Kent and Medway NHS
Strategic Health Authority

REPORT INTO THE CARE AND TREATMENT OF

PETER WILD

MARCH 2003

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SUMMARY

Background

On 16th June 1999 Peter Wild killed his landlady, Nancy Broadbridge, at the house they shared in Ramsgate. He was then aged 53.

Before he moved to Ramsgate in April1998 Peter Wild had a history of mental health problems. He had been receiving treatment for depression over many years and he had taken a number of overdoses. As well as suffering from depression, he had consistently been described by psychiatrists as having an inadequate, or dependent, personality. His psychiatric history included four hospital admissions, of which the two most recent (both in 1997) were under the Mental Health Act when he was detained after incidents of threatened violence involving the use of knives. He had also been a heavy drinker throughout his adult life and this had caused brain damage, in the form of moderate frontal lobe atrophy, which was revealed by tests carried out after the homicide.

Peter Wild's contact with mental health services in Kent between April 1998 and June 1999 was as follows:-

- He attended Royal Road Day Centre in Ramsgate from April until December 1998 when he was excluded because of concerns about his behaviour. This is a voluntary sector service and neither his attendance nor his exclusion was known to the statutory mental health services.
- He was referred by his general practitioner in April 1998 to the catchment area consultant psychiatrist for assessment for day treatment. This assessment did nor take place because he was considered to be an out of area patient and deemed not to be entitled to receive non-urgent NHS treatment in Kent.
- A telephone referral was made by the police to an acute admission ward at Thanet Mental Health Unit on 9th June 1999 after he had come to Ramsgate police station in a distressed state saying that he was hearing voices telling him to kill his

landlady. The police were advised that he should seek a referral from his general practitioner.

- On 14th June 1999 he was seen at home by the catchment area consultant psychiatrist. He had been referred by his general practitioner for an urgent assessment with a view to admission to psychiatric hospital following an incident when he had gone to a cliff with the thought of throwing himself off. He refused the offer of a bed and was assessed as not being detainable under the Mental Health Act.
- On 15th June he attended the Thanet Mental Health Unit without an appointment, seeking admission. At the request of the catchment area consultant psychiatrist, he was assessed at the Lydden Day Hospital by a nurse who found him not to be a suitable candidate for day treatment and referred him immediately to the Social Services duty officer at the Westbrook Centre in Margate for advice about social security benefits.
- He was seen by the duty officer at the Westbrook Centre later on 15th June where a screening assessment was carried out. He was referred to a local solicitor for benefits advice and an appointment was made for him to see the consultant psychiatrist as an outpatient later in the week.

The main findings of the Inquiry are:-

- That the reasons for his exclusion from Royal Road Day Centre should have been communicated to his general practitioner and consideration should have been given to seeking an assessment of his mental health and social care needs by specialist mental health services while he was attending the Centre.
- That the referral for assessment for day treatment in April 1998 should have been accepted.
- That the telephone referral from the police on 9th June 1999 should have been accepted and that an urgent assessment should have been carried out at that stage.
- That the 14th June domiciliary assessment was adequate and the decision not to admit compulsorily under the Mental Health Act was justifiable.
- That on 15th June there was a failure to assess adequately both the deterioration in his mental state and the associated risks. This failure is attributable in large part to

the inadequacy of the assessment process but there was also a clinical failure to register significant changes in his mental state since the previous day's domiciliary visit.

- That the assessment at the Westbrook Centre was constrained by an unduly restrictive interpretation of eligibility criteria for specialist community mental health services.
- More generally, the Inquiry has concluded that:
    - There was a lack of clarity in the arrangements for accepting urgent referrals.
    - That the assessments lacked a clear focus and in particular insufficient weight was given to Peter Wild's psychiatric and personal history and to the assessment of risk.
    - That Peter Wild's mental health problems were not properly understood by those who assessed him and that as a consequence he was not offered appropriate services.
    - That the eligibility criteria for specialist mental health services were applied in such a way as to exclude someone like Peter Wild who, while not suffering from a major mental illness such as schizophrenia, did have a history of mental illness and associated problems of personality and of substance abuse.
    - That the relationship between non-statutory services, such as Royal Road Day Centre, and statutory services was poorly defined.
    - That the arrangements for communication between the police and statutory mental health services were inadequate.
    - That multidisciplinary working within specialist mental health services, particularly between Social Services and Health, was compromised by administrative and organisational factors.

The Inquiry has made a number of recommendations arising from these findings. These are set out in Chapter 7. The recommendations take account of the major process of change, which has been undertaken in East Kent since 1999, in implementing the Sainsbury Model of Care (see Appendix 3). The Inquiry supports

this process and believes that the Sainsbury Model goes a long way towards meeting the shortcomings identified in Peter Wild's case.

The Inquiry's recommendations include the following:-

- In relation to voluntary sector services, that they develop and implement policies on risk management and the sharing of information with statutory services.
- In relation to the police, that they be given information by mental health services to enable them to respond effectively to the needs of people suffering from mental disorder.
- In relation to referrals and assessments by statutory mental health services, that:
    - there be a central co-ordinating point to which all referrals are directed;
    - the format of assessments be standardised;
    - all assessments routinely include an assessment of risk factors;
    - the arrangements for emergency assessments are clarified;
    - in assessing eligibility for specialist mental health services, account is taken of risk factors and a person's social care needs.
- In relation to multidisciplinary working, steps are taken to ensure that members of multidisciplinary teams are working to the same policies and are participating effectively in decision-making.
- With a view to ensuring that people who suffer from mental illness and also have problems of substance abuse are not excluded from services, that staff who carry out assessments receive training in substance abuse and that questions about substance abuse are asked routinely as part of the assessment process.

CHAPTER 1: INTRODUCTION

1. On 16th June 1999 Peter Wild killed Nancy Broadbridge at his home in Ramsgate by stabbing her several times with a knife. He pleaded guilty to manslaughter and in February 2000 was sentenced to life imprisonment.

2. Peter Wild was not well known to mental health services in East Kent: he had been psychiatrically assessed at the request of his general practitioner on 14th June 1999 and the following day had gone to an acute admission ward asking to be admitted and had been further assessed. There had also been a referral to a psychiatrist from his general practitioner in 1998, which had not been followed up.

3. Following the homicide East Kent Community NHS Trust, East Kent Health Authority and Kent County Council Social Services Department commissioned an Internal inquiry to examine all the circumstances surrounding Peter Wild's treatment and care. It reported in March 2000 and its recommendations are reproduced in Appendix 2 of this report.

4. This independent inquiry was established by East Kent Health Authority in January 2001, in accordance with Department of Health guidance,[1] with the following terms of reference:

1. To review the conduct and process of the internal inquiry, the evidence taken and the conclusions and recommendations.
2. To identify areas where the independent inquiry feels there may be weaknesses or omissions in the process, outcome and recommendations of the internal inquiry.
3. To conduct its own more detailed review of those areas identified at (2), and to subsequently draw additional conclusions and recommendations if appropriate.
4. To establish the extent to which the recommendations of the internal inquiry and any recommendations of the independent inquiry are already being addressed by the relevant parties.

[1] Department of Health (1994) Guidance on the Discharge of Mentally Disordered People and their continuing care in the community, HSG 94(27).

5. To provide a report to the Health Authority, Kent County Council Social Services Department, East Kent Community NHS Trust on their findings and recommendations.

5. The members of the inquiry panel are:

Robert Robinson (Chairman): Solicitor and Mental Health Act Commissioner

Colin Dale: Senior Nurse Specialising in Forensic Psychiatry

Nick Georgiou: Former Director of Social Services, Berkshire County Council

Dr Helen Kelly: Honorary Consultant Forensic Psychiatrist to the Mental Health Services of Salford

We have been assisted throughout by Lynda Winchcombe who has managed the inquiry.

6. With Peter Wild's consent, we were provided with his medical and social services records and the criminal case papers. We also received, in addition to the internal inquiry's report and supporting documents, extensive background information about mental health services in East Kent, which was supplemented by presentations from senior Trust and Social Services managers. We took evidence both in Kent and in North Wales, where Peter Wild lived before moving to Kent, and were thus able to question many people who had professional contact with him. Appendix 4 lists all those who gave evidence to us.

7. As compared with many other homicide inquiries, Peter Wild's case is unusual because of his very limited contact with psychiatric services in East Kent. He was assessed there but had not spent any time in East Kent as a psychiatric in-patient or received any therapeutic or other help from specialist mental health services, apart attendance at a voluntary sector resource in Ramsgate. Indeed, those who assessed him in East Kent doubted whether there was a role for specialist services. Yet, as we show in chapters 2 and 3 of this report, he had a long-standing diagnosis of depression, as well as problems of personality and substance abuse, and his history includes a number of suicide attempts and two incidents of threatening behaviour when mentally unwell. While we do not suggest that he should have been cared for by specialist forensic services, we are in no doubt that general psychiatric services

must be able to respond to the demands which someone like Peter Wild makes, both at times of crisis and at other times when support is needed to maintain his stability in the community.

8. It is important to say at the outset that in this report we are looking at the situation as it was in 1998/99. Since then there have been positive changes in local services. We have tried to take account of these changes in our discussion of the issues and in framing out recommendations. In preparing this report we have tried to have one eye on recent developments, at a time of rapid change within mental health services both nationally and locally. We also take account of the major improvements which are now underway within local services as a result of the adoption and implementation of the Sainsbury Model of Care which is discussed further in chapter 5 and is summarised in Appendix 3. It would be misleading to read our account of Peter Wild's care and treatment in East Kent as a description of current practice.

CHAPTER 2: PERSONAL AND PSYCHIATRIC HISTORY BEFORE MOVING TO KENT

Introduction

1. Peter Wild is the main source of information about his life before he moved to Kent at the age of 52. The accounts he has given at different times, in particular to psychiatrists who have examined him, have been inconsistent. There is no way in which it would now be possible to verify much of the detail, but we believe that what follows is broadly accurate.

Personal history

2. Peter Wild was born on 1st August 1945 in Stoke-on-Trent. His birth resulted from an extra-marital affair which apparently led to the breakdown of his mother's marriage. Presumably because she was not able to provide him with a home, Peter Wild's mother arranged for him to live with an aunt and uncle. They brought him up, together with their own children, until he was 10 (or possibly 15) years old when he went to live with his mother who had by then remarried. Peter Wild's account of his early childhood is of feeling frightened of his uncle who, so he has consistently claimed, was physically and verbally abusive towards him. The overall impression of Peter Wild's childhood is of significant emotional deprivation. He has also reported behavioural problems at school and has claimed that he started drinking alcohol regularly when he was 10 years old. He left school at 15 without any qualifications.

3. Peter Wild married for the first time when he was 19. There were difficulties from early on in the marriage and it ended in divorce after only a few years. There were two children of the marriage. He met his second wife within a couple of years or so of the breakdown of the first marriage. He remained with her until 1996 when he left the matrimonial home and moved from Stoke to Rhyl in North Wales. From his own accounts of the marriage, which are corroborated to some extent by the contemporaneous general practitioner records, his wife offered him considerable support when in his mid-forties he began to experience acute psychiatric difficulties

and was unable to work. Peter Wild's explanation for the breakdown of his second marriage is that it resulted from his psychiatric problems combined with his excessive drinking.

4. Throughout his twenties, thirties and early forties Peter Wild remained in employment and worked variously in semi-skilled and unskilled manual jobs. Although he had a number of different jobs and occupations during these years he was apparently always able to find work. The first record of ill-health significantly affecting his capacity to work is in his general practitioner's medical notes in 1990: "He has become weak and nervous and unable to work". His mental health thereafter remained poor, as appears from the frequent visits to his general practitioner complaining of depression and suicidal thoughts. In 1992 or 1993, following many months of unemployment, he found work but soon gave up because he was unable to cope. He has since then remained unemployed.

5. When he has been at liberty to do so, Peter Wild has regularly drunk large amounts of alcohol. His own estimates of his alcohol consumption, given at different times to psychiatrists and others who have interviewed him, vary considerably. He told us that during his younger days, when he was in employment, he had been able to drink heavily without any adverse effects. Indeed, apart from acknowledging that it caused problems in his second marriage, Peter Wild seems never to have believed that alcohol has been a source of difficulties for him and he did not heed medical advice over many years to moderate his drinking.

6. In 1996 Peter Wild moved to Rhyl, leaving behind his home and marriage. He chose Rhyl apparently because one of his stepchildren had a caravan there, although after moving he did not stay in the caravan or have any contact with the stepchild. This was the first time since his twenties that Peter Wild had been on his own, without the support of a partner. He initially found accommodation in a bed and breakfast hotel before renting a flat. For reasons which are not clear his tenancy was ended by the landlord so that by May 1997 he was homeless and staying with friends, sleeping on floors and the like. In Rhyl Peter Wild made a social life among those who like himself had gravitated towards this resort on the North Wales coast. His life there was described in a report written by Jon Morgan, who became his social worker in

Rhyl: "[He] has a network of acquaintances who frequent local hostelries to drink, play darts, dominoes and pool."

7. It was because Peter Wild came into contact with mental health services in the summer of 1997 that accommodation was found for him at that time in a hostel for offenders and people with mental health problems. Peter Wild recognised that he had not coped well on his own and for this reason he agreed to move into the hostel after being discharged from hospital in July 1997. He was in receipt of Disability Living Allowance and other benefits, with a total weekly income in excess of £150. After paying for his accommodation he still had plenty of money left over, much of which was spent on drink. The hostel provided him with meals and the couple who ran it would see that he took his medication as prescribed. After moving to the hostel, he made one further attempt at independent living when he moved in with a woman acquaintance. According to Jon Morgan this was both short-lived and unsuccessful, resulting as it did in Peter Wild being financially exploited:

> "He was completely ripped off. I remember him complaining that she had taken him for everything, money and everything else."

8. Peter Wild stayed at the hostel until he left Rhyl in March 1998. During this period of some 8 months he remained in contact with Jon Morgan whom he normally saw monthly. Jon Morgan described the purpose of these monthly meetings as being:

> "to deal with any 'housekeeping' problems with regard to where he lived, his tenancy, his medication, his physical health as well .... It was keeping that contact going with him."

As he told us, Jon Morgan also helped Peter Wild obtain Disability Living Allowance:

> "If Pete had a bit of money in his pocket he could get his fags, he could get a pint and a game of pool, he was a happy man."

The arrangement worked well and, despite the fact that Peter Wild continued to drink heavily, there was no repetition of the behaviour, described below, which led to the two psychiatric admissions in Rhyl.

9. In late 1997, the couple who ran the hostel decided to move from Rhyl and to set up a residential home in the South of England. They took Peter Wild on at least one excursion to view properties and in March 1998, having found one to their liking

in Ramsgate, they moved there. They invited him and other residents to join them. Peter Wild was happy to go with them. He told us:

" I wanted to move to Kent: it was a beautiful place."

Unfortunately, neither he nor the couple told Health or Social Services where he was going. Although Peter Wild and Jon Morgan had discussed the possibility of a move, it was only when Jon Morgan asked after him in Rhyl, following a couple of missed appointments, that he knew Peter Wild had left. As to where he had gone, the only information was that he had moved to "the South Coast".

Psychiatric History

10. Peter Wild's first psychiatric admission was in 1966 (aged 21) to the City General Hospital, Stoke following an overdose. He was in hospital for five days. The discharge summary says he had suffered a reactive depression caused by problems in his marriage but it also comments that defects in his own personality had contributed to these difficulties: "He was inclined to blame all his troubles on his unfortunate early life and to disclaim all responsibility for his excessive drinking...".

11. The general practitioner records from Stoke show that from at least 1988 Peter Wild was continuously prescribed antidepressants, with changes in drug and dose reflecting both fluctuations in his mental health and also the advice given by the different psychiatrists who assessed him over the years. He came to the attention of psychiatrists through taking overdoses of aspirin or prescribed medication on four further occasions (1990, 1991, 1994 and 1995). Only the last of these incidents led to a psychiatric admission. The admission lasted for three weeks by which time the acute depressive symptoms and suicidal thoughts had gone but he was left with residual feelings of anxiety. He was discharged to outpatient care. The associate specialist in psychiatry who assessed him on admission concluded: "he has felt unwanted and unloved ... He is just not coping at the moment....".

12. Peter Wild's first contact with psychiatric services in Rhyl followed the same pattern. In August 1996 he took an overdose. He complained to the psychiatrist who assessed him of being unable to cope and of feeling stuck in Rhyl. He said he needed

to be looked after and asked to be admitted to hospital. The psychiatrist found few signs of depression and no evidence of psychosis. He described Peter Wild as suffering from "alcoholism and probably inadequate personality". A referral was made to the day hospital but there is no evidence that he ever attended. The account Peter Wild gave of his alcohol consumption on that occasion was that he had cut down to drinking 10 pints of beer on two or three days a week. He also said he had continued taking his prescribed antidepressant medication.

13. Peter Wild's third psychiatric admission, and his first in Rhyl, was in May 1997 after an incident in an amusement arcade when he drew a knife on a security guard who confronted him for stealing two packets of sweets. The police were called but he was not charged with any offence. He was taken into hospital by the police under section 136 of the Mental Health Act. Initially he agreed to stay but subsequently had to be detained under section 2 of the Act. On admission he was thought disordered, hostile and told doctors that he had been hearing voices telling him what to do. His mental state quickly settled on antipsychotic medication and he was discharged by a Mental Health Review Tribunal after 12 days. The diagnosis was of a brief psychotic illness brought on by substance abuse. It is recorded in the psychiatric report prepared for the Mental Health Review Tribunal that Peter Wild described himself as a chronic alcoholic and said that he could drink 20 to 30 pints of beer, presumably in a day. The report concluded: "he had a dependent personality and he coped with stress by taking overdoses and abusing drugs and alcohol. He clearly indicated that he knows about his drink problem but he also declined any offer of help with this particular problem." On discharge he was referred to the community mental health team and offered appointments by his allocated community worker, which he did not attend.

14. His second admission in Rhyl, and his fourth in total, was less than a month later. It followed an incident at the railway station when he threatened someone with a knife, possibly believing him to be a male prostitute. He was arrested and, following a Mental Health Act assessment, detained under section 2. The diagnosis was hypomania, characterised by overactivity, flight of ideas and pressure of speech. He was again treated with antipsychotic medication. The opinion of Dr Trevelyan, the consultant psychiatrist in charge of his treatment, was that: "This hypomania is

independent of alcohol and continues whether sober or not." On this occasion Peter Wild's application to the Mental Health Review Tribunal was unsuccessful. He was discharged by Dr Trevelyan at the end of the 28 day period of detention under section 2, by which time his mental state had settled but he was proving difficult to manage in hospital because he was drinking while out on leave. He was discharged on antipsychotic and antidepressant medication.

15. After leaving hospital Peter Wild did not receive any psychiatric follow-up but, as we have seen, he met regularly with Jon Morgan over the next eight months prior to moving to Kent. He appears to have remained mentally stable throughout this time. The charges arising from the incident at Rhyl station were finally dealt with in December 1997 when he was convicted of having a bladed instrument. He was conditionally discharged for two years and the knife was confiscated.

Conclusion

16. **Despite treatment with long-term antidepressant medication, Peter Wild has suffered over many years from low mood and anxiety and has taken a number of overdoses. He has been a heavy drinker throughout his adult life. His personality has consistently been described by psychiatrists as inadequate or dependent. Nonetheless, until the early 1990's he was always in employment, and his second marriage lasted for some 20 years.**

17. **When Peter Wild moved to Rhyl, without social support, he was unable to cope. Together with the continuing problems connected with his use of alcohol, he experienced episodes of acute mental illness. These were associated with threats of violence and the use of knives. The psychiatric history in Rhyl demonstrates how easily Peter Wild could slip from low mood to overt mental illness and how, when unwell, he was capable of acting in a potentially dangerous way. On the other hand, the experience of the last eight months in Rhyl shows that with social support, in the form of hostel accommodation and some social work contact, together with regular medication, he could remain well. This stability was maintained despite the fact that he continued to drink heavily.**

CHAPTER 3: PERSONAL AND PSYCHIATRIC HISTORY AFTER MOVING TO KENT

Introduction

1. This chapter continues Peter Wild's personal and psychiatric history from his arrival in Kent. It does so in much greater detail and draws on a variety of sources, including the oral and written evidence of witnesses to the events described.

Personal History

2. Peter Wild moved to Ramsgate in March 1998. He came with the couple who ran the hostel where he had been living in Rhyl and three or four other men who had also been living there. The two towns have much in common. Both are seaside resorts with plenty of inexpensive rented accommodation. They are places of relative social deprivation. We have been told that such towns attract a disproportionate number of people, like Peter Wild himself, who are rootless and unemployed and who bring with them a range of social problems. They tend to have relatively high levels of psychiatric morbidity. Ramsgate is within the area of Thanet District Council which has the highest Mental Illness Needs Index (101.9) in East Kent.

3. It so happens that the property the couple rented in Ramsgate, 7 Kent Terrace, was registered with Kent Social Services under the Registered Homes Act 1984. It was registered as a small home for up to three people with learning disabilities. But because Peter Wild did not need personal care, and as far as we are aware this also applied to the other residents, the couple were not under any obligation to register with the local authority. None of those who moved with them from Wales had a learning disability and the fact that the home was registered made no difference in practice since Kent County Council Social Services Department was not notified of the arrangement. As far as the Council was concerned, based on the annual returns which had been filed since its registration in 1994, the home was unoccupied and had never been used for its registered purpose. The Council relied on these annual returns

and, given its policy of not inspecting small registered homes, had no way of knowing the true position.

4. Shortly after his arrival in Kent Peter Wild started attending the Royal Road Day Centre in Ramsgate run by Thanet Mind, to which he referred himself. This Centre provides structured activities and social support for people with mental health problems. It is an open and informal place where people can meet, join in a range of activities, have a midday meal and so forth. Peter Wild became a regular user of the Centre.

5. Having apparently settled well in Ramsgate, Peter Wild was faced with a significant change in his circumstances when in the summer of 1998 the couple with whom he was living at 7 Kent Terrace separated and moved from Ramsgate. He not only lost their support but had to find himself other accommodation. He moved into a flat on the ground floor of a small house at 4 Addington Place, Ramsgate, owned by Nancy Broadbridge who lived alone in the flat above. They had met in a pub. She was then aged 68 and in poor health, having previously been assessed by Kent Social Services as suitable for warden controlled accommodation. Like Peter Wild, she was a heavy drinker. There is much evidence to show that their relationship was based on friendship and mutual affection. According to Peter Wild, in the early days there was a sexual relationship but this had come to an end some time prior to Nancy Broadbridge's death.

6. It is clear that over a period of several months, up to the time of her death, Peter Wild looked after Nancy Broadbridge. In moving to Addington Place, he had not only lost his own carers but had now become a carer himself, and for someone whom he felt morally obliged to support. She needed a good deal of physical care and was apparently unwilling to accept it from nurses or domiciliary carers. In the course of his police interviews Peter Wild described the sorry state in which he found Nancy Broadbridge and the necessary care he provided for her when he was released from prison after serving less than a week in late August 1998 for an offence of indecent exposure.[2] She must have valued his help and affection because at the time

[2] We do not have any further information about the offence.

of her death she was in the process of making arrangements to change her will in his favour. For a time, despite their excessive drinking and frequent arguments, the relationship appears to have been a stabilising factor in Peter Wild's life. He valued the opportunity to make a home for himself, something which had not been possible while living in hostel accommodation. He bought a music centre, television and ornaments for the flat. However, his capacity for attracting undesirable company to the house brought him into conflict with Nancy Broadbridge. As he told the police:

> "somehow all the fucking rubbish from Ramsgate seemed to be coming round, women and men .... I had the bloody front door kicked in, I had to replace that."

Nonetheless, according to Peter Wild himself and Dr Ward, the general practitioner with whom he registered in August 1998, the period of relative mental stability continued for a further 9 or 10 months until, as we shall see, there was a rapid deterioration in the summer of 1999.

7. Following the move to Addington Place, Peter Wild continued to attend the Royal Road Day Centre, until he was excluded in December 1998. According to Anne Hopkins, who managed the Centre, the reasons for his exclusion were that he befriended vulnerable women at the Centre, who would go with him to the pub and buy him drinks, and that he had allegedly sold stolen goods and his medication at the Centre. Anne Hopkins also says that there was an occasion when Peter Wild handed her a box of kitchen knives. Her account is that he told her he had collected them over many years and asked her to dispose of them, saying he no longer had any use for them. He told us that it was unwanted cutlery (knives, forks and spoons) and was his contribution to a fundraising sale at the Centre. Anne Hopkins says that the incident did not concern her and did not play any part in the decision to exclude Peter Wild. However, as we record in paragraphs 17 and 28 below, when enquiries were made of the Centre in May and June 1999 it was reported that he had been excluded for carrying knives and that his interest in knives precluded him from attending again. There is no suggestion that Peter Wild was ever violent or threatening towards anyone at the Centre.

8. It is also noteworthy that during this time he was seen on two occasions by Ian Venables, a substance abuse worker from the Kent Council on Addiction, who was doing outreach work at the Centre. Peter Wild denied any problems connected with

his drinking and had no interest in receiving specialist help. Ian Venables's impression was that his main interest in the Centre was as somewhere to play pool before the pubs opened and that he appeared less vulnerable than the other clients. Peter Wild's mental health remained stable throughout the period of his attendance. It was not known to Kent Social Services or to any other statutory service that he was attending the Centre. Nor was any information passed to statutory services when he was excluded. In Chapter 5 we consider further the Centre's relationship with statutory services in Thanet.

9. While Peter Wild was living at Addington Place there was a significant change in his financial circumstances. On 9th February 1999 Dr Ward wrote to the Benefits Agency in response to a request for medical information in connection with the renewal of Peter Wild's claim for Disability Living Allowance (DLA). His entitlement to DLA was reviewed and was not renewed for a further period. Payments of DLA stopped on 1st May 1999. According to Peter Wild, this reduced his weekly income from £175 to £85.

Psychiatric History

10. In Chapter 2 we described in some detail Peter Wild 's two admissions to psychiatric hospital in Wales and the community support he received following discharge in July 1997. We have seen that statutory services in Wales played no part in his decision to move to East Kent or in finding him accommodation there. It was a private arrangement, made between Peter Wild and the couple whom he regarded as his carers. It was entirely voluntary. We were told by Jon Morgan, the social worker in Wales, that had he known where Peter Wild had gone:

> "I would have picked up my social work diary, looked at the nearest mental health team there and at least spoken to a colleague ... and said this guy is in your area, if you want to know ...get in touch."

11. Soon after the group had arrived in Ramsgate the carers ensured that Peter Wild registered with a local general practitioner, Dr Pick. Peter Wild's first appointment with Dr Pick was on 19th March 1998 when he was accompanied by the male partner of the couple with whom he had moved to Kent. Following that initial

meeting and a further consultation on 2nd April, at the suggestion of the carer Dr Pick referred Peter Wild to the East Kent Community NHS Trust catchment area locum consultant psychiatrist, Dr Kalidindi, for day treatment. Although Dr Kalidindi was a locum he had been in post for about three years. He was acting up as a consultant, as he had not passed the examination for membership of the Royal College of Psychiatrists. Dr Pick's referral letter was written on 14th April 1998. It stated that Peter Wild had moved with a carer and "several other emotionally and mentally disturbed individuals from North Wales". Dr Pick, who had seen the others as well as Peter Wild, said they were well looked after but that the carer felt Peter Wild needed some activity "to maintain his stability". Dr Pick mentioned that he had requested the old medical notes from Wales but "the need for day treatment cannot await [their arrival]".

12. When Dr Pick's letter reached Dr Kalidindi's office the decision was made to refer the request for day treatment to the Contracts and Primary Care Department within the Trust. Dr Kalidindi told us he could not remember having seen Dr Pick's letter and he was therefore unable to explain the decision to involve the Contracts and Primary Care Department. Although it is not clear how the decision was made, its basis must have been that the proposed day treatment was not thought to be urgent and that Peter Wild was, or at least appeared to be, someone who had been "placed" in East Kent by a statutory authority for another area, rather than having moved there by choice. Under the relevant Trust guidance on out of area placements, which we consider further in Chapter 5, if Peter Wild had been "placed" non-urgent secondary health care would not have been offered until funding had been secured from the Health Authority for the area from which he had come.

13. The effect of referring Dr Pick's request to Contracts and Primary Care Department was that they assumed, without further enquiry, that Peter Wild had been "placed" in Kent. They then started the process of securing funding from the Health Authority in North Wales, although they did not in fact write for nearly a year because it took them that long to get Peter Wild's previous address in Rhyl.

14. Dr Kalidindi's secretary promptly informed Dr Pick that his referral of Peter Wild for day treatment had been put on hold while funding was arranged. Dr Pick

told us that he had no previous experience of this procedure, which he assumed was a bureaucratic necessity. Because the funding issue was not resolved, and because neither Dr Pick nor his successor as Peter Wild's general practitioner considered it clinically necessary to make a further referral, Peter Wild was not assessed for day treatment in East Kent until, as we shall see, he was referred over a year later by Dr Kalidindi to the Lydden day hospital.

15. Shortly after referring Peter Wild to Dr Kalidindi, Dr Pick received the medical records from Peter Wild's former general practitioner in Wales. They disclosed the previous psychiatric history, and included psychiatric summaries and reports from the two hospital admissions in Wales. Dr Pick read these but did not think it necessary to forward them at that stage to Dr Kalidindi as he did not consider Peter Wild's current condition necessitated formal review by a psychiatrist, notwithstanding the previous psychiatric history. Peter Wild remained Dr Pick's patient until August 1998. Dr Pick saw him on six occasions and actively kept his mental state and psychiatric medication under review. Peter Wild remained mentally stable throughout and Dr Pick had no particular concerns about him.

16. When Peter Wild moved to his rented flat in Nancy Broadbridge's house in August 1998, he registered with Dr Ward who was his general practitioner for the rest of his time in Ramsgate. On 4th September 1998 Dr Ward received the medical records from Dr Pick, including those which had come from Wales. Between August 1998 and June 1999 Dr Ward saw Peter Wild on six occasions. Dr Ward continued to provide regular prescriptions of the psychiatric medication, an antidepressant and a very low dose of an antipsychotic, which had previously been prescribed by Dr Pick. Prior to June 1999, Dr Ward had no concerns about Peter Wild's mental health but treated a number of minor physical ailments.

17. On 19th May 1999 Peter Wild attended Dr Ward's surgery and requested a re-referral to the Royal Road Day Centre. Dr Ward did not observe any depressive or other psychiatric symptoms on that occasion. He told us that he was quite certain about this:

> "he was his usual self and was not anxious or depressed or agitated in any other way".

Dr Ward's secretary telephoned Royal Road but, according to her record of the conversation, was told that they did not think it appropriate for Peter Wild to attend there again because he was "obsessed with knives".

18. At around this time Peter Wild was finding it increasingly difficult to cope. This coincided with his DLA being stopped. The obvious consequence of the reduction in income was that he had less money to spend on alcohol and this restricted his social life. There is no clear evidence one way or the other about changes in his pattern of alcohol consumption at this time but Peter Wild has generally said that he was drinking less, although he told one psychiatrist who assessed him immediately after the homicide that he had drunk a bottle of whisky and eight pints of beer a few days beforehand. At the same time, according to Peter Wild, Nancy Broadbridge's physical condition was deteriorating and there was a corresponding increase in the demands of caring for her. As had happened in the past when he was finding it difficult to cope, Peter Wild's compliance with medication became erratic. Given what we now know, it seems likely that he was experiencing the onset of a depressive illness. In Peter Wild's own words, he "cracked up" under the strain. His deterioration is corroborated from other sources.

19. On the afternoon of Wednesday 9th June Peter Wild presented himself at the public counter of Ramsgate Police Station. We have not had access to internal police documents but the following account is consistent with what was said in Court when Peter Wild was sentenced for killing Nancy Broadbridge. He told the civilian officer at the desk that he was mentally unwell and had been hearing voices telling him to kill his landlady. He said he wanted to be arrested, or detained under the Mental Health Act. He was apparently sober. Having consulted with a senior colleague, Sergeant Fox, the civilian officer telephoned Elmstone Ward, an acute admission ward at the Thanet Mental Health Unit in Margate, to find out whether Peter Wild could be assessed for possible admission. The response was to the effect that a referral would have to be made in the normal way through Peter Wild 's general practitioner and it was not possible for him to come to the ward directly from the police station. This information was given to Peter Wild at the police station, with the advice that he should see his general practitioner, and he left.

20. There is reason to doubt the account Peter Wild gave to the police on 9th June.[3] There was no other occasion during this time when he reported hearing voices. The psychiatrists who examined him both before and after the homicide found no evidence of auditory hallucinations.

21. The next report of Peter Wild 's deteriorating mental state is by Anne Hopkins, the manager of the Royal Road Day Centre, who saw him when he came in unexpectedly on the morning of Monday 14th June. She describes him as:

> "very unstable, very ill. He didn't know what to do with himself. He needed someone to look after him ....he was rambling. The look on his face, asking for help."

She advised him to see his general practitioner.

22. Peter Wild took Anne Hopkins' advice and saw Dr Ward later that same day. Dr Ward told us:

> " ... he came as an emergency [appointment] to see me. He was shaking, said he was suicidal and requested admission. He told me that directly before coming to see me he had stood on the cliff the other side of the fence and was contemplating jumping off."

Dr Ward was struck by the change in his presentation:

> "He came across as very agitated. He sat in the chair hunched up and was shaking. It was obviously very different to how he had come in before."

Dr Ward did not make a formal diagnosis but he did not think Peter Wild's agitation was due to alcohol.

23. Dr Ward made an urgent telephone referral to Dr Kalidindi, who was still the catchment area locum consultant psychiatrist, with a request that he carry out a domiciliary visit with a view to Peter Wild's admission to hospital. The call was taken by Dr Kalidindi's secretary. She noted Peter Wild's current medication, that he had thought of throwing himself off a cliff that morning, that he was feeling low and agitated and that Dr Ward felt he needed admission. Dr Ward's secretary extracted

[3] See also Chapter 4 paragraph 20 below.

from the medical notes some old letters from Peter Wild's time in Wales, which described the circumstances of his psychiatric admissions there and set out some of the relevant history, and these were faxed to Dr Kalidindi's office. Dr Kalidindi read these before going to see Peter Wild. Dr Ward's secretary also mentioned to Dr Kalidindi's secretary the concern about Peter Wild's interest in knives, which had been reported to her on 19th May. This information was also passed to Dr Kalidindi before he left for the domiciliary visit.

24. Dr Kalidindi visited at about 5.00pm that same day, Monday 14th June. He found Peter Wild tidying up outside the house. The flat was clean and tidy, with the dining table set for two people. Peter Wild had calmed down since his consultation with Dr Ward and appeared relaxed. Dr Kalidindi took a brief history, including Peter Wild's account of having recently "cracked up" and of his deterioration in mood over the previous six weeks. Peter Wild told him about sleep problems, reduced appetite, crying and suicidal thoughts. He also told Dr Kalidindi of the recent reduction in his income with the stopping of DLA. Dr Kalidindi asked about alcohol consumption and Peter Wild told him he had not drunk alcohol for a few days. There was no smell of alcohol. Dr Kalidindi assessed his mental state and found that he was neither psychotic nor suicidal. Peter Wild did not mention his recent visit to Ramsgate Police Station and there was no indication that he had thoughts of harming Nancy Broadbridge or anyone else. They discussed hospital admission but Peter Wild insisted he did not want to go into hospital because he needed to be on hand to look after Nancy Broadbridge. Dr Kalidindi noted that, according to Peter Wild, Nancy Broadbridge was sometimes incontinent and he decided to refer this matter separately to her general practitioner in the hope that nursing or other support could be provided. Dr Kalidindi had concerns about Peter Wild's mental health and decided he wanted to assess him further. He advised Peter Wild that he would make an appointment for him to be seen at the Lydden Day Hospital. Dr Kalidindi told us the Day Hospital was sometimes used as an alternative to admission:

> "he would be monitored concerning his mental state by nurses and occupational therapists, and he would be seen by a CPN [community psychiatric nurse] and social worker who did screening for in-patients and Day Hospital patients on a weekly basis; and also he would be seen by us, medical staff."

25. Having satisfied himself that Peter Wild appeared to be managing at home, that he was not acutely unwell or suicidal, and that he was being prescribed appropriate antidepressant and tranquillising (antipsychotic) medication, Dr Kalidindi left saying he would make the referral to Lydden. The following morning Dr Kalidindi telephoned Lydden. He had a brief conversation with Linda Owen, one of the nurses on the unit. It was agreed that Peter Wild would be seen on Thursday 17th June. But before this was communicated to him, Peter Wild had already made his way to the Thanet Mental Health Unit in Margate, of which Lydden is part.

26. He went initially to Elmstone Ward, an acute admission ward, arriving there at about 11.00am on Tuesday 15th June. He was seen by a nurse who found him to be angry and distressed. He wanted to be admitted. The nurse gave him a cup of tea and asked him to wait in the lobby outside the ward. The nurse then contacted Dr Kalidindi by telephone. Dr Kalidindi decided in the circumstances to bring forward the Lydden assessment and arranged by telephone for Peter Wild to be seen there immediately. The nurse then escorted Peter Wild to Lydden, which is a short walk from Elmstone Ward.

27. Peter Wild was seen straight away by Linda Owen, a Registered Mental Nurse who had worked at Lydden for two years. She made herself available at the request of a senior nursing colleague. Linda Owen understood the purpose of her assessment of Peter Wild was to see whether he was suitable for Lydden:

> "I assumed, having just seen Dr Kalidindi, that he had made his referral, and we were assessing for the unit, for his suitability for our therapeutic unit."

She did not have any background information on Peter Wild, as Dr Kalidindi had not had time to forward the records to Lydden or to give them a written account of the previous day's domiciliary visit. When he arrived on Lydden Peter Wild was visibly shaking and repeating that he could not cope and needed help. When Linda Owen interviewed him he told her of his financial problems and said he no longer had enough money to buy alcohol. He also told her that he had lost his carer. He did not answer her questions directly but talked at length about his problems. She was nonetheless able to find out something of his psychiatric and personal history and to satisfy herself that he was not psychotic. He told her about going to the cliff the

previous day and she also established that he was on antidepressant and antipsychotic medication. Her overall impression was that he was saying he could not cope and was demanding to be cared for. The interview lasted about 45 minutes. By the end Peter Wild was more settled but he was still shaking. Linda Owen wondered whether the shaking was delirium tremens. It was unclear to her how Lydden could help him. She thought his problems were predominantly social rather than psychiatric. He showed no interest in attending the day hospital. His problematic alcohol use also made it unlikely, in her opinion, that he would be able to benefit from treatment on Lydden and she thought his drinking might disrupt the treatment of other clients.

28. While Linda Owen had been interviewing Peter Wild a colleague had spoken to someone at the Royal Road Day Centre who explained why he had been excluded, mentioning not only the problems connected with his use of alcohol and the allegations about stolen goods but also that he had been banned for carrying knives. As soon as the interview was over Linda Owen discussed the referral with her colleagues who agreed with her assessment that Peter Wild was not a suitable candidate for their unit. It was decided to refer him to the Social Services Duty Officer at the Westbrook Centre in Margate for help with social security benefits. Linda Owen then contacted Dr Kalidindi and they spoke on the telephone. He supported the decision. As Linda Owen put it to us:

> "Perhaps it was our decision as a team, and we then discussed it with Dr Kalidindi and it was agreed so then it became a shared decision."

29. An attempt was made to speak to someone at Westbrook on the telephone but it was not possible to get through. Linda Owen wrote a short referral letter for Peter Wild to take with him to Westbrook. Although we do not have the letter, which has since gone missing, we have seen a note made by the duty worker at Westbrook which is appears to be an accurate summary of the letter. It said there was no indication of mental illness but that Peter Wild had social problems, specifically that his DLA had been stopped and he was not managing financially, that he also had an alcohol problem and that he had been banned from the Royal Road Day Centre for selling his medication. As Linda Owen explained to us, the letter was written in haste:

> "I can remember very quickly writing a letter and putting it in an envelope because the taxi was there."

The taxi was to take Peter Wild to Westbrook.

30. Meanwhile, Peter Wild was sitting in the garden attached to Lydden, having calmed down considerably. Shortly before he left in the taxi, Dr Kalidindi arrived. He did not take the opportunity to speak to Peter Wild but, given that he was acquiescing in the decision that his referral to Lydden was not going to proceed further, he decided to arrange an appointment for Peter Wild in his outpatient clinic on Friday 18th June. As Dr Kalidindi explained to us, this would have given him the opportunity to review the case again:

> "I would have looked at all the options again if the day hospital did not want him, and if it seemed appropriate I would have considered admission again. It would all have depended on how he had presented on that day."

31. When he arrived at Westbrook, Peter Wild was seen by Pauline Reynolds, a Registered Mental Nurse who had worked for Kent Social Services since 1991, for the last 3 years as a care manager. She was the duty worker that day and saw Peter Wild together with a duty support worker. The mode of referral was exceptional and Pauline Reynolds was, perhaps understandably, unhappy about it. The only information provided was that in Linda Owen's handwritten letter, although Pauline Reynolds was able to supplement this to some extent by talking to Dr Kalidindi's secretary, who was also based at Westbrook and who remembered the details of the previous day's referral from Dr Ward. She passed on the information from the Royal Road Day Centre that Peter Wild had been excluded for carrying knives, as she thought it important that Pauline Reynolds should be aware of this. Pauline Reynolds, together with her colleague, then interviewed Peter Wild. He confirmed that his DLA had been stopped and that he was finding it difficult to buy alcohol and cigarettes. Pauline Reynolds concluded that Peter Wild needed assistance with benefits, for which she made a referral to a local solicitor who was able to see him the following day. She told him the time and place of the appointment before he left Westbrook. She also thought he should be seen again by Dr Kalidindi in case he was in need of further psychiatric assessment or treatment. She made an appointment through Dr Kalidindi's secretary for him to be seen as an outpatient on Friday. This appointment was to be sent to him by Dr Kalidindi's secretary. As well as dealing with these issues, Pauline Reynolds used the interview for an initial screening of Peter Wild's eligibility for community care services provided by Kent County Council. In the

absence of medical evidence that he was suffering from a severe mental illness, Pauline Reynolds believed he would not be eligible. She therefore considered that, on the information available to her, there was nothing more Social Services could do at that stage and that no useful purpose would be served by carrying out a detailed community care needs assessment. She arranged for a taxi to take Peter Wild home to Ramsgate. She told us that he expressed considerable gratitude for what she had done. During the time he was with her Pauline Reynolds had no concerns about Peter Wild 's mental state or behaviour and felt it was safe to be alone with him. She made a record of the interview and her conclusions on the Kent Social Services SS1 screening assessment form.

32. The following morning Peter Wild killed Nancy Broadbridge. His account, given to the police following arrest, was that shortly before midday he went upstairs to see her and she had spoken to him in a very critical way. This happened frequently and he found it hard to bear. He returned downstairs and cut himself across the neck with a kitchen knife, intending to kill himself by cutting his throat but being unable to do so and succeeding only in inflicting superficial injuries. Nancy Broadbridge then came into the room and said something to him. He picked up the knife and stabbed her a number of times, with considerable force. He realised what he had done and immediately ran out of the house into the nearby laundry and asked for help: "I've killed her, I've killed Nancy. Phone the police."

33. The police came and took him to Margate Police Station where he was seen that same day by a consultant psychiatrist, Dr Helme. He did not elicit any psychotic features. His impression was of "personality disorder and alcohol abuse", with the additional possibility of a reactive depression. Dr Helme considered that Peter Wild was fit to be detained and interviewed. A sample of Peter Wild's blood was taken that afternoon, some three hours after the killing. Tests for alcohol and common drugs of abuse were negative.

34. Peter Wild was charged with murder. He was assessed by two consultant forensic psychiatrists while on remand, in connection with plea and sentencing. Both made medical recommendations in support of a plea of diminished responsibility, but they did not recommend a hospital order under the Mental Health Act. Peter Wild's

plea of diminished responsibility was accepted and on 17th February 2000 he was sentenced at Maidstone Crown Court to life imprisonment for manslaughter. The Judge fixed a tariff, that is the minimum period to be served, of two and a half years.

Conclusion

35. For the first year in Ramsgate Peter Wild was generally settled and he coped well with the disruption caused by the forced changes in his domestic situation. From May 1999 there was a rapid decline in his ability to cope with the increased stresses in his life, both personal and financial. His mental state deteriorated and thoughts of killing himself returned. His overwhelming feelings of not being able to cope were compounded by the repeated failure of his attempts to get the help he thought he needed. The homicide can only be explained in the context of his mental state at the time.

36. As is clear from the history, there were a number of opportunities in the days prior to the homicide for services in East Kent to assess Peter Wild. In Chapter 5 we comment on the actions taken by those who saw Peter Wild at that time.

CHAPTER 4: PSYCHOPATHOLOGY AND RISK MANAGEMENT

Introduction

1. We have seen that Peter Wild's contact with psychiatric services dates back to 1966 and that over the years he was assessed by a number of psychiatrists both in and out of hospital. There are consistent themes in his psychiatric history: depression, self-harming behaviour and persistent personality problems. There are also a number of incidents which gave rise to concern at different times: the psychotic symptoms and hypomania in Wales, and the threatened use of knives on two occasions; his presentation at Ramsgate Police Station when he reported hearing voices telling him to kill Nancy Broadbridge; and, soon after, going to a cliff with the intention of throwing himself off. The pattern of Peter Wild's contact with psychiatrists was that they assessed and treated the presenting problem. Even those who knew something of his history did not apparently regard Peter Wild as a danger to others - he was never referred for a forensic assessment – and, except at times of crisis, he was not seen as having a need for specialist psychiatric care.[4]

2. The picture is complicated by Peter Wild's chronic abuse of and dependence on alcohol, but this is not unusual. There is epidemiological data on dual diagnosis which shows that the comorbidity of mental illness, or personality disorder, together with substance abuse, is a growing problem, and there is also evidence that it is associated with increased risks both of self-harm and of harm to others.[5] One of the findings of the Government's Confidential Inquiry is that of people with a lifetime diagnosis of mental disorder who commit homicide: "The majority had alcohol or

[4] The following quotation from Dr Trevelyan, the responsible medical officer during the two admissions in Rhyl, is illustrative of the response Peter Wild evoked in clinicians: "We had this chap on the ward [Peter Wild] who, to my mind, [had] behaved very dangerously yet had apparently calmed down under the effect of medication and was simply behaving in a slightly unco-operative, antisocial way, going out drinking and 'messing us around'."

[5] For the links between substance abuse and offending see Johns A. (1997) Substance misuse: a primary risk and a major problem of comorbidity. International Review of Psychiatry 9: 233-241; and Johns A. (1998) Substance misuse and offending. Current Opinion in Psychiatry 11: 669-673.

drug dependence or personality disorder, rather than schizophrenia or affective disorder."[6]

3. The clinical profile which Peter Wild presents has not been at the forefront of the minds of mental health policy makers. We agree with the following broad statement of the Dual Diagnosis Steering Group: "Historically there has been little attempt to provide a policy framework for people with dual diagnosis and separate strands of policy have focused on either mental health problems or addiction".[7] The priority under the Care Programme Approach[8] has been the management of people who suffer from severe and enduring mental illness, usually taken to refer to a chronic illness, such as schizophrenia, with repeated and sustained psychotic episodes. We share the widely held view that the prevalence of dual diagnosis, which is a consequence both of the decarceration movement and the increased use of illegal substances in society, has not been fully recognised by health service professionals.[9] We received evidence that mental health services generally are not responsive to complex cases where mental illness is combined with personality problems and substance abuse, and that mental health professionals tend not to have received adequate training in substance abuse.[10] We therefore consider it worthwhile to examine the clinical and risk management aspects of the case in some detail before proceeding to discuss the specific issues raised by Peter Wild's contact with mental health services in East Kent, to which we turn in the next chapter.

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[6] Department of Health (2001) Safety First: National Confidential Inquiry into Suicide and Homicide, p.104.
[7] Department of Health (2002) Mental Health Policy Implementation Guide, Dual Diagnosis Good Practice Guide, p.13.
[8] Department of Health: The Care Programme Approach for people with a mental illness referred to specialist psychiatric services HC(90)23/LASSL(90)11. The Care Programme Approach was introduced in 1991 to provide a framework for the care of mentally ill people outside hospital. In its original form it had four main elements: systematic arrangements for assessing the health and social needs of people accepted for specialist psychiatric services; the formulation of care plans to address the identified health and social care needs; the appointment of a key worker to keep in close touch with the patient and monitor care; regular review and, if necessary, changes to the care plan.
[9] Bean P. (2001) Mental Disorder and Community Safety. Palgrave. pp 130-146.
[10] Dr Andrew Johns, evidence given to the Inquiry on 18th February 2002.

Mental Illness

4. Over many years Peter Wild was prescribed antidepressant medication. Most of his contacts with psychiatrists followed overdoses. On some of these occasions he was assessed as being clinically depressed, while on others acute symptoms of depression were not present, even when he was seen very soon after an incident of actual or attempted self-harm. We see this, for example, in the first assessment in Rhyl, made following an overdose; and again when he was assessed by Dr Kalidindi on the domiciliary visit following the referral by Dr Ward in June 1999, which was made because Peter Wild was suicidal.

5. It is also of interest that the two acute episodes of mental illness which led to the admissions in Rhyl were clearly not depression. The first was described as a brief psychotic illness without any affective component, and his presentation on the second occasion was hypomanic.

6. Those psychiatrists who at different times assessed Peter Wild as being depressed believed the depression was reactive, that is triggered by external factors in his life, but also that it was inseparable from the problems of personality which made it difficult for him to cope. At least two psychiatrists diagnosed him as suffering from agitated depression, in which the individual displays psychomotor agitation as a dominant symptom. This diagnosis was first made in 1990 by a psychiatrist in Stoke following an overdose and again by a psychiatrist who assessed him in prison two weeks after the homicide.

7. Allowing for the various complicating factors, particularly connected with Peter Wild's dependent personality and his abuse of alcohol, our conclusion is that the long-standing diagnosis of depression is correct and that in the days leading up to the homicide he was suffering from agitated depression. In our view this not only accounts for his low mood but also for the psychomotor agitation which was observed both by Dr Ward on 14th June and by those who saw him at the Thanet Mental Health

Centre the following day, but which was not present when he was assessed by Dr Kalidindi on the evening of 14th June. We have considered whether his agitated state prior to the homicide was alcohol withdrawal delirium (delirium tremens). We do not believe this to be the case. First, there is no convincing evidence that he had stopped drinking alcohol completely in the days leading up to the homicide. Second, tremors caused by alcohol withdrawal would have been consistently, rather than episodically, present. Third, the fact that he remained agitated in prison for at least three weeks following his arrest strongly suggests that alcohol withdrawal was not the cause.

8. Taking account of his presentation during the two admissions in Wales, together with the rest of the psychiatric history, our overall diagnostic view is that Peter Wild has a vulnerability to mood disorder, more usually depression but sometimes hypomania. The mood disorder is associated with alcohol dependence. It is not possible to describe with any precision the interaction between his alcohol use and symptoms of mental illness. It would appear that each operates on the other such that sometimes one is more important and sometimes the other.

Personality Problems

9. Throughout Peter Wild's psychiatric history, starting as early as 1966, there are references to his dependent and inadequate personality. The history of personality problems was helpfully summarised by Dr Clare Dunkley, consultant forensic psychiatrist, in a report she wrote following her assessment of Peter Wild in July 1999. She concluded that: "Mr Wild has demonstrated long-standing personality difficulties which predispose him to anxiety states in the face of external stressors. These he attempts to self-medicate with alcohol and his abuse of alcohol itself goes on to provide further stress within his life." We agree with Dr Dunkley's analysis, which is consistent with every other psychiatric assessment, and would only add that Peter Wild's anxiety states have frequently been associated with depressive symptoms and self-harming behaviour. It is perhaps unnecessary to debate whether his problems of personality amount to a personality disorder, although we note that Dr Alec Buchanan, consultant forensic psychiatrist, in a report he wrote in December 1999 was of the opinion that, because of his history of regular employment and his ability

to establish and maintain a marital relationship, Peter Wild's abnormality of personality was not so severe as to amount to a personality disorder. We also note that none of the psychiatrists who assessed Peter Wild over the years said he suffered from psychopathic disorder.[11]

Substance Abuse

10. Peter Wild's use of alcohol is clearly a complicating factor in both the diagnosis and treatment of his mental illness. As noted by Dr Dunkley, Peter Wild used alcohol to relieve feelings of anxiety and depression. But the relationship between alcohol consumption and mood is not straightforward: a person who is depressed may drink excessively in an attempt to improve his mood, but excessive drinking may induce persistent depression or anxiety.

11. That Peter Wild has been a heavy drinker throughout his adult life is not in doubt. What is less clear is the pattern of his drinking and its relationship with particular acute episodes of mental illness, including during the period immediately prior to the homicide. Although a number of psychiatric reports over the years allude to his alcohol consumption, they do so imprecisely and none contains an adequate alcohol history. This may be because Peter Wild was not thought to be reliable on the subject of his drinking habits but it also probably reflects a lack of interest on the part of those who assessed him. We note that of the three consultant forensic psychiatrists who assessed him after the homicide, Dr Phillip Sugarman said he would "fulfil the standard diagnostic criteria for alcohol dependence"; Dr Buchanan thought it "unlikely that he was dependent" at the time of the homicide; and Dr Dunkley simply recorded that he "has chronically abused alcohol throughout the majority of his adult life" and, as we have seen above, she described the dynamic relationship between alcohol and mental illness.

12. Peter Wild's psychiatric history includes at least one episode of psychotic mental illness, the first psychiatric admission in Rhyl, when he experienced symptoms

[11] Psychopathic disorder is defined in section 1 of the Mental Health Act 1983 as "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned".

such as auditory hallucinations which from contemporary accounts appear, at least partly, to have been brought on by alcohol. However, if alcohol was responsible it is not clear whether the immediate cause was excessive consumption or alcohol withdrawal, and it is therefore impossible to draw any firm conclusions from that episode. With regard to the homicide, we note the view expressed by Dr Sugarman, that the depressive illness Peter Wild was experiencing at the time was secondary to his heavy use of alcohol, although he was not able to establish with any confidence Peter Wild's pattern of drinking.

13. If one consequence of his use of alcohol was to make Peter Wild vulnerable to mood disorder, then another effect was to damage his brain. The evidence for this comes from a brain scan conducted in February 2000, which showed moderate frontal lobe atrophy; and from psychometric testing in January 2000 which showed functional evidence of brain damage, probably to the frontal temporal lobes. The damage to the frontal lobes was significant. It would have affected his capacity exercise judgement and have led to a risk of misunderstanding things going on around him. Dr Buchanan summarised the evidence as follows: "Mr Wild has suffered from brain damage, probably as a result of his alcohol intake. There is a significant likelihood that this brain damage has affected his ability to concentrate, reason and plan." Dr Sugarman expressed a similar view.

14. It is recorded, and acknowledged by Peter Wild, that in addition to abusing alcohol he has also used other substances, notably cannabis. There is no detailed information on his drug use, but it would appear that while living in North Wales and East Kent he was not using drugs regularly. As with his alcohol use, while we believe he has not attempted deliberately to mislead, he has probably failed to disclose fully the extent of his drug use. There is, however, no evidence of dependence on drugs or of drug use triggering symptoms of mental illness. We therefore agree with the psychiatrists who assessed him following the homicide in concluding that his cannabis and other drug use is insignificant in comparison with his chronic dependence on and abuse of alcohol.

Risk Assessment and Management

Introduction

15. One of the criticisms made by the internal inquiry, with which we agree, is that the assessment of risk in Peter Wild's case was inadequate. In large part that criticism rests on a simple failure to gather and assess relevant information. We develop this further in chapter 5. But it would be misleading to give the impression that the assessment and management of risk in a case such as this is straightforward.

Risk to self

16. Peter Wild has a history of self-harm associated with low mood, anxiety and alcohol use. We have already noted that the comorbidity of mental illness and alcohol use is itself a significant risk factor for self-harm. His experience at times of low mood has been of not coping with the stresses of life, whether in his marriage, his work or in adjusting to his changed circumstances following his move to Rhyl. A similar picture is presented in June 1999 when he goes to a cliff with the thought of throwing himself off because of his deteriorating domestic circumstances and the financial difficulties he was experiencing following the withdrawal of Disability Living Allowance.

17. The history shows that the short-term management of the risk of self-harm and suicide was achieved either by a brief admission to psychiatric hospital or, more usually, discharge home with medication and follow-up by his general practitioner, sometimes supplemented by outpatient appointments with a psychiatrist. As far as we can tell none of these interventions had any effect on the pattern of alcohol use. It is worth recording that Dr Kalidindi's opinion on the domiciliary visit, after the serious incident of Peter Wild going to the cliff, was not very different from what other psychiatrists had thought previously: that the risk of self-harm could be adequately managed without admission to hospital and that compulsory admission under the Mental Health Act was therefore not appropriate.

Risk to others

18. As far as harm to others is concerned, it is now clear that Peter Wild's alcohol use, in association with his vulnerability to mood disorder, was a significant risk factor. However, prior to the homicide there were no recorded offences of actual violence against the person. There were the two incidents of threatened violence in Rhyl, both involving knives, one of which led to a criminal conviction for possession of the knife. But in their different ways those incidents, which are the only recorded episodes of psychotic mental illness, do not fit with the overall pattern of Peter Wild's psychiatric history and perhaps tell us no more than that when acutely mentally ill, particularly if hypomanic, he was likely to become aggressive and possibly violent. The use of knives clearly adds significantly to the potential danger to others at such times. It is significant that he chose to carry a knife and that he brought it out when he felt himself to be threatened. But, prior to the homicide, there is no evidence of which we are aware that Peter Wild had ever attacked anyone with a knife or other weapon.

19. There are other matters which, had they been known, could have indicated to those who assessed Peter Wild shortly before the homicide that the risks were not confined to self-harm and suicide. The first is his interest in knives. Anne Hopkins' account of the handing in of the knives at the Royal Road Day Centre in Ramsgate is evidence of a long-standing preoccupation with knives. Although Anne Hopkins has said that Peter Wild's interest in knives was not a reason for his exclusion, this is contradicted by what Dr Ward's secretary and Linda Owen's colleague were told by staff at the Centre in May and June 1999. The phrase "obsessed with knives", which was recorded by Dr Ward's secretary, is particularly significant in this context. From our own meeting with Peter Wild we got the impression that knives were a source of pleasure to him. He gave us this description of the knife which was confiscated following the second incident in Wales:

"a beautiful knife – with a black handle – German thing, I liked the look of it."

We consider there is sufficient material to support the conclusion that Peter Wild's interest in knives was unusual. Bearing in mind the two incidents in North Wales, we

consider this is something which might well have been brought out by a detailed risk assessment.

20. Another matter, which at the time of the homicide was relevant to the assessment of risk of harm to others, is Peter Wild's visit to Ramsgate Police Station on 9th June when he told the desk officer that he was hearing voices telling him to kill Nancy Broadbridge. When he was assessed by Dr Sugarman while on remand Peter Wild's recollection was "that he was not clearly hearing voices". None of those who assessed him shortly before, or at any time after, the homicide found any evidence of auditory hallucinations or other psychotic symptoms. In the absence of any contemporary psychiatric assessment, it is impossible to know for certain whether his mental state on 9th June was so disturbed that he was, or at least believed himself to be, hearing voices, but it seems more likely that he made this up to get himself arrested and admitted to hospital. After all, his experience in Rhyl was of being admitted as a result of being detained by the police when he was hearing voices.

21. For the purpose of assessing risk in the days leading up to the homicide, it was clearly significant that he was expressing thoughts of killing Nancy Broadbridge. However, in saying this incident, which was not known to the mental health professionals who subsequently assessed him, was relevant to the assessment of risk, we are not suggesting that the homicide was predictable. On the basis of his history, and assuming that he was not experiencing genuine auditory hallucinations telling him to kill Nancy Broadbridge, the prediction would have been that he would have most likely taken an overdose or harmed himself in some other way, as indeed he contemplated doing when he went to the cliff on 14th June. Nonetheless, taken together with the history of aggressive behaviour in Wales, which involved the use of knives, his presentation on 9th June would undoubtedly have given considerable cause for concern about possible harm to others, and specifically to Nancy Broadbridge, had a risk assessment been carried out.

22. There are also the risks arising directly from Peter Wild's alcohol use. Dr Sugarman dealt with this in a supplementary report for the Court in which he said: "If at large I have particular concern that [Peter Wild] may return to alcohol use, with consequent psychiatric and behavioural disturbance. It is of course possible that he

may be abstinent from alcohol, in which case he would present little risk, and possibly no risk to others." Dr Sugarman concluded that: "During further periods of drinking, it cannot be ruled out that he might again behave aggressively with a knife, as he is alleged to have done in the index offence, and on an earlier occasion. It is for this reason that he must be regarded as a significant risk to others."

23. A particular issue in the assessment of risk, arising out of Peter Wild's use of alcohol, is the organic brain damage, which only came to light after the homicide. This would have affected his ability to exercise judgement, plan and choose. The two consultant forensic psychiatrists who provided reports to the Court in connection with Peter Wild's manslaughter plea were both of the opinion that this was a significant contributory factor. In terms of risk assessment, the organic brain damage undoubtedly increased the risk of harm to others.

24. Peter Wild has said he had reduced his consumption of alcohol in the days and weeks prior to the homicide but he had not stopped drinking altogether. For example, he told Dr Sugarman that: "he was drinking less, and his nerves became worse. He was tense, and agitated, and had aggressive thoughts .... He often pictured hanging himself." There is nothing to contradict Peter Wild's own account that he had not been drinking on the day of the homicide, and there was no alcohol in the sample of his blood taken some three hours after his arrest. Equally, it appears likely that he was telling the truth when he said to those who assessed him, both before and after the homicide, that he had reduced his alcohol intake following the withdrawal of DLA. This may well have been a further mental stressor at a time when he was particularly vulnerable. It is not possible at this distance to assess the impact of the reduced alcohol consumption on his state of mind. At best alcohol would temporarily relieve the anxiety and feelings of not being able to cope, and at worst it could add to them. But neither excessive alcohol consumption nor withdrawal from alcohol caused the underlying feelings of hopelessness.

25. If alcohol use is not the decisive factor, then the assessment of the risk of violence to others becomes rather a matter of the interaction between Peter Wild and his environment. Essentially, the issue is his experience of stress and response to it. His account is that he committed the homicide because over a period of days and

weeks he felt he was not coping, and this feeling was compounded by his failure to obtain the kind of help he thought he needed. It should be remembered that in the days leading up to the homicide he did seek help and was able to give a reasonably coherent account of his circumstances to those who interviewed him. From his personal and psychiatric history we can see that in Peter Wild's own mind the decisive issue was his dependence. He believed that he needed a level of support to enable him to cope. That support could take many forms: a partner, supported accommodation, a social worker, a Day Centre. When he lacked support he was liable to be overwhelmed by social stressors and then to become anxious and depressed. Peter Wild would use alcohol to reduce stress in such circumstances. The particular significance of alcohol as a risk factor is in association with his vulnerability to mood disorder and the underlying problems of personality.

Managing risk

26. Turning from the assessment to the management of risk, it is important to state that prior to the homicide, apart from the two brief admissions in Rhyl under section 2 of the Mental Health Act when he was acutely unwell, Peter Wild had not been subject to any powers of compulsion. Certainly, no powers were available to compel him to live in a particular place or to accept any degree of supervision, and still less could he be compelled to restrict his use of alcohol or comply with psychiatric treatment in the community.

27. Over the years in Stoke, particularly when Peter Wild was living with his wife and in employment, the risks were adequately managed by antidepressants and contact with his general practitioner, with occasional, brief psychiatric interventions following overdoses. In Rhyl the arrangements put in place following his second discharge from hospital were, we believe, adequate. They were based on an acceptance that he was not motivated to reduce his consumption of alcohol. The risks were managed by arranging for him to be in supported accommodation, where there was some informal supervision of his psychiatric medication, and by ensuring that there was someone to whom he could turn with any financial or social problems. This role was undertaken by a social worker with whom Peter Wild had a good relationship.

28. We consider that had similar arrangements been in place in East Kent, this would both have reduced the risk of a breakdown in Peter Wild's mental health and provided a framework for managing the consequences had a breakdown occurred. Indeed, prior to his move to Nancy Broadbridge's house, they were replicated to a considerable extent: he was living in supported accommodation, had almost daily contact with Royal Road Day Centre and a good relationship with his general practitioner. During these early months in East Kent Peter Wild remained mentally stable.

Conclusion

29. **In giving our opinion on issues of risk assessment and management, we are conscious that in practice the services in East Kent were not in possession of relevant information which might have led them to similar conclusions. However, it is of concern that although Peter Wild was assessed on three separate occasions shortly before the homicide the nature of his mental health problems and the issues of risk were poorly understood.**

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

Introduction

1. In this chapter we discuss what we consider to be the most important issues raised by Peter Wild's contact with mental health services in East Kent and we make a number of recommendations.

2. Some of the discussion which follows covers areas included within the Model of Care for Adult Secondary Mental Health Services (the Sainsbury Model) which was developed by the Sainsbury Centre for Mental Health in partnership with Health and Social Services agencies in Kent.[12] Mental health services in East Kent are in the process of implementing the Sainsbury Model, which we believe would lead to major improvements, but it is acknowledged that this will take some years to achieve in full. Given the scope of the work involved in the Sainsbury review, the expertise and experience of the members of the steering group who contributed to that process, and the extensive consultation at each stage with "a wide range of stakeholders from the mental health community including local service users and carers", it clearly makes sense for us to take account of the Sainsbury Model in framing our recommendations, and we have tried to do so. We summarise the Sainsbury Model in Appendix 3.

3. The other review we have taken into account is the internal inquiry into Peter Wild's care and treatment. That inquiry made a large number of recommendations, which we set out in Appendix 2. Implementation of those recommendations is continuing, within the framework of an Action Plan. We comment further on this in the next chapter. Despite differing from the internal inquiry on a number of issues, we believe our recommendations are largely compatible with theirs.

4. We have found it helpful to set out with our detailed recommendations the objective they are intended to advance.

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[12] Review of Secondary Mental Health Services, Final Report and Recommendations for the Joint Commissioning and Planning Board, Kent County Council and East Kent Health Authority, November 2000.

Placements in East Kent

4. 5. Shortly after arriving in East Kent Peter Wild was referred by Dr Pick to Dr Kalidindi for day treatment. The referral was made by a letter dated 14th April 1998. The proposed day treatment was not in fact offered because Peter Wild's case was sent, as an out of area placement, to the Contracts and Primary Care Department of the Trust for them to secure funding from the Health Authority for the area from which he had come. This meant that an early opportunity for Peter Wild to be assessed by Dr Kalidindi was lost. Dr Kalidindi told us that he could not remember seeing Dr Pick's letter. But he did not dispute his secretary's evidence to the internal inquiry that he read the letter and directed the action taken in response to it.

5.

6. We are satisfied that Peter Wild was not " placed" in Kent but had chosen to move there. It follows that, as with any other East Kent resident, the funding of day treatment was the responsibility of the East Kent Health Authority and that the Contracts and Primary Care Department should never have become involved in his case. However, because this is of wider importance, and because the procedures were so obviously flawed, we now consider this aspect of the case further.

7. We have been told that because of the availability of inexpensive accommodation in seaside towns such as Ramsgate and Margate, authorities from outside the area frequently arrange for people to move into residential care in East Kent. The question then arises whether the placing Health Authority can in this way relieve itself of responsibility for paying for the healthcare required by someone so placed. The relevant Government guidance is the NHS Management Executive document called Establishing District of Residence. This provides guidance to Health Authorities in deciding "whether they are responsible for paying for a particular individual's care within the NHS". It starts with the statement that: "For a provider, identifying the residence of a patient will be an internal management process which must not delay the response to the patient's medical needs." In the vast majority of cases a patient's place of "usual residence", which is the relevant test for determining funding responsibility, will be the address at which the patient usually resides. The

document draws attention to a number of exceptional circumstances where a person's current address does not qualify as the place of usual residence. One such circumstance is where: "a local authority may place someone in residential care or a nursing home outside the district of usual residence. If this placement is temporary (ie for a short fixed period, after which the placement will be reviewed or terminated), then the district of usual residence remains responsible."

8. In relation to mental health provision within East Kent, local policies were developed by the Trust. The position is summarised in a memorandum on Out of Area Placements issued by the Trust's Contracts Manager in June 1997. It identified the problem of "people placed in homes in Canterbury and Thanet for whom no prior consultation via their home Health Authority has taken place for management of their healthcare or the funding to support it". The memorandum was addressed to managers and clinicians and required of them that "if on referral you identify your patient as someone placed in a home by Social Services from another Health Authority, and is non-urgent, please go through the normal ECR approval procedure ... before commencing treatment". The approval procedure required the clinician to notify the Contracts Department and give them certain information, including the patient's last known address. The Contracts Department would then "approach the home Health Authority for funding to support their healthcare need".

9. This was the guidance which Dr Kalidindi was purporting to follow when he decided to pass Dr Pick's referral of Peter Wild to the Contracts and Primary Care Department. It can be seen that the guidance gives the impression that for all placements, not just the temporary ones referred to in the NHS Management Executive document, funding responsibility remains with the referring Authority. Although it is not clear what considerations led Dr Kalidindi to decide that Peter Wild was placed in East Kent, his decision is the more understandable given the tone of the internal guidance with its emphasis on the problem of large numbers of people being placed in East Kent. Still, we find it surprising, in the light of Dr Pick's letter,[13] that Dr Kalidindi appears to have decided, without further enquiry, that the need for day treatment was not urgent. Dr Kalidindi was not able to offer us any explanation

because he had no recollection of ever having seen Dr Pick's letter. In our opinion he should have made enquiries of Dr Pick, or satisfied himself by assessing Peter Wild in his outpatient clinic, before deciding to refer the case as non-urgent to the Contracts and Primary Care Department. At the very least, having decided the proposed treatment could not proceed without funding from the Health Authority in Wales, he should have written to Dr Pick explaining the position.

10. Once Dr Kalidindi had referred the case to the Contracts and Primary Care Department they assumed Peter Wild had been placed and that the proposed treatment was not urgent. Their only concern was to secure funding. Given the restrictive scope of the NHS Guidance, it was unfortunate that there was no system within the Contracts and Primary Care Department for establishing the facts before starting the tortuous process of securing funding.[14] It also appears there was no established procedure for reporting back to the clinician who had made the referral, so that in Peter Wild's case it was left entirely to the initiative of Dr Kalidindi and his secretary to monitor progress by contacting the Contracts and Primary Care Department.

11. Quite apart from their failure to enquire into the facts, the handling of the case by the Contracts and Primary Care Department was singularly unimpressive, not least in taking a year to write to the Health Authority in Wales. The main reason given for the delay was the difficulty in finding out Peter Wild's previous address, information which could easily have been obtained from Dr Pick or Peter Wild himself, or from those with whom he had moved from Rhyl. We are aware from the evidence given to the internal inquiry that the delay is partly explained by staffing problems within the Department. However, it seems to us that the system itself was at fault because there was no incentive to push matters forward, given that no resources would be used in Kent until the funding was secured.

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[13] Dr Pick said the need for day treatment could not await the arrival of the medical records from Rhyl - see Chapter 3, paragraph 11 above.

[14] The evidence of the Assistant Contracts and Primary Care Support Manager to the Internal inquiry was that the process of trying to secure funding from other Health Authorities can take anything from "a few weeks to a couple of years. We have some cases that have been going on for two to three years."

12. If people who are placed outside their Health Authority's area are to receive necessary treatment it would clearly be a better arrangement for the treatment to be provided on the basis of need and then for the costs incurred to be recouped from the

Health Authority for the place of origin. Any dispute about the patient's place of usual residence for funding purposes could be resolved after the treatment had been given. In 1999 the East Kent Health Authority issued an Out of District Residents Protocol which adopts this solution. We were assured by Trust management that a referral, such as that made by Dr Pick in April 1998 for day treatment, would now proceed in the same way regardless of whether the patient had been "placed" in East Kent. The patient's clinical needs would be assessed and, if required, the treatment would be provided. The clinical response would not be constrained or delayed by issues about which Health Authority has responsibility for funding the treatment.

13. As the policy in East Kent has changed since the events with which we are concerned, and given the assurance we have received that under the new arrangements treatment would not be delayed, it is unnecessary for us to make detailed recommendations about the provision of psychiatric treatment in East Kent for people who move into supported accommodation in the area.

14. However, we do have concerns about the failure to keep Dr Pick informed. The only contact with him was by telephone and he was told simply that the day treatment could not proceed because Peter Wild was an out of area placement. Thereafter, clinicians lost sight of the referral. We think this could have been avoided if Dr Kalidindi had written to Dr Pick explaining the action he had taken and saying how the referral for day treatment would be followed up both clinically and administratively.

Objective

To ensure that people receive treatment on the basis of assessed need without regard to which Health Authority is responsible for payment

This is now achieved in East Kent under East Kent Health Authority's Out of District Residents Protocol which requires non-urgent treatment to be provided to people placed in East Kent on the same basis that it is provided to the resident population.

Recommendations

We recommend that:

1.1 General practitioners are made aware of the Out of District Residents Protocol.

1.2 When a clinician in secondary services considers that funding for a patient's treatment comes within the Out of District Residents Protocol the patient's general practitioner is informed of this in writing.

1.3 There is always a written communication back when a consultant psychiatrist receives a referral from a general practitioner, even where the patient has not been seen.

Liaison between the Voluntary Sector and Statutory Services

15. Voluntary organisations provide a range of services and activities for users of mental health services. An important voluntary resource within Thanet is Royal Road Day Centre in Ramsgate which is run by Thanet Mind and funded by Kent Social Services. Peter Wild attended there from April to December 1998. The Centre describes itself in its own information sheet as: "a Day Centre to support people with emotional difficulties or mental distress", offering "a safe place for people:- to meet socially, talk about their problems confidentially, get advice and understanding, get support and information, take part in various groups." It is staffed by a mix of paid workers and volunteers. The Centre is open from 9.30am to 4.30pm on weekdays and provides a midday meal. Eligibility depends only on confirmation from a general practitioner that the person concerned has mental health needs. Apart from appointments with his general practitioner, attendance at Royal Road was Peter Wild's only contact with services in East Kent prior to June 1999. His main interest in using the Centre was as somewhere to pass the time and to play pool. He was free to use the resource in this way and there was no expectation that he would participate in

groups or other structured activities. He valued his contact with the Centre and, as we have seen,[15] asked Dr Ward to refer him back there in May 1999 when his mental health was deteriorating.

16. It is not within our remit to review the services provided by Thanet Mind. In any case we are aware that in 1999 an independent inquiry, established by Kent Social Services, made extensive recommendations for changing the service and these were adopted and implemented through an Action Plan. However, in reviewing Peter Wild's contact with services in East Kent, we have thought it appropriate to consider the relationship between Thanet Mind and statutory services.

17. Peter Wild went to the Day Centre in April 1998 shortly after arriving in East Kent. To be eligible he had only to show that he suffered from mental illness. Confirmation of this would have been obtained, with his consent, from his general practitioner. According to the Centre's referral form he suffered from "depression, nervous tension and black-outs relating to alcohol". His attendance gave rise to a number of problems and in December 1998 he was excluded. The decision to exclude him was not communicated to this general practitioner. Neither his attendance nor his exclusion was known to the Trust or Social Services, because the Centre did not pass on this information. It is not clear to us why this was not done. We assume it was simply not the practice to share information about users of the service with other agencies. We note that when enquiries were subsequently made by the general practitioner and others, staff at Royal Road willingly responded to them.

18. We have considered whether this degree of separation between a voluntary sector service provider and statutory services is desirable. While the voluntary sector is part of the overall service provision and cannot operate in isolation from statutory services, one of the great strengths of a facility such as Royal Road Day Centre is that service users see it as their own resource rather than a place for treatment. However, the main thrust of the Action Plan for Thanet Mind is to make its services fit better into the statutory sector's vision for the promotion of good mental health. In terms of the Service Principles underlying the Sainsbury Model there is clearly a balance to be

[15] See Chapter 3, paragraph 17 above.

struck between integration of voluntary sector services and maintaining the accessibility of such services, which in part is based on users' perceptions that they are distinct from statutory services.[16] We believe it would be helpful if Thanet Mind and similar organisations could agree with statutory providers a statement of how their service fits into the spectrum of local services.

19. Our specific concern, however, is with the arrangements for the sharing of information about individuals who use voluntary sector services. The voluntary sector is under a duty, as are statutory providers, to respect users' confidentiality. This duty is not absolute, but disclosure of confidential information without consent can generally only be justified if there is a clear and pressing need to make disclosure in the public interest, for example because of a risk of violence, or where disclosure between different agencies is justified on a "need to know" basis. There would in our opinion have been no public interest justification for disclosure of information about Peter Wild, without his consent, arising from his attendance at Royal Road. However, at the point when information was requested following Dr Ward's referral to Dr Kalidindi it is clear that there was a legitimate interest justifying disclosure, primarily in the interests of assessing and treating Peter Wild's mental disorder.[17]

20. This still leaves the question whether information might in other circumstances be disclosed, with the service user's consent. Users of Royal Road Day Centre have to be referred, or at least their referral has to be confirmed, by their general practitioner. We consider that the normal practice should be for information, in certain circumstances, to be passed back to the general practitioner or to the relevant clinician or mental health professional if the service user is known to specialist mental health services. One such circumstance would be where a decision is made to exclude someone from the service. We can see no reason why this should not be made clear to users of the service at the point of referral. Our expectation is that a letter would be written to the general practitioner giving the reasons for the exclusion. In Peter Wild's case it would presumably have been of interest that he had been selling his prescribed medication. Had this information been communicated to

[16] See Appendix 1, paragraph 4.

the general practitioner it is possible that he would have decided to see Peter Wild with a view to renewing the referral to Dr Kalidindi for day treatment. Had the reasons for exclusion been put in writing, or had a written record been kept, this information would have been available to clinicians and others when Peter Wild did finally come into contact with statutory services in June 1999. We note elsewhere that inconsistent accounts were given by staff at Thanet Mind when they were contacted at that time.[18]

21. Department of Health guidance recommends that every organisation should adopt a written policy on record keeping and a policy on disclosure of information which has been agreed with other organisations locally.[19] In 1998/99 Thanet Mind was working without such a policy. We believe this led to a lack of clarity about disclosure of information and to unreliable information being conveyed when requested by statutory services in May and June 1999. Since risk assessment is a necessary component of decisions about disclosure of confidential information, for example where there are concerns about potential violence, we consider this to be an essential element in any policy on disclosure.

22. More generally, we would expect voluntary organisations, such as Thanet Mind, to assist users of their service in securing access to other services to which they may be entitled. To this end consideration should be given to informing statutory services of that person's attendance so that a needs assessment can be carried out. It seems likely that most users of a service such as that provided at Royal Road would already be known to Social Services but this was not the case with Peter Wild. It is arguable that if Kent Social Services had been aware of his attendance at the Centre they would have had a duty to assess him under section 47(1) of the National Health Service and Community Care Act 1990 as a person who "may be in need" of community care services. We accept, of course, that he could not have been compelled to cooperate with such an assessment but it seems likely that he would have done so. Had such an assessment taken place it would have brought Peter Wild

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[17] For a discussion of the use and disclosure of patient information see Department of Health (1995) Building Bridges, A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people, pages 19 - 23.
[18] See above Chapter 3, paragraph 7.
[19] See Building Bridges, footnote 17 above.

into contact with Social Services in Kent and provided an opportunity to consider whether he had social care needs which could be met, for example by the provision of social work support.

Objective

Voluntary organisations have a wealth of experience and skills. They are an essential part of the patchwork of services. It is important that voluntary sector services are planned and delivered in the context of the whole spectrum of services and take account of the policies and priorities of statutory providers.

Recommendations

We recommend that:

2.1 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, should explicitly state how their service relates to the wider spectrum of health and social care in the locality.

2.2 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, develop a confidentiality policy, to be agreed with statutory service providers, that will inform record keeping and information sharing with service users and partner organisations.[20]

2.3 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, develop a risk management policy, to be agreed with statutory service providers.

2.4 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, inform the relevant clinician or mental health professional if a decision is made to exclude a user from the service.

2.5 As a matter of normal practice, basic information about people with mental health needs who are using voluntary sector services is

[20] National Mind issued guidance on a range of service standards in May 2001: "Quality Management in Mind, A manual for local Mind associations"

passed by those services to statutory services so that their community care needs can be assessed.

The Role of the Police and Liaison with Mental Health Services

23. On 9th June 1999 Peter Wild went to Ramsgate Police Station. He was in a state of crisis and was looking for help. The police made enquiries and contacted Elmstone Ward at the Thanet Mental Health Centre in an attempt to get him urgently assessed by mental health services. The advice given to the police, and passed to Peter Wild, was to follow the normal procedure by seeking a referral to secondary services from his general practitioner. In paragraph 54 below we comment on what we consider to have been the unsatisfactory response of mental health services to the police enquiry. Here we consider the role of the police.

24. The police were placed in the invidious position of having themselves to take responsibility for dealing with Peter Wild without any input from mental health services. It is clear to us that the police felt uneasy about sending Peter Wild on his way, with advice to see his general practitioner, given his agitated demeanour and his account of hearing voices telling him to kill his landlady. From accounts we have heard and read of Peter Wild's presentation on that occasion it must have been obvious that he was in crisis and in need of help. His report of what the voices were telling him to do also gave rise to a public safety and protection issue. The police officers who saw and spoke to him should have appreciated this and taken effective action.

25. Consideration could have been given to using powers under section 136 of the Mental Health Act which empowers the police to detain and remove to a place of safety, for the purpose of a psychiatric assessment, a person who appears to be suffering from a mental disorder. The local arrangement in Ramsgate is that Elmstone Ward is the place of safety for this purpose. However, we think this would have been a questionable use of compulsory powers, given that Peter Wild was seeking treatment voluntarily. It would have amounted to the police using section 136 for the sole purpose of circumventing the refusal of Elmstone Ward to arrange an

assessment. It is understandable in these circumstances that the police did not use section 136. It might be suggested that it would have been possible to arrest Peter Wild for threatening to kill Nancy Broadbridge, or to prevent him from doing so. Although we do not know exactly what Peter Wild said to the police, it was obvious to them that his talk about killing Nancy Broadbridge was in the context of his disturbed mental state. It seems unlikely that he was committing a criminal offence in telling the police about his thoughts. It also appears that his behaviour was not such as to amount to either an actual or threatened breach of the peace or to give rise to the common law power to arrest a mentally disordered person where there is an immediate danger to his own safety or the safety of others.[21] The evidence we received from Sergeant Fox, who was present when Peter Wild attended Ramsgate police station, was that under normal police procedures it would not have been possible to get him assessed by a forensic medical examiner without arresting him for a criminal offence or detaining him under section 136. Our view is that there was probably no legal basis for doing either of these things.

26. Given that Peter Wild's presentation did not fit with normal police procedures, we believe the situation called for the police officers involved to take the initiative so as to ensure he was medically assessed. While we have sympathy for the police because of the position they were placed in by the inadequate response they received from Elmstone Ward, we nonetheless consider they could and should have done more. If indeed it would not have been possible for him to have been seen at the police station by a forensic medical examiner, the police could have taken him to Thanet Mental Health Unit, or the adjoining Accident and Emergency Department, and insisted that he was seen. Alternatively, they could have arranged an emergency appointment with Dr Ward, the general-practitioner, and kept Peter Wild at the police station until Dr Ward was able to see him.

27. The final point which emerges from Peter Wild's contact with the police on 9th June is that the police were left with significant information about his mental health

[21] In the case of Black v Forsey, 1987 S.L.T. 681 Lord Griffiths said that this power is "confined to imposing temporary restraint on a lunatic who has run amok and is a manifest danger either to himself or to others – a state of affairs as obvious to a layman as to a doctor. Such a common law power is confined to the short period of confinement necessary before the lunatic can be handed over to a proper authority."

and the potential risk to Nancy Broadbridge. They did not pass this on to mental health services. We think it essential that information about any incident, such as Peter Wild's presentation at Ramsgate police station, which gives serious cause for concern about a person who appears to the police to be mentally disordered, should be communicated by the police to mental health services. We accept that the police are not best placed to assess the risks but there was in our opinion enough material available on 9th June to alert them to the need for a psychiatric assessment. Had the Trust been given information about the incident, and had this been available to Dr Kalidindi and others who assessed Peter Wild less than a week later, it is likely that different decisions would have been made at that time.

28. We have been told by the Trust that adequate arrangements are in place for liaison between the police and mental health services. Specifically, the Trust's Director for Mental Health Services told us that there is, and was in 1999, a police liaison officer who:

> "would have had a very good working knowledge of the senior staff at Thanet Mental Health Unit and [had he known of Peter Wild's presentation on 9th June] would have attempted to contact the most senior member of staff at the unit at the time."

But this arrangement was not known to Sergeant Fox, the experienced police officer who dealt with Peter Wild. He told us this was the first time in 15 years that he had to deal with someone coming to the police station seeking admission to psychiatric hospital. He was not aware of a central point for getting advice and for that reason he contacted Elmstone Ward as the obvious place for Peter Wild to be admitted. He told us that as far as he knew there had not been any changes in liaison arrangements between the police and mental health services since 1999, although because of this case officers and civilian staff at Ramsgate police station were now more conscious of the risks.

29. We accept that Peter Wild's presentation at Ramsgate police station on 9th June was an exceptional event. We consider the initial police response was appropriate in trying to obtain help for him. The most important weakness which the incident exposed was the absence of adequate arrangements to respond to this kind of urgent referral within the mental health services, regardless of its source. But there

was also a failure by the police officers involved both to take responsibility for what was a potentially serious situation and to communicate effectively with mental health services. We were pleased to hear that police officers in Ramsgate have learned from this case and that someone in Peter Wild's condition would not now be sent home with advice to see his general practitioner. But we think there is a need to improve communication between the police and mental health services. It is the responsibility of mental health services to provide the police and other agencies with information about access to services and, specifically, the name and telephone number of who to contact in a psychiatric emergency. Although Peter Wild was seen at the police station in normal working hours, there is a need to ensure that such information also covers emergencies which arise out-of-hours. We consider that the response of mental health services to referrals from the police should be a regular item for discussion at meetings between the police liaison officer and mental health service managers.

Objective

In order to respond effectively to people who appear to be mentally disordered the police, and other agencies, need to be able to call on specialist mental health services for necessary advice and assistance.

Recommendations

We recommend that:

3.1 The Trust provide the police and other agencies (including voluntary organisations) with information which will enable them to obtain necessary advice and assistance in responding to the needs of people suffering from mental disorder. Such information will necessarily include a contact telephone number and details of the Trust's arrangements for accepting emergency referrals outside normal working hours. A process for ensuring regular updating of information will also be required.

3.2 Those working within specialist mental health services make a written record of contacts, including telephone conversations, with the police about mentally disordered individuals who the police consider may

be in need of psychiatric assessment. This record would be sent to a designated liaison person within mental health services.

Referrals for Assessment

30. During his time in East Kent Peter Wild was referred, or self-referred, to mental health professionals for assessment on six separate occasions, five of which were in the week preceding the homicide:

i) By Dr Pick for assessment by Dr Kalidindi in April 1998.
ii) By the police to Elmstone Ward on 9th June 1999.
iii) By Dr Ward for assessment by Dr Kalidindi on 14th June 1999.
iv) By going to Elmstone Ward on 15th June 1999, seeking admission.
v) By Dr Kalidindi for assessment by Lydden Day Hospital on 15th June 1999.
vi) By Lydden Day Hospital to the Westbrook Centre on 15th June 1999.

Only Dr Ward's urgent referral for a domiciliary visit followed the normal procedure. The initial request by Dr Pick for assessment for day services got lost in the system. The attempt by the police to get Peter Wild admitted, or at least assessed, was rebuffed. Peter Wild's self-referral to Elmstone Ward did not lead to him being assessed for admission, but instead the Lydden assessment was brought forward and went ahead without a referral letter and supporting information. The Westbrook assessment was also unusual as it was initiated by staff at Lydden without effective prior notification and with only negligible background information. It is noteworthy that Dr Kalidindi was aware of all these referrals apart from that by the police on 9th June.

31. While the circumstances of Peter Wild's case were clearly exceptional, we are in no doubt that they exposed weaknesses which are of wider relevance. It also needs to be said that part of the role of mental health services is to be able to respond to emergencies and to deal with the unexpected. The demands arising from Peter Wild's mental health needs were not so unusual that services could not reasonably be expected to respond to them. We consider the lack of formality and clarity in the arrangements for accepting referrals was a significant weakness. We make the

following recommendations, which we believe are consistent with the Sainsbury Model.

Objective

The purpose of a referral to specialist mental health services is to ensure that the person concerned receives an appropriate assessment within a timescale which reflects the urgency of the case.

Recommendations

We recommend that:

4.1 There is a central co-ordinating point to which all referrals are directed. It may be that special administrative arrangements will need to be in place for emergency and out-of-hours referrals.

4.2 Time bands are introduced for responding to referrals, depending on urgency, and the source of the referral is informed in each case how soon the assessment will take place.

4.3 There is a written response to the source of the referral.

Assessments

Introduction

32. We have met with the three people, Dr Kalidindi, Linda Owen and Pauline Reynolds, who respectively carried out the assessments on 14th and 15th June. Each of them tackled the task of assessing Peter Wild as they saw it. Our criticisms relate to the narrowness and compartmentalisation of the assessments; the failures to pass on relevant information; and the absence at every stage of a systematic approach to the assessment of both need and risk. We now look at each of the three assessments in turn.

The domiciliary visit

33. The first of the three was Dr Kalidindi's domiciliary visit at about 5.00pm on 14th June. We accept that on the basis of the information available to him, and in the light of his own assessment, it was perfectly reasonable for Dr Kalidindi to conclude that Peter Wild was not a suicide risk or a risk to others such that it would not have been safe for him to remain at home. We think he was right to consider admission but we agree with his judgement that compulsory admission under the Mental Health Act was not warranted. We also think he was right to want to find some way of following Peter Wild up after the visit. He told us his intention in making the referral to Lydden was that Peter Wild:

> "would be monitored concerning his mental state by nurses and occupational therapists, and he would be seen by a community psychiatric nurse and social worker who did screening for in-patients and day hospital patients on a weekly basis; and also he would be seen by us, the medical staff".

34. Dr Kalidindi was looking for an alternative to admission and it was because Lydden was sometimes used for this purpose that he decided to make the referral. What he appears not to have considered is the likelihood of Peter Wild attending Lydden. Although he had agreed to go to Lydden for an assessment, it seems to us that there was no realistic prospect of Peter Wild committing himself to the level of attendance and participation which Lydden demanded of patients. We therefore consider this was an ill-considered referral and that Dr Kalidindi's reasons for making it are not persuasive. For example, he suggested that day hospital treatment would be a better alternative to in-patient treatment because during the previous admission in Rhyl Peter Wild:

> "had not cooperated with the ward team and so on and had been out drinking even though he had been asked not to".

It seems to us the same problems would almost certainly have occurred had he been accepted for day treatment by Lydden.

35. Dr Kalidindi dealt with the immediate presenting problems. In particular, he assessed Peter Wild's mental state, the risk of suicide and whether there was a need

for admission to hospital. It is unsurprising that he did not get an entirely accurate clinical picture on the domiciliary visit, given Peter Wild's presentation on that occasion, but he should have appreciated, if only because of the dramatic change in mood since the consultation with Dr Ward earlier in the day, that Peter Wild's mental state was unstable. He should also have had in mind the possibility of diurnal variation of mood, characterised by low mood in the morning which improves over the course of the day.

36. By virtue of the referral and the domiciliary visit, Dr Kalidindi had assumed overall clinical responsibility for managing Peter Wild's care. One of the consequences of making the referral to Lydden was that he did not retain effective control of what was clearly a changing situation. He accepted in his evidence to us that it was entirely a matter for staff on Lydden, on the basis of their own assessment, to decide whether to offer Peter Wild day treatment. Dr Kalidindi told us that his plan if Lydden did not accept the referral was to see Peter Wild in his outpatient clinic at a future date. This was not communicated to Peter Wild. While we do not suggest he should have made a recommendation for compulsory admission under the Mental Health Act, we believe he should have kept a greater degree of clinical control. He could have done this by arranging at the domiciliary visit to see Peter Wild as an outpatient for further psychiatric assessment, and by making an urgent referral to the community mental health team, of which he was a member, for a wider assessment of Peter Wild's social care needs. More generally, we believe the approach taken by Dr Kalidindi on the domiciliary visit is indicative of what we consider to be a general problem of the compartmentalisation of the assessments of Peter Wild and the lack of co-ordination of services.

The Lydden Assessment

37. We turn now to the assessment which Linda Owen carried out on the morning of 15th June at Lydden Day Hospital. In view of the way the referral was made by Dr Kalidindi, both in his telephone conversation with her that morning and his subsequent conversation with the nurse on Elmstone Ward, we accept that Linda Owen was entitled to see her role as being to assess whether Lydden was a suitable resource for Peter Wild. This was what both she and Dr Kalidindi understood to be

the purpose of her assessment. We see no reason to differ from her conclusion that Lydden was not the right place for Peter Wild, but we do criticise the absence of a systematic assessment of risk and need.

38. Linda Owen spent about 45 minutes with Peter Wild. We think that if her assessment had been more systematic it would have been clear to her that his problems were more complex than she allowed herself to believe. It seems likely that information about his personal and psychiatric history, which did not emerge from the domiciliary visit, would have been brought out. We also think it likely that a simple risk assessment pro forma would have drawn from Peter Wild information relevant to the assessment of the risk both to himself and others, which he might well have been willing to disclose in answer to direct questioning. Obtaining and recording such information would not only have been useful for anyone else who subsequently had professional contact with Peter Wild, such as the staff at Westbrook, but it would also have provided a sound basis for Linda Owen to discuss the case with her colleagues on Lydden and with Dr Kalidindi.

39. Another general concern we have about the Lydden assessment is its failure to give proper consideration to the change of circumstances in what was, as we have already observed, an unstable situation. The changed presentation between the previous evening's domiciliary visit, when Peter Wild was calm, and the agitated state he was in on 15th June was not registered and assessed. Likewise, no weight was apparently given to Peter Wild going to Elmstone Ward that morning, having refused to consider admission when seen by Dr Kalidindi the previous evening. While we accept that Linda Owen was entitled to proceed on the assumption that her role was to assess Peter Wild's suitability for day treatment on Lydden, we believe it to be a failure that the changed circumstances were not properly considered. We also note the willingness of some of those who saw Peter Wild on the morning of 15th June at Lydden to assume he was suffering from delirium tremens. This mistaken view, together with Peter Wild's complaint that he no longer had enough money to buy alcohol, no doubt reinforced the misleading impression of him as someone who was not mentally ill. In contrast, Dr Kalidindi in his evidence to us said that in his opinion Peter Wild's agitation was not attributable to delirium tremens. We find it surprising that, notwithstanding Dr Kalidindi's view that Peter Wild was in need of psychiatric

care and monitoring of his mental state, Linda Owen formed her own opinion that there was no sign of mental illness and that his problems were predominantly social and financial.

40. We have already said that in our opinion Dr Kalidindi assumed overall clinical responsibility for Peter Wild when he went on the domiciliary visit. We believe he should have involved himself more actively in the events of 15th June. He stepped back from the decision-making process, while retaining overall responsibility. Once Peter Wild had presented himself on Elmstone Ward in a state of acute distress and was asking to be admitted, it becomes difficult to understand why Dr Kalidindi persisted with this approach. Apart from requesting that the Lydden assessment be brought forward, he did not take responsibility for what followed. He was given another opportunity to intervene when he spoke to Linda Owen following her interview with Peter Wild, and again when he happened to arrive at Lydden just as Peter Wild was leaving, but even then he made no attempt to take control of the situation and to satisfy himself that the case was being handled properly. Instead he acceded to the decisions made by staff on Lydden, even though they were based on a view of Peter Wild's mental health problems which differed significantly from the one he had formed the previous evening. We consider this amounted to a failure both to take clinical responsibility and to exercise the leadership role which as a consultant psychiatrist was his responsibility. We return to the question of leadership in paragraphs 79-81 below.

41. Although it is necessary to discuss the events of that morning with reference to the individuals directly concerned, their actions must be seen in context. It is our view that a combination of organisational and cultural factors contributed to the failure to ensure that Peter Wild, as a person who was suffering from an acute episode of mental illness, received an adequate assessment when he attended the Thanet Mental Health Unit on 15th June. Lydden staff were gatekeepers of that resource and had no interest beyond establishing whether it was suitable for Peter Wild. The lack of an agreed system for assessing risk and need, which was applied and shared by all those carrying out assessments, meant that the assessment at Lydden served only a very limited purpose and was not seen by staff there or by Dr Kalidindi as providing relevant information to assist him in his further management of Peter Wild's case. On

the other hand, Dr Kalidindi, having decided that Peter Wild had mental health problems and should be engaged, monitored and supported, apparently did not have the will or the means to ensure that this happened. The only resource he could readily command was a hospital bed, something which he had concluded on the domiciliary visit was not necessary for or acceptable to Peter Wild.

42. A systematic assessment on Lydden would, we believe, have disclosed a range of immediate problems, in relation both to Peter Wild's own mental health and to his domestic circumstances. It seems to us unlikely that if such an assessment had been carried out and drawn to Dr Kalidindi's attention he would have been content simply to allow events to take their course. The options open to him were, however, far from clear. But in discharging his clinical responsibilities he would have wanted to consider what could have been offered. That this did not happen is in part attributable to the failure to gather and share information within a multidisciplinary team.

43. The final observation we would make about the Lydden assessment is that we find it difficult to understand the decision to refer the benefits issue to the duty officer at Westbrook. This suggests the problem was so urgent that it had to be dealt with on the day. It seems to us that the question of his entitlement to DLA was not of such immediate urgency. The speed with which he was dispatched and the poor quality of the written referral suggest that the predominant consideration was to close the case which, as far as Lydden staff were concerned, should not have come to them in the first place.

The Westbrook Assessment

44. The next assessment was that conducted by Pauline Reynolds at the Westbrook Centre. This differed from the Lydden assessment in a number of respects: it came by way of a written referral, albeit only a handwritten letter; it had a different purpose, which was to assist with the benefits problem identified by Linda Owen; Peter Wild was now calm and Pauline Reynolds was, we believe, entitled to rely on the statement in the referral letter that there was "no sign of mental illness"; and it was an assessment conducted by Social Services rather than Health. Before the interview Pauline Reynolds spoke to Dr Kalidindi's secretary and was thus able to

supplement the meagre information in the referral letter. She then interviewed Peter Wild for about an hour and found out something of his personal and psychiatric history as well as his present circumstances. He was now calm and, as was the case on the domiciliary visit, he gave a generally reassuring account of himself. She made a brief written record of the interview, on the Social Services form used for the initial screening of clients, of which we have seen a copy. She was able to refer the DLA problem to a local solicitor with specialist knowledge of social security benefits and to arrange an early appointment. She also arranged an outpatient's appointment with Dr Kalidindi as a way of ensuring that if there were mental health issues which had not been picked up on the domiciliary visit there would be another opportunity for Peter Wild to be psychiatrically assessed.

45. It is clear both from what she told us and from the screening form she completed that Pauline Reynolds did not confine her assessment to the narrow issue of benefits. However, as she herself acknowledged, her interview with Peter Wild fell short of being a full assessment of his community care needs. The reason for this was that, as she explained to us, it was her understanding of the criteria for community care services under the Care Programme Approach (CPA)[22] that eligibility depended upon a psychiatrist's opinion that the person concerned suffered from a severe and enduring mental illness. In Peter Wild's case the absence of a psychiatric opinion to that effect meant there was nothing Social Services could offer.

46. Given Pauline Reynolds' understanding of the way the eligibility criteria were applied, which we accept was based on her experience, it was reasonable for her to limit her assessment to a screening exercise. It was also logical to make the referral back to Dr Kalidindi because he was in a position to say whether or not Peter Wild did have a severe and enduring mental illness and accordingly whether he met the eligibility criteria – something which he had not apparently considered on the domiciliary visit.

47. Pauline Reynolds' interview with Peter Wild did not follow any prescribed format and did not include any assessment of risk. As already stated, we accept she

[22] See paragraphs 57-60 below.

was entitled to concentrate on the specific issue of benefits. In conducting the interview as a screening assessment rather than a full community care needs assessment she was acting in accordance with the correct procedure. She made an adequate record of what was said and took appropriate steps to refer Peter Wild for further help. Her conclusion that there was nothing community mental health services could offer Peter Wild was reasonable, given the information available to her and her understanding of the eligibility criteria.

Discussion of Assessments

48. Although we accept what Pauline Reynolds told us, that Peter Wild expressed his gratitude to her and was calm when he left Westbrook, we are also aware that when interviewed by the police following the homicide he said he felt let down by the response he received from mental health services:-

> "I wanted to get admitted because I was in such a bad state, I couldn't hardly speak, couldn't hardly make meself known...They didn't seem as though they wanted to know about my mental health. They said I'd got a drink problem, the one I saw. You know I tried, you know I told them I needed something to calm me down cos I was in such a bad state and well I don't know it's, I was really hyped up. Alright I know I managed to get there on my bloody own but it's only cos I was desperate for something to get me calmed down that I went on my own you know."

49. The fact is that Peter Wild, a man with a significant psychiatric history, went first to his general practitioner and the following day presented himself to an acute admission ward in a distressed state asking for admission. After three separate assessments, all he was offered was an appointment to see a solicitor to try to get his DLA reinstated, and an outpatient's appointment to see the same psychiatrist who had assessed him at home only the previous day. Clearly, the assessment process did not work well, not least in failing to provide any immediate help for Peter Wild or to tell him where to obtain such help when next he was overwhelmed by feelings of anxiety and of being unable to cope. We have already highlighted some of the weaknesses in that process:-.

- The failure to gather relevant background information.

- The compartmentalisation of the assessments so that at each stage a particular issue was being addressed but without linking the assessments together for the purpose of seeing the complete picture.
- The lack of a systematic assessment, including clarity about the type of information which should have been sought, not least from Peter Wild himself, before it could be said that an adequate assessment had been completed.
- The lack of a systematic assessment of risk.
- The failure to communicate effectively between the agencies and individuals involved, including the police.
- A lack of clarity about where overall responsibility for the assessment process lay and the absence of a coordinating point to which information arising from the assessment process would be directed.
- The failure to identify Peter Wild's need for mental health services, in part because he was seen as having a primary problem of alcohol dependence or abuse.

50. We believe that, irrespective of the approach of the particular individuals involved in the assessment process, the problems we have highlighted reflect shortcomings in the administrative and organisational arrangements. They also disclose failures of leadership and a lack of co-ordination between different parts of mental health services. Implementation of the Sainsbury Model of Care would lead to changes which would meet some of our criticisms of the administrative and organisational arrangements:-

- There would be a single point of access.
- Assessments would be co-ordinated through the Community Mental Health Services (CMHS).
- There would be standardised assessments of health, social care needs and risk.

Under the Sainsbury Model there would also be a range of alternatives to hospital admission for people in crisis.

51. Although the Sainsbury Model appears substantially to meet our criticisms, we are not clear whether its implementation might still limit the assessment of someone like Peter Wild, who is seen as not meeting CPA eligibility criteria, to a superficial screening exercise. As appears from the recommendations which follow, we think it essential that anyone who is referred to specialist services should be properly assessed.

Objective

Anyone referred to specialist mental health services should be assessed. In order to meet service users' needs and to manage risk, all assessments should satisfy certain minimum standards.

Recommendations

We recommend that:

5.1 All assessments are recorded in writing, using standard forms and procedures.

5.2 The same standard forms are used regardless of who carries out the assessment.

5.3 The standard forms include space for the service user's personal and psychiatric history. Where this information is available from other sources, such as medical records, this would be noted on the assessment form.

5.4 Assessments take account of precipitating events, including any relevant change in circumstances, leading up to the assessment.

5.5 All assessments include a preliminary assessment of risk which would be incorporated into the standard assessment forms.

5.6 All assessments include recommendations so it is clear what action is expected to follow from the assessment.

5.7 All completed assessment forms are placed on the individual's case file so they will form part of the case record and be readily accessible.

5.8 All relevant mental health professionals are trained in methods of assessment and treatment of people with mental health problems who abuse substances, including alcohol.

Crisis and self-referral

52. Mental health services must necessarily have the capacity to carry out emergency assessments and to admit patients who are assessed as requiring urgent in-patient care. We have been told that in 1999 in East Kent emergency psychiatric assessments were referred to the duty psychiatrist. The situation has since changed as the mental illness support team (MIST), which is based in the Accident and Emergency Department at Thanet District Hospital, is now fully operational. It is a nurse-led service which provides out-of-hours or crisis support to people until midnight, seven days a week.

53. There were three occasions in June 1999 when Peter Wild said he wanted to be admitted to psychiatric hospital. The first was at the police station on 9th June; the second when he saw Dr Ward on 14th June; and the third when he arrived at Elmstone Ward on the morning of 15th June. We accept that Peter Wild's attitude to admission fluctuated and had it been offered on any of these occasions we cannot be sure he would have accepted it and been willing to remain in hospital thereafter. We note that he refused Dr Kalidindi's offer of admission on the evening of 14th June. His presentation both on 9th June at Ramsgate Police Station and on the morning of 15th June when he arrived at Elmstone Ward was such that had he been seen by a psychiatrist on either occasion we think he would have been offered admission and, if he refused, consideration would have been given to detaining him under the Mental Health Act.

53. Of the three occasions mentioned above, it was only on the second, when he was referred by Dr Ward to Dr Kalidindi for a domiciliary visit, that Peter Wild was assessed for admission. On the other two occasions his route into the system was blocked. Had there been a place to which Peter Wild could have been referred by the police on 9th June or from Elmstone Ward on 15th June for an urgent psychiatric assessment, it is likely that he would have been admitted voluntarily to hospital.

What appears to have been lacking on both occasions was the will, and possibly the means, to provide an emergency psychiatric assessment in the absence of an appropriate referral. There was apparently no way in for a person who tried to get access to services either by going to the police or by direct self-referral to the Thanet Mental Health Unit.

54. We have commented above on the police handling of Peter Wild's visit on 9th June and have said that in our opinion they took the correct action in seeking help from Elmstone Ward. Peter Wild's presentation at Ramsgate Police Station on 9th June was not a routine occurrence. This should have been obvious to the member of the nursing staff on Elmstone Ward to whom the police spoke. The appropriate and necessary response would have been to ask the police to arrange for Peter Wild to come to the Thanet Mental Health Unit for an emergency assessment by the duty psychiatrist. It was a significant failure on the part of the individual concerned that this was not done.

55. In Appendix 3 we summarise the Sainsbury proposal for a Liaison Psychiatry Service (LPS), based in the Accident and Emergency Department at Thanet District Hospital, to supplement the duty assessment service provided by the Community Mental Health Services (CMHS). Our understanding is that the LPS would be able, without the need for an appointment, to see someone who comes to the Accident and Emergency Department by whatever means and requests a psychiatric assessment or admission. So, for example, a person who turns up at Elmstone Ward, or is referred by the police or another agency, could be seen as an emergency. The service would be available over a 24 hour period seven days a week. We support this proposal. We are, however, left with the concern that the scope of what is by its nature an emergency assessment might be too narrow to take into account the wider needs of someone like Peter Wild. It is our view that, as far as possible, an emergency assessment should take the same form as a more routine assessment, regardless of who carries it out. The same assessment tools should be used and the assessment should consider not only the immediate clinical needs but the full range of possible interventions, including crisis services, and should, as far as is practicable, also take social needs into account.

56. Although the arrangements for emergency assessments at Thanet District Hospital have changed since these events took place, we remain concerned, pending the implementation of the Sainsbury Model, about the arrangements for emergency assessments.

Objective

Specialist mental health services will assess people with apparent mental health problems in an emergency, regardless of the source of the referral.

Recommendations

We recommend that:

6.1 There is a place designated for emergency assessments, such that anyone who presents at that place will be assessed.

6.2 There is a team designated to cover emergency and crisis assessments, including out-of-hours assessments.

6.3 Information about how to contact the team is widely disseminated to general practitioners, the police, voluntary organisations, service users and carers.

6.4 A written record is made of any request received by specialist mental health services, from whatever source, for an emergency assessment and is passed to the designated team. This would include, for example, a telephone request to a ward or when a person presents on a ward seeking emergency admission.

6.5 All emergency and crisis assessments are based on the same standard forms as are used for more routine assessments.

6.6 All emergency and crisis assessments include an assessment of risk.

6.7 If in a particular case the response to a request for an emergency assessment is a domiciliary visit by a consultant psychiatrist, this would be based on the same standard framework as we recommend for other assessments.

Care Programme Approach (CPA) eligibility criteria

57. In 1998/9, when Peter Wild was living in East Kent, eligibility for community based specialist mental health services was determined by the Joint Agency Eligibility Criteria for Mental Health Services. These had been agreed between the East and West Kent Health Authorities and Kent County Council Social Services Department in 1997 and replaced Kent Social Services' own criteria which had been introduced in 1994. We understand that one consequence of the introduction of eligibility criteria was to restrict the availability of a mental health social work service only to those people who under CPA qualified for specialist care. This contrasted with the previous position, before the eligibility criteria were adopted, when the mental health social work service "was broadly available to assist anyone experiencing mental distress".[23] The 1997 criteria are reproduced in the current Care Programme Approach Operational Procedure, dated January 2000.[24] Their purpose is to define those kinds of mental disorder which are sufficiently serious to warrant specialist care. A person with less serious mental health problems is to be cared for exclusively within what the criteria refer to as the Primary Health Care Team, that is by his or her general practitioner.

58. We have seen that Pauline Reynolds, on the basis of her working knowledge of the Joint Agency Eligibility Criteria for Mental Health Services, concluded that Peter Wild was not eligible for specialist mental health services. This was why she restricted her assessment to an initial screening interview.[25] Neither Dr Kalidindi nor Linda Owen, when they carried out their assessments, appears to have thought about whether or not Peter Wild was eligible for CPA.

59. Local eligibility criteria are necessary because CPA, which is the national policy instrument for the delivery of community based mental health services, applies

[23] Kent County Council Social Services Directorate, Best Practice Review of the Mental Health Service Unit, Richard Wadey, 2000.
[24] Care Programme Approach/Care Management Operational Procedure, East Kent Community NHS Trust and Kent County Council Social Services, January 2000.
[25] See above, Chapter 3 paragraph 31.

only to those who are eligible for specialist care.[26] The Department of Health policy underlying CPA since its introduction in 1991 has been to focus specialist resources on the severely mentally ill.[27] A number of changes to CPA were introduced by the Department of Health in 1999.[28] The January 2000 Care Programme Approach Operational Procedure implements these changes and in so doing distinguishes between Standard and Enhanced CPA. The latter is designed for people with "severe and enduring" mental illness while the former includes anyone else who satisfies the criteria for CPA but whose condition is not "severe and enduring".

60. We have considered the Joint Agency Eligibility Criteria for Mental Health Services. Of particular relevance is the following:-

"To be eligible for acceptance into secondary services (which may include acute admission) the service user will have a confirmed or provisional diagnosis of mental illness requiring specialist treatment or management, having regard to the likely duration, severity and prognosis of the illness, which will include one or more of the underlying conditions:

- Less disabling, stress related ... disorders, including ... generalised anxiety, 'neurotic' or 'reactive' depression ..."

Had Peter Wild's condition in June 1999 been properly understood he would have satisfied the eligibility criteria. He had an established diagnosis of depression and his illness was severe at that time, affecting as it did his ability to cope with the demands of daily life as well as giving rise to an obvious risk of self-harm. It would therefore be misleading to suggest that the criteria themselves had the necessary consequence of excluding Peter Wild from specialist mental health services in East Kent. It was a question of how those criteria were interpreted and applied by practitioners. It appears to us, on the basis of the assessments of Peter Wild, that there was a tendency

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[26] Department of Health: The Care Programme Approach for people with a mental illness referred to specialist psychiatric services HC(90)23/LASSL(90)11. The Care Programme Approach was introduced in 1991 to provide a framework for the care of mentally ill people outside hospital. In its original form it had four main elements: systematic arrangements for assessing the health and social needs of people accepted for specialist psychiatric services; the formulation of care plans to address the identified health and social care needs; the appointment of a key worker to keep in close touch with the patient and monitor care; regular review and, if necessary, changes to the care plan.

[27] See, for example, Building Bridges, footnote 8 above.

[28] Modernising the Care Programme Approach (October 1999)

to place an undue emphasis on the presence or absence of acute symptoms of mental disorder. Insufficient weight was given to both his psychiatric history and to dynamic risk factors, and the additional risks arising from his abuse of alcohol were either not considered at all or were thought to be irrelevant.

Objective

Eligibility criteria must aim both to meet the clinical and wider needs of those people who require specialist services, and to ensure that eligibility takes account of risk.

Recommendations

We recommend that:

7.1 Eligibility criteria reflect dynamic risk factors, in addition to diagnosis and other clinical indicators such as the presence or absence of symptoms.

7.2 Eligibility criteria make clear that abuse of alcohol or drugs is a relevant risk factor which, in association with a mental illness, indicates a greater need for specialist mental health services.

Assessment of Eligibility for CPA and Community Care Services

61. We have said that the Joint Agency Eligibility Criteria for Mental Health Services did not necessarily exclude Peter Wild. The risk is that in practice criteria may be used to rationalise or justify decisions to exclude people from services rather than to determine people's entitlements. This risk is much greater where, as with Peter Wild, the diagnosis of mental illness is complicated by personality difficulties and substance abuse, and where mental health services are not designed to address these problems. We are not in a position to do more than make some observations based on this one case, but from our reading of the documents and our meetings with practitioners and managers, a fairly consistent picture has emerged.

62. Our impression is that, in the absence of an established diagnosis of a major mental illness such as schizophrenia, the only reliable route into specialist services would have been through a recognised episode of acute illness, or an incident of self-harm or of dangerous behaviour. Someone who was not considered to be acutely unwell at the time of the assessment but who arguably satisfied the eligibility criteria, and who might have benefited from a relatively low level intervention such as regular contact with a mental health social worker, would have had very little prospect of being assessed as needing that service. Further, because of the unlikelihood of an assessment in the community leading to the offer of a service for a person such as Peter Wild, the tendency was to restrict any such assessment to what the Joint Agency Eligibility Criteria for Mental Health Services document refers to as a "screening assessment". Such an assessment, unlike a full CPA assessment, does not require the "care needs to be individually and holistically assessed", or for there to be an "assessment of the risks associated with the individual's mental health".

63. In so far as the assessments of Peter Wild took place within the framework of the eligibility criteria, what was done amounted to a screening assessment. This was what Pauline Reynolds was doing when she saw him. But, as we have pointed out,[29] she was carrying out her screening assessment in the belief that only a psychiatrist would have had the professional authority to assert in a case such as Peter Wild's that CPA eligibility criteria were satisfied. At that stage the only psychiatric assessment had been confined to the immediate presenting issues on the domiciliary visit and the question of eligibility under CPA for specialist mental health services had not been addressed. It is no doubt possible that had Peter Wild seen Dr Kailidindi at the outpatient's appointment Pauline Reynolds made for him the further assessment of his eligibility for specialist services would have been considered. But from our meeting with Dr Kalidindi this appears not to be the way in which he approached matters. He was not thinking in terms of eligibility under CPA for specialist services, including social work, rather he saw it as his responsibility to meet Peter Wild's clinical needs. When asked about the purpose of the proposed outpatient's appointment, he told us:

> "I would have looked at all the options again if the day hospital [Lydden] did not want him, and if it seemed appropriate I would have considered admission again. It would all have depended on how he presented on that day."

[29] See paragraph 45 above.

64. Although Peter Wild's case is unusual because of the speed of events, we are not convinced that the outcome would have been different had he been referred to services in a different way. There is no reason to suppose that the Lydden assessment would have come to a different conclusion had it taken place on the appointed day; nor, for the reasons given by Pauline Reynolds, is it likely that any assessment by Social Services would have led to a decision to offer him a social work service.

65. We think it is particularly significant that Peter Wild was someone with personality problems who also abused alcohol. We believe these considerations made it less likely that he would be seen as a person in need of specialist mental health services. This is to raise the more general issue of the role of specialist mental health services in responding to the needs of people who have personality and substance abuse problems in addition to a mental illness. We turn to this issue below when we consider dual diagnosis.

66. We have two specific concerns arising out of the application of the eligibility criteria in Peter Wild's case. The first is that those who assessed him did not as part of their assessment consider objectively whether or not he satisfied the criteria. Neither Dr Kalidindi nor Linda Owen made any reference to the criteria and Pauline Reynolds assumed, in the absence of psychiatric evidence to the contrary, that Peter Wild was not eligible. We have considered whether either the January 2000 Operational Procedure for CPA or the Sainsbury Model of Care would lead to a different approach. Both are primarily concerned with the organisation and provision of services to those who are assessed as being eligible, rather than with the determination of eligibility. The Operational Procedure, for example, starts from the position that "All people accepted by specialist psychiatric services can expect an initial assessment of their health and social care needs by a mental health practitioner". The document goes on to deal with referrals and screening. It says that when a referral is received "a preliminary judgement will have to be made as to whether the referral meets the Joint Eligibility Criteria". If the preliminary judgement is favourable the case will automatically be allocated to a mental health professional who will "screen the referral against the Joint Eligibility Criteria" within 10 working days of receipt of the referral. Our understanding of the Sainsbury Model is that in

this respect it adds nothing to the Operational Procedure. It appears to us that if the process outlined in the Operational Procedure were to be followed rigorously, such that anyone who carried out an initial assessment had to deal explicitly with the eligibility criteria, this would represent a significant improvement on what happened in the assessments of Peter Wild. We would add that where at the original assessment there is any doubt about eligibility it should be a requirement of the procedure that relevant information be obtained to enable an informed judgement to be made.

67. Our second concern is that in treating Peter Wild as someone who appeared not to satisfy the criteria there was no requirement, as part of a screening assessment, to assess risk or his social care needs. It is our opinion, using the formulation in the Sainsbury Model, that "people who have been diagnosed or are suspected of having a mental disorder" should receive a standardised assessment of social care needs and also an initial risk assessment. We do not think such an assessment should be dependent upon the person concerned satisfying CPA eligibility criteria. The Operational Procedure document includes a preliminary mental health risk assessment form which is to be completed in respect of "all people referred to the Mental Health Service". We support the use of such a form in all cases, leading to a fuller assessment of risk in cases where the preliminary assessment identifies the need for a detailed risk assessment. As far as the assessment of social care needs is concerned, it appears to us that there is nothing in the Operational Procedure document which differs from the position set out above, that a person's entitlement to a specialist mental health social work service depends upon satisfying the criteria for CPA. If, as in Peter Wild's case, this is used as a reason for not assessing the social care needs of people who do not satisfy the eligibility criteria, it fails to take account of the duty in community care law to carry out an assessment of anyone who "may be in need of" community care services.[30] It appears to us that anyone who is diagnosed or suspected of having a mental disorder may be in need of community care services and should be assessed accordingly. We would expect, as with risk assessment, that this would initially be a preliminary assessment. The distinction between what we have in mind and what happened when Peter Wild was assessed by Pauline Reynolds is that

[30] See section 47(1) of the National Health Service and Community Care Act 1990.

the initial assessment would not be constrained by CPA eligibility criteria but would be a genuine enquiry into social care needs.

Objective

In assessing people who may be in need of specialist mental health services account needs to be taken of relevant risk factors and of an individual's social care needs.

Recommendations

We recommend that:

8.1 Any assessment of a person's eligibility for CPA includes an assessment of risk.

8.2 The risk assessment procedure evaluates and records in writing the precise nature of the risks, the adequacy of current arrangements and the need for further measures.

8.3 The assessment takes account of abuse of alcohol or drugs.

8.4 CPA eligibility and risks arising from substance abuse are incorporated into the standard assessment forms recommended at 5.1 above.

8.5 Assessment for eligibility for CPA should always include a preliminary assessment of community care needs, even if it is believed that the individual concerned does not satisfy CPA eligibility criteria.

Multidisciplinary working

68. As in other areas of the country, there has in East Kent over several years been progress towards closer integration of Health and Social Services functions in providing mental health services. By 1999 the position in Thanet was that Health and Social Services staff were based together at the Westbrook Centre. They jointly comprised the community mental health team (CMHT) for Thanet, but the team had

separate Health and Social Services locality managers. Building Bridges[31] includes the following paragraphs on the objectives and operational needs CMHT's:-

> 2.3.11 Specialist services working in hospitals and the community are increasingly working as teams. This is recognised as the most effective way of delivering the multi-disciplinary, flexible and sensitive services which the principles [essentially, the principles underlying CPA] outlined above demand.
> 2.3.12 However, effective team-working is demanding. Teams can be undermined for a variety of reasons, including professional misunderstandings, reluctance to change working practices and poor support.
> 2.3.15 In reviewing their policy, teams need to consider issues such as:
> - the general aims of the team, its client group and catchment area;
> - the team's membership;
> - criteria for accepting referrals, allocation of cases and mechanisms for deciding disputes;
> - leadership of the team;
> - issues of team and professional accountability.

69. We consider the question of clinical leadership below at paragraphs 79 - 81. Here we confine ourselves to the operational weaknesses in joint working which, from the evidence we received, adversely affected the work of Thanet CMHT during the period with which we are concerned.

70. The circumstances of Peter Wild's referral and assessment are so unusual that it would be unwise to draw general conclusions from them without other evidence. However, what we were told by practitioners leads us to conclude that at the time when Peter Wild came into contact with services in East Kent, Thanet CMHT was not performing its intended central coordinating role within specialist mental health services. Instead, decisions were being made separately in Health and Social Services.

71. We took evidence from Andy Oldfield, who managed the Health side of Thanet CMHT. He told us about the process of integration, which started in the late 1980's and proceeded satisfactorily until the mid-1990's, when the introduction of eligibility criteria led to the withdrawal of social work involvement in a number of existing cases,[32] as well as affecting the eligibility of new clients:

> "Previously we were doing joint assessments and there was joint working, and that stopped in a very short space of time ... The way I perceived it was that it

[31] See footnote 16, above.
[32] See paragraph 57, above.

was nearly a fatal blow to the community mental health team in some respects in terms of joint working and integration. It went almost overnight. A lot of working practices we had built up were taken away .... My feeling was that Social Service staff had become increasingly demoralised about the marginalisation of their role; they were unhappy about what they were not allowed to do."

He described working practices at the time of the events with which we are concerned:

"There were weekly multi-disciplinary team meetings where clients of mutual interest were discussed and plans were made. Things are a lot more formalised and a lot more integrated now than they were then. At the time there were a number of ways in which people could come into our services. They could be referred directly from a consultant psychiatrist into the social work team, CPN team, et cetera; largely a lot of those clients would be dealt with by individual factions of the team. In some respects you could say we were a multi-disciplinary team to certain extent but not completely."

72. Andy Oldfield's account was corroborated by Pauline Reynolds, from the Social Services side of the Thanet CMHT, in her evidence to us. Like him, she referred to the Joint Agency Eligibility Criteria for Mental Health Services as if they had been imposed by Kent Social Services with the object of reducing social work involvement in mental health. In contrasting the time when she first joined Social Services in Thanet, in the early 1990's, with the situation in 1999 she told us:

"When I first started we worked very much as a team, and then there were changes, maybe four or five years ago ..... Basically Social Services criteria became so tight it was impossible for us to talk in a similar way to our Health colleagues ... It was almost like two separate teams ... It was less interesting. We were only working with people who had long-term mental health problems – which has always been the bulk of our work, but prior to that we were always allowed to do short term preventative stuff, which was quite satisfying, if you could send somebody off on a totally different route that was brilliant – but we were not doing that sort of work at all."

73. We accept this evidence as showing that, despite the maintenance of good personal relationships between Health and Social Services staff, effective joint working was not being achieved in practice. We are not sure that senior management in the Trust or Social Services would entirely accept this analysis of the situation in 1998/99, but what is clear is that since then there have been a number of initiatives

aimed at improving joint working. Of these, the most comprehensive is the Sainsbury Model of Care.

74. One of the principles underlying the Sainsbury Model is integrated provision: "ensuring 'seamless' and well-coordinated service delivery by integrating Health and Social Services and breaking down barriers between professional groups". We believe the proposed Community Mental Health Services (CMHS), with Health and Social Services staff being under the same line of management, would go a considerable way to overcome the barriers and problems of communication to which we have referred.

75. Peter Wild's case also illustrates a more general problem, of how new clients are to be given multidisciplinary assessments and decisions made about the provision of services in a system where the perception is that such decisions are constrained by bureaucratic procedures which are not well understood and which do not appear to work well in practice. In so far as the CMHT was intended to play a co-ordinating role, the evidence we received suggests that its effectiveness was compromised by the different priorities of Health and Social Services. We refer again to Andy Oldfield's evidence about the Social Services side of decision-making within the CMHT:

> "I think there were three levels of management before a decision could be made as to whether they would get involved or not, and that could sometimes take many weeks." He went on to explain how this affected him and his Health colleagues: "If the referral had been made to a community psychiatric nurse (CPN) he probably would have received a CPN assessment. Then if there were factors that came out of that, the way we had to work at the time was that we would have to refer to Social Services and ask them to get involved. It was very difficult to try to get joint multi-disciplinary assessments to happen."

76. As discussed above,[33] we believe the Sainsbury Model provides a solution to this general problem. The key lies in the proposal that apart from emergency referrals to the Liaison Psychiatry Service (LPS), access to services would always be by way of an assessment by the Intake team of the CMHS, which would have as one of its key functions decision-making about service provision for people who suffer from serious

[33] See paragraph 50 above.

mental illness but who do not qualify for Enhanced CPA. Apart from overcoming the problem identified above, we believe it would also speed up and make more transparent the decision-making process.

77. We have already commented positively on the good working relationships which we understand to have been maintained in Thanet CMHT. However, it would be wrong to equate good personal relationships with effective teamwork. In our view there is a need within the CMHT to ensure that decision-making is based on a clear and open process, with all key decisions having multidisciplinary involvement. This requires in turn that each member of the team has an equal opportunity to contribute to that process and to influence decisions. Effective teamwork is undermined if there is a perception that important decisions affecting the team's work and priorities are taken outside the CMHT, for example by individual clinicians or by departmental management that has not sufficiently involved local CMHT management in the process.

Objective

To have effective multidisciplinary working based on teamwork, clear leadership and professional accountability.

Recommendations

We recommend that:

9.1 Responsibilities for specific services and access to them are described in shared guidance and policy documents and made clear through induction and training to members joining the team.

9.2 Decision-making processes within the multidisciplinary team are clear and understood.

9.3 The roles and responsibilities of senior managers within the team and senior clinicians are defined and worked through so there is clarity of process, with leadership and management responsibilities being well understood and effective.
Decision-making processes within the multidisciplinary team are clear and understood.

9.4 Each discipline defines its role, relationship to others and responsibilities within the team.

9.5 Regular multidisciplinary team meetings are held with the purpose of promoting cohesion within the team, mutual understanding of roles and clarity of process. Meetings would not be confined to consideration of individual cases: there would on a regular basis be discussion of more general issues affecting the team as a whole.

9.6 Time is made available, whether through team meetings or by other means, to identify the training needs of individuals.

Dual Diagnosis

78. The term 'dual diagnosis' is used in psychiatry to refer to the simultaneous presence of two interdependent disorders, typically mental illness, or personality disorder, and substance misuse. In Chapter 4 we referred to the issue of dual diagnosis in general terms and the challenge it poses for mental health services.[34] In our discussion of CPA eligibility in paragraph 65 above we commented on the tendency to exclude from specialist mental health services people whose mental illness is complicated by substance abuse. This is a subject with major implications for policy makers, managers and clinicians, and goes far wider than the scope of this Inquiry.[35] Our purpose here is to make recommendations which could be implemented within specialist mental health services in East Kent. The clear implication of the recommendations which follow is that mental health services would have to accept primary responsibility for treating, and managing the risks presented by, people with a diagnosis of mental illness who also abuse substances. We accept, of course, that there is an important role for specialist drug and alcohol services in responding to the needs of mentally disordered individuals who also abuse substances, but our concern is that such people should not fall into the gap between specialist mental health and dedicated substance abuse services. We believe the answer lies in further developing

[34] See Chapter 4, paragraphs 2 – 3 above.

[35] The Dual Diagnosis Steering Group – see footnote 7 above – use the term dual diagnosis to refer to "people with severe mental health problems and problematic substance misuse". Their report discusses very fully the issues touched on in this section. They emphasise that the response to dual diagnosis must come from mental health services.

the capacity within specialist mental health services to respond to the needs of those with dual diagnosis.

Objective

That specialist mental health services are responsive to the needs of people who have a mental illness and also abuse alcohol or drugs; and that they assess and manage the risks presented by such people.

Recommendations

We recommend that:

10.1 Questions about drug and alcohol use form part of the standard assessment recommended at 5.1 above.

10.2 All disciplines in specialist mental health services receive training in substance abuse which would cover issues such as how to take a drug and alcohol history as part of an assessment; the effects of drugs and alcohol, particularly on people with a mental illness; and the risk factors associated with substance abuse.

Clinical Leadership in Relation to Consultant Psychiatrists

79. We have commented, in the context of the assessments in June 1999,[36] on what we see as Dr Kalidindi's failure fully to embrace the leadership role which we take to be part of a consultant psychiatrist's responsibilities. The consultant psychiatrist is the lead clinician within a multidisciplinary team. This leadership role requires both an understanding of the available resources to which patients can be referred and the development of effective mechanisms for ensuring that, within the resources available, patients receive appropriate care and treatment. As we have indicated at a number of points in this chapter,[37] in the mode of his referral to Lydden and his subsequent consideration of Peter Wild's needs, Dr Kalidindi did not make good use of the available resources. He neither provided strong leadership nor, as far as we can tell, did he work effectively through the CMHT. In criticising Dr

[36] See paragraph 39 above.
[37] See, for example, paragraphs 33 – 35, 39 – 40 and 63.

Kalidindi's performance, we note that both Dr Pick and Dr Ward spoke well of him, and it is also evident to us that he was liked by his colleagues within the Trust. Nonetheless, we have been left with the impression that he was not performing to the standard which would be expected of a consultant psychiatrist, and we believe this perception was shared by some of his colleagues.

80. It is unsatisfactory, although not unusual, that the post of consultant psychiatrist should be filled by a long-term locum who has not passed his membership of the Royal College of Psychiatrists.[38] It appears obvious to us that this situation calls for increased management input and clinical supervision. There is also a clear need for continuing training. We have not gone into the minutiae of the management and supervision of Dr Kalidindi's work but our impression, both from what he told us and from the comments of others, is that these were not given the priority they deserved. We must qualify this statement by acknowledging that we have not been able to put our concerns directly to the Trust's medical director.

81. We have also had the opportunity to consider the Trust's job description for the post of consultant psychiatrist in General Adult Psychiatry, both as it was in 1999 and now. While it refers to the consultant's membership of the community mental health team and the need to conduct ward-based multi-disciplinary meetings, no reference is made to the consultant's leadership role except in relation to the professional supervision of junior doctors. The job description is silent on the issue of continuing professional training and the only mention of supervision of performance is an annual performance appraisal by the Trust's medical director.

Objective

That the responsibilities of consultant psychiatrists are clearly defined in relation to their colleagues within the multidisciplinary team and that effective arrangements are in place for continuing professional development and clinical supervision of performance.

[38] See paragraph 11 of chapter 3 above. Although Dr Kalidindi does not have membership of the Royal College of Psychiatrists, he is an affiliate of the Royal College and takes part in Continuing Professional Development.

Recommendations

We recommend that:

11.1 Consultant psychiatrists, including locums, receive peer supervision through case presentations and discussions.

11.2 Supervision is directed towards improving clinicians' skills by examining the management of cases, the issues arising from them and what alternative strategies might be deployed.

11.3 Supervision is monitored through the Trust's clinical governance forum, with arrangements for auditing frequency and content.

11.4 If there is a long-term locum in a consultant post, the medical director plays a more active role of mentor and supervisor than when the post is filled with a substantive appointment. For example, the medical director would attend team meetings from time to time to keep the situation under review.

11.5 There is adequate evaluation of consultant job descriptions including a requirement to participate in continuing professional development.

Communication and Liaison between Primary and Secondary Care

82. We met with Dr Pick and Dr Ward. They spoke well of the Trust and, as already mentioned, of Dr Kalidindi in particular. But we are left with two concerns about the relationship between primary and secondary care arising from what happened in this case. The first is what we see as the inadequate communication back to Dr Pick following his initial referral of Peter Wild in April 1998. We have already commented on this in the section on Placements in East Kent at paragraphs 5 - 14 above and it is covered by recommendation 1.3. The second is that, having met with two general practitioners, we believe the Trust needs to provide better information to primary care about services. This should be a particular priority whenever new services are developed, as is happening now with implementation of the Sainsbury Model[39] and other developments in specialist mental health services which follow

[39] In Appendix 3 we note the involvement of representatives from primary care in the development of the Sainsbury Model.

from changes to CPA and from the National Service Framework for Mental Health.[40] The recommendations which follow are directed to this latter concern.

Objective

That specialist mental health services communicate effectively with general practitioners.

Recommendations

We recommend that:

12.1 Information about policies and procedures, for example in relation to assessments or CPA, is made available to general practitioners and Primary Care Trusts in a form which is accessible to them.

12.2 In implementing the Sainsbury Model, and other major changes to service provision, the Trust and Kent Social Services work closely with general practitioners and Primary Care Trusts.

Management Issues

83. At a number of points Peter Wild's contact with services in East Kent exposed operational failures. Although we have commented in detail on the roles and responsibilities of individuals, their actions need to be looked at in the context of the systems then in place. The failures we have in mind are:

- The failure to process the referral from Dr Pick in 1998
- The failure to respond adequately to the police request on 9th June 1999 and the failure to make crisis and emergency services known to the police
- The lack of a clear procedure for assessing Peter Wild when he came to the notice of services in June 1999

[40] The National Service Framework for Mental Health was published by the Department of Health in 1999. It sets national standards for the delivery of mental health services and includes a timetable for implementation.

- The extent to which Dr Kalidindi appeared to operate independently as a clinician, outside administrative structures, and where the arrangements for getting access to resources were unclear or unresponsive
- The uncertain application of eligibility criteria for specialist mental health services
- The lack of any formalised procedure within Lydden for Peter Wild's assessment there and for recording its outcome
- The lack of co-ordination and communication between the different parts of mental health services, notably Lydden, Westbrook and the Thanet CMHT

84. We met with senior managers from both the Trust and Social Services. They accepted that, despite its exceptional nature, the problems which arose in Peter Wild's case are indicative of more general weaknesses within services at the time. Quite independently of this Inquiry, management has responded positively by commissioning and taking forward the Sainsbury Review. Our main concern, having received evidence from most of those who were directly involved in the events described in this report, is that Social Services and Health staff should have confidence in any new arrangements and work in accordance with agreed practices and procedures. In so far as we understand the arrangements in place in 1999, it appears they were not followed in Peter Wild's case.

85. We are encouraged by the work we have seen on implementation of the Sainsbury Review. But, on the basis of our Inquiry, we believe there are a number of operational issues which senior management will have to address.

Objective

There is close contact and liaison between all agencies, supported by adequate protocols on information exchange, to ensure good inter-agency communication and effective risk assessment and management.

Recommendations

We recommend that:

13.1 Senior managers of mental health services ensure that all professionals working in community mental health teams receive appropriate, continuing and specific training, and are given regular and recorded professional supervision and managerial support relating to both individual cases and to their caseload more generally.

13.2 Operational managers periodically review multidisciplinary working and circulate their reviews to managers responsible for the disciplines within the team, inviting their comments in order to sustain the involvement of all groups.

13.3 There is a supervision policy for all mental health professionals of all grades, including doctors, which includes provision for the periodic review of every current case managed by a particular individual.

13.4 There is clear guidance and effective systems to ensure that there are adequate lines of communication and that information and documentation is communicated appropriately between all staff concerned with a person's health and social welfare.

CHAPTER 6: THE INTERNAL INQUIRY

Introduction

1. Our Terms of Reference require us to "review the conduct and process of the internal inquiry, the evidence taken and the conclusions and recommendations". More specifically, we are required to identify areas where there may be "weaknesses or omissions in the process, outcome and recommendations of the internal inquiry" and "to establish the extent to which the recommendations are already being addressed by the relevant parties".

2. We understand the purpose of an internal review following a homicide is to find out the facts; to establish what, if anything, went wrong and what was done well; and to identify what needs to be done to prevent a recurrence. An internal review into a homicide proceeds in the knowledge that Department of Health guidance requires that it will followed by an independent inquiry.[41]

The Conduct and Process of the Internal Inquiry

3. The internal inquiry was commissioned by East Kent Community NHS Trust, East Kent Health Authority and Kent County Council Social Services Department. Its terms of reference were to examine all the circumstances surrounding Peter Wild's treatment and care and also to look particularly at: the action taken following the referral by Dr Pick in April 1998; the assessment of Peter Wild's health and social care needs; the extent to which his care corresponded to statutory obligations, relevant guidance and local operational procedures; collaboration and communication between the Trust, Social Services and the general practitioners; and communication between all agencies in contact with Peter Wild from July 1997 (when he was discharged for the second time from hospital in North Wales). It can be seen that the terms of reference were very wide, going beyond the essential tasks listed in paragraph 2 above.

[41] See footnote 1 above.

4. There were six members of the internal inquiry panel. It was chaired by a non-executive director of the Trust. Two of the other members were from the Trust, one from Social Services and one from the Health Authority. The sixth member was a consultant psychiatrist from outside East Kent.

5. The inquiry met on four days in September and October 1999 and took evidence from 14 witnesses. It also received written submissions and evidence, including medical records. Between November 1999 and February 2000 it met on a further five occasions and its report was completed in March 2000. The inquiry's work was delayed by difficulties in obtaining relevant background information, notably from North Wales, but still we consider the period of 9 months from the homicide to completion of the report was too long. The process would undoubtedly have been speedier had the inquiry's terms of reference been narrower.

6. We have read the transcripts of the oral evidence received by the internal inquiry. The questioning of witnesses was rigorous and it is clear that the inquiry panel made a genuine attempt both to establish the facts and to explore the issues arising from Peter Wild's case.

7. We have a number of criticisms of the dissemination of the inquiry's report. First, of the witnesses we saw who had personal contact with Peter Wild, or were otherwise directly involved, very few had seen the report. As we describe below, Dr Pick was criticised in the report but had not been made aware of this before we told him. We consider that anyone who is criticised in a report of this kind should have the opportunity to see the report in draft and to respond. Second, and more generally, apart from the Action Plan for implementation of its recommendations, the organisations involved have not made use of the report. All that has been done is to circulate among staff a summary of the inquiry's recommendations. As the internal inquiry made clear, there were some deficiencies in local services' responses to Peter Wild and we believe the report could have been used for staff training purposes. We think it would have been of particular value to staff if seminars had been organised for discussion of the facts of the case and identification of the lessons to be learned. We see this as being separate from the process of implementing the inquiry's recommendations.

The Conclusions and Recommendations of the Internal Inquiry

8. In Appendix 2 we reproduce in full the internal inquiry's recommendations. For the most part we agree with them and for this reason we have not made recommendations of our own on some of the matters of detail which they cover. We agree with the internal inquiry's fundamental judgement that the key failure of services in responding to Peter Wild in June 1999 was the lack of an adequate multi-disciplinary assessment.

9. Where we differ from the internal inquiry is in some of the general conclusions they drew from their examination of Peter Wild's case which are set out in Section 8 of their report. We focus here on a number of areas where we disagree with their analysis.

North Wales

10. The internal inquiry concluded that "a number of deficiencies in the care provided for Mr Wild in North Wales paved the way for later problems in East Kent". They drew attention to the following: CPA was not implemented and service provision was uncoordinated; little or no attempt was made to enhance his motivation to address his alcohol problem; the potential risk of future violence was not recognised; and no plans for rehabilitation were formulated and implemented. These criticisms were based on reading the medical records from North Wales. We have had the advantage of additionally reading the Social Services records and meeting with some of those responsible for Peter Wild's care and treatment there. We have said in chapters 2 and 4 that the care he received in North Wales, including the after-care, was adequate. While it was clearly significant that information was not passed on when Peter Wild moved to East Kent, we do not consider the criticisms made by the internal inquiry of the after-care arrangements in North Wales are justified or particularly relevant to what occurred after he moved to East Kent. We believe the internal inquiry placed too much emphasis on the supposed shortcomings of services

in North Wales and that this deflected responsibility from individuals and services in East Kent.

Placement in East Kent

11. Although the internal inquiry did not explicitly conclude that Peter Wild was placed in East Kent, this is implicit in the way they described the move and in some of their discussion and the recommendations they made. For example, they criticised services in North Wales for not considering the advisability of the move or the potential risks. The reality, as we have seen, is that Peter Wild moved to East Kent because he chose to do so for what were entirely understandable reasons. There is no reason to suppose that statutory authorities could have influenced that decision.

Communication between General Practitioners and Secondary Services

12. The internal inquiry criticised Dr Pick for not forwarding the North Wales medical records to Dr Kalidindi when he received them following the initial referral in April 1998. We think it most unfortunate that this criticism was made without giving Dr Pick any opportunity to give evidence to the internal inquiry or to respond. We do not agree with the internal inquiry on this particular point, as we think it was quite reasonable for Dr Pick to take the view that there was no need to involve Dr Kalidindi further while Peter Wild's mental state was stable. That Peter Wild remained well for a year after Dr Pick received the records from Wales tends to support his judgement. We are not only concerned that the internal inquiry was unfair to Dr Pick but that he was the only individual who was criticised by name in the report. We return to this below.

Police Involvement

13. The internal inquiry concluded that "the police failed to take appropriate action after Mr Wild expressed the intention to seriously harm his landlady". They made no corresponding criticism of the way staff on Elmstone Ward responded to the police request for help in dealing with what was clearly a mental health matter. This lack of balance undermines their criticism of the police.

The Internal Inquiry's Approach

15. The stated position of the internal inquiry was "not to apportion individual blame preferring the evidence and events as presented to speak for themselves". We have seen they were not entirely consistent, in that criticisms were made of North Wales services, Dr Pick and the police. Significantly, they did not criticise anyone employed by any of the organisations which were represented on the inquiry panel.

16. The tendency of the internal inquiry was to make wide-ranging recommendations, which required policies to be drawn up and implemented, rather than to examine how effectively the organisations were functioning operationally. This may reflect difficulties inherent in the internal inquiry process, as people in senior positions in organisations may understandably be reluctant to make criticisms which reflect badly on the organisation or the performance of senior colleagues. One consequence of this approach is, as we shall see, that the very generality of the recommendations creates difficulties for those who are responsible for their implementation.

Implementation of the Internal Inquiry's Recommendations

17. The Trust and Social Services drew up a Joint Action Plan to implement the internal inquiry's recommendations. The first version of the Action Plan was prepared in July 2000 and it was updated in June 2001. Eugene O'Connor, who is the Trust's Director of Mental Health Services for East Kent, acknowledged in his evidence to us that, while a large number of the recommendations had been acted on, progress had not been made with some of the more wide-ranging recommendations. He linked this to wider policy developments within mental health services, specifically the Sainsbury Model of Care, and the complex process of effecting institutional and cultural change within organisations. His point can be illustrated by reference to recommendations 9.3.2 and 9.3.3.

9.3.2 A designated interview room should be made available at the Westbrook Centre.

9.3.3 Single agency and joint assessment procedures should be urgently reviewed by East Kent Community NHS Trust and KCC SSD.

The first recommendation had been implemented by July 2000. Action on joint assessment procedures, as recommended in 9.3.3, was by June 2001 said to be dependent on implementation of the Sainsbury Model of Care.

18. Given the major changes and policy initiatives within services since June 1999, we find it understandable that some aspects of the internal inquiry's recommendations have become subsumed under broader policy developments. Many of the weaknesses identified by the internal inquiry are being addressed, albeit not directly because of the internal inquiry process. There is a danger that inquiry recommendations can distract senior managers from the more important strategic task of managing major change. We have sympathy for the view expressed to us by Eugene O'Connor when he said:

> "If any one of the partner agencies involved, because of pressure to do something and tick off a box, went away and compiled a protocol, a plan or a procedure in isolation and ticked off that box in terms of a recommendation within your organisation, it would be meaningless. It has to be with the full support of all those other partner agencies and not to compromise the principles and philosophies contained within the Sainsbury Model of Care."

We consider the approach taken to implementation has been reasonable and we note that on a number of issues action was taken expeditiously. We have already referred to what we see as the lost opportunity to use the internal inquiry's report for staff training purposes. This would have reinforced the changes described in the Action Plan.

Conclusion

19. The report of the internal inquiry illustrates well the difficulty of achieving critical objectivity in looking at one's own performance. Nevertheless, it undoubtedly had value as a fact-finding exercise. It also made a number of useful

recommendations. The stated approach of letting the facts speak for themselves has much to commend it but is not achieved if the report is not widely disseminated within local services.

CHAPTER 7: SUMMARY OF RECOMMENDATIONS

The headings in this chapter refer back to Chapter 5.

Placements in East Kent

Objective

To ensure that people receive treatment on the basis of assessed need without regard to which Health Authority is responsible for payment

This is now achieved in East Kent under East Kent Health Authority's Out of District Residents Protocol which requires non-urgent treatment to be provided to people placed in East Kent on the same basis that it is provided to the resident population.

Recommendations

We recommend that:

1.1 General practitioners are made aware of the Out of District Residents Protocol.

1.2 When a clinician in secondary services considers that funding for a patient's treatment comes within the Out of District Residents Protocol the patient's general practitioner is informed of this in writing.

1.3 There is always a written communication back when a consultant psychiatrist receives a referral from a general practitioner, even where the patient has not been seen.

Liaison between the Voluntary Sector and Statutory Services

Objective

Voluntary organisations have a wealth of experience and skills. They are an essential part of the patchwork of services. It is important that voluntary sector services are planned and delivered in the context of the

whole spectrum of services and take account of the policies and priorities of statutory providers.

Recommendations

We recommend that:

2.1 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, should explicitly state how their service relates to the wider spectrum of health and social care in the locality.

2.2 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, develop a confidentiality policy, to be agreed with statutory service providers, that will inform record keeping and information sharing with service users and partner organisations.

2.3 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, develop a risk management policy, to be agreed with statutory service providers.

2.4 Thanet Mind, and other voluntary sector organisations providing services to people with mental health needs, inform the relevant clinician or mental health professional if a decision is made to exclude a user from the service.

2.5 As a matter of normal practice, basic information about people with mental health needs who are using voluntary sector services is passed by those services to statutory services so that their community care needs can be assessed.

The Role of the Police and Liaison with Mental Health Services

Objective

In order to respond effectively to people who appear to be mentally disordered the police, and other agencies, need to be able to call on specialist mental health services for necessary advice and assistance.

Recommendations

We recommend that:

3.1 The Trust provide the police and other agencies (including voluntary organisations) with information which will enable them to obtain necessary advice and assistance in responding to the needs of people suffering from mental disorder. Such information will necessarily include a contact telephone number and details of the Trust's arrangements for accepting emergency referrals outside normal working hours. A process for ensuring regular updating of information will also be required.

3.2 Those working within specialist mental health services make a written record of contacts, including telephone conversations, with the police about mentally disordered individuals who the police consider may be in need of psychiatric assessment. This record would be sent to a designated liaison person within mental health services.

Referrals for Assessment

Objective

The purpose of a referral to specialist mental health services is to ensure that the person concerned receives an appropriate assessment within a timescale which reflects the urgency of the case.

Recommendations

We recommend that:

4.1 There is a central co-ordinating point to which all referrals are directed. It may be that special administrative arrangements will need to be in place for emergency and out-of-hours referrals.

4.3 Time bands are introduced for responding to referrals, depending on urgency, and the source of the referral is informed in each case how soon the assessment will take place.

4.3 There is a written response to the source of the referral.

Assessments

Anyone referred to specialist mental health services should be assessed. In order to meet service users' needs and to manage risk, all assessments should satisfy certain minimum standards.

Recommendations

We recommend that:

5.1 All assessments are recorded in writing, using standard forms and procedures.

5.2 The same standard forms are used regardless of who carries out the assessment.

5.3 The standard forms include space for the service user's personal and psychiatric history. Where this information is available from other sources, such as medical records, this would be noted on the assessment form.

5.4 Assessments take account of precipitating events, including any relevant change in circumstances, leading up to the assessment.

5.5 All assessments include a preliminary assessment of risk which would be incorporated into the standard assessment forms.

5.6 All assessments include recommendations so it is clear what action is expected to follow from the assessment.

5.7 All completed assessment forms are placed on the individual's case file so they will form part of the case record and be readily accessible.

5.8 All relevant mental health professionals are trained in methods of assessment and treatment of people with mental health problems who abuse substances, including alcohol.

Crisis and self-referral

Objective

Specialist mental health services will assess people with apparent mental health problems in an emergency, regardless of the source of the referral.

Recommendations

We recommend that:

6.1 There is a place designated for emergency assessments, such that anyone who presents at that place will be assessed.

6.2 There is a team designated to cover emergency and crisis assessments, including out-of-hours assessments.

6.3 Information about how to contact the team is widely disseminated to general practitioners, the police, voluntary organisations, service users and carers.

6.4 A written record is made of any request received by specialist mental health services, from whatever source, for an emergency assessment and is passed to the designated team. This would include, for example, a telephone request to a ward or when a person presents on a ward seeking emergency admission.

6.5 All emergency and crisis assessments are based on the same standard forms as are used for more routine assessments.

6.6 All emergency and crisis assessments include an assessment of risk.

6.7 If in a particular case the response to a request for an emergency assessment is a domiciliary visit by a consultant psychiatrist, this would be based on the same standard framework as we recommend for other assessments.

Care Programme Approach (CPA) eligibility criteria

Objective

Eligibility criteria must aim both to meet the clinical and wider needs of those people who require specialist services, and to ensure that eligibility takes account of risk.

Recommendations

We recommend that:

7.1 Eligibility criteria reflect dynamic risk factors, in addition to diagnosis and other clinical indicators such as the presence or absence of symptoms.

7.2 Eligibility criteria make clear that abuse of alcohol or drugs is a relevant risk factor which, in association with a mental illness, indicates a greater need for specialist mental health services.

Assessment of Eligibility for Care Programme Approach

Objective

In assessing people who may be in need of specialist mental health services account needs to be taken of relevant risk factors and of an individual's social care needs.

Recommendations

We recommend that:

8.1 Any assessment of a person's eligibility for CPA includes an assessment of risk.

8.2 The risk assessment procedure evaluates and records in writing the precise nature of the risks, the adequacy of current arrangements and the need for further measures.

8.3 The assessment takes account of abuse of alcohol or drugs.

8.4 CPA eligibility and risks arising from substance abuse are incorporated into the standard assessment forms recommended at 5.1 above.

8.5 Assessment for eligibility for CPA should always include a preliminary assessment of community care needs, even if it is believed that the individual concerned does not satisfy CPA eligibility criteria.

Multidisciplinary working

Objective

To have effective multidisciplinary working based on teamwork, clear leadership and professional accountability.

Recommendations

We recommend that:

9.1 Responsibilities for specific services and access to them are described in shared guidance and policy documents and made clear through induction and training to members joining the team.

9.2 Decision-making processes within the multidisciplinary team are clear and understood.

9.3 The roles and responsibilities of senior managers within the team and senior clinicians are defined and worked through so there is clarity of process, with leadership and management responsibilities being well understood and effective.
Decision-making processes within the multidisciplinary team are clear and understood.

9.4 Each discipline defines its role, relationship to others and responsibilities within the team.

9.5 Regular multidisciplinary team meetings are held with the purpose of promoting cohesion within the team, mutual understanding of roles and clarity of process. Meetings would not be confined to consideration of individual cases: there would on a regular basis be discussion of more general issues affecting the team as a whole.

9.6 Time is made available, whether through team meetings or by other means, to identify the training needs of individuals.

Dual Diagnosis

Objective

That specialist mental health services are responsive to the needs of people who have a mental illness and also abuse alcohol or drugs; and that they assess and manage the risks presented by such people.

Recommendations

We recommend that:

10.1 Questions about drug and alcohol use form part of the standard assessment recommended at 5.1 above.

10.2 All disciplines in specialist mental health services receive training in substance abuse which would cover issues such as how to take a drug and alcohol history as part of an assessment; the effects of drugs and alcohol, particularly on people with a mental illness; and the risk factors associated with substance abuse.

Clinical Leadership in Relation to Consultant Psychiatrists

Objective

That the responsibilities of consultant psychiatrists are clearly defined in relation to their colleagues within the multidisciplinary team and that effective arrangements are in place for continuing professional development and clinical supervision of performance.

Recommendations

We recommend that:

11.1 Consultant psychiatrists, including locums, receive peer supervision through case presentations and discussions.

11.2 Supervision is directed towards improving clinicians' skills by examining the management of cases, the issues arising from them and what alternative strategies might be deployed.

11.3 Supervision is monitored through the Trust's clinical governance forum, with arrangements for auditing frequency and content.

11.4 If there is a long-term locum in a consultant post, the medical director plays a more active role of mentor and supervisor than when the post is filled with a substantive appointment. For example, the medical director would attend team meetings from time to time to keep the situation under review.

11.5 There is adequate evaluation of consultant job descriptions including a requirement to participate in continuing professional development.

Communication and Liaison between Primary and Secondary Care

Objective

That specialist mental health services communicate effectively with general practitioners.

Recommendations

We recommend that:

12.1 Information about policies and procedures, for example in relation to assessments or CPA, is made available to general practitioners and Primary Care Trusts in a form which is accessible to them.

12.2 In implementing the Sainsbury Model, and other major changes to service provision, the Trust and Kent Social Services work closely with general practitioners and Primary Care Trusts.

Management Issues

Objective

There is close contact and liaison between all agencies, supported by adequate protocols on information exchange, to ensure good inter-agency communication and effective risk assessment and management.

Recommendations

We recommend that:

13.1 Senior managers of mental health services ensure that all professionals working in community mental health teams receive appropriate, continuing and specific training, and are given regular and recorded professional supervision and managerial support relating to both individual cases and to their caseload more generally.

13.2 Operational managers periodically review multidisciplinary working and circulate their reviews to managers responsible for the disciplines within the team, inviting their comments in order to sustain the involvement of all groups.

13.3 There is a supervision policy for all mental health professionals of all grades, including doctors, which includes provision for the periodic review of every current case managed by a particular individual.

13.4 There is clear guidance and effective systems to ensure that there are adequate lines of communication and that information and documentation is communicated appropriately between all staff concerned with a person's health and social welfare.

APPENDIX 1: DESCRIPTION OF SERVICES IN 1998/99

East Kent Health Authority

1. The East Kent Health Authority was responsible for purchasing health services in East Kent. In the field of mental health the Authority was advised by the Mental Health Joint Commissioning and Planning Board, which in addition to Trust and Social Services membership also included representatives of voluntary sector organisations, user and carer groups and general practitioners.

East Kent Community NHS Trust

2. The Trust provided mental health services for East Kent, an area of 800 square miles with a population of 600,000. In 1999 the Trust's budget was £80 million and it employed 3,300 people. Although mental health accounted for the greater part of this, the Trust also provided a wide range of community healthcare services.

3. The Trust provided acute in-patient mental health services in Canterbury and Ashford as well as at the Thanet Mental Health Unit in Margate. In 1998/99 acute bed occupancy across the Trust exceeded 100% and at the Thanet Mental Health Unit it exceeded 120%. The Trust also provided low secure in-patient facilities in Canterbury and had access to medium secure facilities at the Trevor Gibbens Unit in Maidstone where the East Kent Health Authority purchased nine beds.

4. The Trust provided the Lydden day hospital facility at the Thanet Mental Health Unit and day care facilities (to a level below day hospital requirements) at the Westbrook Day Centre.

5. Other mental health services provided by the Trust included a mentally disordered offenders team for Canterbury and Thanet.

6. Specialist alcohol services for East Kent were provided by the Trust in Canterbury.

Kent County Council Social Services

7. The geographical area covered by the East Kent operational area of Kent County Council Social Services County Mental Health Service Unit was coterminous with East Kent Community NHS Trust. The responsibilities of the County Mental Health Service Unit comprised: the assessment and provision of mental health services, the assessment and provision of services to people with drug and alcohol problems, and the provision of a generic out-of-hours service.

8. In Thanet Kent County Council Social Services funded the Mind Centre in Ramsgate to provide informal day services.

Community Mental Health Teams

9. The Thanet community mental health team covered Margate, Ramsgate, Broadstairs and Sandwich, an area with a total population of approximately 140,000. It was one of five community mental health teams in East Kent. Health and Social Services staff were located together at the Westbrook Centre in Margate but were separately managed.

Mental Health Joint Management Team

10. This team, which met regularly, brought together operational managers from the Trust and Social Services. The aim was to co-ordinate their respective services to provide the best delivery of local care.

APPENDIX 2: THE INTERNAL INQUIRY'S RECOMMENDATIONS

The following is taken from the internal inquiry's report.

9.1 *Nature and scope of the recommendations*

9.1.1 The following recommendations are offered with a view to the objective of preventing future incidents of the kind that led to this Inquiry.

9.1.2 The recommendations have been generated in response to the issues that came to the attention of the Panel during the course of the Inquiry, within its Terms of Reference. Broader issues have not necessarily been addressed.

9.1.3 The recommendations should not be taken as an indication that the corresponding area of concern was a factor that contributed to the events which led to Mr. Wild's arrest. Whilst this may be the case in respect of some recommendations, it is clearly not the case in others.

9.2 *Placement or transfer of patients/clients from one Health Authority/Local Authority to another*

9.2.1 Steps should be taken to ensure that vulnerable people are not left unsupported following the type of f informal placement from outside the County, that occurred in this case.

9.2.2 The possibility of implementing a policy of minimal inspection of small homes, if only to ensure that they are accommodating the numbers and categories of people for which they have been registered, should be considered.

9.2.3 That consideration be given to the immediate implementation of the East Kent Health Authority policy draft "Out of District Residents Protocol" of September 1998.

9.2.4 All referral letters for out of district patients should be brought to the attention of the relevant Consultant who must then make a decision whether or not urgent action is required.

9.2.5 That procedures be adopted to ensure that the responsibility for decisions regarding the urgency of out of district referrals made in such circumstances rests solely with the Consultant to whom the referral has been made.

9.2.6 The NHS Executive should clarify that para.13 of HSG(94)27 applies to all patients with mental health or learning disability problems not only those being discharged from hospital.

9.2.7 The "District of Residence" guidance should not become an excuse for failure to ensure continuity of care. In particular where a patient moves from one area to

another with the assistance/knowledge of an agency (health or social services)in the "exporting" area there must be a mandatory requirement for effective communication and where necessary, a joint assessment of continuing health need. Funding of the agreed care package should remain the responsibility of the exporting agency(ies).

9.3 Assessment

9.3.1 A full record of every assessment should always be produced and filed even when it does not result in a service being offered by the assessing agency.

9.3.2 A designated interview room should be made available at the Westbrook Centre.

9.3.3 Single agency and joint assessment procedures should be urgently reviewed by the East Kent Community NHS Trust and Kent County Council Social Services Department.

9.3.4 Referrals made for assessments at whatever level should always be in writing, except in cases of extreme urgency, and should always be backed up by relevant current and historical information.

9.4 ***Risk Assessment***

9.4.1 Steps should be taken to ensure that all GPs operating in East Kent are aware of the fundamentals of risk of violence and risk of suicide assessment and management in mental health.

9.4.2 That an accessible and compact summary of the basics of risk assessment and management in mental health be produced as a matter of urgency and distributed to all agencies having professional responsibilities in this area, including GPs, voluntary agencies and police.

9.4.3 That the joint framework policy on risk assessment and management in mental health, agreed on a County basis in March 1999,be implemented in East Kent to the fullest extent possible and as quickly as possible.

9.4.4 The joint framework policy should be extended to include all other relevant agencies to the fullest extent possible through the setting up of a multi-agency group to review communication procedures in relation to risk assessment and management in mental health.

9.4.5 That a "fast track" system of joint assessment, short of assessment under the Mental Health Act 1983,should be available when an urgent assessment is deemed necessary by the Consultant or other member of the secondary mental health services.

9.4.6 Professionals should convey to those to whom the patient is being referred information relating to previous or potential harm to the patient or to others regardless of the nature of the presenting problems on which the referral is based.
9.4.7 Professionals should convey to those concerned information which affects the health, safety and welfare of their colleagues.

9.5 *Communication*

9.5.1 That contracts between statutory agencies and private and voluntary organisations involved in providing services to mentally ill people in East Kent should address the issues of confidentiality and passing of information between agencies when personal or public safety may be at risk.

9.5.2 Referral letters and supporting material should not normally be conveyed by the patient. Transmission by fax, rather than conveyance of referral material by the patient, is the preferred option when speed of referral is essential.

9.5.3 If the patient does convey such material, a copy of the referral letter and other documentation should be kept by the referrer, and a further copy forwarded to the agency to which referral has been made.

9.5.4 In the event of an urgent and unexpected referral for assessment, it should be made clear to all mental health staff that it is the shared responsibility of both the person making and the person receiving the referral to ensure that adequate information is made available to the assessing agency. The person taking the referral should ask for additional information if she or he is not satisfied that sufficient has been given.

9.5.5 The problems in the telephone communications between Westbrook Centre and Lydden Day Unit should be investigated and remedied.

9.5.6 That the existing links between the mental health service and alcohol misuse service in East Kent should be strengthened and developed in order to facilitate referrals and enhance the less formal process of exchange of information and advice.

9.5.7 GPs should be reminded of the importance of forwarding all relevant information, especially relating to the patient's psychiatric history when making an initial referral to the secondary psychiatric service.

9.5.8 Joint protocols between mental health services and the police service should be developed covering the communication of information between these agencies.

9.6 *Training*

9.6.1 The Trust should further support training and continuous refresher courses on risk assessment for all staff in professional contact with patients. This training should also be made available to staff of other organizations.

9.6.2 That basic training be provided to all mental health workers in East Kent on issues of dual diagnosis relating to substance (including alcohol) misuse and mental illness.

9.6.3 There should be more formal pre-registration training regarding the issues of alcohol misuse/dual diagnosis within psychiatric nurse training.

9.6.4 Post registration training should include refresher opportunities to look at substance misuse/dual diagnosis.

9.6.5 The assessment skills of NHS and Social Services staff should be enhanced by regular refresher training.

9.6.6 Long-term locums should be required to undertake regular periods of continuing professional development. The panel recognises this as a clinical governance issue.

9.6.7 The Trust and Social Services should ensure a database of staff training records is implemented (where this does not already exist),maintained and available to operational managers.

9.7 *Resource Issues*

9.7.1 Where any of the recommendations in Section 9 are compromised by resource or related issues, this must be recorded by the relevant parties, for communication to Commissioning Authorities for appropriate action.

9.7.2 Appropriate resources should be made available to enable the proper assessment and treatment of patients arriving from outside East Kent.

9.8 *Managerial Implications*

9.8.1 The managerial implications underlying these recommendations should be addressed.

APPENDIX 3: THE SAINSBURY MODEL OF CARE

1. This Appendix summarises the paper produced by Kent County Council and East Kent Health Authority: "Review of Secondary Mental Health Services, Final Report and Recommendations for the Joint Commissioning and Planning Board" (November 2000). The paper "recommends a new model of Secondary Mental Health Service delivery for East Kent" which represents " a significant cultural and operational shift in current practice and service delivery" and " a challenge to achieve a major improvement in local mental health services". We refer to this as the Sainsbury Model because it is based on a review facilitated by the Sainsbury Centre for Mental Health.

2. The Sainsbury Model, as described in the November 2000 paper, has been accepted for implementation by the East Kent Joint Commissioning and Planning Board. This is turn has led to the setting up of a Project Implementation Team comprising senior mangers from Health and Social Services as well as representatives from primary care and service users.

3. The Model of Care is described as:

> A locality based integrated mental health service accessed through the community mental health service providing a single point of entry for assessment and treatment.

4. The Sainsbury Model is based on a number of Service Principles, of which the following are perhaps most relevant to our Inquiry. Paragraph numbers are taken from the November 2000 paper.

> 22. The service is built upon the following principles:
>
> b. **Integration.** Services will be integrated in order to provide a co-ordinated and thorough response. This means that whilst retaining and making best use of specialist roles and skills, integration will be achieved between health professionals, between health and social services and between statutory and non-statutory partners. Staff across the secondary mental health services will be competent in all aspects of health and social care assessment.

d. **Accessible services.** The model will focus on ensuring robust arrangements. Community based services, underpinned by the Care Programme Approach which are easy to access and quick to respond, particularly to service users, carers and primary care.

e. **Equity.** Standardised assessment tools and treatment protocols will ensure that every service user and carer has equal access according to need to the full range of mental health services in their locality.

5. The following are some of the key elements in the Sainsbury Model which are particularly relevant.

23. The central feature of the model of care is the Community Mental Health Service (CMHS) which will operate as part of a wider locality mental health service and provide the main point of access for assessment and treatment of all people referred to secondary mental health services with a suspected, provisional or confirmed diagnosis of mental illness. It will operate in accordance with the Care Programme Approach (CPA)[42].

24. As well as providing the main point of access, the Community Mental Health Service will provide short or longer term treatment management programmes and have access to other locality services including in-patient care and Community Support Services.

28. **Points of access.** There will be two main ways in which referrers/clients may access secondary mental health services. These are:

a. **Community Mental Health Services (CMHS).** An integrated (health and social services) duty service will operate in each locality to accept referrals from primary care and other referrals including self-referral.

b. **Accident and Emergency Departments.** Liaison psychiatry services will be based within the main A & E departments and will also be able to offer community outreach outside the CMHS hours of operation.

c. These services will respond to psychiatric crises during their hours of operation.

Locality Based Mental Health Services

31. There will be three elements to the Locality Mental Health Service:

a. Community Mental Health Services.

b. Alternatives to Admission.

c. Hospital In-Patient Service

32. **Community mental health services.** These services will operate in each locality and will provide the main point of access to all secondary mental

[42] We understand this to mean that eligibility for secondary (specialist) mental health services will continue to depend on satisfying CPA eligibility criteria.

health services including consultant referrals and psychological therapies. The service will be divided into two teams to reflect functional responsibilities:

a. **Intake team.** To provide advice/screening/assessment services, brief interventions and primary care link working.

b. **Enhanced CPA team.** To provide and arrange interventions for people with severe and enduring mental health problems.

33. **Intake team.** The overall purpose of the intake team is to offer a flexible service to support the management of people with less severe mental health problems at primary care level. The intake team will have three functions:

a. Advice, screening and assessment.

b. Brief interventions.

c. Primary care link working.

34. **Advice/screening/assessment service.** A combined duty system rota will:

a. Offer a single point of access to referrers.

d. Provide standardised assessment of health and social care needs and risk of people who have been diagnosed or are suspected of having a mental disorder.

e. Assist people on a short term basis (no more than 28 days) although it is expected that it will be much shorter with the majority of clients dealt with on the day) in a practical way that will ameliorate their distress.

h. Provide a report to the referrer indicating whether the person will be accepted by the secondary mental health service or has been directed elsewhere, for example, to informal day services or counselling.

Alternatives to Hospital Admission

51. Each locality or PCG area will be asked to develop proposals for managing psychiatric crises which arise in the community and do not require admission into acute hospital services. Such services will:

b. Offer early intervention to individuals whose assessed needs indicate that an alternative care setting is preferable to hospital admission.

c. Operate in accordance with established CPA policies and procedures and the Joint Risk Assessment Framework.

52. Service development proposals may include statutory and non-statutory sector
provision of:

a. Crisis Houses.

b. CMHS with Overnight Facility.

c. Intensive Home Treatment.

53. These services will be supported by the CMHS during its hours of operation and the Liaison Psychiatry Service outside of these hours.

Liaison Psychiatry Service (LPS)

67. ... Liaison Psychiatry Services will be developed to:

a. Provide assessment of mental health needs of patients who have been screened by A & E staff as requiring psychiatric assessment.

c. Arrange appropriate plan to meet the needs identified by the assessment process, this may include transfer to psychiatric in-patient service or referral to CMHS.

f. Respond to psychiatric crises arising outside CMHS hours of operation.

68. The LPS will be expected to develop formal links with the locality CMHS.

72. **Hours of operation.** The LPS will be accessible over a 24 hour period, seven days a week.

6. The Sainsbury Model involves major institutional and cultural change. The paper makes recommendations for implementing the Model of Care and detailed work has already started. Of particular relevance to our Inquiry is the recommendation that there should be one operational management line within CMHS, thus integrating the Health and Social Services management functions which are currently separate in community mental health teams.

APPENDIX 4: PEOPLE WHO GAVE EVIENCE TO THE INQUIRY

Mike Ashbee	Staff Nurse, Elmstone Ward
Mike Cosgrove	Non-Executive Director, East Kent Community NHS Trust and Chairman of the Internal inquiry
Jean Evans*	Head of Mental Health Services for Social Services in East Kent
Sergeant Fox	Police Officer, Ramsgate Police Station
Kathy Johnson*	Head of Mental Health Services, Kent Social Services
Dr Andrew Johns (Expert Witness)	Consultant Forensic Psychiatrist
Dr Raju Kalidindi	Locum Consultant Psychiatrist
Oliver Mills*	Director of Operations, Kent County Council Social Services
Jon Morgan	Approved Social Worker, Denbighshire County Council Social Services
Eugene O'Connor	Director of Mental Health Services, East Kent Community NHS Trust ?
Andy Oldfield	East Kent Community NHS Trust Locality Manager for Thanet
Linda Owen	Staff Nurse, Lydden Day Hospital
David Parr**	Chief Executive, East Kent Community NHS Trust
Dr Michael Pick	General Practitioner, Ramsgate
Pauline Reynolds	Care Manager, Kent Social Services
David Tamsitt**	Adult Services Manager, Mental Health Directorate, East Kent Community NHS Trust
Dr Tom Trevelyan	Consultant Psychiatrist, Clwydian Community Care NHS Trust
Diana Thomas	Social Security Benefits Officer, Kent County Council Social Services
Helena Thomas	? Denbighshire County Council

	Social Services
Ian Venables	Substance Abuse Worker, Kent Council on Addiction, Ramsgate
Dr Nick Ward	General Practitioner, Ramsgate
Peter Wild	
Dr Stephen Wood**	Consultant Psychiatrist, Medical Director East Kent Community NHS Trust

* Attended as part of the Kent County Council Social Services presentation to the Inquiry

** Attended as part of the East Kent Community NHS Trust presentation to the Inquiry