The Report of the Independent Inquiry into the Care and Treatment of Kevin Keogh

Commissioned by
Manchester Health Authority

Jane Mackay - Chairman
Sheila Dent
Andrew Hughes
Michael Radford
Barry Windle

Manchester NHS
Health Authority

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Index

Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of Kevin Keogh, in particular:

   a) the quality and scope of his health care, social care and risk assessments

   b) the appropriateness of his treatment, care and supervision in respect of:

      (i) his assessed health care and social care needs,
      (ii) his assessed risk of potential harm to himself or others,
      (iii) any previous psychiatric history,
      (iv) number and nature of any previous court convictions.

2. The extent to which Mr Keogh's care corresponded to statutory obligations in particular the Mental Health Act 1983; the Code of Practice; relevant guidance from the Department of Health (including the Care Programme Approach, HSG (90)23/LASSL(90)11) and Discharge Guidance HSG(94)27.

3. The extent to which his prescribed care plan was effectively delivered and complied with by Kevin Keogh.

4. The history of Mr Keogh's medication and compliance with that regime.

5. To examine the adequacy of the arrangements for collaboration and co-operation between the agencies involved in the care or supervision of Mr Keogh or the provision of services to him and between the agencies.

6. To examine the adequacy of communication between Mr Keogh's family and the agencies involved in the care or the supervision of Mr Keogh.

7. To examine the effectiveness of probation orders with a condition of treatment and to recommend improvements in interagency collaboration if a probation order is breached.

8. To consider the internal investigation carried out by Central Manchester Healthcare NHS Trust.

9. To prepare a report and make recommendations to Manchester Health Authority and Manchester City Council.

Inquiry Members

Ms Sheila Dent	Mental Health Services Manager, formerly Senior Probation Officer
Mr Andrew Hughes	Proprietor of "Mental Health Training", Education, Research and Consultancy from a Service-User Viewpoint
Mrs Jane Mackay chairman	Healthcare Consultant
Dr Michael Radford	Consultant Psychiatrist
Mr Barry Windle	Mental Health Services Manager Social Services

Acknowledgements

The Inquiry met for a period of time from March until July, in the Unitarian Chapel, Cross Street, Manchester. We wish to thank the staff for their forbearance in coping with the constant disruption to their every day activities.

We were indebted to the help and support of Mr Mark Greenwood and Ms Juliet Eadie who ensured that we had all the documentation we required.

We were also greatly helped by the efficient manner that the Fiona Shipley Transcription Service promptly provided us with the transcriptions of all our interviews.

We met with Mr Edwards, Heath Rowson's uncle, and we are grateful to him for being so helpful in what we know were difficult circumstances.

We also met with Mr Keogh's mother, Mrs M Keogh and Mr Keogh's paternal Aunt Mrs B Lynch. They were able to paint a picture of Kevin Keogh's behaviour for us, which was quite different to that from the professionals. From Mr Keogh's late teens both women had spent much time in supporting Kevin in his daily routine and latterly in monitoring his health and passing on information to those who were responsible for his care.

Both families provided us with invaluable insights into these two young men, Kevin Keogh and Heath Rowson. They also posed a series of questions to us and we hope that our report goes some way to answering them.

We spent some time with Mr S Robinson who had been a friend of Mr Keogh's since childhood. Over the years he became increasingly more concerned about Kevin's mental state and on numerous occasions tried to draw this to the attention of professional staff involved with Mr Keogh.

The Inquiry Team would like to acknowledge the effect this incident had on everyone involved and were grateful to all the people who came and gave their evidence despite the personal cost this might have caused.

In all we interviewed 37 people who were invited to bring a supporter in recognition of the serious nature of the proceedings. A full list can be found in appendix 2.

We received a great deal of documentation listed at appendix 3. We are grateful to all the respective organisations for the time spent on photocopying and indexing such documents.

The process adopted by us for the Inquiry proceedings can be seen in appendix 1.

Introduction

We recognise that we carried out our Inquiry with the benefit of hindsight and in the knowledge that a homicide was committed. As is usual in such inquiries, our terms of reference were framed around the care and treatment of a patient in the context of their involvement with mental health services. In the case of this Inquiry, the relevant context was the forensic and general mental health services, the Probation service and the relationship between those services.

Some of the problems we identified are commonly recognised in Inquiry reports, such as poor communication, failures of team working, lack of continuity of care and poor risk assessment. There were systemic barriers to effective communications both between and within agencies. This report has highlighted instances of these throughout the text.

Our objective has been to identify lessons to be learnt from this tragedy and not contribute to a culture of blame. We would like to acknowledge the complexity and difficulties that young men like Kevin Keogh present to busy inner city services which are often stretched to the limit.

We hope that this report, its recommendations and any locally agreed action plan will help improve the quality of the mental health service in Central Manchester. Our recommendations are intended to build on the work which we were assured had already been undertaken by the agencies involved. We hope that we have suggested ways in which the service can develop further to provide a better quality of care. It was our intention to take account of the three elements which ensure a comprehensive and responsive mental health service, these being, protection and the welfare of patients, provision of support to carers and the safety of the general public.

Overview

Kevin Keogh was born 5 August 1966, the second of four children. He has an older sister, and a younger brother and sister. They are all in full time employment. His parents live in Stretford, Manchester. His father is an Irish born Catholic and currently works for an electrical wholesaler in a manual job and his mother works part time.

Kevin denied having any problems at school and stated that he made friends easily. He is reported to have left school having taken 3 GCSE's, although we were unable to establish what grades he achieved and then started work. He worked on and off until 1997 when he went sick because he said he was "feeling unwell with so much work" and felt he was "not up to it" anymore.

Kevin Keogh had already been through the criminal justice system, having had 10 previous convictions for offences ranging from robbery, burglary, possession of drugs, criminal damage and causing actual bodily harm. In 1990 he was found guilty of Assault Occasioning Actual Bodily Harm (AOABH) and received a custodial sentence of nine months imprisonment. In 1995 he was found guilty of robbery, burglary and theft and was sentenced to two concurrent sentences of 42 months and 18 months. In 1997 he was again charged with AOABH and remanded to HMP Manchester. In March 1998 he was the subject of a two year Probation Order with a condition of psychiatric treatment which involved attending Dr P Snowden's clinic. At that time Dr Snowden, Consultant Forensic Psychiatrist at the Edenfield Centre Prestwich Hospital had set up an outreach outpatient clinic at the Moss Side Probation Office.

Following his discharge from prison in March 1998, Kevin Keogh was seen by both forensic and general adult psychiatric services and on one occasion was assessed under the Mental Health Act 1993.

During the latter days of November 1998 Kevin Keogh befriended an American, Heath Rowson, spending time together drinking in public houses.

Heath Rowson and his brother were brought up in California as their parents had emigrated to America from Manchester at about the time he was twelve years old. We were also told that his parents divorced after arriving in America and the two boys stayed with their mother.

Heath Rowson had left America some six weeks before meeting Kevin Keogh returning to Hulme Manchester, his childhood home, to find work. He had made contact with his maternal uncle and stayed with him.

At the time of his death Heath Rowson was married with two small children, Bradley aged nine years and Heather aged five.

On Saturday 28 November Heath Rowson spent most of the day, drinking with Kevin Keogh at his flat. He returned on the Sunday morning to his uncle where he was staying. Later that day, having had something to eat with his uncle and collecting £10 from him, Heath went out again.

On Sunday evening at 11:15pm 29 November two Council security officers found the body of an injured man lying on the pavement outside Kevin Keogh's flat. He was unconscious and had received a large cross-shaped injury to the back of his head. The paramedics were called, administered first aid at the scene and he was taken to Manchester Royal Infirmary where he was pronounced dead at 12:20am Monday 30 November. The dead man was identified as Heath Rowson.

Kevin Keogh was arrested at 5:00pm Monday 30 November. He was examined by a police surgeon who found no evidence of psychiatric disorder, only some intellectual impairment. He was charged with the murder of Heath Rowson and remanded to HMP Manchester.

Kevin Keogh was moved to the Healthcare Centre of HMP Manchester in early April 1999 as he was verbally abusive to staff and unable to cope with the regime on the 'wing'.

Kevin Keogh was transferred to the Edenfield Forensic Psychiatry Centre on 22 July for assessment under the Mental Health Act 1993.

Kevin Keogh pleaded guilty to manslaughter due to diminished responsibility and was sentenced at Manchester Crown Court on 27 September 1999 to be transferred to a secure hospital under Section 37/41 of the Mental Health Act 1983. He is currently being cared for in the Edenfield Forensic Psychiatry Centre.

During the course of an Inquiry such as this, it is inevitable that many things are disclosed to the Team members. However, we have sought to use the information put before us to tell a story which will, hopefully, help those people affected by this tragedy come to a better understanding of how someone's mental distress cannot always be detected.

We were told many things which could have led us to believe, as did others, that Kevin Keogh and Heath Rowson knew each other prior to the fatal and tragic death. However we were left in the knowledge that although there were some common threads in their lives, it was highly likely that the fatal meeting between Kevin Keogh and Heath Rowson was an incredible coincidence.

Our sympathy goes to all those so tragically affected by the untimely death of Mr Rowson particularly his wife and children who live in America.

Chapter 1 Kevin's Childhood and Early Adult Years

Kevin Keogh was born 5 August 1966. Kevin's father, is an Irish born Catholic and works for an electrical wholesaler in a manual job and his mother works part time either cleaning or childminding. He has an older sister who is married and works as a secretary and a younger sister who still lives at home and works as a secretary. His younger brother also lives at home and works as a glazier.

He attended primary school in Stretford and later attended secondary school until he was fifteen years old. He had no problems at school although his mother told us he always had difficulty in concentrating. He was reported as having taken three GCSE's.

He was reported to have had an uneventful early childhood, achieving normal milestones. His attendance at the GP surgery was for the usual childhood complaints but it has to be noted, in 1978 at the age of 12 years, he was prescribed chlorpromazine although the entry in the records did not detail any symptoms. The Panel was told that he had seen someone, possibly a psychologist or psychiatrist, about his poor concentration when he was about eleven. We could find no evidence of this and assumed the School Health Service might have seen him, the records of which would not have been kept beyond Kevin reaching 21 years.

From the age of 15, Kevin worked in a variety of jobs, these having been as a labourer, wholesale assistant and for a removal company. He said he was not able to work after 1997, as he felt "*unwell with so much work*" and not "*up to it*". He became financially reliant on Sickness Benefit.

Kevin left home at sixteen years old and from what we heard still kept in touch with school friends.

His first brush with the Criminal Justice System was in 1984 aged 18 years when he was charged with burglary and fined £125.

In 1985 Kevin was charged with two counts of criminal damage and had a sentence of 36 hours at an attendance centre for each offence.

In 1988 he appeared in Court again. This time being charged with burglary with intent to steal and failing to surrender to bail on two occasions. For each of these three offences he received fines of £150, £50 and another £50. Later the same year he was found to be in possession of a controlled drug and was fined.

In 1989 Kevin was in Court on two more occasions. The first was as a result of criminal damage for which he had to pay compensation and costs and received a conditional discharge. On the second occasion he was charged with assault and was fined.

In 1990 Kevin was charged again with assault and received a custodial sentence of nine months with an added number of days for non payment of fines and in relation to the conditional discharge for criminal damage the previous year. He had been involved in a fight with a taxi driver having tried to get away without paying the fare. He was released from prison and sometime later he was charged with carrying a loaded air weapon in public and received a 12 month conditional discharge.

In October 1992 Kevin attended his GP as he was "*not feeling himself*" and wanted to move, which he did to Old Trafford. He was not sleeping well, as he was feeling paranoid about the people living near to him stating that they were rough. He was prescribed Dothiepin and vitamin capsules.

In 1994 he saw his GP, as he wanted to move again. He admitted to drinking six pints of beer nightly.

Chapter 2 Kevin's life from 1995 until 1998

In 1995 Kevin was charged with robbery, burglary and theft and received two terms of imprisonment of 42 months and 18 months to run concurrently. A pre-sentence report was completed. The report stated that Kevin had a poor record with 12 convictions spread over a period of 16 years. Most of the offences, usually drink related, although Kevin did not feel he had an alcohol problem, were dealt with by fines and conditional discharges. The Probation Officer felt there were unresolved issues which needed addressing if he was to make something positive of his life but felt unable to make any recommendation to the Court.

Comment

In the Probation report there were comments in relation to Kevin's childhood, which do not appear anywhere in any of the other documents. He said that he ran away from home because he felt unfairly treated by his father. When we spoke about this to Mrs Keogh she told us that they did not get on and that she thought Kevin was always in the shadow of his older brother who was brighter than Kevin.

1996

Kevin was released from HMP Stafford 22 May 1996 and remained on licence until 7 April 1997. He attended 11 June but failed the next appointment on 18 June and a warning letter was sent 20 June. He was later breached on two occasions for failing to keep in regular contact with his Probation Officer.

Kevin went to see Dr Singleton, General Practitioner, his GP in early June. He told the GP that he had been attacked in Prison before the preceding Christmas and was still experiencing pain when extending his arm as well as discomfort in the back of his head. He said he was "*stood on*" in Prison.

On 2 July a summons, regarding a breach of his licence, was issued for Kevin to appear before the Court which he failed to do. On 16 July a warrant for his arrest was issued because of the breach of licence.

In August Kevin's paternal aunt, Mrs B Lynch, went to see his GP and said that Kevin was hearing voices, some were telling him to kill a policeman and others were talking about him. He was also laughing inappropriately, feeling depressed and not changing his clothes. At that time Kevin was supposed to be living with friends. They had, however, been evicted, because of their many parties and had all moved out of the house before Kevin had actually moved in. Now living on his own, Kevin would not go out and apparently was talking to himself a lot. He had broken a couple of the windows and put up a sign: *"Room to let - £7"*. Dr Singleton saw Kevin a few days later and referred him to Dr L Montague, Consultant Psychiatrist, for an opinion.

Dr Montague saw Kevin on 29 August 1996, having spoken to Mrs Keogh beforehand. He told Dr Montague that he was quite happy living on his own. When he was working, as a casual warehouseman, he had enough money to pay the bills. He denied feeling depressed but sometimes thought about the unpleasant things that had happened to him in prison. He maintained that he had been beaten up.

Comment

Certainly his mother and friend said how different he was when he came out of prison on this occasion.

In the notes it was reported that he made good eye contact and after some initial hesitation was quite pleasant and friendly. He was unshaven, casually dressed but did not appear to be neglecting himself or his surroundings which were fairly basic.

Dr Montague made a domicilary visit and wrote in her letter to Dr Singleton

> *" I could elicit no evidence of paranoia or any psychotic symptomatology. He was quite adamant that he did not feel he needed any help. I can find no evidence of mental illness at the present time. He probably is short tempered and liable to be aggressive,*

particularly when drunk, and there may be some degree of personality problems underlying this although this is difficult to fully assess at a single interview. It may be that his unpleasant experiences in prison bother him more than he is prepared to admit. If he were more willing to talk about this he might benefit from some counselling but obviously it is not possible to proceed unless he is well motivated. There is at present no indication for medication or further psychiatric treatment here".

Comment

It is unfortunate that Mr Keogh was not referred to a voluntary counselling agency at this time. He may not have been compliant but clearly his mother and aunt were both aware that he was not behaving in a normal fashion. This could have been an opportunity to engage him in a therapeutic manner.

Mr Keogh was not meeting the requirements of his Parole licence and appropriate action was taken regarding breach. Concerns regarding his behaviour do not appear to have been linked with the possibility of mental disorder at this stage.

Kevin was arrested on 9 September 1996 and appeared before the Court on 10 September in breach of his licence. He appeared at Court again on 24 September, having re-established satisfactory contact with his Probation Officer. Kevin had moved from his parents' home and secured his own tenancy at Chester Road.

The following day Mrs Keogh went to see Dr Singleton (GP) because she was still concerned about him and felt sure he was "*schizophrenic*" and she was frightened of his violence. He prescribed chlorpromazine for Kevin again.

Kevin failed to attend his appointments with the Probation Officer on 5 and 12 November and breach proceedings were instigated again. In November Kevin attended his GP complaining of pain in his shoulder and 'flu like' symptoms.

1997

In February 1997 Kevin was seen by his GP complaining of having had a bad experience at the dentist and feeling self conscious about his body. He reported that he was staying in because he lacked confidence. He denied feeling depressed but said he was not able to do the things he was able to do before. He still complained of a painful shoulder.

One day in the summer, Kevin had been on a bus with a friend, Mr S Robinson. As the bus approached a set of lights, they changed to red. The bus driver stopped the bus with a jerk and Kevin fell forward. When we saw Mr Robinson he told us that Kevin was "*obviously paranoid*" as he thought that the bus driver was deliberately trying to hurt him in some way. Mr Robinson tried to explain to Kevin that it was an accident as the driver was just stopping the bus.

Mr Robinson also told us that Kevin's habit of "*touching his shoulder*" started just before this incident and that Kevin was always talking about his neck,

> *"He was always on about such and such, he was always on about his neck. He was near enough 100 per cent that he had broken his neck, and yet people had looked at it and he had not had any injuries whatsoever".*

Kevin had been so convinced that his neck was broken that he went to Casualty one night but having been assessed, it being determined that as there was nothing wrong with him, he was sent home.

On 31 October 1997 Mrs Keogh visited Dr Singleton, with Kevin. Mrs Keogh told Dr Singleton that Kevin was neglecting himself. Kevin complained of a painful left shoulder and depression. Dr Singleton gave him another medical certificate for one month and a repeat prescription for dothiepin 75mg at night.

On 1 November 1997 Kevin was arrested for assaulting a bus driver. During the previous evening Kevin had been drinking at home. Shortly after 9:00am he saw a bus outside his flat and he decided to go and speak to the driver because he thought the driver was "*taking the Mickey*" out of him. He pushed the driver over the bonnet of a stationary car. The bus driver fell to the

ground; Kevin sat astride him and punched him in the face. The bus driver said that Kevin had also tried to bite his ears and face. Kevin kicked the bus driver in the head and face whilst he was on the floor. Police were called to the scene. Kevin denied being able to hit the driver with any force as he had been off sick and seeing his GP because of a shoulder injury caused by another bus driver.

The bus driver was taken to hospital but was discharged later that same day.

Comment

He was seen by his GP six times between February and November for a painful shoulder.

When Kevin was arrested he smelt of drink and at the police station the police officers reported that he said

> *" I'm going to find the driver and make sure he doesn't fetch the case to court. Would you like to see them stood around smoking and laughing. That's why I gave him a kicking and I enjoyed every minute of it. I'd do it again. His day will come and when it does, everybody will know about it".*

Following his arrest Kevin was remanded to HMP Manchester.

On 3 November 1997 Mrs Keogh went to see Dr Singleton again and told him she was concerned about Kevin. Kevin had told her that he had seen both a tin of beans and a bottle move and that a ghost was turning the lights on and off as well as shutting the bedroom door. She also told Dr Singleton that Kevin had assaulted a bus driver, blaming the bus driver for his painful shoulder.

On 20 November, Mr S Robinson, Kevin's friend, contacted Dr Singleton requesting that Kevin was seen by a psychiatrist. Dr Singleton agreed to refer him as soon as he was released from prison.

Comment

It is unfortunate that Dr Singleton did not make contact with HMP Manchester Healthcare as he was the only person who at this time would have had a full picture of Kevin's health.

Chapter 3 Court Proceedings and the Probation Service in early 1998

Kevin appeared in Court 27 January 1998 and pleaded not guilty to the charge of affray and guilty to the charge of Section 47 assault. The Court proceedings were adjourned so that a psychiatric report could be prepared. Dr Anne Jasper, Senior Registrar to Dr Snowden, Consultant in Forensic Psychiatry at the Edenfield Centre was requested by Kevin's solicitor to prepare a psychiatric report for the next Court appearance for sentencing.

Dr Jasper had seen Kevin Keogh on two occasions, once as part of the Court Diversion Scheme on 3 November and again on 24 February. Dr Jasper had seen him in November at the request of Ms M Murphy, the Community Psychiatric Nurse (CPN). She was working at the Magistrates Court and when she saw Kevin, he complained about having a broken neck. She was concerned and so requested a psychiatric assessment. Dr Jasper remembered Kevin as being very guarded and very "*touchy*" that day and said that it had been very difficult to know what was going on because he wasn't very co-operative. He had been in the cells a couple of nights and was in quite a physically dishevelled state, not wanting to say very much. Kevin started to tell her about ghosts or spirits in the house, but then decided that she did not believe him and was not listening and so declined to say anything more.

The CPN contacted Dr Singleton,(GP), and found out that he, too, was worried about Kevin's mental state. Dr Singleton told Ms Murphy that he had been trying to do something about Kevin and that a psychiatrist had been to see him in the past. Following her assessment, Dr Montague had decided there was no further action to be taken. Kevin had not been actively involved with any mental health service. Dr Jasper wrote a report for the Magistrates and a referral letter to Dr Singleton, informing him about her findings but the letter was never sent to Dr Singleton as Kevin was remanded to HMP Manchester. Dr Jasper also recommended that if he went to prison the report should go with him to cover both options of him being released on bail and going to prison. Although Dr Jasper thought he needed to be seen by someone she did not think he needed to be detained under the Mental Health Act 1983. Dr Jasper assumed that Kevin would have a

psychiatric assessment whilst he was in prison as her report would go in the prison healthcare records.

Comment

Despite the report written by Dr Jasper being sent to HMP Manchester, where he was remanded, and it being in the medical notes when she saw him later, the Prison Healthcare Service did not make a referral to the psychiatric services.

Not only was the referral not made for an assessment but Dr Jasper's report was not in the notes when Kevin was remanded to HMP Manchester for the murder of Heath Rowson.

We interviewed Dr W Walker, Senior Medical Officer HMP Manchester, and he told us that none of the notes made at this time were available. It was the practice of HMP Manchester for a nurse in the Healthcare Centre to review the notes and then destroy them after a year if there was nothing "*significant*" in them.

Comment

Dr Jasper told us that the flow of information between the community and HMP Manchester was quite difficult. In her experience, records from the previous time she had been in the prison, even if it had been only a few weeks ago, would not be available. Often a new set of notes was started each time somebody saw a patient.

Because of Kevin's previous history, we were surprised that there was nothing *"significant"* in the notes. The destruction of these notes was not helpful and is against the practice of other HMP Healthcare establishments in the country.

When Dr Jasper saw Kevin in February 1998, she found him more approachable and co-operative than in the previous November. This interview had been easier to conduct. Kevin was able to describe what had happened in the incident with the bus driver outside his flat. He had stayed up all night drinking and had gone out of his flat early the next morning. Kevin was quite

clear in his own mind that he had been provoked and also denied the level of violence in the attack. He said nothing, which led Dr Jasper to think either that he had delusional ideas or that there was anything odd in what he was saying. However at the end of the interview she remembered feeling confused because he accused her of laughing at him and at that time in the proceedings, she had not laughed at all.

When we met with Dr Jasper she told us that

> *"Then at the end he suddenly got very bristly with me and said "You are laughing at me", which was quite a change in that situation and made me feel quite awkward. Then he also said a couple of things about somebody glueing the locks at home and people in the flat were out to get him, or were out to kill him, or something like that, but he wouldn't elaborate that any further. It was only a very small part of the interview that was worrying. There was a hypothesis that maybe that he had persecutory or delusional ideas. But for most of the interview he was fine with me, and it was very straightforward".*

Dr Jasper completed her report in which she stated that he did not need to be detained under the Mental Health Act 1983 but required further assessment and for his mental state to be monitored. This could be provided as part of a condition attached to a Probation Order, and Kevin would then have to attend psychiatric outpatient appointments with Dr Snowden. For some time, members of Dr Snowden's team had held regular clinical sessions at the Moss Side Probation Office and arrangements could be made for Kevin to attend for a psychiatric appointment there when he was seeing a Probation Officer.

Mr T Reynolds, Probation Officer, Greater Manchester Probation Service, completed the pre-sentence report dated 16 March 1998. Mr Reynolds interviewed Kevin Keogh on two occasions in HMP Manchester. Previous Probation records did not raise concerns regarding mental health problems and the only other information he had, was a copy of Kevin's previous convictions.

When Mr Reynolds interviewed him, Kevin did not accept that he had a problem with alcohol or that he had an inability to control his temper. He did admit, however, that he suffered from depression and said a number of things indicative to Mr Reynolds of feelings of paranoia

Mr Reynolds told us

> *"Within 10 minutes of speaking to him it became obvious that there was a mental health issue. - I write hundreds of reports over the years, "The word **'paranoia'** stood out in huge letters. When I got back to the office I went into my senior, Bunty Corstaphine, and said we need a psychiatric report" and that is why I remember Kevin Keogh".*

He went on to say:

> *"He* (Kevin) *went at some length to describe his motivation for the offence as being a previous incident in which a bus driver braked suddenly with the express purpose of hurtling him down the bus, and he seemed quite obsessed about this and felt that this bus driver had something against him even though he didn't know him; so it was irrational - yes, - it was leading to paranoia".*

Mr Reynolds discussed his findings with Dr Jasper who told him that she too felt that further assessment was necessary as she also had noted features which could indicate a paranoid personality. In his report, Mr Reynolds recommended that the only feasible option was a Probation Order with a condition of treatment and such an order should include:

1. Monitoring of Mr Keogh's situation through National Standards for contact with Probation through his regular requirement for attendance at the Probation Office.
2. A further assessment and monitoring of his situation through direct contact with the Psychiatric Services under the direction of Dr Snowden, Consultant Psychiatrist at the Edenfield Forensic Unit, Prestwich Hospital.
3. Alcohol education and awareness work with Mr Keogh through his contact with the Probation Service.

Comment

Dr Jasper and Mr Reynolds had reached agreement about a way forward for a difficult case and had articulated their reasons for the proposal. There was an issue at this stage

about Mr Keogh's willingness to engage in the process, given his previous lack of engagement with the Probation Service.

A two-year Probation Order with a condition of treatment was served on 13 March 1998 and an appointment made for Kevin to attend the Probation Office the following week. He was expected to attend on a weekly basis until the Probation Officer decided with the Senior Probation Officer (SPO) that it could be changed.

When Mr Recorder Collier granted the Order, he said
" I am sure you understand this a serious offence and would normally attract a sentence of 12 months plus three months unexpired license making a total of 15 months. ***However it seems to me that you may be a greater risk to the public if you don't receive help"***

Comment
The comments made by Mr Recorder Collier were quite prophetic. However, they were to remain in the Probation records and were not shared with any other professional member of staff working with Kevin until this Inquiry.

Mr Reynolds also completed an initial risk assessment of Mr Keogh, recording *"medium/ medium"* in the relevant sections headed likelihood and level of risk.

Mr Reynolds did not remain as Kevin's Probation Officer and the case was transferred to Ms Linda Quarmby, Probation Officer Greater Manchester Probation Service. We were told that the transfer would have occurred during a team meeting when individual caseloads were discussed.

Comment
Mr Reynolds provided a thorough and reasoned Pre Sentence Report (PSR) for the Court, and put forward a well argued case for a probation order with a psychiatric condition although there was a concern regarding compliance, however, the proposal to the Court appeared the most appropriate option at that time.

Mr Reynolds had built up considerable expertise in mental health but this was the first case that Ms Quarmby had had of this nature. Her expertise was in the field of sexual offences.

Chapter 4 Involvement between Kevin Keogh and the Mental Health Services in Central Manchester until the Mental Health Act (1983) Assessment in April 1998

On 18 March 1998 Dr Jasper wrote to Dr S Benjamin, Senior Lecturer and Honorary Consultant, Central Manchester Healthcare NHS Trust, referring Kevin to his service. In the letter she said

" I am writing to refer this 31 year old man whom I saw in HMP Manchester in February 1998. He was convicted of assault at Manchester crown Court in January 1998 following an assault on a bus driver in November 1997. He was remanded in custody and when sentenced on the 13th March 1998, he was given a three year probation order with a condition of psychiatric treatment. Dr Snowden was named as the psychiatrist in charge of his treatment at that stage. My purpose in writing at this point is to alert your services that we are involved with this gentleman and pass on further information in case that is required in the future.

When I assessed him my concern was that he might be suffering from a schizophrenic illness, the reason for looking at a condition of psychiatric treatment within the probation order was in order to enforce attendance at outpatients so that further assessment could be undertaken. If it becomes clear that admission is required it is unlikely he would require admission to conditions of medium security, such as those at the Edenfield Centre and it would be at that stage that we may well be consulting with the team who are responsible for Mr Keogh's area and be seeking further support from their services……"

Dr Jasper's letter goes on to detail background information including his forensic and past psychiatric history already discussed in this report. She went on to give details of his use of alcohol and a description of the index offence.

She continued by relating Kevin's mental state when she saw him on the 24th February 1998.

" Mr Keogh was wearing his own clothes when I saw him in HMP Manchester. He was unshaven and his clothes did not look clean or tidy. He was co-operative and relaxed most of the time with me, but appeared to be sensitive about certain comments I made which had been made in the normal format of an interview, which he felt were unsympathetic of me. He denied any abnormality of mood and stated that he was fed up with being in prison and would like to be out. His speech was at a normal rate. His thoughts appeared to have a persecutory nature to them in that he was suggesting people had done things in the past to annoy him deliberately. He stated that this was not the case in prison. Mr Keogh also stated that he was hearing noises in prison, like he had in his flat. Mr Keogh did not think that he had any psychiatric disorder, and did not think he was likely to require any treatment.

<u>Opinion</u>

My concern is that Mr Keogh may be suffering from mental illness but I am not confident of this at the present time to make a clear diagnosis. It would also appear that his mental state had improved in prison and I did not feel that he was in any way detainable under the Mental Health Act. Mr Keogh would not have considered admission to hospital on an informal basis at this stage, however he did agree to attend outpatients psychiatric clinic, which we hold at Moss Side Probation Office.

My aim for those sessions is to get to know him better and hopefully assess his mental state more fully. It may be that it will turn out that there is nothing particularly wrong with him, in which case I am unlikely to be requesting further help from local psychiatric services. However, if it becomes clear once he is back in the community, facing the stresses of day to day life that he is becoming psychotic, I would like to get in contact with his local services in order to request support.

I would be grateful if someone could contact me and let me know who the consultant is. I would be quite happy for him to be seen and assessed by the local team. I would be happy to discuss this case on the telephone with the team who may be involved in the future".

On 19 March 1998 Kevin attended the GP surgery complaining of neck pains and to request a medical certificate. Dr Singleton gave him one for two months

Ms Quarmby saw Kevin on 30 March 1998. She found him difficult to engage, with little eye contact. She told us that he did not seem to think he needed any psychiatric treatment but he had agreed to see the Probation Officer. He had not got an appointment with a psychiatrist as of that time and Dr Jasper would not have known the outcome of the Court case. She telephoned Dr Jasper's secretary to make an appointment for Kevin and this was arranged for 3:00pm 14 April at the clinic at Moss Side Probation Office. As Ms Quarmby was going on holiday for two weeks, arrangements were made for Kevin to see the duty officer when he attended the Probation Office.

Comment

Due to the lack of agreed protocols, there was already a lack of clarity regarding who is responsible for communicating the Court decision. Neither was there an agreed process for the agencies to work on a joint plan for Kevin's care and supervision.

Dr Benjamin wrote back to Dr Jasper on 31 March

> *"Thank you for your letter of 18 March. I am the consultant who organises the outpatient service for the West Sector of central Manchester and therefore I allocate patients. I note that at this stage you are not referring Mr Keogh and indeed have not decided whether or not he has a mental disorder. At present our service can hardly cope with demands for urgent referrals of patients with severe mental disorders, and patients are allocated to the first available clinic depending on the degree of urgency. In the circumstances I am not able to provide the name of the consultant in whose clinic Mr Keogh might be seen in the future. By all means refer him, however, if there is a clear indication that he requires psychiatric input which cannot be provided by the primary care team".*

Kevin's mother, Mrs Keogh, telephoned the Probation Office to say that Kevin would not be attending his appointment on 9 April 1998 as she thought he was mentally unwell. Due to their

concerns about Kevin's non attendance, Mrs Keogh and her sister in law, Mrs Lynch, went to the Probation Office the following week 14 April 1998 and saw Dr Jasper.

They discussed their perceptions of Kevin's mental state, as they were sure he had deteriorated since leaving prison. They believed that he had ideas about people trying to harm him and he was hearing voices. They had been with him when he was apparently listening to someone who clearly was not there. Mrs Lynch told Dr Jasper about her own family's history of mental illness. Three female relatives had committed suicide and there were several uncles who had "*behaved*" in a similar fashion to Kevin. Mrs Keogh told her that Kevin had taken to his bed, was suspicious of everyone and would not open the door to people. She had a key and went daily to take his meals, to clean the flat, do his shopping and wash his clothes. He would stay in the same dirty clothes, all the time if she did not take them off him. She knew that he had behaved in the same way in prison. He had not showered for two months after he left prison and his hair was a mess.

Following this discussion with Mrs Keogh and Mrs Lynch, Dr Jasper sent a hand written note to Ms Quarmby and formally referred Kevin to Dr Benjamin on the 15th April. In the referral letter she said

> *"Thank you for your letter of the 31st March regarding Kevin Keogh. Since his release from prison it would appear that his mental state has deteriorated. I haven't seen him because he did not come to my clinic, but through discussion with probation officer, his mother and paternal aunt, I understand there has been a worrying deterioration in his mental state.*
>
> *I would now like to officially refer Mr Keogh as I suspect he may well be suffering from Schizophrenia. He is not co-operating with anyone and there would appear be a risk both to himself and other people. I, therefore, feel it is appropriate that he be assessed for admission under the Mental Health Act. Since he will not get out of bed let alone out of his flat this will probably have to be done at his flat. Mr Keogh's mother has a key and would be happy to co-operate with people in gaining access. I would be happy to be*

involved in the assessment if the team would find it useful. I do not feel that at this stage he requires admission to conditions of medium security so I think we have a limited role currently from this service. I would be grateful if you would let me know how things proceed".

Dr Jasper also wrote to Dr N Singleton, Kevin Keogh's General Practitioner, copying it to Ms Quarmby and Dr Benjamin. In the letter she told him about Mrs Keogh and Mrs Lynch coming to see her the previous day. In the letter she detailed much of the conversation she had had with Mrs Keogh and Mrs Lynch

"I prepared a psychiatric report on Mr Keogh when he was in Manchester Prison.....he was found guilty of assault and sentenced to a two year probation order with a condition of psychiatric treatment with Dr Snowden, Consultant Forensic Psychiatrist, named as the doctor to be initially involved in that. As part of this probation order condition I offered Mr Keogh an out-patient appointment on the 14 April 1998 at Moss Side Probation offices where we hold a regular clinic.....

.....Mrs Keogh, Kevin's mother stated that Kevin has now taken to his bed, he is suspicious of everyone and won't open the door to people. She can get in because she has a key. She takes him all his meals as he has stopped going out shopping. She keeps the flat clean and washes his clothes for him. She can only get him to change his clothes by taking away the dirty clothes he has been wearing and laying out clean ones for him. Without that, she says he would remain in the same dirty clothes day in and day out. She reports that when he left prison he had not showered for two months and his hair was a complete mess.

Mrs Keogh and Mrs Lynch were both concerned that Mr Keogh is now hearing voices. They have seen him when they have been in the room apparently listening to someone who isn't there and answering as if in conversation. They felt that he had developed very odd beliefs. He makes complaints about physical illnesses and has a complicated system of beliefs about how these occurred and who is to blame. One of these

underlying beliefs is that the injury was sustained on a bus when the driver braked hard. He was convicted of assaulting a bus driver who had parked outside his flat..... Mrs Keogh stated that she knows he is now blaming things on a girl who he says came to the flat and put super glue in his locks and he regularly makes threats about this girl. He states that this was the start of all his problems and he regularly makes verbal threats towards this girl. She believes he has a particular girl in mind, although he would not know where she lived. She was very concerned to find him out in the middle of the night pacing up and down the street stating he would kill this girl for the trouble she had caused him..... Mrs Keogh had come out in the middle of the night because Mr Keogh had telephoned her from a phone box and she had been so concerned about the way he was talking, she had got in the car and driven round to check he was all right. She spent several hours getting him to return to his flat and getting him to calm down sufficiently so she could leave the flat.

Mrs Keogh is very concerned as she has seen her son's mental health deteriorate over the last three years. She feels he is far worse than he has ever been and she really thinks something must be done. She is quite prepared to co-operate with anyone who wishes to come and assess her son by letting them into the flat with the key she has. She believes Mr Keogh is suffering from schizophrenia as she has experience of that with a friend. His symptoms are very much the same as those which her friend demonstrates.....

..... Since his delusions incorporate other people against whom he is making verbal threats, I think we do need to consider that there is a risk to other people. It is my opinion, therefore, that he requires assessment for admission to hospital under the provisions of the Mental Health Act 1983".

.....I wrote to Dr Benjamin when I saw Mr Keogh prior to his release.....Dr Benjamin stated he would not allocate him to a particular consultant at this stage as I was not expressly requesting psychiatric input. Dr Benjamin did state, however, that I should

refer him if there was a clear indication that he required psychiatric input which not be provided by the primary care team. I feel this is the case now. It does not appear to me, that the risk Mr Keogh poses at this stage is such that requires care in medium security, so I feel the appropriate course of action is for a request for an assessment to be made under the Mental Health Act with a view to a possible admission to hospital for further assessment and any necessary treatment. I think Mrs Keogh will be in contact with you about arranging for that to happen. I will write also to Dr Benjamin stating that I am formally referring Mr Keogh now to Central Manchester Services and that my opinion is that the way forward at this stage is to undertake a formal assessment at Mr Keogh's home for admission under the Mental Health Act. It may be that central Manchester Services would also require referral from yourself in order to facilitate the necessary domicilary visits".

The letter, copied to Dr Benjamin and Ms Quarmby, was received by fax at the surgery on Thursday 16 April 1998 and was seen by Dr Dean (GP), Dr Singleton's Practice Partner as he was on holiday until Monday 20 April 1998. Dr Dean telephoned Kevin's mother the same day and arranged with Mrs Keogh to visit Kevin Keogh the following day, 17 April 1998.

The same day 16 April, Kevin Keogh, with his mother, attended the Probation Office and saw the duty officer as Ms Quarmby was on holiday and not returning until 17 April.

On 17 April Dr Dean visited Kevin at his flat. Although Dr Dean did not record what time she went to the flat, she remembered it was in the afternoon and Kevin was still in bed and undressed. Mrs Keogh had told her about her concerns, that she was very, very worried about him and she felt he was very ill. She was doing all the looking after him, cleaning his flat and bringing him food. When Dr Dean asked him questions he just smiled at her in a very strange way and didn't answer. She told us

"He seemed very guarded in his approach to me. I was very concerned because of what his mum had said and his obvious state and when I got back to the surgery, I tried to phone Dr Montague, but was told that she could not see him because he was out of area

so then I contacted the MRI (Manchester Royal Infirmary). *I tried to get through to Dr Benjamin. I think it was approaching 4 o'clock and I had an evening surgery, so I left a message on an answering machine to say that I was very concerned and he needed an urgent psychiatric referral."*

Comment

Dr Dean went on holiday. She told us that she did not follow up on her referral neither did she know whether Dr Benjamin ever received the message.

Following her visit on 17 April Dr Dean did not write anything in the notes as she was already late for evening surgery and Dr Singleton did not have full details of her visit or her concerns when he went on 20 April. She had recorded the visit in the Practice Visit book. It was only as a consequence of this Inquiry that she recalled the visit and decided to attend the Inquiry with Dr Singleton. Neither Dr Singleton nor Dr Dean were called to the Trust's internal inquiry.

Coincidentally Dr Jasper's last working day at the Edenfield Unit was the 17 April as she had finished her placement and was taking study leave in the following week. She did, however, tell us that she had called into the office to deal with any outstanding matters and that she was prepared to be involved in a Mental Health Act Assessment with the local team when it was arranged.

In the meantime, Dr Benjamin discussed Kevin Keogh with Dr Nathalie Robins, his Specialist Registrar, and requested that she should organise a formal Mental Health Assessment under the Mental Health Act 1983. She contacted Mr T Regan, the duty Approved Social Worker, (ASW), Manchester Social Services and Ms Quarmby, who gave her background information about Kevin Keogh.

Comment

There appeared to be some doubt about the communications between the key professionals prior to the assessment. Dr Robins stated that she had contacted Dr Jasper although Dr Jasper had no recall of this. She had made it clear in her letter that she was willing to be involved in an assessment. Although of the opinion that admission was indicated she did not express this directly.

Mr Regan contacted Mrs Keogh, and although she had a key to Kevin's flat he made the decision to obtain a Warrant under Section 135 Mental Health Act 1983 in order to have police presence at the assessment. He told us the reasons for this were twofold,

a) *"Kevin had given her the key and permission for her to enter his premises but this did not extend to the group of professionals and police who were due to attend*

b) *If Mrs Keogh were to allow us to enter the property without Kevin's prior knowledge then he would later blame her for enabling us to invade his privacy"*

Dr Procter, Clinical Director told us that he thought this process should be invoked only after reasonable attempts had been made to gain access by other means.

Dr Benjamin told us that in view of Kevin Keogh's previous history as detailed in the letters from Dr Jasper he had suggested a police presence as he thought it would be safer for Dr Robins to carry out the assessment with this added protection.

On Monday 20 April 1998 at 9:00am Dr Robins contacted Dr N Singleton, Kevin's GP who agreed to meet her at Kevin's flat later that morning at midday. This was Dr Singleton's first day back from his holiday.

Dr Robins also contacted Dr A Procter, Consultant Psychiatrist, Central Manchester to ensure there was a bed available on Oxford Ward, a locked psychiatric ward at Manchester Royal Infirmary. He also arranged for a Staff Nurse, from this ward, to attend the assessment.

Dr Singleton, Dr Robins, Mr Regan, Ms Quarmby and the Staff Nurse, from Oxford Ward attended Kevin's flat with the police officers. Although Ms Quarmby attended, she was unsure of her role there. Mr Regan spoke to Ms Quarmby outside the flat and told her that she was not needed and therefore she did not go in with them.

When they entered the flat Kevin was still in bed and so the interview was conducted in his bedroom. Kevin was interviewed for about 15 minutes during which time two friends arrived, one being Mr S Robinson who had known Kevin since childhood. He told us that Mrs Keogh had telephoned him and as she was upset by the presence of the police. He went to the flat to offer support to her and Kevin.

Comment

During the course of our Inquiry we were told that at least four police officers attended. However in Ms Quarmby's records there is a note which appears to have been written following her attendance that day, "two officers were in attendance".

There was also some debate as to whether the police officers stayed outside the flat or went inside.

Mr Robinson told us

> *"When I walked in there all I could see were numerous policemen, social workers, his own GP, psychiatrist, probation officers, everybody else. Straightaway my immediate thought was 'they've come to take him away.' You have always heard in the past where if they take people away you never hear anything about them. Kevin thought they were there because he didn't turn up for his probation which is why they were there anyway".*

When Mr Robinson was asked to confirm that Kevin was going out, for example, he agreed that Kevin was. However when we spoke to Mr Robinson he told us that he only said this because he feared that Kevin would be "*taken away*".

Dr Robins spoke to Mrs Keogh and although tearful accepted that Kevin was not exhibiting anything the assessment team could detain him for. Dr Robins wrote in the clinical notes "*she is*

not fearful for her safety and for him not to go to hospital will try and persuade patient with friends' help to attend OPA with Dr Jasper regularly"

Comment

The Inquiry felt that the onus for Kevin to be compliant with the agencies involved in his care and supervision was left with his family and friends. Kevin's friends may have agreed, on that occasion, that he was better since leaving prison but following our meeting with Mr Robinson it was evident to us that he did not understand that Kevin could have been admitted to hospital. The presence of the police made him think, "*Kevin was being removed to an institution and not a hospital.*"

Mrs Keogh, who saw Kevin every day, knew he was staying in bed, not opening the door and had become suspicious of everyone but little attention seems to have been paid to her views.

After the assessment Mr Regan wrote to Mrs Keogh, copying the letter to Ms Quarmby, explaining why Kevin was not admitted to hospital under Section 2 of the Mental Health Act 1983. In the letter he went to say

> *"Whilst I accept that there are serious concerns about Kevin's recent behaviour, he did not present as acutely ill to either myself or the two doctors present. Under the Mental Health Act, we can only admit a patient against his wishes if he is suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment; and he ought to be detained in the interest of his own health or safety or with a view to the protection of other persons. When we interviewed Kevin, we did not feel he met the above criteria. However this does not mean that he is not suffering from a mental illness- it does mean that we did not believe that he was suffering from an illness of a degree which warrants detention in hospital. If Kevin fails to attend for his appointments with the psychiatrist he would be in breach of the conditions of his probation. In that event Ms Quarmby could apply to the courts to have*

an alternative sentence imposed upon him and this could include a Hospital Order under the Mental Health Act".

Comment

Ms Quarmby did not take part in the assessment. Following the discussion with Mr Regan in which he told her she was not required Ms Quarmby returned to her office. Apart from Dr Singleton she was the only professional who knew Kevin Keogh and yet her views did not seem to be taken into account. She told us that she was "*frustrated*" with the outcome of the assessment, as she did not feel things had moved on. Dr Singleton who had knowledge of Kevin's previous mental state, felt he played only a minor role in the assessment, he told us "*They didn't seem to take much note of what I had to say. I was there but they didn't question me about how I'd known him before*".

On 21 April Ms Quarmby wrote to Dr Jasper informing her of the outcome of the previous day's assessment. She wrote *"Perhaps it would be appropriate for us to see each other either before or after your next session to share our thoughts/ideas about best to progress with him!"*

Comment

Ms Quarmby was possibly not aware that that Dr Jasper's last working day at the Edenfield centre was 17 April the previous Friday.

Mr Robinson telephoned Ms Quarmby to say that he would ensure that Kevin kept his appointments.

On 22 April Dr Robins wrote to Dr Jasper with the outcome of the assessment and concluding that there were no grounds to detain Kevin. By this time, of course, Dr Jasper had left.

Comment

Dr Robins also appeared not to have known that Dr Jasper's last working day was 17 April.

When a service is dependent on the input of Specialist Registrars it is important to share information about changes in personnel.

Chapter 5 May 1998 until the Incident in November 1998

On 30 April Dr Snowden's secretary wrote to Mrs Keogh offering an appointment for Kevin to see Dr Snowden at the Moss Side Probation Office at 3:00pm 12 May 1998. An appointment was also sent to Kevin's address.

A letter was sent from the Probation Service to Kevin asking him to attend Moss Side Probation Office 6 May 1998 to discuss any employment and training, which could be available for him. He did not attend.

On 12 May Dr Snowden saw Kevin at the Moss Side Probation Office clinic. The notes he made of the meeting have been lost but he wrote to Ms Quarmby agreeing with Dr Jasper's suspicion that Kevin was mentally ill. He also informed her that Kevin had agreed to see Mr T McLaughlin, a CPN working with Dr Snowden, at home. He also wrote in the letter that the reason Kevin was not admitted following the recent assessment was because

> *"it was not thought he was ill enough to be admitted to hospital. I understand the reasoning behind this as the diagnosis (if there is one) is not entirely clear, so the best way forward is to monitor through mental health input by Tom."*

On 13 May 1998 Kevin attended the GP complaining of a painful shoulder and depression and was given a medical certificate for three months.

On 18 May Mr Robinson telephoned the Probation Office to say Kevin would not keep his appointment as he was visiting Amsterdam. He had to make arrangements to obtain a passport. Mr Robinson was told that Kevin should attend the next day but Kevin forgot to do so.

On the same day, Ms Quarmby received a letter by fax from Dr Snowden. His secretary had received a telephone call from Mr Robinson who wanted '*information of a clinical nature*'. Mr Robinson was irate that Dr Snowden was not seeing Kevin but that he was to be seen by Mr

McLaughlin CPN in two weeks time. Dr Snowden requested that Ms Quarmby do something about Mr Robinson's outburst.

Comment

The Inquiry Team were at a loss to understand what Ms Quarmby could have done about Mr Robinson. We recognise that it is distressing for staff who, through no fault of their own, are the recipient of relatives' and friends' anger. On the other hand, clinical and administrative staff need to understand the possible reasons for such anger and frustration.

On 26 May Ms Quarmby saw Kevin for about 10 minutes. It was difficult to elicit any information from him and so she spoke to Mrs Keogh and Mr Robinson who attended with him.

On 4 June 1998 Kevin attended the Probation Office and was reminded he was due to see Mr McLaughlin the following the day at the Probation Office. On 5 June Kevin did attend and saw Mr McLaughlin but the interview only lasted a short time, as Kevin was verbally aggressive.

Mr McLaughlin chose not to discuss the interview with Ms Quarmby, although she could hear the shouting.

Comment

It is unfortunate that there is no recorded note of the meeting. Neither was there a record of any discussion with Kevin, or the Senior Probation officer (SPO) regarding Kevin's behaviour towards Mr McLaughlin, or consideration of breach action.

On 18 June Ms Quarmby saw Kevin and thought he was bored and distracted. Ms Quarmby wrote in her notes, *"Kevin finds the idea of a probation order very puzzling. Seeing the Duty Officer for a few minutes, meeting someone he does not know seems fairly pointless and appears to put Kevin off reporting at all"*.

Comment

The arrangements for reporting had now been changed from one weekly to two weekly. Ms Quarmby wrote in her notes, *"despite the enforcement issues, Kevin is only responding to this Probation Order because his mother and or Stephen Robinson ensure that he does".*

On 9 July Ms Quarmby saw Kevin. Both Mr Robinson and Mrs Keogh had telephoned to say that they were still concerned about Kevin's mental health and they were frustrated that the psychiatric services did not seem to be progressing anything. No one had heard from Mr McLaughlin or indeed Dr Snowden.

On 22 July Kevin was arrested for a Breach of the Peace. The circumstances surrounding this event have remained unclear. Kevin had been drinking and on his return home said he found his front door open and assumed he had been burgled. He created such a disturbance that the police were called. He was reluctant to go with them and following his arrest he was escorted away by members of the Tactical Aid Squad.

On 23 July Kevin did not attend for his Probation appointment because he was in custody. Ms M Murphy CPN assessed Kevin in the cells of Manchester City Magistrates Court. She had been asked to see him by Group 4 staff as he had been shouting in the cells.

During the assessment he denied any symptoms of mental illness, his only complaint was of pain in his neck which he believed was broken, despite there being no physical evidence to suggest this was true. Ms M Murphy suggested, in her Court report, that if Kevin was remanded to prison he should be cared for in the Healthcare Centre and should be seen by the visiting psychiatrist. She also made an appointment for Kevin to see Dr H Whitworth, Dr Snowden's Senior Registrar, the following week, should he be released and which he agreed to keep.

Ms Murphy wrote to Ms Quarmby informing her about Kevin's appearance at Court and copying to her the Court report. Ms Quarmby also received a telephone call from Mrs Keogh

informing her of the court appearance. Ms Quarmby noted. *" I am pleased that at least he will get to see Dr Snowden again".*

On 29 July Dr Whitworth saw Kevin who was accompanied by Mr Robinson. He told her that Mr Keogh had, for the last twelve months or so, been misinterpreting the actions of others. For example when people licked their lips, Mr Keogh would assume they were referring to him in a sinister way, or when passing people in the street, he would believe that they were talking about him. He had also noticed that Kevin had begun to talk to himself. He frequently complained about physical problems such as a broken neck and pains in his head despite being healthy.

Kevin told Dr Whitworth about the incidents with the bus drivers whom he felt were deliberately braking outside his flat just to annoy him. He also told her about the woman who had sprayed anti-freeze into and put Superglue in the locks and had effectively locked him in his flat. Kevin admitted to being very angry with her and volunteered "*I would throw her out of the window if I saw her*" Dr Whitworth wrote in the notes that she found Kevin guarded, suspicious, preoccupied and somewhat perplexed.

She could not identify any evidence of formal thought disorder but Kevin did complain of paranoid delusions, hypochondriacal delusions and delusions of reference. It was also apparent he was responding to auditory hallucinations although the context of the voices were unclear. In Dr Whitworth's letter to Dr Singleton she said,

> *"It would appear that Mr Keogh does have a psychotic illness and I believe it is probably schizophrenia. It may be exacerbated by his current cannabis use."*

The plan was for Kevin to take Olanzapine 10mg daily, to be reviewed in a week and for contact with the CPN service to be arranged.

Comment

We can only assume the CPN service that Dr Whitworth referred to was that of Mr McLaughlin, but as far as we know he never saw Kevin after 5 June when Kevin had been verbally abusive to him.

Ms Quarmby was away from 3 August until 4 September.

Comment

It is unclear who took responsibility for the Probation Order during the periods of Ms Quarmby's sickness and annual leave. Kevin remained passive throughout the period of the Order, and appeared to drift unchallenged.

Kevin Keogh did not attend for appointments with Dr Whitworth on 5 and 12 August.

On 12 August Mr Robinson telephoned Dr Whitworth to say that he could not persuade Kevin to get out of bed. Kevin was reasonably well but did not have any medication. We were told that Kevin did not want to take the medication because, he said, it changed the colour of his skin, although to everyone else it appeared normal.

The same day Kevin attended his GP with a painful shoulder and depression and was given a medical certificate for a further three months.

On 20 August Dr Whitworth wrote to Ms Quarmby informing her that Kevin had been referred again to Dr Benjamin's team. In her letter to Dr Benjamin she wrote

> *"There does seem to be some change in Mr Keogh's presentation. On mental state examination Kevin was agitated and restless. He repeatedly muttered to himself and looked to the wall, whispering several words under his breath such as "piss off". I believe that Mr Keogh does need ongoing psychiatric assessment and treatment. I wonder if one of your team could make contact with Mr Keogh and offer the appropriate advice and support. It may well be this will need to be done on a domicilary*

basis. We have discharged him from our care at the Edenfield Centre and have relayed this information to his probation officer".

Comment

Kevin's discharge from the forensic service seems to have happened without any face to face handover or discussion with either the clinical team or the Probation Officer. He was also discharged before the Community Mental Health Team (CMHT) accepted the referral.

On 2 September Dr M Ang, Specialist Registrar to Dr Benjamin, with Ms S Kendal, CPN, saw Kevin at home. Prior to the assessment Dr Ang spoke to Mrs Keogh and afterwards spoke to a friend of Kevin's. Dr Ang found Kevin guarded and was unable to elicit any further symptoms of psychosis. Throughout the whole interview Kevin appeared to be only superficially engaged and for half the time sat reading a newspaper. He had to be asked if he would put down the newspaper to talk to Dr Ang and Ms Kendal. Because of the expressed concerns in the referral letter, they specifically asked him whether he had any ideas of feeling threatened, feeling persecuted, or feeling annoyed, particularly about this woman whom he had referred to but who he would not name. Kevin denied any florid ideas of persecution as such or any ideas of harm towards others or himself.

Dr Ang told us that as Dr Whitworth had seen Kevin Keogh in July and wrote the referral letter in August he felt that Dr Whitworth was not specifically asking for another Mental Health Act assessment. He believed that this referral differed from the one earlier in April. Again Dr Ang did not think Kevin was detainable under the Mental Health Act 1983. He felt it was more appropriate that Kevin was followed up by a CPN.

Ms S Kendal, (CPN), spoke to Mrs Keogh. Mrs Keogh felt Kevin would benefit from talking to a female and that it would be quite safe for her to visit him at home as she would be there to let her in.

On 10 September Ms Quarmby saw Kevin and found him to be cheerful and chatty. He told her he was not taking any medication, as he did not believe he needed it. Following the meeting Ms Quarmby prepared a Supervision Plan and in it she reviewed the previous three months, and planned the next three months. She wrote

> *"Kevin remains in his flat but contact has been interrupted by my sick leave. He has, however, increased contact due to recent (July) court appearances for beach of the peace. Still no diagnosis, or concrete plans of action other than the CPN contact and referral to Central Manchester Health Authority (MRI). Will move to monthly reporting"*

Comment

The Inquiry found it difficult to understand how a decision to move to monthly contact could be made, given the problems of the previous three months. These included the lack of a diagnosis, any psychiatric care plan and the failure of Kevin to engage in the process of offence focussed work.

On 18 September Ms Quarmby received a letter from Dr Ang in which he hoped that a change could be made to the condition of the Probation Order for Kevin to attend the outpatient department at the Rawnsley Building. He also requested that Ms Quarmby attend his clinic on the 6 October.

Mr Keogh was referred to the CPN service by Dr Ang and was allocated to Ms A Sedman on her return to work.

Comment

We were told that there were two reasons for waiting for Ms Sedman to return, these being, firstly that it was felt that the level of risk Kevin posed was low and secondly, that Ms Sedman was skilled in working with reluctant clients.

On 29 September Ms Sedman visited Kevin at home but he was out. She told Dr Ang that she had not seen Kevin. Dr Ang was due to see Kevin in outpatients the following week.

On 6 October Ms Quarmby attended the outpatient clinic as requested. Mrs Keogh was also present and, according to Ms Quarmby, she was very concerned about Kevin and did not understand why there were still no grounds to admit Kevin to hospital. Dr Ang saw Kevin who appeared much the same as before but had noticeable oral tardive dyskinesia movements. Dr Ang later referred him for a neurological opinion. In a letter, dated 8 October, to Dr Schady, Senior Lecturer in Neurology, Dr Ang wrote *"I would be grateful if you would assess this interesting man, who most likely is suffering from a schizophreniform illness, but has been guarded every time I have seen him. Kevin is lacking in motivation with poor self care and frequently forgets appointments"*

Comment

We have been unable to find any further correspondence about this appointment and were unable to ascertain whether it occurred. In the HMP Manchester Healthcare Records there is a note dated 21.1.99 stating there was an appointment booked for 9.3.99.

On 7 October Ms Sedman visited Kevin at home and his mother let her in. He was not depressed but appeared paranoid and possibly psychotic. She tried to engage him through a discussion about his finances when he became quite distressed saying he had enough money. He did very little outside the flat, preferring to stay in and watch the television. He told her that he did have a friend who he saw occasionally. Following this visit, Ms Sedman gave Mrs Keogh details of how she could be contacted.

On 8 October Dr Ang wrote to Dr Singleton to update him about Kevin's progress. He wrote in the letter

> *"Information from his mother is still strongly suggestive of psychotic behaviour. She notes that he frequently talks to himself in his flat and has poor self-care. For example, he has said he doesn't want to shower as the water pours out of his body and that he won't shave as the blood rushes up his neck. If however his mental state deteriorates it is likely he may need assessment under the Mental Health Act"*

On 21 October Dr Ang and Ms Sedman CPN visited Mr Keogh at home and carried out a CPA assessment. Dr Ang again wrote to Dr Singleton with outcome of the visit. Kevin had told him he had been burgled the previous day and his toaster had been stolen. Kevin told Dr Ang that the police had broken his neck. He also described an event when firecrackers and skyrockets had been let off in the hall. Kevin considered this to be the work of the police. He denied feeling that anyone was deliberately annoying him.

Comment

This was the last time Dr Ang saw Kevin Keogh as he left the Trust to take up another position at the end of October. Dr Ang told us that he discussed Kevin Keogh with Dr Benjamin when he handed over all his patients. He told us that

> ***" Mr Keogh, of all my patients, was the one about whom I was most concerned for obvious reasons. I was very certain that this man had a mental illness. He was currently unwell, was unmedicated and with his past history……".***

He was somewhat reassured that there was CPN involvement, there was ongoing monitoring and that there was a plan in place should there be any deterioration.

On 22 October Kevin failed to keep an appointment with Ms Quarmby. Mrs Keogh telephoned to say that Kevin was waiting for a joiner to repair his front door which had been kicked in.

On 4 November Ms Sedman visited Kevin who had just got up. His mother was present and expressed concerns that he was still unwell and about his lack of hygiene.

On 12 November Ms Sedman visited Kevin who continued to appear paranoid, still denying any psychotic symptoms. Mrs Keogh told her that she was going on holiday for two weeks. Ms Sedman told us that on this visit she felt a bit uncomfortable with him which was only eased because Mrs Keogh was present. Kevin would not sit down with her and smirked all the time.

He was grinning inappropriately, seemed quite distracted and could not concentrate on their conversation.

Comment

Contact between the key staff engaged in supervising and supporting Kevin was much more in evidence during this time than any other time during the period of the Probation Order. However, there is no evidence of contact between the CPN and Probation Officer whilst Mrs Keogh was on holiday.

On 24 November Ms Sedman visited Kevin but on this occasion she did not see him. He could have been in but, as his mother was on holiday in Thailand, there was no one else there to let her into the flat.

Comment

At the time of leaving, Dr Ang was not aware that Mrs Keogh was going abroad on holiday. A Specialist Registrar had not been appointed to the vacant post and Dr Benjamin was leaving the Trust at the end of November. No further out patient appointment was made.

The plan was for the CPN to keep in contact although she knew that Mrs Keogh was going on holiday and would not be there to let Ms Sedman in. The absence of Mrs Keogh was clear alteration of the balance of risk and was not taken into account as such.

On 28 November Heath Rowson, having met Kevin Keogh during a drinking session, spent the day with Kevin in his flat. Whilst Mrs Keogh was away she had arranged for a family friend, Ms L Hannon, to visit Kevin and take him a meal. She called late morning, at about 11:30am, with Kevin's lunch. She was unhappy with Heath Rowson being in the flat as she thought he took advantage of Kevin. She told him to leave which he did, only to return later with cans of lager. Kevin accompanied her to the bus stop later in the afternoon. Later that evening Ms Hannon telephoned Mrs Lynch, Kevin's aunt, and told her that the bedroom window in Kevin's flat had been broken.

On 29 November between 9:30am and 12 midday Heath Rowson returned to his uncle, Mr F Edwards' house where he was staying and changed his clothes. Heath left the house only to return for his meal at about 4:30pm, having been drinking. He had something to eat and left again at 5:00pm having collected £10 from his uncle who was keeping his money for him.

That was the last time Mr Edwards saw his nephew.

On the same day Mrs Lynch went to Kevin's flat at around 3:00pm with lunch for Kevin and some plastic to cover up the broken window. Kevin opened the door for her. There was another man in the flat who introduced himself as "Heath". She told him to leave which he did. She covered the broken window with plastic and left about 4:30pm. Ms Hannon returned to Kevin's flat at 7:25pm with some money for him. She offered to wash Kevin's jeans as they were very dirty, but he refused. She left about 7:55pm.

Later that night at 11:11pm, the Greater Manchester Ambulance Trust received a call to the effect there was an unknown male who had either been assaulted or run over. He had a major laceration to the rear of his skull, no pulse or normal respirations. He was taken to Manchester Royal Infirmary where there were several attempts at resuscitation. At 12:04am he was pronounced dead.

The post mortem showed that Heath Rowson had died from a head injury consistent with a blow or blows from a heavy object to the left rear side of the head with bruising to the front right side of the face. There were abrasions on the back which were consistent with dragged along the floor.

On 30 November Mr Robinson telephoned Ms Quarmby to inform her that Kevin Keogh was at the police station.

Ms Quarmby attended the police station as the 'Appropriate Adult' when Kevin was interviewed.

Chapter 6 Kevin's Stay in HMP Manchester and his Move to the Edenfield Centre

On 2 December Ms Sedman contacted Mr J Keogh, Kevin's brother, to offer any help to the family.

On 3 December Kevin appeared before the Manchester City Magistrates Court and was charged with the murder of Heath Rowson and remanded to HMP Manchester.

On 21 December Ms Quarmby wrote to the Governor of HMP Manchester, outlining Kevin Keogh's mental health history. In the letter she said

> *"As his supervising officer, I have several concerns about Mr Keogh's mental health. Mr Keogh needs constant persuasion to manage his personal hygiene as he has some rather bizarre ideas about water and its effect on his health. Consequently, I am concerned that his personal hygiene will deteriorate whilst he is in custody. It may alienate him from other inmates and cause friction. Mr Keogh sometimes appears to hear voices and also displays odd facial tics and body language. A close friend has telephoned me to let me know that in the past Mr Keogh has expressed suicidal ideas, when he has been under pressure"*

On 15 January 1999 Dr R Gater, Consultant Psychiatrist Central Manchester, wrote to Dr Walker at HMP Strangeways. He informed his that Kevin Keogh had been under the care of the Psychiatric Department at Manchester Royal Infirmary and *"most likely suffers from a schizophreniform illness, but it was difficult to elicit diagnostic symptoms at interview and he was not prepared to take anti-psychotic medication"*.

On 25 January 1999 Dr Walker replied to Dr Gater thanking him for alerting them about Mr Keogh's psychiatric history but as yet he had not revealed any such problems to the prison staff.

On 25 February Ms Sedman visited Kevin in prison at Mrs Keogh's request. Mrs Keogh was concerned that Kevin was not receiving any treatment in prison.

Comment

Ms Sedman continued to keep in touch with Mrs Keogh, offering support by telephone or personal contact if it was required. We consider this to be commendable practice.

On 30 March Kevin was transferred to the Healthcare Centre HMP Manchester because he was being verbally abusive towards the staff, although he maintained he was transferred because he had broken his neck.

0n 22 July Kevin was transferred to Edenfield Centre under Section 38 Mental Health Act 1983 for an assessment. He presented with a good social front and interacted well with his peers. He expressed delusional beliefs, showed florid psychotic symptoms and mimicked people. He had no insight, was able to mask symptoms and rationalise his behaviour. He wore the same shirt for some time despite having many clean clothes.

On 27 1999 September Kevin Keogh was found guilty of manslaughter due to diminished responsibility at Manchester Crown Court and ordered to be detained at the Edenfield Centre under Section 37/41 of the Mental Health Act 1983.

Chapter 7 The Discussion, Findings and Recommendations of the Inquiry

The Trust's Internal Inquiry

The Inquiry Team was invited to review and comment on the internal inquiry conducted by Central Manchester Healthcare NHS Trust following the death of Heath Rowson. Trusts have a responsibility to firstly, carry out a review and secondly, conduct an internal inquiry following any serious incident involving a patient. It is usual practice for the Trust to report the findings and any action taken to the Health Authority. In the event of a violent incident the Health Circular, *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community* HSG(94)27, states that "*an immediate investigation should be carried out to "identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach*".

An incident review took place within a week of the homicide and involved the Clinical Director, managers and the two CPNs based in the West Sector Community Mental Health Team. They made the following recommendations:

1. Probation orders should be transferred appropriately
2. Third party letters in the medical notes should be made available and copied to all the team members involved in the case
3. Any transfer from the Forensic services in Salford should include a CPA and a handover meeting should be arranged in each case

Central Manchester Healthcare Trust then conducted an internal inquiry (The Terms of Reference Appendix 4) which was chaired by a Non Executive Director and included representatives from both Manchester Health Authority and the City of Manchester Social Services. We were told that there were another two investigations underway at the time. One was in the psychiatric service and the other one in the maternity services. These were seen as more important as it was assumed that this incident would require an external independent inquiry. A series of transcribed meetings were held with some of the professionals involved with Kevin Keogh although we were surprised

to learn that Dr Singleton was not invited. Not all the panel members were present at all the meetings because of other work commitments. The outcome of the inquiry was a series of questions which, as part of the need for "*ownership*" by the Trust Board were later translated into a four point action plan. They were about the way in which the CMHT gathered information, liaised and accessed the main case notes as they were held centrally and not with the CMHT. The fourth point was to look at other good practice guidelines and enhancing the level of understanding in relation to Probation Orders. The Trust Board, at their meeting in March 1999, received the report and its action plan.

In establishing our Inquiry we had the benefit of previous experience of homicide inquiries and the time to explore the situation more fully. However, given that many of the issues raised were related to the Probation Service, we were surprised that a member of the Probation Service was not invited to be a panel member.

Any incident such as this is distressing for staff and they need much support and some members of staff may require counselling. We were pleased, therefore, to be told "*Staff were supported throughout the internal review procedure and through supervision from the line manager and the offer to attend the Trust's counselling department was made to staff.*" Unfortunately staff we interviewed were not aware that there was a counselling department and the first they had heard about it was through this Inquiry and the sharing of a senior manager's statement to the Inquiry.

We also learnt that one of the CPNs was not fully briefed about the procedure for the internal inquiry and thought she was going for "*an informal chat*" and as a consequence felt very unprepared for the interview. It is to her credit that she continued with the interview but then was not given any feedback. Nor did she see the report until a short time prior to attending this inquiry.

Recommendation

We recommend that the Manchester Mental Health Partnership reviews its serious incident policy and takes account of the terms of reference when appointing the members.

We recommend that the Manchester Mental Health Partnership reviews its serious incident policy in the light of the experience of staff who have contributed to this inquiry. The policy should ensure that there is a supportive framework which includes counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any action plan which has to be implemented.

Operation of the Care Programme Approach

There were clear problems in the way the Care Programme Approach was operated in the provision of care to Kevin Keogh.

Forensic Services Edenfield Centre.

There was little evidence of the operation of CPA at all. Thus, there appeared to be no clear Care Plan or Management Plan guiding staff in their involvement with Mr Keogh, other than a broad-based notion to determine the nature and extent of his mental illness. For example, Kevin's use of alcohol was identified in the Pre-sentence report and written in the Probation supervision plan. However this was not addressed in the Care Programme Approach.

Accordingly, there was no evidence of any formal Care Planning meetings to which all those involved in Mr Keogh's care, not least his family and friends, could share information and agree a plan of care.

An important facet of such a meeting would have been the opportunity to share risk assessments that had been carried out and arrive at a consensus as to the risks that Mr Keogh presented.

Had a more coherent Care Plan been in place then, the overall picture at the point when care was handed over to local services would have been clearer and more comprehensive. It was also likely that the handover would have occurred earlier in a more appropriate way. **The forensic services are not currently part of the City wide services in Manchester and particular attention should be given to including them in the future arrangements for CPA.**

Central Manchester Healthcare Trust Mental Health Services

We found that the Care Programme Approach (CPA) was instigated when Dr Ang and Ms Sedman became involved and an initial Care Plan was drawn up. However this was done following their initial visit to Mr Keogh. There might have been more benefit if there had been a more formal gathering of all those involved to assemble a more complete picture. The Care Plan was seen as an initial one, to be revised when contact had been made with others involved, and in the circumstances this would not have been unreasonable.

Involvement of all the agencies

The Care Programme Approach could have been the vehicle used to ensure more effective communication between all the agencies and individuals involved with Mr Keogh. Not least it would have enabled Mrs Keogh (Kevin's mother) to express her real concerns about the deterioration in his condition in a proper context and for a joint risk assessment and risk management plan to be agreed.

During the Inquiry disparate views were heard as to the extent to which other professionals were routinely invited to Care Planning Review meetings. Thus, within the Trust the view was that **all** those involved would be routinely invited whereas Probation, for example, felt that it would be unusual for them to be invited

Recommendation

We recommend that the current Care Programme Approach policy be revised in the context of recent guidance from the Department of Health, and the move towards a city wide Partnership. Within this review heed should be paid to the establishment of protocols with other agencies and interested parties, particularly the forensic, probation and prison services as to the expectations in terms of their involvement and contribution.

Role of Appropriate Adult

A number of issues arose around the involvement of an Appropriate Adult during the period when the Police questioned Mr Keogh. There was clear confusion within the Probation Service as to the appropriateness or not of Mr Keogh's Probation Officer acting as an Appropriate Adult for him. Whereas in some other areas Probation have an explicit Policy that Probation Officers should not act as Appropriate Adults, this was not the case within Greater Manchester Probation Service at the time of the incident. With the exception of the first interview when a Duty Officer from Social Services fulfilled the role, Mr Keogh's Probation Officer acted as the Appropriate Adult on his behalf on every subsequent occasion when Mr Keogh was interviewed by the Police,

The original rationale for this was said to be that, as his Probation Officer, she was the person who probably knew him best and had had most contact with him. However it was also clear that at the time of the incident Mr Keogh's Probation Officer had had no formal training in acting as an Appropriate Adult and was not altogether clear what the role entailed.

It was also unfortunate that in acting as Appropriate Adult, Mr Keogh's Probation Officer was confronted in the Police Station by a friend of Mr Keogh, who was understandably upset at a perceived lack of care contributing to the current outcome.

This confrontation most graphically represents the clash of roles occupied by Mr Keogh's Probation Officer in these circumstances.

Having said this, there was no evidence within that presented to the Inquiry to suggest that the lack of any formal training as an Appropriate Adult had any negative impact on Mr Keogh during the investigations carried out by the Police.

We found that there was no clear process by which the Police were able to make contact with an Appropriate Adult where one is deemed to be necessary. Indeed the Police Officer we spoke to,

described the process as, at best, an ad hoc one resulting in the Appropriate Adult often being whoever was willing to fulfil the role at the time.

Recommendation

We recommend that the appropriate local agencies should develop a more coherent and formal process whereby Appropriate Adults, suitably trained and supported, are available to the Police on the occasions when they are necessary. One model successfully developed in other areas has been to contract with a voluntary organisation to provide such a service.

Mental Health Act Assessment April 1998

The Clinical Director told us that he would have expected a preliminary meeting of all the professionals involved and including Kevin Keogh's family and friends prior to the assessment. If this discussion had taken place, the possibility of a voluntary admission could have been explored as well any other options. Similarly the rational for invoking Section 135 MHA 1983 and the involvement of the police could have been more fully discussed.

Although estimates of the duration of the assessment interview, in April 1998, varied from 15 minutes to 2 hours the consensus seems to be that the time spent interviewing Kevin Keogh lasted approximately 15 minutes. Given the extent of the concern prior to the assessment and the ability of some people to 'mask' symptoms for this period of time, this does seem a brief interview.

Indeed, Mrs Keogh told us that Kevin was able to appear rational for up to half an hour but would then begin to express strange ideas and show odd behaviour thereafter.

Whilst it does seem that attempts were made by those present to explain to Mr Keogh and his friends and family the purpose of the interview, this was not understood by them. The outcome of the assessment was clearly fed back to Mrs Keogh and Kevin's friends. We could find no indication that they were involved or consulted as part of the assessment to gain a fuller picture of the situation. It might have been better, with hindsight, if the professional staff present had

tested out the extent of Mrs Keogh and Kevin's understanding as to the nature and purpose of the interview.

It is common practice for people in this situation to be described as "*non sectionable*". Technically it is untrue because all that is required legally is a suspicion of mental disorder and suspicion of risk to others or the person. Presenting decisions in this way invariably inhibits further discussion. Dr Procter agreed with view.

Involvement of the General Practitioner in Mental Health Act Assessments

The General Practitioner, whilst present during the interview appeared to play a very subsidiary role and expressed his dismay about the outcome of the assessment to the Inquiry.

Dr Singleton had been Kevin Keogh's GP for a number of years even though Kevin had moved house. It was unfortunate that Dr Singleton did not feel able to say very much at the time. He told us that he was used to working with a different team of healthcare professionals led by Dr Montague who had, of course, seen Kevin previously. He had also just returned from holiday and did not know of the concerns expressed by Dr Dean as she was on holiday.

Drs Dean and Singleton told us that they had not been offered any training in mental health assessment.

Involvement of the Police in Mental Health Act Assessments

In undertaking such assessments, professionals need to be mindful of their own personal safety. It does appear in this instance, that given the number of other people present, it should have been possible to have the Police available nearby rather than present during the interview.

Contingency Plan Following Mental Health Assessment

Having decided that compulsory admission was not appropriate, the lack of a clear contingency plan, other than a continuation of relatively infrequent outpatients and probation appointments that Mr Keogh was struggling to attend, feels remiss. Given the extent of the concern prior to the

assessment and the feedback from Mrs Keogh, it would seem that a more coherent alternative to hospital admission should have been considered.

Recommendation

We recommend that a jointly agreed protocol be developed to clarify the procedure for assessments for compulsory admission under the Mental Health Act (1983), embracing and clarifying the following issues:

a) **The value of communicating with all interested parties prior to the assessment**

b) **The circumstances in which the Police would be involved in an assessment, including the extent of that involvement**

c) **The need for any assessment to be thorough enough to elicit symptoms of mental illness, even where these are being suppressed**

d) **The need to meaningfully incorporate the information provided by carers, family and friends in any assessment and taking into account any previous history as well as current mental state**

e) **The need to test out whether the purpose of the assessment and its outcome have been clearly understood by the person being assessed and those involved in his or her care**

f) **The role of General Practitioners in the assessment process and their training needs**

g) **The need for an explicit plan as an alternative to admission to hospital where compulsory admission has been deemed to be inappropriate**

h) **The importance of coherent and inclusive information gathering as part of the assessment process**

Probation Orders

The statutory purpose of supervision under a Probation Order is defined in Section 2(1) of the Powers of Criminal Courts Act 1973 (as substituted by Section 8(1) of the 1991 Criminal Justice Act as

- Securing the rehabilitation of the offender
- Protecting the public from harm from the offender, or
- Preventing the offender from committing further offences

To achieve this, supervising officers should address the following objectives

- Confronting offending behaviour, challenging the offender to accept responsibility for his or her crime and its consequences
- Making offenders aware of the impact of the crimes they have committed, the community and themselves
- Motivating and assisting the offender towards a greater sense of personal responsibility and discipline, and to aid his or her re-integration as a law-abiding member of the community
- Intervene to remedy practical obstacles preventing rehabilitation e.g. skills for employment, action to counter drug/alcohol abuse, homelessness, and to help the offender acquire relevant new skills
- Ensuring that the supervision programme for the offender is demanding and effective

National Standards for the Supervision of Offenders in the Community, *(Guidance Document aimed at promoting effective working between Health and Probation Services Dept of Health/ Home Office 1995)*, provide a measurable framework to strengthen the supervision of offenders in the community, providing punishment and a disciplined programme. Local Probation Services are expected to agree local practice guidelines to enable the standards to be delivered.

When the Probation Order includes a condition for treatment of the offender's mental condition, the supervising officer should liase with the relevant services and agencies. The purpose is to ensure that the offender co-operates with any treatment ordered by the court, proposed in the Pre Sentence Report (PSR) or considered appropriate by the supervising officer after assessment.

HM Inspectorate of Probation carried out a Thematic Inspection in 1993, which highlighted the complexities involved in supervising offenders on Probation Orders with psychiatric conditions.

The thematic Inspection stated "*Many of the problems and frustrations observed in the supervision of these orders appear to have some root in a failure by those concerned to address and come to an accommodation and agreement about these fundamental issues. Recognition of these issues and addressing them when need arises would seem a pre-requisite for good inter-agency co-operation. Pretending they do not exist is a recipe for frustration, waste of resources and ineffectiveness*"

Many of the issues and difficulties highlighted in this case were commented upon in the Thematic Inspection report and recommendations were made nationally regarding the implications for Probation management.

Evidence presented to the Inquiry suggested that the lack of practice guidelines hampered the supervising Probation Officers' attempts to engage with other local agencies. Ms Quarmby's inexperience of working with mentally disordered offenders was also an issue. We believe that there is a need to develop and effectively implement a policy for the supervision of people with experience of mental distress. Such people form a significant and growing proportion of the workload that any probation service has to deal with. We recognised that support was given within the framework of supervision but supervision is also about accountability and professional development. It should not be acceptable for practitioners with little or no experience and, more particularly, little or no training to be allocated Probation Orders with psychiatric conditions. Whilst we recognise that inexperienced staff should be given the opportunity to develop skills in this area, we feel this should only be after a period of induction.

We learnt that the internal inquiry was initially unaware that Kevin Keogh was subject to a Probation Order with a psychiatric condition. This has implications for both the Health and Probation services in terms of communication.

Recommendation

We recommend that all the agencies involved in the care, treatment and supervision of people who are subject to a Probation Order should discuss the recommendations of the 1993 Thematic Inspection and implement locally agreed communications systems.

We recommend that the Manchester Probation Service should develop a mental health training programme which takes account of the findings and recommendations of this report for practitioners and their managers.

We heard from all concerned, with the exception of Dr. Snowden, who had set up this example of good practice several years previously, that the clinic provided by forensic psychiatrists at the Probation office was useful and effective. This allowed for extra contact, between forensic and Probation staff. However, Dr. Snowden with specific responsibility for clients attending this probation office, feels that his attendance there has been less than welcomed, and has overseen the degradation of the facility from a weekly session, to an irregular occurrence. We feel that to hold an out-patient clinic in this setting is a good example of developing forensic services and their interface with other community agencies. We regret the decision to scale down this practice particularly as it was valued by the local Probation service.

Recommendation

We recommend that the Forensic Service reconsider the provision of a clinic in a probation setting.

Management of Risk and Public Protection

National Standards for the supervision of offenders in the community require an assessment of the risk posed by the offender in every case. The assessment should consider the risk to the public of re-offending or of causing serious harm and its likely nature. Assessments should also consider the risk of suicide or self harm and risk to staff. Risk assessment is not a one off activity; it should be undertaken systematically at regular intervals so that any change in

circumstances or specific new problems arising are noted and appropriate action taken, e.g., to apply to the court for amendment of the order.

The National Standards were used as a time framework to carry out risk assessments, but it became more like a paper exercise. There was a lack of co-ordination with other agencies, and a lack of application in terms of the evidence available to support practice, which appear to have resulted in a minimisation of risks posed. At the time of the Mental Health Act assessment and also at the time of the Breach of the Peace incident in July 1998, there is no evidence that the level of risk was reassessed.

Sharing of Information about Individuals Assessed as Presenting a Risk of Serious Harm

During the course of our Inquiry we were told of the Multi Agency Risk Panel (MARP) which had initially been set up between the Greater Manchester Probation and Police Services. The purpose of the panel is to focus on the small number of offenders who pose a major risk to public safety. The Police and Probation Service involve other agencies as appropriate to 'best manage' the risk posed by this group of people. The panel adopts a 'case management approach' which ensures discussion about assessment and level of risk, formulates an individual plan which can be monitored, implemented and reviewed as well as formal registration.

Knowledge about any potential risk, which Kevin Keogh may have posed to the general public, was known to the Probation Service and implied in the medical notes but there was no forum where this information could have been shared with all the agencies involved. It is considered good practice to have such a forum which gives all agencies the opportunity to learn from past experience and improve public safety. It is not intended that this process would take away the need for each agency to act in accordance to its own guidance but is seen as a way of enhancing their collective knowledge and understanding.

Recommendation

We recommend that the Manchester Health Authority, Greater Manchester Probation and Police Services, the City of Manchester and NHS Trusts set up a forum which enables staff

from different agencies to share concerns and information about people who are considered to present as a risk but do not fit the criteria of the MARPS system. A range of such fora have been developed in other areas and fill the void between MARPS and individual agencies.

Supervision Plan

A Supervision Plan should be drawn up in writing, in consultation with the offender, within 10 working days of the making of the Probation Order. The Plan should be based upon the requirements of the Probation Order, including any additional statutory requirements, drawing, where available, on the assessment of the offence and offender and the outline Supervision Plan contained in any PSR.

The plan should address:

- The offender's motivation, pattern of offending, relevant problems/needs, the risk of re-offending or serious harm to the public and the requirements of the order.
- Identify work to be done re. the impact of the crimes they have committed on their victims, themselves and the community.
- Describe the purpose and the desired outcomes of the supervision for the offender.
- Set out an individual programme which addresses the objective for supervision and identifies the methods to be tried.
- Set out the nature and frequency of contact.
- Identify a timescale for achieving each objective.

The Plan should be designed with the aim of achieving the following outcomes as appropriate and should explain how they will be achieved:

- A change of behaviour to make the offender a responsible and law-abiding member of the community.
- Maximisation of the offender's employability.
- Reduction in the risk of re-offending and causing serious harm to the public.

- A greater sense of merited self-respect.

The Supervision Plan should, where possible, be agreed with the offender and signed by both the offender and the Probation Officer. A copy should be given to the offender and another held on file.

Every three months from the start of the order, and more frequently, if appropriate, the elements of the Plan and its progress should be reviewed with the offender. Progress should be recorded in writing and the plan amended as necessary, signed again by both, with a final review on completion of the Order.

A Supervision Plan was prepared within the time frame required by National Standards, but it failed to capture the elements outlined above. Kevin signed none of the Plans. Health service colleagues were unaware of the existence of a Supervision Plan.

Frequency of contact with Probation Services and Enforcement of Probation Orders

Offenders should attend a minimum of 12 appointments, normally weekly, with the supervising officer in the first three months of a Probation Order; six in the next three months; and thereafter at least once each month to the completion of the supervision. Attendance at a programme or specialist project as part of the supervision should count as part of the supervision, as should home visits. The offender should be made aware of this and of the action that will be taken for failure to comply. The signing of a register by the offender, without any contact with supervising staff, should not count towards the completion of the order.

National Standards state that the overall purpose of enforcement is to secure and maintain the offender's co-operation and compliance. Any apparent failure to comply with the requirements of the Order should be dealt with as soon as possible, and in any event within two working days, seeking an explanation from the offender. The incident, the offender's explanation, or lack of one, the supervising officer's opinion of whether any explanation is acceptable and the likely consequences for the effectiveness of supervision should be recorded. If the explanation is not

considered acceptable, the incident should be formally recorded as an instance of failure to comply with the order.

Kevin failed to keep five of the twelve appointments required in the first three months of an order. Mrs Keogh and Stephen Robinson contacted Probation on each occasion; therefore the failed appointments were recorded as acceptable. There is no evidence of discussions with Kevin regarding his failures to comply with the Probation Order. Kevin himself told us that he had expected to be taken back to Court. Indeed he thought the police presence in his flat when the Mental Health Act assessment was being carried out in April 1998, was to take him into custody for breach of Probation.

Enforcement issues were not addressed with Kevin following his Court appearance in July 1998 partly due to his Probation Officer being on sick leave and annual leave. At a time in September 1998, when Kevin's behaviour was becoming more difficult and his mental health deteriorating, the Supervision Plan reflected a move to monthly reporting.

Recommendation

We recommend that Manchester Health Authority, the Greater Manchester Probation Service and the City of Manchester in conjunction with the Forensic Service, develop working relationships between mental health services and probation services as described in the document ' A Guidance Document Aimed at Promoting Effective Working between Health and Probation Services' published in 1995.

Kevin Keogh's Healthcare Needs in HMP Manchester

Kevin Keogh was eventually transferred to the Healthcare Centre at HMP Manchester in March 1999. This was some four months after his arrest. We know that professional staff had expressed concerns about his mental distress, however Dr Walker told us that Kevin Keogh was not showing any signs of mental illness. His mother, though, told us that he had worn the same shirt for five months despite having clean clothes, had smelly feet and had not shaved. This was

a pattern of behaviour that he had exhibited before. She tried to speak to a Prison Officer but they were not interested. She also spoke to a Probation Officer in the prison but with no effect.

She was stopped from taking in clean clothes for him because she and Kevin had not complied with Prison rules. Kevin had to make a request but by the time he returned to the 'wing' he had forgotten. Mrs Keogh told us she had even written to the Governor saying how concerned she was about Kevin. Mrs Keogh was eventually able to see Dr Davies, a visiting psychiatrist, but by this time Kevin was disruptive on the 'wing' and had been transferred to the Healthcare Centre.

There has been much public criticism of the healthcare received by prisoners. In answer to this '*The Future Organisation and delivery of Prison Health Care*' was published in 1999. We accept that forensic services are already involved in the delivery of care to prisoners but on occasions it might be more beneficial to the individual patient if the local supervising psychiatrists and members of the community based teams are more actively involved in their aftercare arrangements.

Recommendation

We recommend that the Health Authority and the HMP Manchester set up a working group to assess the needs of prisoners who are exhibiting mental distress involving the local community mental health services and the use of beds in the NHS. This working group should also consider Probation Orders with condition of treatment.

We recommend that the HMP Manchester develops a mental health awareness training programme for Prison Officers.

The Inquiry Team was dismayed by the apparent disregard of good record keeping whilst Kevin Keogh was in HMP Manchester. It has been mentioned earlier in this report that records which this Inquiry considered to be important in the continued understanding of Kevin's breakdown in mental health were destroyed. The record keeping and general system for dealing with correspondence at HMP Manchester were not of a reasonable standard.

Recommendation

We recommend that as part of the new way of working between the Health Authority and HMP Manchester there is a review of the record keeping systems which takes account of individual prisoners health care needs whilst they are in prison and subsequent discharge planning.

Training

The Inquiry heard differing views about the level of available training in mental health issues for all agencies. We feel that there is an urgent need for a comprehensive training needs analysis which takes account of:

- Mental health legislation
- Assessment and management of risk posed by mentally distressed people
- Roles and responsibilities of the different agencies
- Enhanced use of the needs assessment (MANCAS) evaluation tool
- Care planning and case management

Multi- disciplinary and multi-agency training may do much to bring about the integration of mental health services in Manchester

Recommendation

We recommend that the Health Authority and other commissioners should be responsible for the development, implementation, monitoring and evaluation of an overarching mental health training strategy which takes account of all other agencies who are involved with people who experience mental distress.

The Relationship between the Forensic and General Mental Health Services

During our Inquiry we heard that personal relations between forensic and general mental health clinicians were reported to be good. Systems' faults had been identified and guidelines were

given to us in various stages of ratification. These were in relation to mental health and Probation on the one hand and to general and forensic mental health services on the other. Dr Snowden was due to present guidelines on the latter at a national forum. In his evidence, however, Dr Snowden said that he changed his mind about these guidelines based on this incident.

It appeared to be generally accepted that the forensic mental health service was the more appropriate service to work with Mentally Disordered Offenders because it had more time to consider the needs of people such as Kevin Keogh who had been through the criminal justice system. However there is a problem with this approach as the forensic mental health service does not have full access to local mental health resources in both the community and non forensic inpatient services. As a consequence there is no systemic solution to the implementation of a comprehensive care pathway for such people.

There is an argument that if Kevin had been managed by general mental health services from the beginning, the system would have operated better. Against this is pressure on general mental health resources as well as the acceptability and availability of general psychiatrists to provide advice to the courts and prisons.

These difficulties are further highlighted when there a reliance on medical trainees to manage cases and when, by the nature of their specialist training, they change jobs and are supervised by different Consultants at least once a year.

Recommendation

The Health Authority reviews the mental health services available to people in all parts of the criminal justice system in the light of the findings of this Inquiry.

Chapter 8 Summary of Recommendations

The Inquiry Recommends that

1. The Manchester Mental Health Partnership (MMHP) reviews its serious incident policy and takes account of the terms of reference when appointing the members.

2. The MMHP reviews its serious incident policy in the light of the experience of staff who have contributed to this inquiry. The policy should ensure that there is a supportive framework which includes counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any plan which has to be implemented.

3. The current Care Programme Approach policy be revised in the context of recent guidance from the Department of Health, and the move towards a City wide Partnership. Within this review particular heed should be paid to the establishment of protocols with other agencies and interested parties, particularly the forensic, probation and prison services as to the expectations in terms of their involvement and contribution.

4. The appropriate local agencies should develop a more coherent and formal process whereby Appropriate Adults, suitably trained and supported, are available to the Police on the occasions when they are necessary. One model successfully developed in other areas has been to contract with a voluntary organisation to provide such a service.

5. A jointly agreed protocol be developed to clarify the procedure for assessments for compulsory admission under the Mental Health Act (1983), embracing and clarifying the following issues:
   a) The value of communicating with all interested parties prior to the assessment
   b) The circumstances in which the Police would be involved in an assessment, including the extent of that involvement

c) The need for any assessment to be thorough enough to elicit symptoms of mental illness, even where these are being suppressed

d) The need to meaningfully incorporate the information provided by carers, family and friends in any assessment and taking into account any previous history as well the current mental state

e) The need to test out whether the purpose of the assessment and its outcome have been clearly understood by the person being assessed and those involved in his or her care

f) The role of General Practitioners in the assessment process and their training needs

g) The need for an explicit plan as an alternative to admission to hospital where compulsory admission has been deemed to be inappropriate

h) The importance of coherent and inclusive information gathering as part of the assessment process

6. All the agencies involved in the care, treatment and supervision of people who are subject to a Probation Order should discuss the recommendations of the 1993 Thematic Inspection and implement locally agreed communications systems.

7. The Greater Manchester Probation Service should develop a mental health training programme for practitioners and their managers.

8. The Forensic Service reconsider the provision of a clinic in a Probation setting.

9. Manchester Health Authority, Greater Manchester Probation and Police Services, the City of Manchester and local NHS Trusts set up a forum which enables staff from the different agencies to share concerns and information about people who are considered to present as a risk case but do not fit the criteria of the MARPS system. A range of such fora have been developed in other areas and fill the void between MARPS and individual agencies.

10. Manchester Health Authority, the Greater Manchester Probation Service and the City of Manchester in conjunction with the Forensic Service develop working relationships between

mental health services and probation services as described in the document ' A Guidance Document Aimed at Promoting Effective Working between Health and Probation Services' published in 1995.

11. The Health Authority and the HMP Manchester set up a working group to assess the needs of prisoners who are exhibiting mental distress involving the local community mental services and the use of beds in the NHS. This working group should also consider Probation Orders with condition of treatment.

12. HMP Manchester develops a mental health awareness training programme for Prison Officers.

13. As part of the new way of working between the Health Authority and HMP Manchester there is a review of the record keeping systems which takes account of individual prisoners health care needs whilst they are in prison and discharge planning.

14. The Health Authority and other commissioners should be responsible for the development, implementation, monitoring and evaluation of an overarching mental health training strategy in partnership, which takes account of all other agencies who are involved with people who experience mental distress.

15. The Health Authority reviews the mental health services available to people in all parts of the criminal justice system in the light of the findings of this Inquiry.

Appendix 1

Purpose of the Inquiry

An inquiry is a learning tool: its purpose is to learn any lessons which may minimise the possibility of a recurrence of the tragic event, which is why the report is made to the bodies that have power to change the way the service is provided. The outcome should be that any feasible improvements are made, for the future good of everyone. The independent panel should do all they can to reduce apprehension on the part of those taking part.

Procedure to be adopted by the Inquiry

1 Every witness of fact will receive a letter in advance of appearing to give evidence. This letter will ask them to provide a written statement as the basis of their evidence to the inquiry and inform them:

- of the terms of reference and the procedure adopted by the inquiry;
- of the areas and matters to be covered with them;
- that when they give oral evidence they may raise any matter they wish which they feel might be relevant to the inquiry;
- that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another inquiry witness;
- that it is the witness who will be asked questions and who will be expected to answer; but on occasions it might be sensible for the supporter to join in;
- that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2 Witnesses of fact will be asked either to affirm or confirm that their evidence is true.

3 Any points of potential criticism will be put to witnesses of fact, either verbally when they first give evidence, or in writing at a later time, and they will be give a full opportunity to respond.

4 Written representations may be invited from professional bodies and other interested parties regarding best practice for persons in similar circumstances to this case and as to any recommendations they may have for the future.

5 Anyone else who feels they may have something useful to contribute to the inquiry may make written submissions for the inquiry's consideration and, at the chairman of the inquiry's discretion, be called to give oral evidence.

6 All sittings of the Inquiry will be held in private.

7 The draft report will be made available to Manchester Health Authority for any comments as to points of fact.

8 The findings of the Inquiry and any recommendations will be made public.

9 The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, except insofar as it is disclosed within the body of the inquiry's report.

10 Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the report, and any recommendations, will be based on those findings.

Appendix 4

Internal inquiry terms of reference

- To review the circumstances and subsequent actions, and in particular the point of transfer and subsequent aftercare given by Central Manchester Healthcare Trust to KK, giving particular emphasis to the following areas:

(a) The suitability of his treatment, care and supervision in the context of:

- His actual and assessed health and social care needs
- The actual and assessed risk of potential to himself and others
- His previous psychiatric history
- Any previous forensic history

(b) The extent to which Kevin Keogh's care complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies and relevant guidance from the Department of Health (Care Programme Approach HC(90)23/LASSL(90)11), Discharge Planning HSG(94)27 and any Home Office Circulars.

(c) The extent to which Kevin Keogh's prescribed care was:

- Adequate
- Documented
- Understood and agreed by him
- Monitored by the relevant agencies

2. To examine the adequacy of the collaboration and communication between all the agencies including the Probation Services, Central Manchester Healthcare Trust, Manchester Social Services, as well as his family.

Appendix 5

Background Reading

Department of Health The Care Programme Approach HSG(90)23/LASSL(90)11

Department of Health and the Home Office 1991 A Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services chairman Dr John Reed

NHSME 1991 Criminal Justice Act 1991 Mentally Disordered Offenders Health Service Guidelines

Department of Health 1993 The Health of the Nation Key Area Handbook -Mental Illness

Department of Health 1993 The Health of the Nation-Mentally Disordered Offenders

Department of Health 1993 Caring for People with Severe Mental Illness, Information for Psychiatrists

Department of Health 1994 Introduction of Supervision Registers for Mentally Ill People HSG(94)5

Department of Health 1994 Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94) 27

Department of Health and Home Office1994 Report of the Department of Health and Home Office Working Group on Psychopathic Disorder. Chairman Dr John Reed

Department of Health 1995 Building Bridges A Guide to Arrangements for Inter Agency Working for the Care and Protection of Severely Mentally Ill People

Social Service Inspectorate & Dept of H 1996 Mentally Disordered Offenders Improving Services

Department. of Health 1999 National Service Framework for Mental Health

Department of Health1999 Effective Care Co-ordination in Mental Health Services Modernising the Care Programme Approach A Policy Booklet

Department of Health 1999 Still Building Bridges. The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management

Department of Health 1999 Safer Services National Confidential Inquiry into Homicides and Suicides by People with Mental Illness

Department of Health/ Home Office 1995 A Guidance Document Aimed at Promoting Effective Working Between the Health & Probation Services

Department of Health/ Home Office 1997 Taking your Partners: Using Opportunities for Inter-Agency Partnerships in Mental Health

Home Office 1996 Probation Circular 76/1996 Serious Incident Reporting

HM Inspectorate of Probation 1993 Probation Orders with Requirements for Psychiatric Treatment Report of the Thematic Inspection

HM Inspectorate of Probation 1995 National Standards for the Supervision of Offenders in the Community

HM Inspectorate of Probation 1995 Dealing with Dangerous People: the Probation Service and Public Protection. Report of the Thematic Inspection

HM Inspectorate of Probation 1998 A guide to Effective Practice: Evidence Based Practice

HMSO 1994 Report of the Inquiry into the Care and Treatment of Christopher Clunis Jean H Ritchie et al.

HMSO 1994 and 1999 Code of Practice Mental Health Act 1983

Home Office Circular No.12/95 Mentally Disordered Offenders:Interagency Working

NHS Executive 1999 The Future Organisation and Delivery of Prison Health Care

Smith G1997 Risk Assessment and Management as the Interface Between the Probation Service and Psychiatric Practice Institute of Psychiatry

Social Services & the Sainsbury Centre for Mental Health 1997 Together We Stand: Effective Partnerships

Jones R1999 Mental Health Act Manual (Sixth Ed) Sweet & Maxwell

Manchester Health Authority 1999 Independent Review into the Events Surrounding the Release of Darren Tighe

Zito Trust 1996 Learning the Lessons 2nd Edition Mental Health Inquiry Reports published between 1969 1996 and their recommendations

Peay J 1996 Inquiries after Homicide Duckworth,