Executive Summary of the Report of the Inquiry into the Care and Treatment of **Christopher Edwards** and **Richard Linford**

A report commissioned by

North Essex Health Authority

Essex County Council

HM Prison Service

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North Essex Health Authority
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in association with Essex Police

Kieran Coonan, Q.C
Professor Robert Bluglass, CBE
Gordon Halliday
Michael Jenkins
Owen Kelly, C. St. J., QPM

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MEMBERSHIP OF THE INQUIRY PANEL

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A Recorder of the Crown Court.

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Emeritus Professor of Forensic Psychiatry, University of Birmingham; previously Clinical Director of the Reaside Clinic, Birmingham, and Medical Director, South Birmingham Mental Health NHS Trust.

Gordon Halliday

Formerly Director of Social Services, Devon County Council.
Member of the Mental Health Act Commission.

Michael Jenkins

Formerly Governor of Oxford Prison and Long Lartin Prison.
HM Deputy Chief Inspector of Prisons, 1987-1990.

Owen Kelly, C. St. J., QPM

Commissioner of the City of London Police 1985-1993.

TERMS OF REFERENCE

"To investigate the death of Mr. Edwards in Chelmsford Prison, including factors in his and Mr. Linford's detention which are relevant to that, and in particular: the extent to which their reception, detention, management and care corresponded to statutory obligations, Prison Service Standing Orders and Health Care Standards, and local operational policies.

1. To examine the adequacy, both in fact and of relevant procedures, of collaboration and communication between the agencies (HM Prison Service, Essex Police, the courts, Mid Essex Community and Mental Health NHS Trust and its predecessor, and Essex County Council Social Services Department) involved in the care, custody or control of Mr. Edwards and Mr. Linford, or in the provision of services to them.

2. To examine the circumstances surrounding the arrest, detention and custody of Mr. Linford and Mr. Edwards by Essex Police, including whether all relevant information was effectively and efficiently passed between Essex Police, the prison service, the courts, and any other relevant agencies during this process.

3. To examine all the relevant circumstances surrounding the treatment and care of Mr. Christopher Edwards and Mr. Richard Linford, by the health service and social services, and in particular: the extent to which Mr. Edwards' and Mr. Linford's care corresponded to relevant statutory obligations, relevant guidance from the Department of Health (including the Care Programme Approach (HC(90)23 and LASSL (90)1, and Discharge Guidance HSG(94)27) and local operational polices.

4. To prepare a report and make recommendations to North Essex Health Authority, Essex County Council Social Services Department and HM Prison Service, and other such agencies as are identified as appropriate during the course of the Inquiry."

INTRODUCTION

During the weekend of 26/27 November 1994 **Christopher Edwards,** who was then aged thirty, and **Richard Linford**, aged thirty-two, were arrested by Essex police officers.

Christopher Edwards was arrested in Colchester on Sunday, 27 November. He had been pestering young women in the street. He was taken to Colchester Police Station. The police officers suspected that he might be mentally ill. As a result he was assessed by an approved social worker (ASW), Mr. P. Thomasson, who then discussed the matter with the duty Consultant Psychiatrist, Dr. B. Pinkey, on the telephone. Their view was that Christopher Edwards was fit to be detained in the police station. Mr. Thomasson also believed that he was fit to be interviewed. Whilst Christopher Edwards was detained at the police station his behaviour towards female police officers was sometimes abnormal: he spoke constantly about sexual matters. He was believed to represent a risk to women. On Monday, 28 November, he appeared at Colchester Magistrates' Court and was remanded in custody for three days. He had no previous convictions. He was represented by the duty solicitor. His behaviour in court was also abnormal. During his detention in custody at the police station and at court he was placed in a cell on his own.

Christopher Edwards arrived at Chelmsford Prison in the late afternoon. He was screened by a member of the healthcare staff who saw no reason to admit him to the Health Care Centre. He was admitted instead to the main prison and placed in cell D1-6.

In 1991 Christopher Edwards had been diagnosed as, possibly, suffering from schizophrenia. Until July 1994 he lived at home with his parents and was prescribed Stelazine by his local GPs. Six months before his arrest he moved to Colchester and ceased taking his medication. He had had no contact with the mental health services for almost three years.

Richard Linford was arrested in Maldon on Saturday, 26 November. He had assaulted his friend, Ms. V. and her neighbour Mr. L. He was seen by a police surgeon, Dr. J. Wakely, at Maldon Police Station, because it was suspected that he was mentally ill. He was then assessed by Dr. M. Durrani, the Psychiatric Registrar at the Linden Centre. He discussed the assessment on the telephone with Dr. C. Anderson, Consultant Psychiatrist. They decided that he did not need to be admitted to hospital. After he was transferred to Chelmsford Police Station, Dr. Wakely saw him again. All three doctors believed that Richard Linford was fit to be detained in the police station and fit to be interviewed if necessary. Richard Linford's conduct, both before his arrest and during his detention in the police station was bizarre, but was attributed by the doctors to the effects of alcohol abuse and amphetamine withdrawal and to a deliberate attempt to manipulate the criminal justice process. The doctors were well aware that he had a psychiatric history. Dr. Durrani, in particular, had assessed and treated him on previous occasions and knew that he had been diagnosed at various times as suffering from schizophrenia, or alternatively as having a personality disorder, but also as someone who became ill when he abused alcohol and illicit drugs.

Dr. Anderson also knew something of his history, having assessed him (coincidentally) with Mr. Thomasson on 27 September 1994. Whilst in custody during the weekend there were further episodes of bizarre behaviour and he was violent to police officers. He was not reassessed by a doctor.

In the late afternoon of Monday, 28 November, he appeared at Chelmsford Magistrates' Court. He was represented by a solicitor. He was remanded in custody. Whilst he had been detained at both police stations he had been placed in a cell on his own. He arrived at Chelmsford Prison shortly after Christopher Edwards. He was located in cell D1-11 and then cell D1-6, with Christopher Edwards. He was later screened by the same member of the healthcare staff who had screened Christopher Edwards earlier that afternoon.

Shortly before 1 a.m. on 29 November 1994, Richard Linford attacked Christopher Edwards in cell D1-6 and stamped and kicked him to death. Although the emergency buzzer had been activated from within the cell it was not heard by anyone. The system may have been tampered with. Later that day Richard Linford was transferred to Rampton Special Hospital: he was by then acutely mentally ill.

On 21 April 1995, at Chelmsford Crown Court, Richard Linford pleaded guilty to the manslaughter of Christopher Edwards by reason of diminished responsibility. A Hospital Order was made under section 37, Mental Health Act 1983, together with a Restriction Order under section 41. He remains in Rampton Hospital. The diagnosis is paranoid schizophrenia.

Richard Linford had a psychiatric history since 1986. He had been detained in the Sub Regional Medium Secure Unit at Runwell Hospital in 1988 under section 37, Mental Health Act 1983 following a serious assault upon his mother. He had been admitted, both formally and informally, to hospital on frequent occasions. He had been violent towards staff, patients and members of the public. In September 1994 he discharged himself from hospital and refused to take any medication. During the two months prior to his arrest he was assessed on six occasions by the psychiatrists at the Linden Centre but was not admitted to hospital again.

On 24 October a case conference decided that unless he agreed to take depot medication, with good effect, within eight weeks, he would be detained under section 3, Mental Health Act 1983. Within a week of that case conference it was clear that he would refuse to take any medication. Had Richard Linford not been arrested on 26 November it is probable that he would have been detained under the Act a few days later. He would, in those circumstances, have been admitted to the Linden Centre for a very short period before being transferred to Plashet I Ward at Runwell Hospital. Had he been detained under the Mental Health Act even a few days beforehand, this tragedy would have been avoided.

Two fundamental questions have been addressed during this Inquiry:

(i) Why was Richard Linford not admitted to hospital before November 26?

(ii) Why were Christopher Edwards and Richard Linford not admitted to hospital, or alternatively to the prison Health Care Centre, following their arrests?

We realise that there may be a public expectation that when an individual with, or even without, a history of mental illness presents to doctors with behaviour that is apparently bizarre or difficult to explain, he will be admitted to hospital (with appropriate security if necessary) for

treatment. A failure to do so may seem astonishing. However, the decision-making process has to balance a number of conflicting factors: the presence or absence of mental disorder; the clinical diagnosis; the severity of evident mental disturbance; the criteria and constraints imposed by the Mental Health Act 1983; the cooperation of the individual, the need to protect the public and the individual's civil rights. The immediate availability of appropriate accommodation may also influence the decision. In this report we have endeavoured to avoid the benefit of hindsight and, with these factors in mind, to judge the decisions which were made whenever Christopher Edwards or Richard Linford presented.

The Terms of Reference have constrained us to carry out what were, in essence, two separate Inquiries. We have examined the adequacy of the past care and treatment of both Christopher Edwards and Richard Linford in the community. In Richard Linford's case, that has been extensive. We have completed a full investigation into the circumstances surrounding their arrest, detention and remand into prison custody. To achieve the task allotted to us, the Inquiry sat in private for a total of 56 days to hear evidence. It was not possible to sit continuously. The Panel met subsequently on frequent occasions to discuss the many issues which have been raised by the evidence. A substantial number of expert witnesses assisted us. Two prison officers refused to attend to give evidence. Otherwise we had the greatest possible cooperation from individuals and from the relevant agencies.

We must record our appreciation for the assistance that Christopher Edwards' parents have provided to the Inquiry, both in their oral evidence and in their cogent written submissions. We have used those as a touchstone whenever possible. We extend to them our sympathy, once again, at the tragic loss of their son.

To Mrs. Titheridge, Richard Linford's mother, we also extend our sympathy for the tragedy that has befallen her.

We undertook, at the outset of this Inquiry, not to leave any stone unturned in seeking explanations for Christopher Edwards' tragic death. We hope that we have discharged that duty. Equally, however, where Inquiries of this type are held it is important that a "witch hunt" is not mounted. We are keenly aware of the anxiety and stress engendered in healthcare workers and others by the need for an Inquiry such as this one.

There is a growing bibliography of Inquiry Reports. The publication of yet another one serves to undermine public confidence, at least to some degree, in current health policies for the mentally ill. Common themes have emerged from those reports: poor communication between agencies; inadequate arrangements following discharge from hospital; poor risk assessment and inadequate resources. Several reports have been followed by Government responses which have attempted to bolster the support for individual patients in the community who, it is believed, are no longer in need of long-term hospital care. The establishment of Supervision Registers and the introduction of Supervised Discharge, are two such examples.

Government policy in this area has not only been reactive but also pro-active. In 1990 the Home Office issued Circular 66/90 after extensive collaboration with the Department of Health. It urged *"that wherever possible mentally disordered people should receive care and treatment from the health and social services' authorities rather than be cared for within the criminal justice system"*. It set out best practice for every service involved and it was reinforced by the conclusions of the Reed Report (Home Office/Department of Health 1992). With the exception

of Essex Police, these policies had not been translated into practice in Mid Essex by November 1994.

Similarly, the Care Programme Approach and inter-professional working had been promoted by the Department of Health. Five of the key elements in the joint health/social services Circular *"Caring for People"* HC(90)23/LASSL (90)11: inter-professional working; the involvement of patients and carers; the need to keep in touch with patients; the need to ensure services are provided; and the crucial role of the "Key Worker", may be used as benchmarks against which the care provided to Richard Linford in particular, may be judged. This Inquiry has revealed significant failings in those respects in Mid Essex, during 1994.

Although the relevant agencies responded quickly after the death of Christopher Edwards to try to rebuild the relevant services, the Care Programme Approach (CPA) is still not firmly embedded in daily practice in Mid Essex - and, we suspect, elsewhere. Dr. Coxhead, Consultant Psychiatrist (and Richard Linford's Responsible Medical Officer), described the overall level of community provision in Mid Essex, even in 1997, as *"dangerous"*. Although there have been improvements, he identified a lack of secure beds; an inadequate number of community mental health nurses; the continuing difficulty in admitting patients to Runwell Hospital; an inadequate Court Diversion Scheme and the absence of a psychiatrist in Mid Essex with forensic training. The problem of access to beds has become worse since the death of Christopher Edwards. The Linden Centre is having to cope with situations for which it was never designed.

Services in 1994 were being provided against a background of major change in both health and social services. Each of the partner agencies had to grapple with their own specific problems. The lack of coterminous geographical boundaries is a continuing problem. The major mental health voluntary organisations have emphasised that a significant reduction in the availability of hospital beds has occurred, as against an increase in the number of detentions being made under the Mental Health Act 1983. The under-resourcing of mental health services in Mid Essex has been acknowledged during the course of this Inquiry.

Despite these difficulties, the strategic objective of the Government to reduce ill-health, social disability and death caused by mental illness, and to promote mental health, was one of the key priorities for *"The Health of the Nation"* (Department of Health 1992).

The Green Paper, *"Developing Partnerships in Mental Health"* (DOH 1997) went some way towards acknowledging that problems in service delivery persist, and identified options for the future development of mental health services. The Secretary of State has indicated that there is to be a substantial review of mental health services, including a review of mental health legislation. **WE RECOMMEND that special consideration should be given to strengthening the arrangements for community supervision and support for patients discharged from psychiatric care, including improved powers of return to hospital where compliance with community care is failing.** The present arrangements, including Supervision Registers and Supervised Discharge Orders, have been introduced piecemeal, although the Care Programme Approach does now appear to be taking shape. Nonetheless, a more coherent strategy is needed. *"The New NHS"* (DOH 1997) identified a new function for Regional NHS Offices: the commissioning of specialist hospital services, including medium-secure services. We welcome that development in policy. If the pattern of the past few years - tragedy followed by Inquiry, followed by the introduction of further bureaucratic safeguards - is to be broken, then such a major review of our mental health services should be delayed no longer.

We owe a debt of gratitude to Richard Randall and Heather Kent, the solicitors to the Inquiry, for the efficient and helpful way in which they obtained and presented the evidence to us, and to Christine Chambers for the skilful compilation of the text of the Report.

Kieran Coonan, Q.C.

Professor Robert Bluglass, CBE

Gordon Halliday

Michael Jenkins

Owen Kelly, C. St. J., QPM

EXECUTIVE SUMMARY:

CHRISTOPHER EDWARDS

Executive Summary : Christopher Edwards

Preamble

1. Christopher Edwards, who was born in 1964, was a highly intelligent young man and a successful graduate of the University of Adelaide. Not long after graduation he began to exhibit despondency, mood changes, a lack of confidence and solitariness, together with a religious preoccupation which increasingly worried his parents. Some of these features were reflections of his underlying personality. His parents' concern led, in due course, to psychiatric assessment in 1991 and the suspicion that he was developing a serious mental illness, possibly schizophrenia. He refused hospital assessment but accepted medication, which helped him. At the time he was not detainable under the Mental Health Act 1983. Although an offer of support from the community mental health nurses was seriously delayed, it was Christopher Edwards himself who rejected that offer.

2. The clinical management by the consultants at Severalls Hospital in 1991 and 1992 (at that time the responsibility of Mid Essex Mental Health Services, a directly-managed unit of the then Mid Essex Health Authority) cannot be criticised. Christopher Edwards' condition was relieved by repeat prescriptions of Stelazine which were issued by the GPs over the next two-and-a-half years. His parents persuaded him to take it. He always refused to acknowledge that he might be mentally ill and never sought the assistance of the community mental health nurses, or the Consultant Psychiatrist. He never had any contact with social services. He never saw a general practitioner. He lived at home with his parents until July 1994: thereafter he lived on his own in Colchester. It was during this latter period that he ceased taking his medication.

Arrest and psychiatric assessment

3. On Sunday, November 27, Christopher Edwards approached some young women in a street in Colchester and made inappropriate sexual suggestions to them. His behaviour was disinhibited: it was a manifestation of mental disturbance. He was arrested. His behaviour remained abnormal in the police station: he tried to grab female police officers and he talked constantly about sexual matters.

4. The police officers who had been in contact with him suspected that he might be mentally ill and might require admission to hospital. Although the custody officer did not summon a medical practitioner, an experienced approved social worker, Mr. Thomasson, was called to Colchester Police Station and interviewed him. After the interview the "officer in the case", PC O'Mahony, who also suspected that he might be mentally ill, suggested that another opinion should be obtained. Mr. Thomasson discussed the case on the telephone with Dr. Pinkey, Consultant Psychiatrist. They agreed that there was possibly some evidence of a developing schizophrenia but that, given his presentation, he did not need urgent medical treatment or

admission to hospital, i.e. he was fit to be detained in the police station. It was felt that a psychiatric assessment could, if necessary, be carried out at the pre-sentence stage of the proceedings, if any.

5. Mr. Thomasson's view remained the same even after he spoke to Christopher Edwards' parents on the telephone at the police station. They told him that their son had been assessed in 1991 by psychiatrists and that it had been suspected that he was suffering from schizophrenia. This information by itself did not, understandably, change the result of Mr. Thomasson's assessment that Christopher Edwards was not, at that time, acutely mentally ill, and thus did not need immediate admission to hospital.

6. Ideally, if suitable beds had been available, Christopher Edwards should have been admitted for assessment under section 2, Mental Health Act 1983. Otherwise, Mr. Thomasson's assessment and conclusion was reasonable, as was Dr. Pinkey's advice. There was no need, on the basis of what he was told, to assess Christopher Edwards himself. The assessment took place at a time when he was not psychotic, but rational and stable.

7. However, there is some doubt whether Mr. Thomasson was given a full account of the circumstances which surrounded Christopher Edwards' arrest and subsequent behaviour in the police station: if he had been provided with that information, he accepted that he would have called Dr. Pinkey to assess Christopher Edwards.

8. Even though an approved social worker interviewed Christopher Edwards and discussed his assessment with a Consultant Psychiatrist, it was a serious omission that no medical practitioner was asked by the custody officer to see Christopher Edwards. This failure constituted a breach of the Codes of Practice (Code C) issued under the Police and Criminal Evidence Act. The custody officer was, however, influenced by the fact that the Consultant Psychiatrist, Dr. Pinkey, had expressed a reassuring opinion on the telephone and had supported Mr. Thomasson's view.

9. If Dr. Pinkey had assessed Christopher Edwards and had been armed with knowledge of the circumstances surrounding his arrest and subsequent detention in the police station, together with a summary of the psychiatric background from his parents, he would probably have obtained a more complete picture of a developing mental illness than was gleaned by Mr. Thomasson. Dr. Pinkey would then have given serious consideration to admitting Christopher Edwards to hospital that same evening.

10. It is with dismay that we are driven to conclude that Christopher Edwards would not have been admitted to hospital on Sunday evening, even if Dr. Pinkey had assessed him and had had the benefit of all relevant information. Dr. Pinkey assumed that no "low-secure" bed was available. He could not be admitted to "The Lakes" since that consisted of acute open wards only; he could not be admitted to Willow House where, although conditions of security existed, he would need, initially, to be admitted to an acute open ward.

11. Moreover, he could not be admitted to the medium-secure unit at Runwell Hospital because he was not sufficiently disturbed to meet the clinical criteria for admission. Although admission to the Intensive Care Unit at Runwell Hospital was possible (and there was a bed available), that was subject to an assessment by the psychiatrists at Runwell. Dr. Pinkey had no direct access to these beds. There was, too, a well-established perception that it would take days to

arrange such an assessment. In any event, admission to the Intensive Care Unit could only take place by way of an Extra Contractual Referral which would need to be arranged.

12. The case of Christopher Edwards demonstrates the overwhelming need for swift and direct access by the local psychiatrists to "low-secure" beds.

Form CID2 - Exceptional Risk

13. Mr. Thomasson told PC O'Mahony that it was his and Dr. Pinkey's view that it was unlikely that Christopher Edwards was suffering from an acute mental illness. Despite that advice, she still believed that Christopher Edwards was mentally ill. She believed, too, that he was a potential danger to women.

14. In those circumstances, PC O'Mahony, as "officer in the case", should have completed Form CID2, and Christopher Edwards should have been described on the Form as a prisoner who was *"reasonably suspected of being an exceptional risk"* on the grounds of *"mental disturbance"*. It was a serious failure by Essex Police (as opposed to a personal failure by PC O'Mahony) that it was not completed. The Form is used by Essex Police to warn the prison authorities of those prisoners who are considered by police officers to be an exceptional risk, on the grounds set out on the Form. A similar Form is used nationally (Form POL1).

15. PC O'Mahony did not complete Form CID2 because she had received advice from Mr. Thomasson which conflicted with her own opinion and because she - and many other Essex police officers - had received inadequate guidance and instruction in its application. The document itself is also ambiguous: it is inadequate as a method of warning the prison authorities of possible risk factors. This failure applies with equal weight to the case of Richard Linford.

16. The death of Christopher Edwards has propelled a close scrutiny of these arrangements. The Form is to be replaced in due course by a Prisoner Escort Record (PER) Form.

17. PC O'Mahony did, however, warn the Crown Prosecution Service, in a memorandum, of her grave fear that Christopher Edwards was a danger to women and that he might be mentally ill. She was correct to do so.

Colchester Magistrates' Court

18. Christopher Edwards appeared at Colchester Magistrates' Court on Monday, 28 November. His language and behaviour in court was, once again, disinhibited, inappropriate and, in some respects, bizarre. He was represented by the duty solicitor but was not seen by a probation officer. It was apparent to those who were concerned with him in a professional capacity that he might be mentally ill. The question whether the court had the power to remand him to hospital or to order that a psychiatric report should be prepared during a remand in custody was addressed. In the event, he was remanded in custody for three days. His condition had deteriorated since Mr. Thomasson had seen him.

19. The requirements of section 30, Magistrates' Court Act 1980 could not be fulfilled, since the duty solicitor correctly judged that it was inappropriate to make any admissions on behalf

of his client on a first appearance: there was a question mark over his mental state. Hence the court could not order that a psychiatric report should be prepared.

20. This had an important consequence. Had a warrant of commitment been issued under section 30, the local practice at Chelmsford Prison was to admit such a prisoner to the Health Care Centre irrespective of his actual presentation on arrival.

21. Although the application of section 35, Mental Health Act 1983 (which provides for a remand to hospital for assessment) does not appear to have been addressed - and it should have been - it would probably have been an academic exercise. Even though the requirements of the section might have been fulfilled within the time available that day, the court would have been reluctant, given PC O'Mahony's graphic warning to the Crown Prosecution Service that Christopher Edwards was a danger to women, to remand Christopher Edwards to an open acute ward at "The Lakes" or at Willow House. He required conditions of security. These constraints were identical to those which would have applied if Dr. Pinkey had considered admission to hospital on Sunday evening.

22. No Court Diversion Scheme existed at Colchester Magistrates' Court at that time. Such a scheme was eventually set up in 1995. Nonetheless, there is no guarantee, even today, that an accused person in similar circumstances would be admitted to hospital on a first remand appearance. There is even greater pressure on secure beds now than in 1994.

23. No attempt was made by the court to notify the prison authorities, particularly the Senior Medical Officer, that Christopher Edwards was suspected of suffering from a mental illness. Such notification could have been by telephone, or by endorsement on the reverse of the warrant.

Information supplied to Chelmsford Prison

24. However, the prison authorities were alerted that Christopher Edwards was a potential danger to women and that he was suspected of being mentally ill, by other means. In particular:

(i) Mr. Paul Edwards informed Barbara Godbold, a probation officer at the prison, by telephone, of his son's psychiatric background and expressed concern about his mental state. She, in turn, provided that information to Dr. Findley, Senior Medical Officer at the prison. He refused to give any undertaking that Christopher Edwards would be admitted to the Health Care Centre and emphasised that he would be screened by the healthcare worker upon arrival, the outcome of which would determine where he would be allocated within the prison. He rejected her advice because he knew by this time that a warrant had not been issued under section 30, Magistrates' Court Act 1980 and that an approved social worker had assessed him as fit to be detained in the police station (albeit twenty-four hours earlier).

Dr. Findley failed to pass on this information to the healthcare worker, Mr. Neal, who carried out the health care screening of Christopher Edwards that evening, and he failed to make any record of the information she had given him.

(ii) Earlier that afternoon, Barbara Godbold had also been informed by the probation service at Colchester Magistrates' Court that Christopher Edwards was a potential

danger to women. She informed Dr. Findley about that, too. He responded by ensuring that no female staff were on duty at reception.

(iii) The police gaolers at the court were sufficiently concerned at what they had seen during the morning that they telephoned the reception staff at the prison. The prison staff were told that the court had *"wanted to remand him to a mental hospital"*; that he was a potential danger to women and that consideration should be given to admitting him to the Health Care Centre upon his arrival.

(iv) Prison Officer Blyth had alerted the reception staff on his return from an earlier escort duty to Colchester Magistrates' Court.

25. The prison staff appreciated that a prisoner would probably be admitted to the prison Health Care Centre if he arrived at the prison with a warrant which had been issued under section 30, Magistrates' Court Act 1980. Accordingly they telephoned the court to ask if the warrant could be issued under section 30. They were advised that it could not. The Health Care Centre staff knew that these steps were being taken.

Reception and health care screening at Chelmsford Prison

26. Christopher Edwards arrived at the prison at the same time as Dr. Findley went off duty. Thereafter, there was no medical officer on duty within the prison, in breach of current *Prison Service Health Care Standards.* When Mr. Neal assessed Christopher Edwards later that afternoon he had not been provided with any information from Dr. Findley, nor had he been provided with any of the information that the police gaolers had supplied to the prison reception staff earlier in the day. He treated Christopher Edwards purely as someone who was alleged to have assaulted a female Police Constable and not as someone who might be mentally ill.

27. The criterion for admission to the Health Care Centre at Chelmsford Prison was whether the prisoner was behaving in an overtly bizarre manner.

28. Mr. Neal found no evidence of bizarre behaviour in Christopher Edwards' presentation, although the reception staff thought he was acting *"oddly"*. Accordingly, he was allocated to cell D1-6 in the main prison. Initially he was alone. Later, prison staff allocated Richard Linford to the same cell.

29. Although Christopher Edwards was probably not behaving in an overtly bizarre manner when he was screened in the prison (given the fluctuating nature of his mental disturbance), Mr. Neal was inadequately trained in the recognition of mental disorder and he had been given inadequate guidance to screen those who might need admission to the Health Care Centre. The screening process was rushed and did not take place in adequate conditions of privacy. Even though Christopher Edwards would have been assessed by a medical officer the next day, the screening process is too superficial to achieve its objective. No written practice guidance existed. His performance during healthcare screening had never been audited. He did not possess counselling skills, as required by the *Prison Service Health Care Standards.*

30. Had Mr. Neal been provided with the information which Mr. Edwards had given Barbara Godbold and which the police gaolers had given the prison reception staff, and if he had been

provided with a completed Form CID2 which identified *"mental disturbance"* he would, at the very least, have approached Christopher Edwards in a very different light. He may have had sufficient residual doubts to cause him to err on the side of caution and admit him to the Health Care Centre for the first night. Had the court expressed its concern by communicating directly with the prison, that, too, might have provided Mr. Neal with additional assistance.

Sharing a cell

31. Normal location at Chelmsford Prison means that prisoners are required to share a cell. The practice by which prisoners are required to share cells which contain integral sanitation was condemned by HM Chief Inspector of Prisons in a Report of a Short Inspection of Chelmsford Prison in 1993. The cells on landing D1 were all shared, and all contained integral sanitation. This practice not only applied in 1994 but continues to be defended by the prison service today. On that ground alone, Christopher Edwards and Richard Linford should not have shared a cell, either with each other or with anyone else. Had each been allocated a single cell, this tragedy would not have occurred. The next day, both would have been seen by a medical officer. Richard Linford would inevitably have been assessed as mentally ill by that stage and he would have been admitted initially to the Health Care Centre and then to Runwell Hospital. If Richard Linford had shared a cell with someone else, that other prisoner's life would also have been at risk, such was his mental condition that evening.

32. Richard Linford was allocated cell D1-6, which was already occupied by Christopher Edwards, because the other cells on landing D1 had by then been allocated to other prisoners. Richard Linford had initially been allocated to cell D1-11 before he was processed or screened: he was placed there while the other prisoners who were congregating in the reception area were processed. Prison staff were concerned about his dishevelled appearance, uncooperative manner and the obvious injury to his eye. He was moved out of Cell D1-11 when it became necessary to allocate a cell on landing D1 to two convicted and sentenced prisoners. They were required to be kept apart from remand prisoners such as Christopher Edwards and Richard Linford. The other cells were already full.

33. We reject the allegation that both Christopher Edwards and Richard Linford were placed together because they were suspected of being mentally ill.

The cell call system

34. The cell call system for cell D1-6 was defective. Even though either Christopher Edwards or Richard Linford pressed the button inside cell D1-6 which caused the green warning light outside the cell to be illuminated, the warning buzzer on the landing did not sound, or, if it did, it sounded only briefly. It should have sounded continuously, even if the prisoner stopped pressing the button in the cell.

35. This system, which we are told operates in many prisons, is capable of being deliberately disabled simply by wedging a matchstick behind the re-set button on the control panel. We cannot rule out the possibility that the system was tampered with in this way by a member of the prison staff, perhaps to deflect "tiresome" requests by prisoners at night, or even by a prisoner. In any event, the mere fact that this system is capable of being so easily disabled is a cause for grave concern. It is an inadequate and unsafe system.

36. The cell call button in cell D1-6 may have been pressed up to seventeen minutes before the sound of Richard Linford banging on the cell door raised the alarm. At that point the green light was noticed. Had the cell call system been operating properly - had the buzzer been heard - a prompt response by prison staff to the sound of the buzzer may have saved Christopher Edwards' life. By the time prison officers entered the cell, after a five-minute delay whilst they donned protective clothing, it was too late. Richard Linford had inflicted multiple injuries on Christopher Edwards. He had been kicked and stamped to death.

Diagnosis

37. The provisional diagnosis of schizophrenia which was made by Dr. Murray and Dr. Wright in 1991 was, with hindsight, almost certainly correct. Christopher Edwards managed in the community because he was persuaded by his parents to take his medication, Stelazine, for 2½ years. He began to break down after he stopped taking it.

38. He may have been psychotic when he was at Colchester Police Station - albeit intermittently - although he was not then severely ill. He began to deteriorate at court but recovered, to an extent, on admission to Chelmsford Prison. He may well have deteriorated again during the ensuing hours such that he may have been acutely mentally ill when he was fatally attacked by Richard Linford. That Richard Linford was floridly psychotic when he killed Christopher Edwards, there can be no doubt.

Conclusions

39. Had Dr. Pinkey had direct access to a suitably secure bed on Sunday evening, 27 November, it would have been possible to admit Christopher Edwards for assessment rather than leave it as an adjunct to the criminal justice process. No such beds existed in North East Essex.

40. There was a failure by Essex Police to ensure that adequate guidance was given to individual police officers in the use and application of Form CID2: as a result, no formal notification was given to the prison that Christopher Edwards might be mentally ill.

41. No formal, or informal, notification was given to the prison by court staff that Christopher Edwards was considered to be mentally ill.

42. When individual police officers did alert prison staff that attempts had been made to remand Christopher Edwards to hospital for a psychiatric report, the prison staff on duty failed to pass on this information to Mr. Neal, the member of the healthcare staff who screened Christopher Edwards that evening.

43. Dr. Findley failed to pass on crucial information which he had received from Barbara Godbold, a probation officer at the prison, to Mr. Neal. She had obtained this directly from Mr. Paul Edwards, Christopher Edwards' father.

44. The cell provision for remand prisoners at Chelmsford Prison is inadequate: they are required to share cells which contain integral sanitation. This practice had been condemned by HM Chief Inspector of Prisons in 1993.

45. The cell call system was defective and unsafe: it was capable of being disabled.

46. These features, taken together, amount to a systemic collapse of the protective mechanisms that ought to have operated to protect this vulnerable prisoner. These deficiencies resulted in the needless and tragic loss of a talented young man and much loved son and brother.

EXECUTIVE SUMMARY:

RICHARD LINFORD

Executive Summary : Richard Linford

Preamble

47. Richard Linford was born in 1962 and also comes from a professional background but his formative years were less settled than those of Christopher Edwards. His father died when he was aged five, and, after his mother had remarried, his step-father died when he was aged fifteen.

48. Like Christopher Edwards, Richard Linford graduated from university, but only after a prolonged course. He obtained a science degree. His mental illness was probably developing at that time.

49. After university, he began to be seen around his home town of Maldon in a deteriorated state. Sometimes he was inappropriately dressed. He often walked around barefoot. His mother began to be increasingly concerned about him.

50. Richard Linford began using a variety of different drugs, including amphetamines, in his teenage years. There were violent outbursts, and he probably first experienced auditory hallucinations in 1980. There was evidence of personality instability, with moodiness, lack of interest, and periodic depressions. This, with hindsight, suggests the early and insidious development of schizophrenia. There were frequent medical assessments by GPs and psychiatrists, and a variety of diagnoses were applied, including "personality problems" and "reactive depression". The diagnoses were often complicated by drug and alcohol misuse.

51. In 1987 he assaulted his grandmother and the local Vicar. In 1988 he assaulted his mother on two occasions and was charged on the second occasion. Whilst on remand in Norwich Prison he assaulted his cell mate and a prison officer. In September 1988 he was detained in Runwell Hospital under section 37, Mental Health Act 1983.

52. By the time he was discharged from Runwell Hospital in late 1989, the diagnosis was schizophrenia. Thereafter there were periodic breakdowns and further admissions to hospital, during which he proved difficult to manage. As the years passed, he acquired a reputation for being aggressive and violent toward residents and staff alike, and for being manipulative. The diagnosis fluctuated between schizophrenia and personality disorder, and the complications of substance abuse.

53. In January 1994, during yet another admission to Severalls Hospital, the diagnosis of schizophrenia was questioned by Dr. Khetarpal, Consultant Psychiatrist, and the preferred diagnosis by the time of discharge was 'personality disorder and the effects of substance abuse'. The difficulty in reaching a firm diagnosis was understandable. Neuroleptic medication was used during this admission to good effect, until Richard Linford objected to it. After January 1994 he remained without any neuroleptic medication whilst he lived in the community, in a flat rented from Maldon District Council.

54. After he was discharged from Severalls Hospital in January 1994, the care plan gradually collapsed. He missed appointments with Ed Stirton, an unqualified member of the Community Rehabilitation Team, and he was discharged from art therapy at Cherry Trees Day Unit because of disruptive behaviour. No monthly reviews as contemplated by the care plan took place. There was poor communication between all those who were concerned with his care. The person appointed as care coordinator, Alison Lamb, did not appreciate precisely what her role was and did not realise that Dr. Heine, Consultant Psychiatrist and a member of the Community Rehabilitation Team, was responsible for his care in the community. There was negligible care management and care coordination. He began to deteriorate. In May 1994, he assaulted a friend from school and was admitted once again to Severalls Hospital as an informal patient.

55. At the outset of this admission, from 10 May to 3 June, Richard Linford refused to be cared for by Dr. Khetarpal who had been caring for him since 1989. As a result, Dr. Coxhead, Consultant Psychiatrist, agreed to take over his care: his case load was the lightest of all the other Consultants. But the arrangement, which was designed to help Richard Linford, was fatally flawed. Dr. Coxhead had no connection with Maldon: he operated in another sector of the County. He had no other patient in Maldon and no connection with the community teams there. There was thus a risk that he would become isolated from the implementation of the care plan after Richard Linford was discharged from hospital. This is precisely what happened.

56. Dr. Coxhead was bequeathed an uncertain diagnosis and he did not know Richard Linford well. In June he rejected Alison Lamb's view that Richard Linford should not be discharged from hospital but should be detained under the Mental Health Act. He rejected her opinion that he posed a risk of *"serious injury or worse"* to members of the public. Although Alison Lamb knew Richard Linford well, Dr. Coxhead did not believe that he was potentially homicidal.

57. Despite being appointed to continue as Richard Linford's care coordinator in May 1994, Alison Lamb maintained she did not appreciate this.

58. At the end of May, community support from the Community Rehabilitation Team was withdrawn by Dr. Heine because of the difficulty of managing a patient such as Richard Linford with inadequate resources. The main element of the care plan was the monitoring of his mental state by two community nurses who, it was intended, would see him together, for safety reasons, at the social services offices.

59. Despite the lessons of the previous few months and despite his history and reputation, there was no improvement in the delivery of community care after he was discharged from Severalls Hospital in early June. Communication between Dr. Coxhead and Alison Lamb was non-existent.

60. Crucially, Richard Linford failed to cooperate with the community nurses. He also failed to attend any out-patient appointment with Dr. Coxhead at Severalls Hospital. He was not being monitored by anyone. No-one visited him at his flat: his behaviour towards his elderly neighbours was becoming intolerable.

61. Richard Linford remained in the community without neuroleptic medication. The indication given shortly before his discharge in early June, that he would, in future, take depot medication, was swiftly retracted.

62. Senior management failed to supervise Alison Lamb during 1994. They failed to discover what her responsibilities were in relation to Richard Linford. She was left to operate autonomously. Her recording practices were very poor indeed.

63. Alison Lamb's relationship with her seniors was abrasive. When she did seek assistance and advice from them after Dr. Coxhead had rejected her serious concerns about Richard Linford (see paragraph 56), her letter went unanswered. She was seen as difficult to work with and uncooperative, even though it was acknowledged that she was, in other respects, a skilful and experienced social worker. But she was not considered to be, nor was she, a team-player. Notwithstanding that, her assessment of Richard Linford was correct: he was potentially homicidal.

64. Alison Lamb was the only active qualified social worker in the Maldon Mental Health Team during this period. The team was seriously under-staffed: she served a population of 54,000.

65. At the end of July 1994 Dr. Teatino, one of Richard Linford's general practitioners, was called out to see him. He described his flat as 'squalid'. He was very concerned about his mental condition. He alerted the community nurses and asked them to visit him. They did not do so, but they did advise Dr. Coxhead that Dr. Teatino was concerned. This was the first warning that Dr. Coxhead had that all was not well.

66. Dr. Coxhead asked Alison Lamb to arrange a case conference, which took place on 18 August 1994. Richard Linford did not attend, nor did the GPs. The conference did not know the full extent of the problems that Richard Linford was causing his neighbours. The conference decided that the structure of the care plan should remain the same and that the community nurses would make further attempts to monitor Richard Linford's progress in the community. Fortunately, no serious incident had taken place since his discharge from hospital in early June. A review date was fixed for 18 November.

67. Not only was there no improvement, after this case conference, in the quality of care being provided by the team, but the structure of the care plan all but collapsed once again. Alison Lamb immediately went on compassionate leave until October 17: she returned to work on a part-time basis, only, until mid-November. The community nurses failed to send out an appointment until some weeks later, and when they did so it was for an appointment in early October. Although out-patient visits had been reaffirmed as an element in the continuing care plan, Dr. Coxhead stopped sending Richard Linford any appointments, recognising that he was not going to attend them in any event.

68. No-one told Dr. Coxhead that Alison Lamb had gone on leave or that the nurses had failed to make any contact with Richard Linford. While Alison Lamb was on leave there was no active approved social worker attached to the Maldon Mental Health Team.

69. In early September 1994 Richard Linford was admitted informally to the Linden Centre, a psychiatric unit with open wards in the grounds of Broomfield Hospital. It had recently opened, and provided out-patient and in-patient facilities for the first time, for the population of Mid Essex. Richard Linford was admitted because he had thrown a burning mattress out of the window of his flat. He was clearly psychotic, but he discharged himself by walking off the ward three days later.

70. On 15 September he was treated for lacerations to his wrists at the Broomfield Hospital Accident & Emergency Department: he was agitated, and shouted *"Why didn't Jesus save me?"*. He was seen by a doctor from the Linden Centre but was not admitted.

71. On 27 September he was assessed twice by doctors from the Linden Centre: once in the morning and once in the evening. On both occasions he claimed that he was Jesus Christ and walked, or lay down, in the road. On the second occasion he was assessed for two hours by Dr. Anderson, Medical Director of the Mid Essex Community and Mental Health NHS Trust, and by Mr. Thomasson (who also saw Christopher Edwards on 26 November) at Colchester Police Station. He was not admitted to hospital.

72. At the end of September, Dr. Coxhead became concerned at the nature and frequency of these assessments and decided that a further case conference should be convened before 18 November. Some delay occurred in making the necessary arrangements because it was still not known that Alison Lamb was absent on leave.

73. In the meantime, Richard Linford was assessed at the Linden Centre on two further occasions. He was not admitted. The medical staff did not find any evidence of acute mental illness.

74. The case conference took place on October 24. It was attended by a cross-section of those who were concerned with Richard Linford's care. The meeting included representatives from the Maldon District Council Housing Department. Mrs. Titheridge attended, but her son did not do so: he had not been invited. Nor had any representative from the probation service, or from Runwell Hospital.

75. But for the complete absence of any proper monitoring of Richard Linford's condition in the community, Dr. Coxhead would have been alerted at a much earlier stage to the difficulties he was causing his neighbours and to the serious concerns which were being expressed by the Housing Department. The case conference would, and should, have been convened some weeks earlier.

76. In what has proved to be a chilling observation, Dr. Smale, one of Richard Linford's general practitioners warned the conference that Richard Linford *"could actually murder someone"*. The Linden Centre Staff, and Inspector Robertson from Maldon Police Station, also advised that he was capable of serious violence and ought to be detained in a secure environment. This had been Alison Lamb's view, at least since May 1994. Yet no formal risk assessment was carried out. Dr. Coxhead contemplated the practical difficulty of admitting Richard Linford directly to Runwell Hospital under section 3, Mental Health Act 1983: he had no direct access to those beds. Admission would depend on the outcome of an assessment by the psychiatrists at Runwell Hospital. Plashet I (intensive care) and Plashet II (RSU) had their own criteria for admission. Dr. Seewoonarain, Consultant Forensic Psychiatrist, would probably have taken the view that Richard Linford was insufficiently disturbed at that time, and would have wanted to be satisfied that adequate community care really could not be provided.

77. Despite the range of concerns which were expressed at the conference, it was resolved by all those present that one last attempt to persuade Richard Linford to take depot medication was justified. This was subject to the proviso that if he failed to respond within eight weeks, then he would be detained under section 3 of the Act. In the meantime Dr. Coxhead would write to

Runwell Hospital to warn them that he may require a bed since the Linden Centre would probably not be able to contain him for very long following his detention under the Act.

78. Dr. Coxhead did not accept, at that stage, that the risk to public safety was as serious as others had contended. He did not think that Richard Linford was potentially homicidal. He undertook, however, to review the past history and reassess the diagnosis.

79. The arrangements for the next eight weeks did not involve any specific role for the community nurses. It was intended that Richard Linford would be invited to attend the GPs' surgery to receive his medication. They never saw him again.

80. By November 7, Dr. Coxhead knew from the GPs that Richard Linford was steadfastly refusing to take any depot medication. From that point it became inevitable that Richard Linford would need to be detained under the Mental Health Act.

81. Dr. Coxhead reviewed the medical history and concluded that the preferred diagnosis was indeed schizophrenia. Although he dictated a letter to Dr. Seewoonarain at Runwell Hospital he made no note of this change in diagnosis. A combination of secretarial delay and illness intervened to prevent the letter being sent until November 18. There was in any event, so far as Dr. Coxhead was concerned, no real urgency: he still did not believe that Richard Linford was potentially homicidal or really dangerous, and nothing seriously untoward had occurred in the community in the meantime. Even though, on November 9, Richard Linford had been drinking and had taken a non-life threatening overdose of diazepam tablets which had been prescribed by the GPs the previous day, that was not sufficient to inject serious urgency into the situation. Dr. Coxhead anticipated that he would be able to detain Richard Linford by the end of the month.

82. Unfortunately, on three separate occasions in November, the GPs prescribed Richard Linford with amphetamines, despite his history of substance abuse. The last prescription was on 21 November and was for seven days' supply. The prescriptions were stopped after Dr. Coxhead wrote and expressed his concern.

83. After the case conference on October 24, Richard Linford was not monitored, although an unqualified care worker spent time talking to him and helping him with his shopping. That was the extent to which community support for this difficult and potentially dangerous patient had shrunk.

84. If Dr. Coxhead had appreciated, on October 24, that Richard Linford did represent a real risk of serious injury, or death, to members of the public, an attempt would probably still have been made to see if Richard Linford would accept depot medication. But there would have been a significant difference in the care arrangements. Dr. Coxhead would have written to, or telephoned, Dr. Seewoonarain at Runwell Hospital immediately and, as soon as he knew on November 7 that Richard Linford was continuing to refuse to take medication, he would have detained his patient under the Act within a day or so thereafter. He would have been admitted to the Linden Centre for a matter of hours and then he would have been transferred to the Intensive Care Unit at Runwell Hospital.

85. Richard Linford was arrested on 26 November after he assaulted a female friend and her neighbour. He was behaving in a bizarre manner. He was seen by the police surgeon, Dr.

Wakely, at Maldon Police Station, who thought he might be either mentally ill or *"putting it on"*. He asked Dr. Durrani, the Registrar at the Linden Centre, to assess him.

86. Dr. Durrani and Mr. Reid, the Charge Nurse, did not attempt to locate Richard Linford's medical notes before the assessment. (The notes were, in any event, locked in a cabinet.) However, they recalled Richard Linford well, having assessed him, or cared for him, either at Severalls Hospital or at the Linden Centre. Dr. Durrani discussed his assessment with Dr. Anderson on the telephone. It was concluded that Richard Linford was fit to be detained in the police station: they believed that he was suffering from the effects of alcohol and substance abuse against a background of personality disorder. That was, and had been for some time, the working diagnosis. Richard Linford told them that he had been taking amphetamines, which was true. Dr. Durrani, Dr. Anderson and Mr. Reid were aware of the various diagnoses which had been applied to him, although they did not know that Dr. Coxhead, by this stage, had reverted to a diagnosis of schizophrenia. Nor did they know anything about the case conference or the outline plan to detain Richard Linford under the Act. They found no evidence of psychosis: they thought that he was trying to avoid the consequences of the criminal justice process. This had been the perception of others on previous occasions, too. However, if suitably secure beds had existed in Mid Essex then Richard Linford could have been detained under section 2, Mental Health Act 1983 for assessment, even though he was not considered to be acutely mentally ill, on the basis of his past history and presentation.

87. If Dr. Durrani, Dr. Anderson and Mr. Reid had known about the case conference and the plan to detain Richard Linford, then Dr. Coxhead would have been contacted immediately. He would have been content for Richard Linford to remain in custody because he would have appreciated that Richard Linford would probably be transferred to Runwell Hospital under section 48, Mental Health Act 1983 in any event. The perception amongst medical and nursing staff at the Linden Centre was that it would have been impossible to arrange for an assessment to be carried out by the psychiatrists at Runwell Hospital over the weekend. The custody route to Runwell Hospital was believed to be quicker. No contact was made with Runwell Hospital that weekend. If contact had been made, Dr. Durrani would have discovered that a bed was available in the Intensive Care Unit.

88. Alternatively, Dr. Coxhead acknowledged that if Richard Linford were to be remanded on bail then he could be detained under the Act within a few days, as planned; although since the allegations involved violence, that would have injected some extra urgency into the situation.

89. Dr. Wakely saw Richard Linford later that day at Chelmsford Police Station. His behaviour on this occasion was markedly different compared with his behaviour at Maldon Police Station some three hours earlier when Dr. Wakely had seen him for the first time. This time, he was rational, apologetic, and no longer aggressive.

90. Dr. Wakely discussed the case on the telephone with Dr. Chapman, one of the GPs, who told him that Richard Linford, using his scientific background, had previously tried to blow up one GP and electrocute another. This was second, or third-hand information, and was not accurate: nonetheless it served to confirm Dr. Wakely's view that Richard Linford was a manipulator and that he was dangerous.

91. Dr. Wakely then advised the police officers that Richard Linford was *"sane"; "not mentally ill";* and that he was suffering from a behavioural disorder. He did not tell the police - or if he did, it was not spelt out clearly - that Richard Linford might be suffering from an underlying mental illness, namely schizophrenia. This is probably because it was not then considered to be

the working diagnosis. In any event, Dr. Chapman's disclosures to Dr. Wakely, although they were in fact unfounded, supported the diagnosis of behavioural disorder and substance abuse.

92. Later that weekend, whilst he remained in custody, Richard Linford attacked two police officers. He also behaved bizarrely at Broomfield Hospital when he attended for a facial X-ray. The custody officers did not call for him to be reassessed by a doctor. They believed that his behaviour was a manifestation of his manipulative and dangerous personality disorder. They relied on what Dr. Wakely had told them. Originally they had been astonished that he was not admitted to the Linden Centre, but Dr. Wakely's explanation reassured them.

93. PC Snelleksz, the "officer in the case", did, however, believe that Richard Linford was mentally ill, despite Dr. Wakely's advice and despite the assessment which had been carried out by Dr. Durrani. However, he agreed with the view that Richard Linford was dangerous. He advised the Crown Prosecution Service of this danger, in graphic terms, in a memorandum and recorded Dr. Wakely's opinion that he had a behavioural disorder. But he did not complete Form CID2, simply because he did not know of its existence. He had described Richard Linford as a *"menace"* and *"very dangerous to members of the public"* in Form MG7 which he supplied to the Crown Prosecution Service representative. If he had completed Form CID2 he would have highlighted Richard Linford's dangerousness and would have expressed the opinion that he was, despite the contrary views of two psychiatrists and a police surgeon, suffering from a *"mental disturbance"*; that he abused drugs and was a suicide risk. Other officers were similarly ignorant of the existence of this Form. This constitutes a serious indictment of Essex Police in failing to provide adequate instruction and guidance to police officers in the use of this vitally important document. It would otherwise have provided the prison authorities with formal notification, not only that Richard Linford was dangerous to others but also that he, too, might be vulnerable.

94. If a reassessment of Richard Linford's mental condition had been sought on Sunday evening, or even on Monday morning, it is at least possible that acute mental illness would have been identified, such was the developing - yet fluctuating - nature of his condition at that time.

95. If mental illness had been identified then it is likely that he would have been admitted to the Linden Centre despite the security difficulties there. The Linden Centre would have had to manage as best it could until Runwell Hospital could carry out its own assessment and admit him.

96. Richard Linford was taken to court late on Monday afternoon. He was represented by a solicitor but was not seen by a probation officer. Alison Lamb attended court, too. The court was presented with a *"sane but dangerous"* description of him. He was remanded in custody and taken directly to Chelmsford Prison.

97. Even though the police and the Crown Prosecution Service knew that he had been described as dangerous, no formal warning of his dangerousness was given to the prison authorities, probably because the level of dangerousness was not considered to be "exceptional".

98. On arrival at the prison Richard Linford was located temporarily in cell D1-11, because of his dishevelled appearance, uncooperative manner and the injuries to his face. (These had been sustained partly in the struggle with his friend's neighbour and partly as a result of him banging his head against the wall of his cell in the police station.)

99. He was then placed in cell D1-6, which was occupied by Christopher Edwards who had already completed the admissions procedure. Richard Linford was moved into cell D1-6 because all the other cells on landing D1 had by then been filled with other prisoners, and two sentenced prisoners, "B" and "M", had to be located apart from the remand prisoners.

100. Richard Linford was removed from cell D1-6 so that the admission procedures could be completed. He was screened by Mr. Neal, the healthcare worker who had earlier screened Christopher Edwards. Mr. Neal knew nothing about him, save that he had been *'difficult'* in the police station. He told Mr. Neal only that he had seen a psychiatrist - and named Dr. Coxhead - *"six months ago"*, but he denied taking drugs. Mr Neal noted no bizarre behaviour at that stage and consequently saw no need to admit him to the Health Care Centre. Accordingly, he was returned to cell D1-6 with Christopher Edwards. When they were last seen together there was no suspicion on the part of anyone that Richard Linford would act violently towards his cell mate. They seemed perfectly content in each other's company - a fact confirmed when Richard Linford was interviewed by Professor Bluglass for the purposes of this Inquiry.

101. Shortly before 1 a.m., Richard Linford killed Christopher Edwards in cell D1-6 by kicking and stamping him to death. At the time, Richard Linford was acutely mentally ill. He was psychotic. He was hearing voices. He was deluded. How long the attack lasted is not known. What is known, is that one of them pressed the alarm button in the cell. That caused the green light to come on outside the cell. It should have activated a continuous buzzer sound on the landing. It did not do so. The system could have been deliberately disarmed by the wedging of a matchstick behind the buzzer re-set button on the landing. Landing D1 was last patrolled at 00.43 hours; up to seventeen minutes might have elapsed after Christopher Edwards or Richard Linford first pressed the button in the cell before the sound of Richard Linford banging the cell door raised the alarm. If the buzzer had sounded and the prison staff had responded earlier, that might have saved Christopher Edwards' life. Further minutes were lost whilst prison staff were ordered to don protective clothing. By the time they entered the cell, Christopher Edwards was dead.

102. Later that day, Richard Linford was admitted to Rampton Special Hospital suffering from paranoid schizophrenia after he was assessed by Dr. Helen Stuart of Runwell Hospital.

103. On 21 April 1995, at Chelmsford Crown Court, Richard Linford pleaded guilty to the manslaughter of Christopher Edwards by reason of diminished responsibility. A Hospital Order under section 37, Mental Health Act 1983, together with a Restriction Order under section 41 was made, and he was returned to Rampton Hospital where he remains to this day.

104. His Honour Judge Greenwood told him:

> *"I hope that those responsible for your welfare at Rampton Hospital see that you are not released until everybody is as certain as any human being can be that you are not a danger to the public."*

105. There were multiple failures in the delivery of adequate community care to Richard Linford during 1994. The major factors are summarised overleaf.

The failure of Richard Linford to cooperate

106. The primary and underlying cause of the failure to provide adequate care was Richard Linford himself. Even before he was discharged from Severalls Hospital on 8 January 1994 he had been refusing to take medication. For the next eleven months, whilst in the community, he remained without medication. When he was an in-patient he occasionally accepted medication and his carers were led to believe he might be persuaded to accept depot medication in the community. After he was discharged from Severalls Hospital, in early June 1994, the very essence of the care plan was based on that assumption.

107. When he had accepted medication in the community between 1989 and 1993, it had been effective. When he stopped taking it - for whatever reason - he had suffered a relapse. Thus a relapse after January 1994 was always predictable.

108. Richard Linford was uncooperative with almost every aspect of the support which was offered to him during 1994. He was discharged from the Community Rehabilitation Team and Cherry Trees Day Centre for non-cooperation or disruptive behaviour. He refused to accept Dr. Khetarpal as his Consultant in May, which had serious consequences. When the care plan in June 1994 provided for community nurse support - which remained the principal method of monitoring his mental condition throughout this period - he failed to attend the appointments which the nurses offered. He failed, too, to attend out-patient appointments with Dr. Coxhead.

109. Within days of the watershed case conference on October 24, he refused to contemplate taking depot medication.

110. The lack of medication was associated with a gradual, and in the latter part of 1994, an accelerated deterioration in his mental state. His failure to cooperate with his carers was a manifestation of that decline.

Sectorisation of Consultant practice

111. Until 10 May 1994 Richard Linford was under the care of Dr. Khetarpal at Severalls Hospital. He had treated him for a number of years and knew him well. When Richard Linford refused to be treated by him any further, Dr. Coxhead took over his care. Dr. Coxhead, however, had no connection with Maldon: his patients and his community teams were located elsewhere in the County. His only patient in Maldon was Richard Linford. This sectorisation of clinical practice led to a lack of working knowledge of the area and of the members of the local teams - particularly of Alison Lamb and the community nurses who were attempting to care for Richard Linford. This led, in turn, to significant gaps emerging in the flow of information which should have been supplied to Dr. Coxhead at crucial times. Despite this, it was Dr. Coxhead who, fortunately, felt the situation required - as it did - care reviews to take place earlier than planned. They took place on August 18 and October 24. Even so, this lack of information meant that these care reviews were held later than they should have been.

Inadequate implementation of the Care Programme Approach in Mid Essex

112. A Department of Health Circular, HSG(94)27: *"Guidance on the Discharge of Mentally Disordered People and their continuing Care in the Community"*, which was issued on 10 May 1994, summed up the essence of the Care Programme Approach in the following way:

> *"It is essential for the success of a continuing care plan that decisions and actions are systematically recorded and that arrangements for communication between members of the care team are clear. The patient and others involved (including, as necessary, the carer, health and social services staff, and the patient's GP), should be aware of the content of the plan."*

The role of the care coordinator (as the key worker is known in Essex) received additional emphasis in *"The Health of the Nation - Building Bridges"*, 1995:

> *"The key worker is the lynchpin of the CPA. He or she has the responsibility for coordinating care, keeping in touch with the patient, ensuring that the care plan is delivered and calling for reviews of the plan when required . . . Since the key worker is vital to the success of the whole process it is important that he or she be identified as soon as possible."*

113. Judged against these and other benchmarks, the delivery of care to Richard Linford was seriously flawed.

114. Although a CPA policy had been drawn up in 1992, its implementation in Mid Essex, even by 1994, was poor. The policy itself was also inadequate.

115. Health and social services' structural reorganisation led to a fading of the initial impetus for implementation. There was no continuous training of staff, whether on the health side or social services side, in CPA. It was poorly understood and practised. There was confusion about roles and responsibilities at practitioner level.

116. Alison Lamb, who was an experienced approved social worker, also had an inadequate understanding of CPA. She failed to appreciate that she had been appointed Richard Linford's care coordinator in January 1994; alternatively, if she did appreciate it, she had a poor appreciation of what was involved - such as keeping in touch with the client. She failed to record the decisions of care reviews or circulate such information to those who needed it. She failed to monitor Richard Linford's progress systematically and inform others, such as Dr. Coxhead, of his deteriorating circumstances. She failed to establish any professional relationship with Dr. Coxhead, even allowing for the geographical difficulties. These features are, however, in part a reflection of the inadequate policy which was drawn up in 1992. Inadequate practice guidance in the operation of CPA had been issued by health and social services. These deficiencies were compounded by a continuous failure by social services to organise adequate supervision of Alison Lamb throughout the whole of 1994.

117. These personal failings were symptomatic of a wider failure by her employers - The Mid Essex Group - to inculcate the culture of CPA amongst its employees.

118. When the Mid Essex Community and Mental Health NHS Trust was formed in April 1994, it was realised that all was not well with the operation of CPA. Steps were taken in mid-1994 to review its operation. Preliminary proposals were submitted to the Trust Board at the end of October 1994. The death of Christopher Edwards acted as a catalyst for a more radical appraisal. Reforms were eventually instituted in December 1995.

Inadequate community nursing provision

119. The Community Mental Health Team in Maldon had no professional links with Dr. Coxhead. The only patient they had in common was Richard Linford. From June 1994 the care plan required the community nurses to meet Richard Linford at the social services offices in Maldon and to operate as a pair for safety reasons. When Richard Linford failed to keep appointments, no attempt was made to see him at his flat throughout this period. There were large gaps between the appointments when they were offered. The result was that the nurses achieved nothing and Richard Linford remained unmonitored for five months.

120. The Community Mental Health Team and the Community Rehabilitation Team were far too small and both were overstretched. This has been recognised by the Mid Essex Community and Mental Health NHS Trust. Both teams have been amalgamated and restructured. The catchment areas of the Consultant Psychiatrists have been redefined so as to match the areas served by the (new) Community Mental Health Teams.

Failure to communicate key information

121. There were multi-professional failings in this respect. Not only did Alison Lamb fail to pass on information, but others who did appreciate that she was the care coordinator failed to provide information to her. The hospital failed to pass on discharge information; the GPs failed to alert her to Richard Linford's change of GP in February 1994, or to his appearances at the surgery in November 1994. The community nurses failed, particularly after August, to inform Dr. Coxhead or social services, in Alison Lamb's absence, that Richard Linford was not keeping appointments and that they had not been able to see him for weeks on end. Nor was Dr Coxhead told of Alison Lamb's absence.

122. There was no real understanding in the field that relevant information has to be routed at least through the care coordinator in order that he or she may be best placed to monitor what is going on.

123. The failure to communicate information is a reflection of a poor understanding of the basic concept of the Care Programme Approach.

Insufficient staff-supported housing

124. There was insufficient staff-supported housing provided directly by social services and by the Mid Essex Community and Mental Health NHS Trust (and by its predecessors) for patients such as Richard Linford.

125. Places are, and were, at a premium, but when they can be found - such as at Greenwoods, in Stock, Essex - they are funded by Social Security benefits and by "top-up" funds from social services budget.

126. Proper accommodation for patients such as Richard Linford is vital. He was allocated a single person's flat where conditions became squalid. He became depressed and a progressive nuisance to his neighbours, one of whom became ill as a result. In the absence of wider community support from social services or the nurses, some form of monitoring by means of staff-supported accommodation was essential.

Failure to communicate key information after arrest

127. Even after Richard Linford was arrested, systems of communication that were designed to be protective of others did not operate.

(1) PC Snelleksz, the "officer in the case", failed to complete Form CID2. He would have completed it if he had known of its existence. He would have completed it because:

(i) he believed that Richard Linford was mentally ill, despite Dr. Durrani and Dr. Wakely's contrary opinion, which he faithfully reproduced in Form MG7;

(ii) he believed that Richard Linford was *"very dangerous";* abused drugs and was a suicide risk.

That omission illustrates the failure by Essex Police to instruct police officers properly in the use and purpose of this vitally important document. Other officers were also unaware of the existence of this form, despite its inclusion in Force Standing Orders.

(2) Even though police officers at Chelmsford Police Station, including in particular the custody officers, believed Richard Linford to be *"very dangerous"*, they did not formally alert the prison to this risk factor. The prison reception staff were told merely that he had been *"fighting and causing trouble in the police station"*, which was a pale reflection of the true position.

(3) The police officers at Chelmsford Police Station were not told by Dr. Wakely, or by Dr. Durrani, in clear terms, that it was possible that Richard Linford was suffering from schizophrenia. Dr. Durrani (and thus Dr. Wakely) did not know that Dr. Coxhead had come to prefer schizophrenia as the correct diagnosis. The police officers were told in "black and white" terms that Richard Linford was suffering from a behavioural disorder and from the effects of alcohol abuse and drug withdrawal, and that he was manipulative and dangerous. They were told that he was mimicking psychiatric illness. They were told that he was therefore *"sane"*. This description was, in turn, the prime cause of the police officers' failure to react subsequently when Richard Linford was violent (he assaulted, or attempted to assault police officers in the police station) or behaved bizarrely (there was evidence of religious mania, he hit his head against the wall of his cell, and he walked into the shower fully clothed). The police officers did not recall Dr. Wakely or any other police surgeon to carry out a reassessment of his mental condition. Had they done so, it is possible that signs of acute mental illness would have been evident. In those circumstances Richard Linford would inevitably have been admitted to the Linden Centre immediately, even if temporarily. Dr. Wakely did not have any communication with the medical officer at the prison, although it was recognised in the profession, at that time, that it was good practice to do so.

128. Dr. Durrani and Mr. Reid did not seek access to Richard Linford's notes before they assessed him on 27 November at the Linden Centre. Nor did Dr. Anderson, who had assessed Richard Linford on September 27, advise them to do so. The notes should have been sought even though Dr. Durrani and Mr. Reid, in particular, had assessed and cared for Richard Linford in the past, notwithstanding that the assessment was limited to determining whether Richard Linford was fit to be detained in the police station.

129. That the notes were inaccessible in a locked cabinet, in Dr. Coxhead's secretary's office - although unknown to Dr. Durrani - represents an unsatisfactory management practice. That has been recognised by the Trust. It is now Trust policy that the relevant clinical notes should be obtained, where possible before any assessment is carried out. The failure to obtain access to the notes had potentially serious consequences. If they had obtained access to them they would have discovered the details of the case conference, and further, that Dr. Coxhead was contemplating the detention of Richard Linford under the Mental Health Act. Dr. Coxhead would, in turn, have been contacted and would have advised that his diagnosis was now schizophrenia.

130. There would, in those circumstances, have been a significant difference in the nature of the information which would have been given to the police officers by Dr Wakely. Although Dr. Durrani's conclusion - that there was no sign of acute mental illness - may well have remained unchanged, this information would have been sufficient to have placed the police in a better position to recognise the onset of acute mental illness when signs of "deterioration" became evident later. If so, the police officers would probably have called for a reassessment of his mental condition and Richard Linford may well have been admitted to the Linden Centre.

Court Diversion Scheme

131. Probation officers sometimes did not see new defendants before they appeared in court and there was no Court Diversion Scheme operating in Mid Essex, in particular at Chelmsford Magistrates' Court, in 1994, despite this having been identified as Government policy as early as 1990 (HOC 66/90). Had one been operating, Mr. Stone (Richard Linford's solicitor) and Alison Lamb would have been able to seek advice and perhaps arrange for an assessment before Richard Linford was brought over to court from the police station at 4 p.m. It is impossible to be certain about the outcome given the limitations of the present scheme, which was established in 1995. Such a scheme will only operate to divert those who are making a first remand appearance if access to Runwell Hospital, or other hospitals, can be arranged the same day. Otherwise, unless bail is considered suitable, accused persons who are suffering from a mental illness will continue to be remanded in custody.

The Prison Health Care Centre

132. The health care screening at Chelmsford Prison was inadequate, in that Mr. Neal carried out the screening exercise with limited information. He did not have a completed Form CID2. He did not have any knowledge of Richard Linford's previous convictions; nor did he have any copy of Dr. Wakely's entry in the forensic medical examiner's examination book. However, even if he had had this information, Richard Linford would probably not have been admitted to the Health Care Centre because the determinative criterion for admission was the manifestation of bizarre behaviour: Richard Linford did not behave in that fashion during the screening process. The Senior Medical Officer and the healthcare staff did not consider the content of Form CID2 to be determinative.

The criterion of 'bizarre behaviour' was, in any event, unlikely to identify all cases of mental disorder.

Operational failures at Chelmsford Prison

133. There were two operational failures by the Prison Service:

(1) **The sharing of cells**

Neither Richard Linford nor any of the other prisoners on landing D1, including Christopher Edwards, ought to have been sharing a cell if the recommendation of HM Chief Inspector of Prisons, in 1993, had been accepted and implemented.

These cells, which contain integral sanitation, are unsuitable for double occupancy by remand prisoners. The recommendation of HM Chief Inspector of Prisons should be implemented urgently.

(2) **The failure of the cell call system**

The mere fact that this vitally important system can be disabled, simply by wedging a matchstick behind the re-set button, is a cause for grave concern. The health and safety of prisoners depends on an effective and failsafe mechanism for communication. This system does not fulfil this requirement. There should be a two-way communication link to a control room.

Christopher Edwards' life might have been saved if the buzzer had remained sounding, after the button in the cell had been pressed - whoever pressed it. Although there was no-one nearby to see the green light outside the cell, the buzzer would have been heard. How long elapsed between the button in the cell being pressed and the sound of Richard Linford banging the cell door, which eventually raised the alarm, is unknown, but it could have been up to seventeen minutes.

The test carried out on this system by Essex Police in the early hours of 29 November, and which purported to establish that it was working correctly, was inadequate. It was not working correctly.

CONCLUSIONS

Conclusions

134. Richard Linford killed Christopher Edwards in cell D1-6 at Chelmsford Prison during the night of 28/29 November 1994. After inquiring critically into the recent histories of the two young men we conclude that, ideally, neither should have been in prison; and in practice they should not have been located together in D-Wing. Yet there seems to have been a tragic inevitability in the responses of those who should have been able to help them and to keep them apart.

135. This Report is now, sadly, one of many to highlight poor record-keeping, inadequate communication and limited inter-agency cooperation, in the context of government policies that were admirable in concept but unachievable for many authorities because of scarce resources. There were too few low-security beds in the psychiatric hospitals which served Mid Essex, too few psychiatrists and social workers to meet the demands of mentally disordered offenders, and too much bureaucratic change.

136. Consequently, there was too little enthusiasm and energy to embrace the more constructive practices which had been initiated by the Home Office, for diverting mentally disordered offenders, and by the Department of Health for Care in the Community.

There was a pragmatic preference by the clinicians for the criminal justice route to admission to hospital for psychiatric assessment and treatment.

The Prison Service did not live up to its own standards, which had been published in response to the Woolf Report (Home Office, 1991c).

We have described these shortcomings in detail.

137. The failures were not all 'on the ground'. Policies need not only to be framed, costed and financed in such a way that they can be adopted locally, they also need to be followed up by someone with accountability. Many practices have been improved during the course of this Inquiry. We have set out, as best we can, the full picture as it was in 1994, the improvements that have been made since then, and what remains to be done.

138. Care in the Community must remain the preferred option but it will always involve some risk. Risks must be regularly assessed to minimise the danger to public and patients alike. Patients' cooperation and compliance should always be expected and encouraged but cannot always be assumed. No more security should be used than is necessary, but there must be access to local low and medium-secure accommodation for the assessment and treatment of mentally disordered offenders. More such beds are still needed in Mid Essex.

139. Although the Reed Report (DOH/HO, 1992) set out the necessary strategy for dealing with mentally disordered offenders, it had not been possible to implement the elements of that strategy, in the time available, to prevent the tragic death of Christopher Edwards. However such policies and practices which were in place in 1994 should have been sufficiently integrated to ensure that the two men did not meet when and where they did.

140. Many opportunities arose to influence the course of events which led, ultimately, to the death of Christopher Edwards. None of those opportunities was seized.

141. Our recommendations are designed to improve policy and practice, to achieve better funding, and to reduce the likelihood of such a tragic event occurring again. We do not underestimate the difficulties of achieving the integration of services, particularly where there is no accountable lead agency.

SUMMARY OF RECOMMENDATIONS

Summary of Recommendations

		MAIN REPORT Para. refs
A.	**CARE IN THE COMMUNITY : CENTRAL GOVERNMENT**	
1.	The review of mental health services (which was recently announced by the Secretary of State) should: (i) give special consideration to the strengthening of the arrangements for the community supervision and support of patients who have been discharged from psychiatric care, with particular reference to the means by which patients may be returned to hospital where there is a failure to comply with community care arrangements. (ii) consider the outcome of the consultation exercise which followed the publication, by the previous government, of the Green Paper *"Developing Partnerships in Mental Health"*.	Introduction 1728
B.	**CARE IN THE COMMUNITY : ESSEX**	
2.	The work of the joint Care Programme Approach Monitoring Group should continue to be given the support of all agencies so as to ensure that the joint CPA policy is fully implemented.	1598
3.	Progress reports on the implementation of the Joint Action Plan, published in June 1995, should continue to be issued until such time as Essex Social Services and the Mid Essex Community and Mental Health NHS Trust are satisfied that the deficiencies identified in June 1995, and in this Report, have been eradicated.	1635
4.	Arrangements should be made to ensure that general practitioners are able to provide an effective contribution to the operation of the Care Programme Approach, particularly in respect of those patients who have been identified as representing the greatest risk, either to themselves or to others.	1639
5.	A care coordinator who becomes aware that an accused person, who is suspected of suffering from mental disorder, is to attend court, should: (a) seek further information about the accused person from the responsible medical officer;	1413

		MAIN REPORT Para. refs
	(b) communicate all relevant information to the probation service and to the accused person's legal representative; (c) communicate, at the earliest opportunity, all relevant information to the senior medical officer at the prison if the accused person is remanded in custody.	
6.	A booklet should be compiled for the specific use of Care Co-ordinators which should identify their duties and illustrate their pivotal role in the management of care plans.	1601
7.	Key recommendations from previous Independent Inquiries should continue to be collated and used to improve the development and implementation of CPA policy.	1682
8.	Those medical staff, social work practitioners and members of Community Mental Health Teams who are concerned with the operation of CPA should be provided with training to assist them in carrying out proper risk assessments.	1705
C.	**ASSESSMENT PROCESSES**	
9.	The Royal College of Psychiatrists; the Royal College of General Practitioners; the Association of Police Surgeons, and the Medical Defence organisations should promote, as good practice, the making of a written note by a medical practitioner whenever he or she is asked to express a clinical view on the medical condition of a prisoner, even if it is expressed in a telephone call. The note, or an equivalent, should then be forwarded to the referring source.	143
10.	Essex Social Services should remind all approved social workers that they should ask to see the police surgeon's notes (if any) when they are carrying out a psychiatric assessment of a prisoner in a police station.	153
11.	A psychiatrist or approved social worker who has carried out a psychiatric assessment of a prisoner in police custody should provide the appropriate prison medical officer, as soon as possible, after a remand in custody with any information which is relevant to the mental state of the prisoner.	1046
12.	Medical practitioners should, wherever practicable, seek access to relevant clinical notes before commencing an assessment for the purposes of determining whether a person is fit to be detained in police custody, or fit to be interviewed by police officers.	1274

		MAIN REPORT Para. refs
D.	**JOINT PLANNING**	
13.	North Essex Health Authority should incorporate, in the strategic planning of mental health services for Mid Essex, provision for an appropriate number of low-secure beds.	1673
14.	North Essex Health Authority should establish, as a matter of urgency, a community forensic psychiatric service.	1676
15.	A Consultant Psychiatrist with at least one year's training in forensic psychiatry should be appointed in Mid Essex.	1678
16.	The Mid Essex and Community Mental Health NHS Trust should adopt the necessary measures to facilitate the appointment of a lead clinician from the Department of Psychiatry.	1683
17.	Housing Associations and Housing Departments should consider the adoption of allocation policies which take account of the care needs of any applicant who is subject to the CPA, and of any special needs or attributes of his or her prospective neighbours. The housing agency should be involved in the care plan.	1717
18.	The County Mental Health Strategy Group should bring forward further plans for the establishment of staff-supported accommodation schemes.	1719
E.	**COURT PROCEDURES AND COURT DIVERSION**	
19.	Greater priority should be accorded to the training of Magistrates in dealing with mentally disordered offenders. This should include a greater awareness of the existence and application of the civil powers of detention under the Mental Health Act 1983.	1386-1388
20.	The Home Office should provide Magistrates' courts, the probation service, the Law Society and the Crown Prosecution Service with guidance on the use of the proposed Prisoner Escort Record (PER) Form.	1299
21.	Training should be provided to Magistrates' court clerks to ensure that they are reminded of the existence and application of the civil powers of detention under the Mental Health Act 1983.	1389
22.	Magistrates and court clerks should be encouraged to communicate any concerns that they may have about a prisoner who is remanded in custody to the prison medical officer.	1390
23.	Solicitors who seek membership of local Duty Solicitor Schemes should be required to demonstrate an awareness of the relevant provisions of Parts I, II and III of the Mental Health Act 1983; and of the Code of Practice of local Court Diversion Schemes, and of	1394-1395

		MAIN REPORT Para. refs
	the local protocols in respect of section 136, Mental Health Act 1983.	
24.	Members of Duty Solicitor Schemes should attend, periodically, a Mental Health Law module as part of their continuing education obligations. Alternatively, arrangements should be made for awareness training to be provided by the Essex Mentally Disordered Offenders Steering Group.	1396
25.	Legal representatives should consider whether it may be appropriate to address the question of transfer to hospital under section 48, Mental Health Act 1983, with the prison medical officer, whenever it is believed that a client who has been remanded in custody may require psychiatric assessment or treatment.	1397
26.	Crown Prosecution Service advocates should undergo appropriate training in dealing with mentally disordered offenders as part of their continuing professional education.	1403
27.	The Coordinator of the Mid Essex Court Diversion Scheme should be responsible to a psychiatrist who has had forensic training.	1362
28.	A small multi-agency advisory group of practitioners should be set up to support the Coordinator of the Mid Essex Court Diversion Scheme in the management of complex cases.	1363
29.	A clinical psychologist should be attached to the Mid Essex Court Diversion Scheme for a trial period.	1367
30.	North Essex Health Authority should continue to provide a funding commitment to the Court Diversion Schemes in North Essex.	1382
31.	The existing Court Diversion Schemes in North Essex should be provided with additional funding so as to enable a 24-hour, seven days a week service to operate.	1383
F.	**POLICE**	
32.	Custody officers should be reminded of their obligations under the Codes of Practice issued under the Police and Criminal Evidence Act 1984.	182
33.	Forensic medical examiners should inform the medical officer of the local prison of any information which relates to a prisoner's physical or mental health, and particularly of any assessment which has been carried out by a psychiatrist or approved social worker. (When the PER Form is introduced, such information should be in a sealed envelope attached to the Form.)	1296

		MAIN REPORT Para. refs
34.	Police officers should obtain the details of a defendant's previous convictions as soon as possible and supply them to the Crown Prosecution Service and the prison. (Details of the convictions should be attached to the PER Form when it is introduced.)	1195
35.	Guidance and training should be provided to police officers in the use of the PER Form when it is introduced.	1298
36.	Police officers should be encouraged to advise custody officers of the existence of any risk factors that may apply to a particular prisoner.	1298
37.	*Understanding Mental Health* training should be provided to existing and new staff, in duty time, by divisional training officers together with appropriate assistance from FMEs, the Psychiatric Adviser and Diversion Coordinators.	1303
38.	The programme of training in *Understanding Mental Health* should be monitored for its effectiveness.	1306
G.	**PRISON**	
39.	All staff should be briefed fully on the purpose and use of the PER Form when it is introduced.	1429
	Reception	
40.	Guidance should be issued particularly to reception staff, which should address: (i) the action to be taken when a Form CID2, or PER Form is received; (ii) the need for the identification and recording of signs and symptoms of mental ill-health; (iii) the need to share any information or concerns about a prisoner's mental health with the Health Care Centre staff.	1463 1120
41.	Whenever a prisoner is admitted to the prison under a warrant issued under section 30, Magistrates' Court Act 1980, he should be admitted to the Health Care Centre for the first night in custody.	1464
42	The separate holding cells in the reception area of Chelmsford Prison should be taken out of use.	1132
43.	Prison officers should complete external training before appointment to the reception team. The Governor should ensure that they are familiar with the *Admissions Guide, Health Care*	1425

		MAIN REPORT Para. refs
	Standards, and the practice guidance which governs admissions to the Health Care Centre at Chelmsford Prison.	
44.	Information which is received from outside the prison, and which concerns a prisoner's physical or mental health, should immediately be supplied to the Health Care Centre.	1164
	Health Care	
45.	More sophisticated health screening guidance should be developed for healthcare workers in prisons.	1163
46.	The operation of the screening process should be regularly audited.	1474
47.	Proper criteria should be developed for admission to the Health Care Centre.	1163
48.	The Health Care Centre staff should ensure that healthcare workers who are carrying out screening duties have been supplied with any relevant information which has been received.	1159
49.	The Governor, the senior medical officer and the senior probation officer should review, periodically, the arrangements which govern the receipt and transfer of information which has been received from outside the prison.	1410
50.	A medical officer should be on duty throughout the normal reception period.	1167
51.	All healthcare workers should be adequately trained in accordance with *Health Care Standards* and should be able to recognise symptoms of mental disorder and understand fully the criteria for admission to the Health Care Centre.	1473 1475
52.	The healthcare worker in reception should be provided with the PER Form (when it is introduced), the previous convictions, and any documentation of a medical nature before interviewing the prisoner.	1197
53.	The healthcare worker in reception should always complete a body diagram when there are signs of physical injury or self-harm.	1242
54.	Two healthcare workers should be available to carry out the health screening of prisoners in reception.	1460
55.	The health screening of new prisoners, in reception, should be carried out in the medical room so as to provide privacy and confidentiality.	1426

		MAIN REPORT Para. refs
	Sanitation	
56.	No prisoner should be required to share a cell which has had simple sanitation installed.	1437
57.	The annual certification of cells should include in-cell sanitation as a relevant factor.	1436
	First Aid and Resuscitation	
58.	All prison officers should be trained in basic First-Aid.	1446
59.	At least one trained First-Aider, in addition to any healthcare worker, should be included in every night duty team.	1444
60.	First-Aiders' refresher training should take place every twelve months.	1445
61.	Standards of resuscitation should be incorporated within *"Prison Health Care Standards"* and within Section K of *"Prison Operating Standards"* so that effective resuscitation is available within four minutes of the discovery of need.	1458
62.	Health and Safety policy statements should specify the level of resuscitation that can be provided by qualified First-Aiders, health-care workers and medical officers, and should include a description of the available resuscitation equipment and its schedule of maintenance.	1457
63.	The Senior Medical Officer should be responsible for maintaining the resuscitation skills of qualified First-Aiders, healthcare workers, and medical officers.	1456
64.	More extensive training in cardio-pulmonary and respiratory resuscitation should be given to qualified First-Aiders.	1455
65.	A defibrillator should be available within the prison and sufficient staff should be trained in its use.	1450
66.	Consideration should be given to the training of all healthcare workers to Advanced Cardiac Life Support (ACLS) level.	1454
	Cell communication	
67.	The existing cell communication and warning system should be replaced by a two-way communication system linked to a control room.	1493
68.	The existing communication system should be regularly inspected by senior management.	1494

		MAIN REPORT Para. refs
	Communication with families	
69.	CI52/1990 should be revised and should emphasise the importance of demonstrating support for bereaved family members.	1441
H.	**HOME OFFICE**	
	Prison Escort Record	
70.	The proposed PER Form should make clear that the person responsible for the prisoner's custody at each stage in the custody chain has a duty to assess risks and to record the existence of any relevant risk factor. The custodian should record any *suspicion* of mental disorder. The Form should make provision for the attachment of any previous convictions.	1295 1297
71.	The Home Office Circular which will introduce the PER Form should be addressed to Police Forces, the Probation Service, the Crown Prosecution Service, Clerks to the Justices, the Law Society, the General Council of the Bar, and HM Prison Service. It should be copied to the Department of Health for distribution to Health Authorities and Trusts, who have responsibilities for services to mentally disordered offenders.	1299
	Forensic Medical Examiners	
72.	It should be a requirement of appointment as a forensic medical examiner that: (i) the appointee is a member of an appropriate body which can determine standards for appointment; (ii) the appointee should attend an initial training course which conforms to a syllabus agreed by the appropriate professional bodies; (iii) the appointee should, thereafter, attend a modular development training programme which complies with a syllabus which is agreed by the appropriate professional bodies. Such a syllabus should include an element of joint training of forensic medical examiners and custody officers; (iv) the appointee should, within a specified time, acquire the Diploma of Medical Jurisprudence and be approved under s.12, Mental Health Act 1983; alternatively, such approval should be a requirement for reappointment.	1316 1316 1316 1316
73.	The initial training course and the developmental modular training course should include specific guidance and training in the	1316

		MAIN REPORT Para. refs
	identification, and appropriate management, of mentally disordered offenders.	
74.	The senior forensic medical examiners should ensure that all forensic medical examiners in Essex are aware of local psychiatric - including forensic - services and facilities, and encourage regular contact between both groups.	1316
75.	The senior forensic medical examiners should consider, in conjunction with the Essex Mentally Disordered Offenders Steering Group, the specific requirements, in Essex, for continuing professional development in the area of mental disorder.	1316
76.	Forensic medical examiners should certify in writing, either on the custody record itself or by attaching to it a copy of the entry which has been made in the FME's examination book, his or her own opinion - and the reasons for that opinion - that a prisoner is fit to be detained in the police station or, as the case may be, fit to be interviewed. FMEs should also set out in writing on the custody record any advice which has been given to the custody officer concerning the future care of the prisoner.	1316
77.	Where a forensic medical examiner is not approved under section 12, Mental Health Act 1983, a psychiatric assessment should be sought in the case of any prisoner who is suspected of suffering from a mental disorder before any determination is made that the prisoner is fit to be detained in a police station or fit to be interviewed.	1316
78.	Where a forensic medical examiner is approved under section 12, Mental Health Act 1983, he or she should carefully consider whether a psychiatric assessment should be sought whenever an issue of fitness to be detained in a police station, or fitness to be interviewed arises, in circumstances where there is a suspicion that the prisoner is suffering from a mental disorder.	1316
79.	Forensic medical examiners should be reminded of the need to communicate relevant information to prison medical officers in the case of those persons who are detained in the police station and who are suspected of suffering from a mental disorder, physical illness, substance abuse or suicidal tendencies, and who may be remanded in custody by the court.	1316
80.	Arrangements should be made to ensure that the details of any assessment which has been carried out by a forensic medical examiner, or by a psychiatrist, are provided to the Crown Prosecution Service on a first remand appearance of an accused person.	1316

		MAIN REPORT Para. refs
81.	Arrangements should be made to ensure that forensic medical examiners are provided with effective information and guidance on the use of the proposed PER Form when it is introduced.	1316
82	The British Medical Association should be encouraged to update and extend the material in its booklet *"Health Care of Detainees in Police Stations"*, which was published in 1994 and which is now out of date. The revised edition should reflect the developments in the field since that date, with particular reference to HOC 66/90, HOC 12/95, Court Diversion Schemes and, when published, the new PER Form and Circular. It should emphasise that psychiatrists and forensic medical examiners should communicate relevant information to prison establishments.	1316
	Area Criminal Justice Liaison Committees	
83.	Area Criminal Justice Liaison Committees should be asked to monitor progress on the implementation of HOC 66/90 and HOC 12/95.	1337
I.	**ESSEX PROBATION SERVICE**	
84.	Duty probation officers at court should be reminded that they should attempt to see a defendant before he or she appears in the Magistrates' Court, and if there is any suspicion of mental disorder they should raise the matter with the police, legal representatives and court clerk.	1328
85.	Probation officers and probation service officers at court should be given effective guidance on the use of the national PER Form when it is introduced.	1411

Appendix

Richard Linford
A schedule of hospital referrals and admissions

RICHARD LINFORD

A schedule of hospital referrals and admissions

1986	18.6.86	Admitted to Chelmsford and Essex Hospital : overdose: Codeine Phosphate.
	21.6.86	Discharged.
	2.9.86	Out-patient at Severalls Hospital
1988	2.1.88	Admitted informally to Severalls Hospital (Dr. Khetarpal) following GP referral (Dr. Roper).
	7.1.88	Discharged.
	9.1.88	Assaulted mother → Admitted to Severalls from Maldon Police Station under section 4 MHA → s.2 → then informally.
	4.3.88	Discharged : "Diagnosis unsure".
	9.3.88	Royal Shrewsbury Hospital: informal admission via local GP.
	31.3.88	Took own discharge.
	17.6.88	Attempted to jump from window. Informal admission to Severalls Hospital : seclusion.
	15.7.88	Took own discharge.
	17.7.88	Assaulted mother : a.b.h.
	18.7.88	Remanded in custody to Norwich Prison and then Chelmsford Prison.
	25.8.88	Pleaded guilty to assault on mother.
	29.9.88	Section 37 Order.
	21.10.88	Admitted to Runwell Hospital medium-secure unit from Chelmsford Prison. [Dr. Seewoonerain/Dr. Heine] Diagnosis : schizophrenia.
1989	21.4.89	Section 37 Order renewed : detention at Runwell Hospital extended for a further 6 months.
	4.8.89	Transfer from Runwell Hospital to Severalls Hospital with weekend leave.
	5.10.89	MHRT : Re-graded to informal patient status.

1990	23.3.90 ↓ ↓ 5.12.90	Discharged from Severalls Hospital to Greenwoods Therapeutic Community. Admitted to Severalls Hospital : s.2 MHA : seclusion.
	20.12.90 ↓ ↓ ↓ 15.7.91	Transfer to Runwell Hospital from Severalls Hospital : s.2 MHA → s.3 MHA. At Runwell Hospital Transfer to Severalls Hospital from Runwell Hospital.
1991	26.7.91	Transfer to Runwell Hospital from Severalls Hospital.
	4.11.91	Discharge (after home leave), and after short Greenwoods assessment to mother's home.
1992	6.1.92 ↓ ↓ ↓ ↓	G.P. VISITS { Community Mental Health Team { accepts RL : Bob Edwards as CMHN Oct. '92 { { Social Services Department { (Alison Lamb) closes file.
1993	10.2.93	Admitted as informal patient to Severalls Hospital - (had ceased medication : psychotic). Dr. Coxhead assessed RL
	29.4.93 ↓ ↓ ↓ ↓ 30.10.93	Discharged to 55B, Mill Road, Maldon. July 1993 : Bob Edwards sees RL for last time. August 1993 : Community Rehabilitation Team (Dr. Heine) accepts RL as a client. GP Visits / OPD at St. Peter's Hospital.
	29.10.93	Attacked mother (kicked her down stairs).
	30.10.93	Attacked members of the public. Admitted via Maldon police station to Severalls Hospital - informally then s.5(2), then s.3. [Dr. Khetarpal / Dr. Holmes / Dr. Coxhead]
	3.11.93	Transfer to Willow House, Severalls Hospital.
	15.11.93	Transfer to Mirbeck Ward, Severalls Hospital.
	14.12.93	2nd opinion : Dr. Chad.

1994	8.1.94	Discharged. Care Plan : CPA/117. No medication. Diagnosis of schizophrenia "re-opened"
Care Plan ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓	8.3.94	Discharged from Cherry Trees Day Unit : non-cooperation (Rosemary Gittings).
	10.5.94	Attacked JL in the street. Detained under s.136 MHA (jumping out of window). Informal admission to Severalls Hospital from Maldon Police Station : Dr. Durrani / Dr. Coxhead.
	10.5.94	Meeting : Drs. Khetarpal, Coxhead, Chad and Anderson : Dr. Coxhead agrees to become RMO.
	24.5.94	Care Plan review : Dr. Coxhead and Alison Lamb.
	26.5.94	Alison Lamb's correspondence: she identifies risk of violence.
	27.5.94	Discharged from CRT by Dr. Heine.
	3.6.94	Discharged from Severalls Hospital. Amended care plan.
	20.6.94 ↓ ↓ ↓	Broomfield Hospital A& E Department : admission : excessive alcohol. Discharged 22/6. GP VISITS: ↓ Failure to attend OPD ↓ and CMHT nurses.
	18.8.94	Case Conference at Linden Centre : Dr. Coxhead, R. Gittings, A. Lamb and J. Proctor.
	19.8.94	Alison Lamb absent on compassionate leave until 17.10.94.
Alison Lamb on compassionate leave	30.8.94	C. Harrison in post.
↓ ↓ ↓ ↓ ↓ ↓ ↓	9.9.94	Linden Centre : (Burning mattress incident) C. Harrison and GP, Dr. Teatino, attended : Informal admission. [Drs. Coxhead, Holmes and Canfield]
	12.9.94	AWOL
	14.9.94	Discharged in absence.
Alison Lamb on compassionate leave ↓	15.9.94	Broomfield A&E : cut wrists Seen by Dr. Netherwood. RL declined admission to Linden Centre.
	27.9.94	a.m. Section 136 (?) Seen at Linden Centre by Dr. Walsh : Not admitted.

Alison Lamb on compassionate leave ↓ ↓ ↓ ↓ ↓ ↓ ↓		p.m. section 136 Assessed at Colchester Police Station by Dr. Anderson and Mr. Thomasson (also Dr. Wilson, Police Surgeon). Not admitted.
	3.10.94	Boat incident : s.136 - Assessed at Linden Centre by Dr. Coxhead and Dr. Canfield. Not admitted.
	12.10.94	Overdose : (? Heroin/air injection) Broomfield Hospital A&E. Admitted to ward for observation. Assessed by Dr. Holmes and Mr. Gardner. Not admitted to Linden Centre.
	13.10.94	Discharged from ward.
	21.10.94	Arrived at Villa II, St. Peter's Hospital. DNA at Linden Centre.
	24.10.94	Case Conference : *"He could actually murder someone".*
	2.11.94	Dr. Haeger's letter to Dr. Coxhead: Refuses to take proposed medication.
	9.11.94	At Broomfield Hospital A&E : diazepam overdose. Seen by Dr. Holmes and Mr. Gardner. Not admitted.
	10.11.94 11.11.94 21.11.94	Amphetamines prescribed by GPs.
	26.11.94	Arrested. Assessed at Linden Centre : Dr. Durrani, Dr. Anderson, Mr. Reid. Not admitted.
	28.11.94	Chelmsford Magistrates' Court → remanded in custody.
	28.11.94	TRANSFERRED TO CHELMSFORD PRISON Screened by Health Care Officer (Mr. Neal)