointment.¹⁴ The notes of the attendance at Manor Road make no reference to a request for admission. It is recorded that Mr Stone was "using injectable heroin most days" and was "advised that we will not continue to prescribe *methadone* if he continues with street drugs." However, the *methadone* prescription was increased to 40mg daily.
- 14.9 On 7th March 1996 Dr W - Psych wrote to Mr Stone’s GP stating that he had stopped using street heroin and was taking only prescribed methadone.
- 14.10 On 4th April 1996 Mr Stone attended Mr Y - RMN and said he was still not using heroin, but by his next appointment on 18th April 1996 he said he was occasionally using illicit heroin. At two appointments in May 1996 Mr Stone reported he had “considerably reduced his use of illicit heroin”.
- 14.10 On 11th June 1996 Mr Stone saw Dr W - Psych at Manor Road who recorded that he was using only his prescribed medication (*diazepam* 15mg daily, *nitrazepam* 10mg daily, *methadone* 40mg daily and *Haldol* injection 100mg every two weeks). Dr W - Psych noted that Mr Stone wanted to change his circle of friends and had joined a health club. He reported he had a “nightmare about prison” but "says he is in control" and “believes that all these drugs are keeping him away from crimes.”
- 14.11 On 17th June 1996 Ms ZP - CPN (Forensic CPN) saw Mr Stone at his mother’s house. In her records she described him as in reasonable spirits. He told her that he still wanted to stop his drug habit and felt a detoxification programme would be of help. However, he said that Manor Road would not offer this option to him and that he was at a loss to understand why.
- 14.12 On 2nd July 1996 Mr Y - RMN saw Mr Stone at Manor Road. His note records:

“Attended
Looks very well. Still keen to move to Maidstone

¹⁴ See Probation Service chapter at paragraph 10.5.

Taking up keep fit and keen to consider a hospital detox
See again in two weeks”.

14.13 The Panel asked Mr Y - RMN about this request for detoxification. Without being able to recall what was said on any specific occasion, Mr Y - RMN stated that on every occasion he saw any patient he would raise the possibility of in-patient detoxification, but that he never got from Mr Stone a specific request to go in for detoxification then and there. Had he made such a request it could have been granted. He accepted that his records could have been clearer on this point.

14.14 On 4th July Mr Stone attended Ms ZP - CPN (CPN) at TGU in an agitated and aroused state¹⁵. Ms ZP - CPN recorded that:

“He expressed some angst regarding his treatment at Manor Road, the main complaint being that he has not been offered an inpatient detox programme at Medway Hospital. Michael believed this is the only method to assist his heroin withdrawal which would in turn facilitate his temporary removal from the drug scene.”

14.15 As part of the subsequent management plan Ms ZP - CPN spoke to Mr Y - RMN on the telephone on 5th July to enquire about Mr Stone’s condition and treatment. There is no record of this conversation in the Manor Road notes but Ms ZP - CPN’s own record states:

“Discussed Michael with Mr Y - RMN who updated me on his progress at Manor Road. Michael has been offered an in-patient detox programme on several occasions but has declined the offer when a bed becomes available.

Although Michael willingly attends for out-patient appointments he is unable to maintain positive progress with his heroin withdrawal and needs to be maintained at a certain level of methadone 40mg daily.

There are also concerns from staff at Medway Hospital in coping with Michael’s extreme behaviour when withdrawing from heroin, giving rise to the conclusion that this is not the most appropriate placement in terms of security and resources.”

14.16 Mr Y - RMN was asked about this record by the Panel:

“Q. Do you recall saying that to Ms ZP - CPN?

A. Yes, I can recall saying to Ms ZP - CPN that Michael had been offered a hospital detox on occasions.

Q. Then that provokes me into asking you when had he been offered an in-patient detox programme?

A. I am sorry, I am not trying to be difficult, but it is a consistent thing. I am for ever saying to people, "What you need to do is become drug-free, and if you would like to go into hospital we have a waiting list which is a board with pegs in for people going into hospital." The number of people that go to the doctor when a bed becomes available saying, 'No', then they go to the bottom again is a regular occurrence. All the time we are encouraging people to look at becoming drug-free, be it in the community by going on a reducing regime, be it in hospital on an in-patient detox - all the time trying to act positively towards people detoxifying.

¹⁵ See Forensic Services chapter at paragraph 8.

- Q. And yet at no stage do we see a record of him being offered and declining admission. There is no plan here, is there, at any stage for him to be admitted in the sense of a recognition that the time has now come for an admission and for him to be placed on a waiting list, for instance?
- A. No.
- Q. So the basis of your recollection is no more than an impression that this is what happened, or is it based on anything more specific?
- A. I am quite convinced that Michael was well aware that a hospital detoxification would be available, and I would have regularly made that quite clear to him, and throughout my whole involvement with Michael he was aware that hospital admission was an option.
- Q. That is rather different from actually being able to remember whether you offered him a place when he was keen to accept one?
- A. I cannot actually specify a date or a time when I said, "A bed is available, Michael. Are you going to pack your bag?"
- Q. Did you ever get to that stage?
- A. Not to that stage, no."

14.17 As to whether Mr Stone was ever offered or refused a detoxification bed Dr Z - CPsych informed the Panel that the Manor Road Team did not refuse a bed and that if Mr Y - RMN stated that a bed had been offered, then it had been.

14.18 Dr W - Psych could not remember Mr Stone ever being offered an in-patient bed for detoxification.

14.19 Ms ZP - CPN was also asked about her own record of Mr Y - RMN telling her that Mr Stone had refused hospital admission and stated that she had received no information to similar effect from any other source.

14.20 Mr RR - SW, TGU social worker, who was present during part of the meeting with Ms ZP - CPN on 4th July informed the Panel that he had specifically asked Mr Stone on 4th July if he wanted to come in for detoxification but was given a "non-committal and guarded reply". He was asked by the Panel :

- "Q. Is that code for saying he did not say no or what did he actually say?
- A. Michael cultivated, as I later found out, a way that if you asked him a straight question of giving a non-committal reply...He cultivated that, because he is neither saying yes or no. I think he is acknowledging that you are putting him on the spot, you are saying to Michael, "Now what do you want?"

14.21 Ms ZP - CPN also expressed her opinion to the Panel that, in her experience, Mr Stone was always ambivalent about detoxification treatment and that the wards at Medway Hospital were a "totally unsuitable environment" for Mr Stone. She said that Mr Y - RMN had told her that he would have to question seriously whether someone like Mr Stone would be admitted to Medway Hospital because it was an open ward on which patients with any potentially violent behaviour could not be coped with.

14.22 Mr Y - RMN confirmed to the Panel his view that the in-patient detoxification ward (Shelley Ward) at Medway Hospital was unsuitable for Mr Stone on the grounds that the staff there had no training with people who could be paranoid and dangerous, and that he might have caused fear among other members of the relatively small illicit drug-taking community who were there and might know him. However, Mr Y - RMN denied that this meant there was no facility for Mr Stone if he had accepted an offer of

in-patient treatment. He would have told Dr Z - CPsych that if he was not prepared to admit Mr Stone to Shelley Ward they would have had to find somewhere else for him to go.

14.23 Dr Z – CPsych, however, expressed a different opinion about Mr Stone’s suitability for admission to Shelley Ward. He thought he would have been acceptable there.

14.24 The Russell murders occurred on 9th July 1996. No record of contact with Mr Stone by any agency on this day has been found.

COMMENT:

The main focus of modern substance misuse services is on management and treatment in the community. Nonetheless, there is a well recognised and important role for inpatient detoxification.

The notes record several occasions when in-patient detoxification was requested or agreed to by Mr Stone, these include:

- *two specific written requests for in-patient detoxification from Mr Stone when in prison (supported by a similar request from his solicitor) in October and November 1993;*
- *a treatment plan formulated in May 1995 to admit Mr Stone when he reached a target dose of 15mg methadone in the community which was not then followed when condition was met in August 1995;*
- *Mr Stone’s reported keenness to be admitted for detoxification in October 1995;*
- *Mr Stone’s reported keenness to be admitted for detoxification on 2nd July 1996.*

The Panel conclude that at no time during Mr Stone’s treatment had the Manor Road staff team either explicitly or clearly offered Mr Stone in-patient detoxification in one of their beds at Medway Hospital. They accept that Mr Y - RMN and Dr Z - CPsych believed they were willing to make an offer of a bed if Mr Stone genuinely wanted one, and that in general terms admission may have been discussed with the patient. There may have been discussion between Dr Z - CPsych and Mr Y - RMN on the subject. However, such discussions may have been influenced unduly by a belief derived from their general experience that Mr Stone would reject a bed if actually offered one, resulting in requiring the patient to show a determination to get a bed, before he was made an offer of one. The Panel would have expected a constant pattern of refusal of offered treatment to be apparent from the records. Instead, there is a record of requests for treatment from the patient with no recorded response, positive or otherwise. The absence of such a record indicates that an insufficiently encouraging response was given to these requests for help. Such a course is unlikely to be seen as helpful by the patient.

The Panel recognise that patients at drug addiction centres are likely to be difficult, unpredictable, and continually changing in their approach to treatment. Mr Stone may not have been any different. Nonetheless, the Panel find the lack of documented and clear responses to the several requests for treatment to be a major failing in the care offered to Mr Stone. The more

difficult the patient, the more important it must be to be respond positively to his requests for help, and to be in a position to address a history of a lack of cooperation where this is an obstacle to progress.

Further, it appears that Mr Y - RMN held the opinion that it was inappropriate to admit Mr Stone to the detoxification beds on the open ward at Medway Hospital. This view does not appear to have been discussed with or shared by the consultant psychiatrist overseeing Mr Stone's addictions treatment, nor was it communicated to either Mr Stone or members of other professional teams involved in his care.

Mr Y - RMN's assertion, made to Ms ZP - CPN on 5th July 1996, that Mr Stone had been offered an in-patient detoxification programme on several occasions but had declined the offer when a bed became available is not supported by any evidence. Indeed Mr Y - RMN himself acknowledged to the inquiry Panel that at no stage did Mr Stone refuse any planned admission offered to him.

It is impossible to predict the outcome of any in-patient detoxification at Medway Hospital which may have been offered in 1994 or 1995 and its impact upon the future course of Mr Stone's condition, even if he had accepted it, but it is more likely to have been beneficial than harmful.

The Panel has noted the proximity in time between Mr Stone's recorded keenness for in-patient de-toxification on 2nd July 1996 and the Russell murders of 9th July 1996. There is no evidence that Mr Stone would actually have been an in-patient for this purpose on 9th July 1996 if he had been offered a bed before that date. A bed may not have been available; even if one was, he may have declined the offer.

15. ADMISSION FOR DRUG DE-TOXIFICATION: AUGUST 1996

- 15.1 On 8th August 1996 Mr Stone failed to turn up for his appointment with Ms ZP - CPN and Mr VV - SW at the TGU. Ms ZP - CPN contacted Dr W - Psych at Manor Road who told her that there had been no contact with Manor Road for four weeks, although on his last visit Mr Stone had been in reasonable spirits with no cause for concern. Ms ZP - CPN then spoke with Mr Stone's mother, who said that she remained in daily contact with her son and his drug habit was on a downward spiral, although physically and mentally he was not presenting any problems.
- 15.2 On 15th August 1996 Mrs Stone phoned Ms ZP - CPN and now reported serious concerns about her son's health. He was spending £100 per day on heroin while taking 40mg of *methadone* and said he felt in urgent need of hospital admission for detoxification. Ms ZP - CPN contacted Manor Road to relay this information: neither Mr Y - RMN nor Dr W - Psych was available, but other staff were willing to arrange an appointment for Mr Stone. Ms ZP - CPN then relayed this offer of an appointment to Mr Stone and encouraged him to contact her if he had further problems.
- 15.3 On 21st August Mr Stone attended Mr Y - RMN at Manor Road with his mother. Mr Y - RMN recorded that Mr Stone reported to him that he was using up to £100 a day of heroin and crack cocaine. He noted Mr Stone's account ("confirmed by his

mother”) of a recent deterioration in his mental state and wrote “Reports from fellow addicts indicate paranoid behaviour, including ideas of guns etc”. Mr Y - RMN noted that Mr Stone “seemed poorly orientated and distressed” and was complaining of a recent skin trauma as a result of injecting. Mr Stone requested an informal admission.

- 15.4 The case note entry for the following day noted that Dr Z - CPsych and Dr T - CPsych(F) had discussed the case by telephone and that Dr T - CPsych(F) was to see Mr Stone in the morning.
- 15.5 Mr Stone was voluntarily admitted to the Trevor Gibbens Unit by Dr T - CPsych(F) on 23rd August 1996.¹⁶ This was an unusual admission as it represents the only occasion on which Dr T - CPsych(F) has admitted a patient to a Regional Secure Unit bed solely for drug detoxification. Dr Z - CPsych thought that not only had there been some concern about whether Shelley Ward could cope with him, but Mr Stone had not been particularly keen on going there.
- 15.6 In evidence Dr T - CPsych(F) explained that it was Mr Stone’s suggestion directly to him which prompted him to consider a detoxification admission to the TGU. Dr T - CPsych(F) stated that, because of Mr Stone’s deteriorating clinical state at the time, he agreed to doing something which by rights, he said, should have been the business of the drug addiction team.

COMMENT

The Manor Road case notes do not record the content of the discussion between Dr Z - CPsych and Dr T - CPsych(F) nor record any reason why Mr Stone was not admitted to one of the drug units detoxification beds at this time. There is no documentary evidence to support the suggestion that the matter was discussed with nursing staff on the ward at Medway Hospital or that any concerns were expressed by nursing staff about his potential admission. Nor is there any documentary evidence to support the assertion that Mr Stone was not keen to be admitted to Shelley Ward.

The Panel conclude that Dr T - CPsych(F) was put in the position of having to consider Mr Stone’s admission to his own unit through the absence of any constructive offers of help and lack of positive intervention by the Addictions Service. This is not to suggest that Dr T - CPsych(F) was reluctant to assist the patient in this way, but the Panel consider it striking that it should have been thought necessary to admit a patient solely for detoxification to a regional secure unit.

16. CONTACT WITH MANOR ROAD FOLLOWING DISCHARGE FROM TGU: DECEMBER 1996 -JULY 1997

- 16.1 Mr Stone was discharged from the Trevor Gibbens Unit on 12th November 1996. He attended Manor Road, and an undated record shows it was planned that he would see Mr Y - RMN fortnightly and that Manor Road would not prescribe any medication for him. This plan was communicated to the GP by a letter dated 12th December 1996.

¹⁶ See Forensic Services chapter at paragraph 10.

- 16.2 Mr Stone was next seen at Manor Road on 9th January 1997. When he saw Mr Y - RMN he reported having used £12.50 worth of heroin on one occasion but said he did not want to return to drugs.
- 16.3 On 30th January 1997 Mr Y - RMN saw Mr Stone as an emergency. Mr Stone said he had been using heroin, *methadone*, *morphine* and cocaine but had now stopped. Mr Y - RMN recorded that Mr Stone had been prescribed *naltrexone* by Dr T - CPsych(F). In fact the TGU records show that Mr Stone had been prescribed *naltrexone* 50mg mane from 18th October 1996 whilst an in-patient on Dr Z - CPsych's advice in order to reduce his temptation to take opiates. On 4th December this prescription of *naltrexone* had been stopped and Dr T - CPsych(F) had copied his two letters to the GP to this effect to the Manor Road Centre.
- 16.4 On 11th February 1997 Dr T - CPsych(F) copied a letter (written to the GP) to Mr Y - RMN in which he noted that Mr Stone was asking to be considered for a specialist drug rehabilitation placement. The Manor Road team took no specific action in response to this request.
- 16.5 Mr Stone was next seen at Manor Road on 3rd April 1997 by Mr Y - RMN and Dr W - Psych. He reported increasing heroin use and requested methadone. As an alternative he was prescribed a *dihydrocodeine* detoxification and a plan made to see him in a week's time.
- 16.6 On 25th April 1997 Mr Y - RMN and Dr W - Psych again saw Mr Stone. It is recorded that he was in an aggressive mood and said that the drug service had nothing to offer him.
- 16.7 Mr Stone returned with his mother on 23rd May 1997 when it was noted that he was using large amounts of heroin and that he claimed to have suffered an overdose. He said he would "like a way out of drug use". On 30th May he was put on a third *methadone* reduction programme starting at 50mg daily and reducing by 5mg each week.
- 16.8 On 13th June 1997 Mr Y - RMN noted that Mr Stone was on a *methadone* detoxification and that he was to be subject to urinalysis in a week's time. In his letter to the GP (dated 26th June 1997) Mr Y - RMN noted that the detoxification was subject to a "strict" contract with which Mr Stone had agreed to comply. The contract covered areas such as presenting for weekly urine drug testing, staying away from other drug users and keeping his appointments with Mr Y - RMN. In addition, the contract specified the pattern of detoxification.
- 16.9 Two urine screen test result reports are included in the clinic notes dated 20th June 1997 and 8th July 1997.

COMMENT

Dihydrocodeine detoxifications are a recognised alternative to methadone detoxification and it was appropriate to consider it at this stage of Mr Stone's treatment.

Drug-reduction programme contracts such as entered into in May 1997 are not uncommon in drug services. This is the first indication within the notes that Mr Stone was subject to urine testing at the addiction clinic.

17. ARREST: JULY 1997

17.1 Mr Stone was arrested in July 1997 and it is recorded on 23rd July 1997 that police officers interviewed Mr Y - RMN about Mr Stone's involvement with the Manor Road centre. Mr Y - RMN asked that the police apply in writing if they required further information. Following consultation with a solicitor, Mr Y - RMN recorded that no clinical notes should be released to the police without a note from either magistrates or a court.

17.2 On 28th July 1997 a formal request from Kent police was received for the release of Mr Stone's records to them, addressed to Ms YB, Addictions Services team leader. The original clinical records were sent to the Trust headquarters who thereafter dealt with police requests for access to the records. There is no indication that any copy of the records was made before they were handed over to police.

17.3 Thereafter the members of the Addiction Service team had no further involvement in Mr Stone's case.

COMMENT

Given the serious nature of the crime under investigation when the police required the records, we consider that it was proper to hand them over. Indeed, in the context of this type of investigation there may well have been no choice [for example, had an application been made under s.9 and Schedule 1 of the Police and Criminal Evidence Act 1984].

RECOMMENDATIONS

Paragraph 3

The West Kent Health Authority should ensure that Thames Gateway NHS Trust reviews the standards of the application of CPA in services they commission and ensure that this review is a continuing process.

The Panel note however, that considerable changes have already taken place in CPA procedures and documentation since the events with which this inquiry is concerned.

Paragraphs 3,5,7 & 9

The Thames Gateway NHS Trust should remind their practitioners that a dual diagnosis patient with both drug abuse and mental health problems should be made subject to the Care Programme Approach.

Paragraphs 13.13, 14.22

The Trust should arrange for the clinical and nursing team to review their practice in the management of patients who may be offered in-patient detoxification treatment and to effect changes to ensure that:

- (1) Any plan intended to lead to in-patient detoxification treatment is clearly set out in the records and discussed with the patient.*
- (2) Where the plan is changed this should be recorded, with an indication of whether the change was authorised by a medical practitioner.*
- (3) If a patient is offered a place on a waiting list for in-patient detoxification or a bed, this should be recorded, as should any refusal by the patient of such an offer.*
- (4) Where a patient on such a plan is subject to CPA, the original plan, any alterations to it, and its progress, including any offer of treatment refused by the patient should be reported to the multi-disciplinary group.*

Paragraph 14.22

There should be a review of the ability of Shelley Ward to accept potentially violent patients for detoxification. If it is decided for security or other reasons that such patients cannot be accepted there, alternative facilities must be identified.

The admission criteria for all identified detoxification beds should then be reviewed to ensure that no patients in need of in-patient detoxification will be denied access to an in-patient facility.

Paragraph 15

Those responsible for commissioning secure forensic psychiatric services should reach an agreement with Health Authorities and Trusts in their catchment area to ensure:

- (1) Appropriate in-patient detoxification facilities are available for those forensic patients who do not require a secure bed.*
- (2) Adequate addiction services are available for in-patient and out-patients of the forensic services.*