REPORT TO NORTHUMBERLAND HEALTH AUTHORITY OF THE INDEPENDENT INQUIRY TEAM INTO THE CARE AND TREATMENT OF RICHARD STOKER

DECEMBER 1996

INDEX

NORTHUMBERLAND HEALTH AUTHORITY

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF RICHARD STOKER

TO THE CHAIRMAN AND MEMBERS
NORTHUMBERLAND HEALTH AUTHORITY

SECTION ONE - INTRODUCTION

Our Terms of Reference

We were appointed by Northumberland Health Authority on 4 April 1996 to enquire into the care and treatment of Richard Stoker and to report to the Authority in due course with our Report, Findings and Recommendations.

The establishment of the Inquiry was under the terms of the NHS Executive circular HSG(94)27 following the death of another patient, Halina Elizabeth Szymczuk, at Ashington on 29 May 1995. Halina S was discovered dead at her home in Sweethope Avenue, Ashington on Monday 29 May 1995. Subsequent police investigations confirmed that she had been stabbed to death. On Tuesday, 30 May 1995, Richard Stoker was charged with her murder and was subsequently taken into police custody. The trial of Richard Stoker took place at Newcastle Crown Court in February 1996 and he was found guilty of the manslaughter of Halina S on the grounds of diminished responsibility. Sentencing was then adjourned for reports and at Newcastle Crown Court on 29 March 1996 he was committed to Rampton Special Hospital. Following the conclusion of the Court proceedings, Northumberland Health Authority established this Independent Inquiry to examine the care and treatment of Richard Stoker and the circumstances leading to the death of Halina S.

Before we convened and met at Morpeth to hear and consider the evidence of witnesses, we held a series of briefing meetings and we considered in detail a number of papers, files, reports and records which had been made available for our consideration, a summary of which is set out in Appendix C to this report.

The Inquiry

We met together at Morpeth on 17, 18 and 19 June 1996 and again at Scotch Corner on 11 November 1996 to hear and take evidence from witnesses whose information and views we considered essential to a full and effective consideration and examination of this case. Details of the witnesses we then heard are set out in Appendix D. We were considerably assisted at our first meeting by the willingness of the brother of Halina S to come before us to express the

family's views and concerns at what had occurred, and to highlight for us the questions which were uppermost in their minds as requiring examination. We refer to this in more detail in subsequent paragraphs.

Additionally, two of our members with the co-operation of the Authorities at Rampton Hospital, travelled to Rampton to visit Richard Stoker and to talk to him about certain aspects of the case.

We later met on a number of occasions to draft and consider our Findings, Report and Recommendations which we now submit to Northumberland Health Authority in the exercise of the Terms of Reference which we set out in Appendix A. These Terms of Reference are wide-ranging and involve examination of a considerable amount of written material and the evidence of many witnesses. It has been a remit which caused all of us a great deal of concern because of the nature of the issues involved, and if we are anywhere critical in this Report of any stage of the care and treatment of Richard Stoker, it is because the facts, circumstances and evidence compel us to that view. We recognise at all times the care and concern, ability and experience of all those in the Health Services and Probation Service who have, over the years, devoted care and attention to Richard Stoker - but the purpose of such an Inquiry as this is to review all the facts and circumstances - inevitably with the benefit of retrospect and hindsight - and to consider whether anything might have been done differently which could or would have affected the outcome. We would, therefore, be failing in our duty if we did not draw attention to any area which we feel that action, 'might have been done better'.

It has also been a lengthy task , and we are grateful for the secretarial support and assistance which has been provided to us. We are extremely grateful to all of those who have made papers and documents available to us, including the Crown Prosecution Service and the Northumberland Police, and the Authorities who have placed their files and records at our disposal.

During the concluding stages of our consideration of the case we also had the opportunity of meeting with a representative of The Mental Health Unit (formerly Section C3) of the Home Office to consider with her the procedures applying to the care and supervision of Conditionally Discharged Patients and the application by the Home Office of its statutory provision and controls applicable in such cases.

Having seen and heard all the relevant witnesses and having considered all papers, documents, reports and statutory provisions and the local operational policies, we now submit to the Northumberland Health Authority our conclusions and recommendations for their consideration.

SECTION TWO

MISS HALINA ELIZABETH SZYMCZUK

Halina Elizabeth Szymczuk was a single lady, 48 years of age, born on 23 February 1947, who had a history of mental health problems going back many years. She had been admitted from time to time at St George's Hospital, Morpeth and was last in hospital in March 1989. From St George's she was discharged to Sweethope Avenue Hostel, a staffed residential home in Ashington managed by Social Services. She made excellent progress there, and was soon moved to single person accommodation with outreach support from Sweethope and achieved a high degree of independence and stability. She attended North Seaton Sheltered Employment Scheme five days per week and was a frequent visitor to the Sweethope Avenue Hostel where she was welcomed and where she kept up her long established contacts.

We were pleased to note from the reports and papers available to us that she was well liked and respected in the community in which she lived, and had excellent support from her key worker and the staff at Sweethope Avenue Hostel.

Her brother , Mr Edward Szymczuk, accepted our invitation to come and talk to us about Halina, and he was able to speak highly of the care and support Halina received from the NHS and from Social Services and the extent to which they had helped her to make a success of independent living within the community. He spoke of her pride in having and maintaining her own flat, which she looked after well, and her competence in managing her money and affairs. It was clear to us that despite her background difficulties, Halina had made a success of her independent living in the community and we again here express our very sincere regret - as we all indicated to Mr Szymczuk when he came to see us - that she should have died in this way.

While paying tribute to the care and support that Halina received, Mr Szymczuk was understandably very concerned and disturbed at her death at the hands of Richard Stoker. He perhaps best summarised his view in a written note to us in which he said:

> 'We have, like yourselves, only questions, and the desire that the problems arising from the care and treatment in monitoring - or indeed the miscare and treatment in monitoring - of Richard Stoker are fairly met; and that lessons learned would be put in practice so that further incidents of this kind are avoided. We will then feel Halina's senseless death will not have been in vain'.

We are very conscious indeed of the family's concerns and we trust that in this Report we have addressed them fully and that we have been able to point, fairly, to any lessons that might be learned from this tragic event.

SECTION THREE

THE BACKGROUND AND HISTORY OF RICHARD STOKER

The reports and document put before us give the following background and history of Richard Stoker:

Original Offence and Committal to Rampton

Richard Stoker was born in Blyth on 25 August 1936, the younger of two children to his parents. His father, a sergeant-major in the armed forces, was killed in action at Dunkirk and his mother subsequently remarried and had two further children.

His early life was apparently happy and he seems to have achieved his developmental milestones without delay, although on entering formal education it quickly became apparent that he was slow academically and had great difficulty attaining even basic literacy and numeracy skills, such that on leaving school in Blyth at 15 years he remained unable to read and write. He subsequently obtained employment at a local shoe shop, where he remained for two years before leaving to take up better paid employment as a labourer in a local wood yard.

In 1956, when he was 19 years old, there occurred an episode as a result of which he was accused of a minor sexual offence on two young girls, and as a consequence he underwent psychological testing. Intellectual assessments available at that time (which failed to allow adequately for poor literacy skills), placed him in the range of subnormality as a consequence of which he was certified as a mental defective and detained for two years at Aycliffe Hospital, until his release in September 1958.

He returned to the Blyth area, where he obtained employment as a labourer and, although he worked for a number of local firms, he essentially remained in full employment over subsequent years. He married in July 1965 and the couple later had two daughters. He had at this time obtained employment as a surface worker at a local pit, and for a period he seems to have enjoyed a happy and settled marital relationship and stable employment.

Some two years prior to the offence for which he was originally convicted and committed to Rampton, Richard Stoker suffered a head injury, when he was struck on the head by a brick and knocked unconscious. It was around this time that his behaviour is said to have changed, the family describing him as having suffered a 'personality change', although it is thought these effects may have been his reaction to increasing marital friction. According to reports he became morose and irritable, began neglecting his personal hygiene and he began drinking excessively, the latter leading to financial difficulties. There are said to have been frequent rows, often on the shortage of money. It appears he was prone to take out his anger on inanimate objects. It was in this emotional and financial setting that the initial offence was committed.

In 1976, Richard Stoker, knowing that his mother-in-law had a substantial amount of money in her house, decided to attempt to steal this from her, relying on her deafness to hide his attempts at breaking in. He was unfortunately disturbed at this by the lady, whom he knocked unconscious and, realising she could identify him, he took a knife from the kitchen drawer and stabbed her to death. He later threw the knife into the river and attempted to burn the purse.

On his arrest he made a full confession and assisted the police in their enquiries. Whilst awaiting trial he injured himself by stabbing himself through the hand with a half inch cold chisel. He was seen by a number of psychiatrists and at his trial was convicted of manslaughter on the grounds of diminished responsibility due to mental subnormality. His measured IQ at that time was around 60.

Conduct and Progress at Rampton Special Hospital and the Regional Secure Unit - Hutton Unit

Following his conviction and sentence Richard Stoker was admitted to Rampton Special Hospital on 8 June 1976, and whilst on the admission ward he apparently presented no management problem. He was transferred to various wards over the next 4 years and on no occasion is he said to have presented any difficulties. He obviously missed his family, which led on several occasions to him becoming depressed with thoughts of suicide. He never received any psychotropic medication during his stay, whilst psychological testing put him in the dull-normal range of IQ with the comment that his poor educational achievements had probably in the past given a falsely low value to his previous readings.

Whilst at Rampton, initial examination in September 1976 by the Senior Clinical Psychologist, concluded that Richard Stoker was capable of functioning at the borderline subnormal level, but was virtually illiterate and innumerate and, as a result of this, his educational attainments were well below the levels of which he was capable. His complete lack of basic educational attainments probably increased his dependence upon others for support and it was suspected that he must have had great difficulty in managing his everyday affairs and remedial education was recommended to increase his effectiveness and independence in coping with everyday life.

The analysis of the personality profile he presented was said to have resembled that of 'a neurotic, poorly adjusted, delinquent; one who clearly had difficulty in coping with stress and was prone to asocial behaviour but not prone to impulsive, thrill-seeking behaviour or habitual aggression'. It was added that there were firm indications that he had a very poor stress tolerance and that, in view of his shyness and inadequacy, interpersonal and social situations may have been a particular source of stress for him. He appeared most likely react to stress with anxiety, depressive brooding and physical tension. He tended to lack insight and be extremely hostile and mistrusting in his attitudes towards others and was more likely to blame others rather than himself for problems or difficulties.

His first assessment at Rampton was in 1982 (with a view to transfer to St George's Hospital) when it was felt he had not then received sufficient preparation for discharge. He was consequently reassessed at Rampton in November 1984 after he had been transferred to a pre-discharge villa, where he had made excellent progress. He had successfully completed a course of training in a self-contained flat in the Villa and a Mental Health Tribunal held in September agreed that Richard Stoker be transferred to a local Mental Hospital, once a place was available. He was subsequently transferred to the Regional Medium Secure Unit, the Hutton Unit, Middlesborough, in July 1985 where it is said he presented as no management problem whatsoever.

Admission to St George's Hospital, Morpeth

Richard Stoker was transferred to St George's Hospital at Morpeth in March 1986 under the care of Dr Brown, Consultant Psychiatrist, and initially was observed in the locked ward for a period of several months. On admission he was said to be pleasant and cooperative in attitude and this continued for the most part throughout his stay. He was found employment, within the hospital setting, and he was reported to be a conscientious and hard-working individual. It is reported that within the ward setting he never showed any major management problem and that on contact with more disturbed patients never showed any tendency to violent or impulsive behaviour.

He was transferred to Ingram Ward at St George's, an open rehabilitation ward, in November 1986 and showed no change in his behaviour and is said to have remained pleasant and cooperative throughout. He had a number of days leave to Sweethope Avenue Hostel, a Social Services Hostel for discharged psychiatric patients. Following a Mental Health Review Tribunal in June 1987 he obtained a Conditional Discharge, subject to the continuing supervision of the Responsible Medical Officer (who was Dr Brown), the Probation Officer and a condition of residence at Sweethope Hostel, Ashington, and left the Hospital in January 1988 to live at Sweethope.

Events following his Conditional Discharge in the Community

At the outset, Richard Stoker attended outpatients at St George's Hospital on a regular basis and was said on the whole to have co-operated well in this respect.

The view was expressed that considering the length of his previous hospitalisation Richard Stoker settled well into the environment offered at Sweethope Avenue, where he continued with good self-care in this sheltered environment whilst cooperative with other residents in the rota system for household duties. Eventually, when nearby accommodation was obtained for use by the hostel as an independent two bedroomed living flat, he and another female resident, Ms SG from Sweethope, were moved into the flat. Over subsequent months the relationship between Richard Stoker and Ms SG developed and eventually the couple were married in October 1989.

Whilst there had been relatively few major upsets when the couple were occupying the hostel training flat, presumably because the hostel staff were available to arbitrate disputes, the couples removal into independent accommodation brought with it incidents of marital discord, which continued until his wife, Sarah, was readmitted into hospital. It appears that in general their relationship was characterised by periods of closeness and affection and almost mutual dependence, interspersed by arguments, when Richard Stoker generally emerged the loser. His anger and frustration at those times had increasingly turned to himself, and there were several episodes where he self-inflicted injuries, such as cuts on his arms and chest. During the course of these rows he occasionally took or borrowed money, which he then spent on alcohol and his tendency to self-harm was noted to increase when he was intoxicated.

By midsummer 1992 the frequency and intensity of the rows did seem to increase to a worrying degree and Richard Stoker was seen several times in the local Accident and Emergency Department with self-inflicted injuries, occasionally associated with intoxication.

In drink he was heard to make threats against his wife, whilst she in turn demanded he leave the home. Re-admission to St George's Hospital was offered to Richard Stoker, but, although he did attend the ward, he was on admission much more subdued, the effects of the alcohol having worn off, and he refused to stay.

Following this, with his agreement and co-operation, it was decided to apply to the local Council for a separate accommodation on the grounds that he and his wife were separating, and likewise for him to arrange with the DHSS for him to receive his own benefit.

When separate accommodation was made available to Richard Stoker in 1992, it was decided that he and his wife would visit each other, providing they were on amicable terms, in the hope that this arrangement would defuse what seemed to be an escalating pattern of arguments and short-lived separations. For several weeks there was relative peace, for although they continued to spend long periods together, Richard Stoker now had the added security of his own accommodation. This situation came to an abrupt end when his wife was readmitted to Sweethope in March 1993, and subsequently to St George's Hospital.

Following his wife's readmission to St George's Hospital and her refusal to see or communicate with him, Richard Stoker became very distressed and he required a great deal of support and reassurance and this, we believe, was the commencement of a significant time in his care, management and treatment.

It was also at that time that he began associating with another (male) client from Sweethope Avenue, who had a history of alcohol abuse, and undoubtedly for several months after the breakdown of the marital relationship, Richard Stoker was known to be drinking to excess on occasions, such episodes being intermittently associated with incidents of self-harm.

Then in January 1994, Richard Stoker offered temporary accommodation to a couple (with learning difficulties), who had been made homeless by a domestic fire, and whilst it appears that his visitors did contribute towards the household expenses, reports indicated that Richard Stoker did seem to be drinking alcohol on a very much more regular basis which undoubtedly contributed to his being short of money. This increased alcohol intake, together with poor budgeting skills, led to him borrowing money from a local loan company, which he began paying back weekly. At times of emotional and financial stress, it was noted that Richard Stoker continued to self-harm and that this occurred more frequently after access to alcohol. Eventually the male member of the visiting couple was placed at Northgate Hospital for further assessment, whilst the young lady, continued to stay at Stoker's flat for a period before moving back to her own accommodation when this was made habitable. The relationship between Richard Stoker and the young lady (Ms DB) had remained only on a friendship basis, as Richard Stoker insisted he considered himself to be still a married man.

The More Recent History

The reports and papers before us indicate that between January and September 1994, there was a further deterioration in Richard Stoker's situation, which led to the professionals concerned considering seeking alternative accommodation arrangements for him.

Essentially the causes of the additional stresses were threefold:

1. Richard Stoker continued to be heavily in debt and, once his loan repayments had been made, he had insufficient money left from his benefits to live even a spartan existence - to such an extent that he was left without any electricity and heating at his home for long periods of time.

2. The relationship with Ms DB continued, but inconsistencies in the relationship did add to the stresses on Stoker and these constantly led to further episodes of self-harm.

3. Following a minor prosecution regarding the care of his dog, Richard Stoker's name was published in the local newspaper which alerted his first wife (from whom he was now divorced) and her family to his area of residence. As a consequence of this, this lady subsequently discovered his address and visited him at his home. The meeting was extremely stressful to Richard Stoker and as a consequence therefore, Richard Stoker indicated that he was in fear for his own continuing well-being and became very anxious to move from the area.

It is clear to us that from at least this stage there was a recognition that steps were becoming necessary to provide Richard Stoker with a more sheltered living environment, and those in charge of his care decided that a further period of hospital rehabilitation might be appropriate. Enquiries were accordingly made to the Consultant in St George's Hospital with special responsibility for this Inpatient Service, but the reports indicate that, due to long term sickness and administrative changes within the Department, it was estimated that an inpatient placement might take three months before availability - and this was therefore not considered to be a satisfactory solution.

Then, following a further incident in August 1994 of self-harm, Richard Stoker was admitted to an acute ward at St George's - but stayed, because of his own insistence, only for a matter of hours. Again, in the following month, he was admitted to hospital overnight because of an episode of agitation and distress exhibited at outpatients, but the only bed available to take him was in an elderly ward which was recognised as being quite inappropriate. However, following these incidents and following one of the few comprehensive Case Conferences which then took place in September 1994, it was decided to endorse Dr Brown's proposal that Richard Stoker's condition and needs would best be met by placement in a Nursing Home for patients recovering from mental illness. There was such a home at Innisfree in Hexham, and the Home was approached as it seemed ideally suited to Richard Stoker's needs, being in an enclosed environment and staffed with qualified psychiatric nursing staff with training towards rehabilitation. It was thought that this would assist Richard Stoker towards a solution of his then current situation and problems and assist him the better in coping with these. It seemed initially, following applications and interviews, that the application for a placement at Innisfree would be successful and this was viewed with confidence by the Care Team - and at that stage supported and endorsed by Richard Stoker himself. However, in January 1995, the application to Innisfree was (to the obvious dismay of the Care Team members) rejected and this solution to his then current problems which had had the support and endorsement of all of those concerned with his care and treatment suddenly came to nought.

Later Developments

From that stage onwards, and until the events which lead to the death of Halina S, Richard Stoker's pattern of living and the management of his case continued much as hitherto. It is clear that he was spending very little, if any, time at his own home and was spending most of his time with and sharing the accommodation of his friend Ms DB. To some extent this appeared to be a stabilising influence and although there were continued examples of alcohol excesses, there were at this time no further reported episodes of self-harm and the Care Team appear to us to have been substantially encouraged by this against further active intervention. So far as members of the Team were concerned (and following their disappointment of the failure of the Innisfree application) they intended to continue to examine two options - which it appears were then being considered as the only options available following the rejection from Innisfree. The first of these was the consideration of finding an alternative housing location since Richard Stoker was anxious to move from his then current residence to a different location. The question of such a move was, therefore, under consideration at the time of the death of Halina S. Additionally, Sarah, his wife, had by this time been discharged from Hospital into a Community living project, and the question of a reconciliation between her and Richard Stoker was under consideration by his Care Team to see whether this might provide a stabilising situation and assist towards the solution of his current problems.

SECTION FOUR

EVENTS LEADING TO THE CHARGE OF THE MURDER OF HALINA SZYMCZUK

The Death of Halina Szymczuk

Over the two weeks prior to the killing of Halina S on 25 May 1995, it appeared that Richard Stoker had been somewhat more isolated in the community than usual since his companion, Ms DB, had been readmitted to hospital for an operative procedure on her hip. He had, therefore, been left in charge of the budgeting for both households and, as a consequence, he was of necessity left with substantial extra money (in the region of £300 together with the proceeds of a further loan). He spent the majority of this on alcohol. It appears that during this period he had met Halina S again (since she was living in the same area of Ashington) renewing what was possibly an acquaintance from the time they had resided at the same time in Sweethope Road Hostel. It appears it is likely that she had called upon Richard Stoker at his home at Bolam Avenue during this period and had asked to be given a cup of coffee. However, since he had no electrical power, he could not provide coffee or any heated drinks, and she countered by inviting him to call at her house 'for a cup of coffee some time'. It was clearly a non-specific arrangement, and she may or may not have expected any response. It also seems likely that Halina S had called at Richard Stoker's house - again on a casual basis - on possibly one or two previous occasions at about this time and Richard Stoker's suggestion is that on those occasions she had referred to his earlier criminal offence and indicated her knowledge about it - probably in a critical way. It was only after the killing of Halina S that any of the Care Authorities heard of this recent contact between Halina S and Richard Stoker.

Inevitably, the only account of the actual events at Halina S's home on Thursday 25 May comes from Richard Stoker in his statements to the Police and in his accounts given to interviewing Officers. His involvement in her death was not known until Tuesday 30 May when he presented himself at Ashmore House (the Community Nursing Service offices) in Ashington and indicated to the Reception Officer that he had 'done a bad thing' and wanted to talk to somebody and wanted to talk to the Police. To the Duty Officer who attended on him immediately he said 'I've done a bad thing. I should go to the Police Station but they will beat me up. Get the Police'. The Police were immediately called, but in the meantime, whilst awaiting their attendance, Richard Stoker made cuts to his wrist and chest - though not of a serious degree. Paramedics attended to give the necessary first aid, and to the Police when they arrived Richard Stoker said 'Yes, I killed her, I killed Lena'. When cautioned by the Police, he continued 'She asked me to go round but we had a row, she told me she knew what I had done when I killed my mother in law. I lost my temper because I had done time for that. I got a knife from the kitchen and stabbed her'.

The Arrest of Richard Stoker

Following his detention and arrest, he was interviewed by the Police on a number of occasions, and throughout there were some discrepancies in the accounts he gave of the actual circumstances of the incident. Initially, he stated that he had gone to Halina S's house socially for a cup of coffee after having taken substantial drink during the evening, and that whilst there he claims there was an argument to such an extent, he said, that he lost control and became increasingly distressed; knocking her to the ground, he picked up a knife from the kitchen and stabbed her several times.

He admitted that he then emptied drawers in the bedroom - presumably in an attempt to suggest the killing had occurred during the course of a burglary - but denies that he took anything from the house. We have seen the transcripts of some five lengthy interviews with the Police which followed his arrest and subsequent charge, and we note that in the course of the fifth and last interview he suggested, for the first time, that he had gone to Halina S's home with the intention of killing her because of a previous argument This statement was contrary to everything he had said previously, and inconsistent with statements at Ashmore House both to the Care Officers and Police, and with the contents of his earlier interviews. It is clear on his own admission that he was substantially intoxicated at the time of the attack and it may well be that he was entirely confused as to the sequence of events and his motives. For ourselves, we considered that his full and earlier accounts of the circumstances in which he had gone for coffee and then been involved in an argument and lost control gets as near to the events as we are likely to get.

Be that as it may, he admitted that after Halina S had been stabbed he returned to his own home and changed his clothing before going out again that night, consuming several more pints of beer, and returning late in the evening to his home where he burned his soiled clothing before settling down for the night at that home. Surprisingly enough, on 26 May (the next day) Richard Stoker kept an appointment which had been made for him to attend a Case Conference held at the Lindisfarne Unit which was for the purpose of considering the position of his wife Sarah and the support services which would be needed on her return to independent living - particularly in view of the fact that Richard Stoker's Care Team were considering that a reconciliation was a possibility at that time. The members of that Case Conference all remained present while the decisions which had been made were being outlined to Richard Stoker - and significantly, no one present was able to detect any unusual behaviour or any evidence of any emotional disturbance in him at that time. Halina S's body was, in fact, not discovered until Monday 29 May when staff at Sweethope House, planning a social event, called at her house to confirm she would be attending that evening, and the Police were immediately notified and commenced their inquiries.

The Trial

After being charged with the events of the murder of Halina S, Richard Stoker was remanded to the hospital wing of HM Prison Durham where he would be under strict supervision as to his own personal conduct and behaviour . During the period of remand there were no further incidents of self-harm and no withdrawal from the position taken by Richard Stoker, namely that he was responsible for Halina S's death.

He came to trial on the charge of murder at Newcastle Crown Court in February 1996 when the Prosecution accepted his plea of 'Guilty' to Manslaughter on the grounds of diminished responsibility. In considering acceptance of the plea, the Crown Court and Prosecution had before them a Medical Report of an approved Consultant Forensic Psychiatrist which set out the following Conclusions and Recommendations:

1. He is not under disability (fit to plead) and is fit to appear in Court;

2. He is suffering from mental impairment within the meaning of the Mental Health Act 1983 but, at present, does not require treatment in a hospital setting;

3. In spite of his mental condition, I do not consider that he had a serious abnormal state of mind at the time of the alleged offence which resulted in him not knowing what he was doing, or that what he did was wrong;

4. As he is suffering from mental impairment and with the possibility that he was upset and intoxicated at the time, there is a likelihood that his responsibility for his actions and omission in doing or being party to a killing was impaired because of a disease of mind;

5. If found guilty as charged or of the lesser charge, I have no medical recommendations to make on his disposal. However, if the Court is considering making a disposal under the provisions of the said Act (Mental Health Act), I strongly recommend that an opinion be sought from a colleague at a Special Hospital.'

Following his plea and consequent conviction of Manslaughter, he was remanded in custody for Special Hospital reports and, on 29 March 1996, he was duly committed to be detained in Rampton Special Hospital for a second time, and there he now remains.

Previous Court Appearances

We are asked by our Terms of Reference to indicate in our Report any previous conviction recorded against Richard Stoker, and we accordingly set these out below:

03 07 45	Blyth Juvenile	Shopbreaking	Bound over 2 years in sum of £2
06 07 48	Blyth Juvenile	Stealing	Fined 10 shillings
06 04 54	Blyth Magistrates	Theft from motor (1 theft T.I.C.)	Probation Order 2 years
28 06 56	Newcastle Quarter Sessions	Indecent Assault on Female under 16 years	Sentence postponed. Order made by Judicial Authority to Certify as Mental Defective.
25 05 76	Newcastle Crown	Manslaughter	Hospital Order S60 Mental Health Act 1959. Plus Restriction Order S65 Mental Health Act 1959
28 02 94	South East Northumberland Magistrates	Protection Animal	Fined £10. Costs £150 for RSPCA. Disqualified for 10 years from keeping any animal . Ordered that dog named Toby and any other animals in the same home be transferred to care of RSPCA.

Richard Stoker's Family

Before concluding our comments on the background and history of Richard Stoker we would have wished, if at all possible, to have had the opportunity of talking to any of his family and relatives who were available. Our enquiries, however, indicate that both his parents died many years ago; his elder brother died in the early 1980s and there had been no contact with his two sisters and a half-brother for the last six years or more, and they had not made any contact with the Authorities. The history set out above refers to the circumstances relating to his former wife, and to his second wife Sarah, and it was accordingly not appropriate to discuss the case with them.

Two members of our Panel were, however, able to visit and talk to Richard Stoker at Rampton Hospital and to receive some account from him of the events leading to Halina S's death.

Richard Stoker was able to see that he was not managing to live on his own in the Community in being unable to manage his finances or control his drinking. He said that he had bouts of low mood which resulted in an increased intake of alcohol and self-harming and he thought that the death of Halina S would not have occurred if he had either been able to move back with his wife or had moved away from the area into new accommodation. He also thought that he had required admission to hospital at times but said that when he had asked for this he had been refused.

It is important, however, to recognise that the purpose of the Panel's visit to Richard Stoker was to provide him the opportunity of putting his version of events as he saw them. The Panel did not seek, therefore, in this interview to correct or challenge any views or issues expressed, leaving all aspects of the matter for full consultation and examination at our subsequent full Inquiry.

SECTION FIVE

OUR REVIEW OF THE CARE AND TREATMENT OF RICHARD STOKER FOLLOWING CONDITIONAL DISCHARGE

Having considered and reviewed in detail the background and circumstances of Richard Stoker and the tragic events of 25 May 1995 when Halina S was killed, we now address ourselves to the circumstances surrounding the care and treatment of Richard Stoker in relation to his health and social care and the appropriateness of that treatment care and supervision and the bearing that this care and treatment (or failings in his care and treatment) may have had upon the events of May 1995.

Up to 1992 - Progress

In Section Three we have reviewed, extensively, the history of Richard Stoker going back over a great many years, but we consider that the proper starting point for the consideration of the specific issues raised by this Inquiry must be the point at which, having been Conditionally Discharged from St George's Hospital following the decision of a Mental Health Review Tribunal, Richard Stoker was initially discharged into the Community under a programme of care designed to manage his resettlement and rehabilitation.

His detention under the original order dated 25 May 1976 was under Section 60 of the Mental Health Act 1959 together with an order under Section 65 of that Act, restricting discharge without limit of time. Notwithstanding the formal terms of such an Order we doubt if society would accept, or be prepared to accept, that committal to such an Institution without limit of time must necessarily involve the patient's committal there for the rest of his life. Rather we would support and endorse the view that with continual reviews and assessments in the interim, there could probably be a stage at which the question of a patient's release into the Community, and on proper terms and conditions, could be reviewed. This indeed occurred when Richard Stoker became the subject of a Mental Health Review Tribunal which sat in June 1987 and promulgated its decision and conclusion with the following preamble :

> 'His progress has been all that could be wished. Ward Manager and Responsible Medical Officer and Social Worker alike testified to his stable, exemplary conduct. Nothing warrants his continued detention in hospital for treatment, even in its broadest sense. His condition does not require it, nor is he to be seen as a threat to anyone's safety. He has been in an open ward. He has abstained from alcohol for the last four months. He relates well to other people; even the quarrelsome do not provoke him. We are satisfied he ought, for the present, to remain liable to hospital recall. That is wholly appropriate after a long period of restriction'.

The Tribunal accordingly directed his Conditional Discharge and set out the following conditions of discharge:

> 'The Conditions of Discharge are that the patient be subject to the supervision of the Responsible Medical Officer and the Probation Officer and that until otherwise directed he shall live at Sweethope Hostel, Ashington'.

In notifying the Mental Health Review Tribunal's decision to those concerned, the Home Office (which continued to have responsibility for monitoring the patient's progress in the Community) underlined:-

(a) That the Home Office have the power at any time, to vary the conditions attached to the patient's discharge, to recall the patient to hospital, to allow formal conditions to lapse or to direct the Restriction Order should be terminated;

(b) That the patient should reside at Sweethope Hostel, Sweethope Avenue, Ashington, Northumberland;

(c) That the patient should reside there under the supervision of a Probation Officer appointed by Northumbria Probation Service;

(d) That the patient should keep in touch with, and receive home visits from the Supervising Officer as directed by that Officer; and

(e) That the patient attend a psychiatric outpatient clinic as directed by the Consultant Psychiatrist at St George's Hospital.

The Conditional Discharge - Its Purpose

It is our view that the Conditional Discharge Order and the conditions imposed in it were designed to ensure that the conditional discharge was and always had to remain the subject of proper controls, checks and safeguards in order to strike a balance between the interest of the patient on the one hand and the proper safety, security and protection of the public on the other. It was right that any such balance should be most carefully supervised and monitored at all times in order that corrective and protective action could be taken at once whenever it might be required and any necessary intervention arranged. It was necessary and appropriate that the circumstances which gave rise to Richard Stoker's original conviction and commitment to Rampton should always be borne in mind in relation to public protection, and that any interests and wishes of the patient and his rehabilitation be always considered most carefully in the light of and against that background.

However, having considered most carefully all the documentation which has been made available to and placed before us, and the evidence that we have heard, we take the view that towards the end of the period which we are considering, (re the end of 1992 and the beginningof 1993) that balance was not effectively maintained to the extent necessary; and that perhaps too much consideration and weight was being given to the wishes and interests of the patient without at the time a sufficiently objective assessment of the proper needs, interests and safety of the public - especially in the light of Richard Stoker's previous conviction and sentence on the charge of Manslaughter and the analysis of Rampton which we have referred to on Page 5 of this Report.

Following the Conditional Discharge Order which we set out above, Richard Stoker was discharged from St George's Hospital in January 1988 and the day to day management and supervision of his life out of the hospital environment became the responsibility of the Responsible Medical Officer (who was Dr Brown who had had contact with Richard Stoker at the time when he was at Rampton and had visited and examined him there on two occasions)

and the Probation Officer appointed by the Northumberland Probation Service. This team was later joined by a Community Psychiatric Nurse from the St George's Hospital Team who ultimately had her base at Ashmore House in Ashington.

In our outline of the history and background to the case we have detailed the Care Programme Management and arrangements operating between 1988 and 1992 and we believe that it was entirely proper for the Authorities at that stage to be satisfied with the progress of Richard Stoker's life in the Community and his integration back into society at that time. The extract which we have quoted above from the determination of the Mental Health Review Tribunal was indeed being borne out and was endorsed by his then manner and adjustment to living in the Community. This is the period which covered his residence in the somewhat protected environment of Sweethope Avenue Hostel and his marriage to Sarah and their joint home together in Ashington. It was clear to us that he was being given proper supervision and guidance during this period. Apart from the 'ups and downs' of normal living which would affect Richard Stoker as with anyone else in the community setting, and some minor incidents, there was during this period cause for reasonable satisfaction with his progress, and there was no substantial cause for concern either in his own interests or self care or, more importantly, in the interest of the Community.

From 1993 Onwards - The Problems

However, it is our clear view that from the end of 1992 onwards, 'things began to go wrong' and were characterised from then onwards by a number of indications which were 'warning signals' that Richard Stoker's then current programme of Care in the Community needed to be reconsidered and reinforced with more positive intervention. A series of problems were arising and persisting and we must ask ourselves whether these were being effectively recognised and objectively addressed. We use the word 'objectively' in the sense of the balance which was necessary to achieve between the personal interests and wishes of Richard Stoker on the one hand and the need to recognise (and indeed to keep in the forefront of one's consideration) that he was a patient subject to a Conditional Discharge Order under the Mental Health Acts, designed to ensure that public interest was at all times recognised and protected and that intervention could take place immediately it was seen to be necessary.

By the end of 1992, the support network available to Richard Stoker on discharge in 1988 had changed considerably. He had lost the placement in the sheltered workshop scheme and, therefore, had been discharged from the hospital day facility. He had moved out of Sweethope Hostel and lost the support of the staff attached to the Hostel. His relationship with his wife, Sarah, a stabilising influence, had disintegrated and his attendance at outpatient appointments was erratic - on top of which he was becoming unpredictable in his behaviour with alcohol abuse and self-harming behaviour becoming more prevalent. We noted a number of particularly relevant events and incidents which should have highlighted cause for concern and the need for action to be considered:

(a) In January 1993 the Probation Service had to write to Dr Brown highlighting their concerns about Richard Stoker's behaviour following the separation from his wife Sarah and, in February 1993, they had highlighted an incident in which Richard Stoker had gone to his wife's flat drunk having cut his wrists;

(b) In May 1993, Dr Campbell, Richard Stoker's GP, wrote to Dr Brown highlighting no less than ten further attendances at Casualty by Richard Stoker (having already indicated five such previous attendances) following lacerations to the wrists and whilst under the influence of alcohol;

(c) Due to Richard Stoker's continued financial difficulties he obtained a loan through a local Loan Company. The weekly payments to reimburse this loan were a severe drain on his already limited financial resources, with the inevitable pressures that this would create;

(d) It was reported in August 1993 that since April 1993 Richard Stoker had attended only one outpatients appointment;

(e) Over this period, there does not appear to have been any record of any formal reappraisal between the Care Team involved in order to tackle and deal with the problems that were occurring. There would appear to have been confusion and frustration between the Agencies with regard to who should take the lead and who should take action to control Richard Stoker's behaviour;

(f) The Probation Services raised concerns with the Home Office regarding Richard Stoker's behaviour - in particular his drinking, self-abusing and threats of suicide and the Home Office, in turn, raised these issues with Dr Brown. They asked that Dr Brown should give consideration to the admission of Richard Stoker to hospital either through the civil sections of the Mental Health Act or through formal recall by the Secretary of State. Such admissions would be with a view to stabilising Richard Stoker's behaviour and the control of his alcohol intake and self-destructive behaviour;

(g) In a report to the Home Office dated 9 August 1993, Dr Brown reviewed the position fully and concluded that she did not feel that the risk posed by Richard Stoker was any greater in his case than that in 'a number of vulnerable individuals in coping with emotional environment stresses' - but this in our view, failed to take account of the reason why Richard Stoker (as opposed to other ' vulnerable individuals') was the subject of a Restriction Order because of his previous record and conviction. However, the Home Office supported a proposal by Dr Brown that she should refer Richard Stoker to psychiatric day facilities and took the opportunity of writing to Richard Stoker warning him regarding his poor compliance in attending outpatients and his behaviour in general;

(h) In August 1993, Dr Brown decided to seek additional areas of support for Richard Stoker and wrote to the Community Rehabilitation Clinic referring him to their care, and requesting that they take the case of Richard Stoker under their care with a view to long term monitoring support. This was accepted by the Psychiatric Nursing Service. However, his initial involvement with the Community Nursing Team lasted only until January 1994 when they had to discharge him from their case list because of his failure to attend appointments. This failure to attend appointments seems almost to have been accepted 'as the norm' in Richard Stoker's case, rather than alerting the authorities of the need to take much more positive steps with regard to him;

(i) The same pattern of problems described above continued throughout 1994. Outpatients appointments were missed - while sometimes Richard Stoker attended in an intoxicated state. On occasions he was argumentative and abusive and the alarming pattern of self-harming continued;

(j) In evidence to us at Morpeth both the Probation Officer, and the Consultant were able to tell us of their first hand experiences of such self-harming - each of them having had Richard Stoker either in their office or indeed in their presence suffering from self-inflicted wounds - and in one case Dr Brown having to remove a Stanley knife from his hand;

(k) In March 1994 he was referred to St George's Hospital for admission. He was seen and assessed there, but was in a state of drink and made threats about cutting his wrists. He was nevertheless offered admission but immediately refused and left - and was allowed to do so. Later that day, after more drinking, he cut his wrists and was seen in the Accident and Emergency Department and the local hospital;

(l) The home circumstances in which Richard Stoker was living at this period appear to us to have been wholly unsatisfactory. This may, of course, largely have been due to his own attitude and behaviour, drinking and self-neglect but it led the Probation Officer, to tell us in evidence that he was not happy with Richard Stoker's living conditions in the Community and that 'his flat was just cold and uninviting and that he was hardly ever there'. Dr Campbell, the GP, told us that Richard Stoker 'clearly was not coping in the Community. He had a very poor quality of life, from what I could see a very spartan existence';

(m) Because of financial problems, Richard Stoker's electricity had been disconnected and he was therefore at home without heating or hot water - and was without these facilities for an appreciable length of time;

(n) In evidence, both the Probation Officer and the Community Psychiatric Nurse expressed their concern and, indeed, 'frustration' at that time over their inability to make progress in a joint way to tackle these increasingly obvious problems;

(o) The deteriorating situation which had accumulated by mid-1994 was perhaps most tellingly summed up in the evidence from the Probation Officer when he confirmed to us that there was then an accumulation of problems.

There was clear recognition between the Probation Services and the Community Nursing Services that some positive action would have to be initiated and the Probation Officer added: 'I think that that is what we were really pushing for - a multidisciplinary approach, really, a co-ordinated way forward, rather than a reaction to crisis';

(p) In September 1994, a long overdue Care Planning meeting was held between Dr Brown, the Probation Officer, the Community Psychiatric Nurse and a member of the Social Services Team. The meeting then wholly endorsed a proposal which Dr Brown had initiated, namely, that Richard Stoker should go to a staffed residential nursing home at 'Innisfree' where he would be under nursing care and in a controlled

environment which would assist the management of his manifest problems and address the obvious inadequacies of his continuing to live in a Community situation. We say that 'it was a long overdue' Care Team meeting because other members of the Care Team had been pressing for it from early 1994 and there was no dispute that it was long delayed.

The Care Team were apparently very confident that the proposed admission to Innisfree would be accepted and arranged - but that was, of course, a matter for decision by the Innisfree Authorities;

(q) In October 1994, Dr Brown wrote to the Home Office asking for clarification on two points. The first point was on readmission (admission to hospital) in relation to Richard Stoker's case and the second was with regard to her own continued responsibility for the case. The Home Office responded in November 1994 and highlighted the powers of recall to any hospital if the Secretary of State thought it appropriate - and they advised Dr Brown that it would remain her own responsibility to find an alternative Supervising Psychiatrist if she wished to be relieved of the case. The Probation Officer confirmed to us that he also had reflected on the opportunity of 'recall' to hospital as being a possible alternative;

(r) It would seem to us, accordingly, that alternatives to the Innisfree proposal were recognised as being necessary, but confidence remained that the Innisfree application would be accepted and this would be a solution to current problems. The Probation Officer's words were that they were at that time 'just treading water, really, just keeping him in the Community and trying to react, keep him as stable as possible';

(s) In February 1995, came the news which was totally disappointing to all the Care Team, namely that Innisfree declined to place Richard Stoker in the nursing home because they did not feel 'it was an appropriate placement' for him at the present time;

Lack of Intervention

It is clear, therefore, that there was in September 1994, a concerted and unanimous decision that Richard Stoker's continued living an independent life in the Community was no longer appropriate and that for all very good and obvious reasons, he should no longer remain in a Community setting but should now be in some 'sheltered' environment such as the nursing home, and all efforts were then lent to achieving that objective. What concerns us very considerably is that although it does seem that other alternatives such as hospitalisation were recognised as being 'in the back of the mind', nothing positive in that regard was done and everything appears to have rested entirely on the Innisfree decision. We would have expected, in the circumstances, that when the place at Innisfree was refused, that should have clearly signalled the need to redouble efforts to intervene and find some other alternative accommodating situation for Richard Stoker. However, that did not happen - and it seems there were various explanations for this at the time.

There had, it seems, been no recorded incidents of self-harm after September 1994 - which endorsed and confirmed Dr Brown's later observations to us in evidence that the period before the May 1995 incident had been 'one of the quieter' periods in Richard Stoker's management. The Probation Service in this interim period were concentrating on a solution to Richard

Stoker's current problems by seeking to arrange a move of house out of the immediate area in which he seemed particuarly unhappy. This would, of course, have involved some drastic tackling of the financial situation in which he had involved himself. The Community Psychiatric Nursing Service were optimistic (as indeed was Dr Brown) that there might be a reconciliation between Richard Stoker and his wife, Sarah, and that this would restore some atmosphere of support and stability which had existed before 1993. Dr Brown, therefore, remained confident that a solution was still capable of being found 'in the Community' and that Richard Stoker's removal therefore into a more controlled and restricted environment was not urgent or indicated at that time.

The members of the Care Team had noted the need for alternatives, and in the troublesome period which we have described addressed themselves to various possible solutions (although the fact that these were separately rather than jointly considered meant they were less likely to be affective). The question of detaining him under the Mental Health Act 1983 had been considered but it was felt 'not appropriate'. The question of recall to Rampton was seen as an option but considered to be 'Draconian' in view of his lengthy period already in the Community. The question of admission to a Rehabilitation Unit at Morpeth was examined but had to be abandoned 'because it could not be arranged'. Admissions to St George's Hospital, Morpeth took place on two or three occasions but were not pursued or persisted in, and he was allowed to leave immediately he wanted to. The question of admission to a nursing home in the controlled environment at Innisfree was positively determined as an appropriate course and efforts made to arrange it - but when that became impossible and had to be abandoned nothing appears to have been put in its place as an alternative - despite the fact that the need for intervention had been underlined when an overnight admission to Hospital had been necessitated immediately prior to the Innisfree proposal because of his anxiety and stress condition.

We think that there is no doubt that the rather more quiescent period of Richard Stoker's conduct from the end of 1994 onwards appears to have encouraged the Care Team to accept the continuance of Richard Stoker's independent living in the Community - despite the fact that the problems of drinking; debt; appalling home conditions; non-attendance of appointments and alcohol abuse still continued. The failure to place Richard Stoker in Innisfree appears to have caused indecision in the planning of further action to deal with these ongoing problems in the Community. In evidence to us at the Hearing, the CPN felt that, in retrospect, too much attention was being paid to Richard Stoker's own views and preferences - rather than the overall objective considerations. The fact that the alternatives we referred to above were raised and considered seemed to us to have underlined the fact that there was an acknowledgement in 1994, that the stage was being reached - indeed had already been reached - when the period of Richard Stoker's suitability for remaining in a situation of independent living in the Community had passed and intervention to achieve another course was necessary. Unfortunately, although there was a recognition and desire to see something done, opportunities were not taken, and the situation was being allowed to 'drift' when the events of May 1995 occurred. We consider that to be the principal and cardinal ground for criticism in this unhappy case.

SECTION SIX

THE ROLE OF THE SUPERVISING CONSULTANT PSYCHIATRIST

The Initial Appointment

On the appointment of a Consultant Psychiatrist to the supervision of a conditionally discharged patient, the Home Office invariably sent out with the letter of appointment a document entitled 'The Supervision and Aftercare of Conditionally Discharged Restricted Patients - Notes for the Guidance of Supervising Psychiatrists'. The Home Office correspondence indicated that this was enclosed in a letter to Dr Brown in October 1987 when she undertook the role of Supervising Psychiatrist to Richard Stoker but Dr Brown, in answer to our questions when she attended to give evidence before us, was of the opinion that she had never received, and certainly not seen that document. This surprised us - and we wondered whether perhaps she had overlooked having received that document back in 1987 at the time of her first appointment.

We considered that this was an important document and one which a Supervising Psychiatrist would have found most helpful - if not essential - in carrying out her role. The Guidance advises:

> 'It is the Home Secretary's hope that, by means of conditional discharge of a restricted patient, a situation of danger to the patient or to others could be averted by effective supervision, by appropriate support in the community or by recall to hospital if need be. He recognises that this hope places great reliance on the personal skills and dedication of individual supervisors. While it will not always be possible to predict and thus prevent dangerous behaviour, it is important that the supervisor sets out to provide more than just crisis intervention. (paragraph 17)
>
> The Supervising Psychiatrist, in any case, is responsible for all matters relating to the mental health of the patient, including the regular assessment of the patient's condition, the monitoring of any necessary medication and the consideration of action in the event of deterioration in the patient's mental state. (paragraph 18)
>
> The Supervising Psychiatrist should be prepared to be directly involved in the treatment and rehabilitation of the patient and to offer constructive support to the patient's progress in the community, rather than simply checking that the patient is free from symptoms and 'staying out of trouble'. The supervising psychiatrist should also be prepared to work with other professionals involved in the patient's care, including the social supervisor and possibly the general practitioner, community psychiatric nurse and hostel staff, and if he is not himself a forensic psychiatrist, the Supervising Psychiatrist should not feel inhibited from seeking advice or information from specialists in this field. (paragraph 20)'

Dr Brown, as we say, does not recollect seeing and considering that Document but, be that as it may, she took the view that she was fully conversant with the duties and obligations of the role of Supervising Psychiatrist, and she told us that she viewed an aspect of her role as being 'To supervise the day-to-day kind of treatment and management of that patient, to

report to the Home Office, to be involved with other professionals who were also involved in producing care plans, management strategies so far as that client was concerned'. This, of course, is a synopsis of her role and though it does acknowledge the primary role of the psychiatrist, there was perhaps in her evidence some inappropriate emphasis on an 'advocacy role' which is performed more appropriately by others in the team nor does it sufficiently recognise the circumstances of the background of this particular patient and the proper need to have constant overview of the risk and risk assessment situation.

Dr Brown, when undertaking the role of Supervising Psychiatrist to Richard Stoker in October 1987, had indeed all the necessary qualifications for that post and responsibility. She was at the time a full time Consultant at St George's Hospital, Morpeth and her responsibilities were as a half time consultant psycho-geriatrician and as a half time acute adult psychiatrist with responsibility for disturbed wards. She had had a good deal of contact with the Special Hospitals and had the advantage, of course, of having seen and considered and examined Richard Stoker when he was at Rampton; she had participated in his assessment there and generally at the time of his transfer from Rampton to St George's and his initial discharge under the Mental Health Review Tribunal's order.

The Role in the Care Team

In the care and management of Richard Stoker she clearly (and in our view correctly) saw her role as being the 'lead role' so far as the Care Team and its other members were concerned, and the lead clinician in all decision making. She did however, go on to express the view that 'in the day to day working situation' she had necessarily had to rely on those who were working in the field and that there was accordingly also a responsibility on those who were working in the community environment, adding 'but the ultimate responsibility is with the clinician'. However, working jointly with those 'in the field' and receiving and taking on board their views depends essentially on satisfactory arrangements for communication and collaboration - and we have already observed in this Report on the extent to which these were very sadly lacking indeed; she could not share the views of those 'working in the field' unless she ensured adequate communication with them.

There is no doubt that the other members involved in the care of Richard Stoker also took the view that the Consultant Psychiatrist was the 'lead' member of the team and the major initiatives and decisions as to management and treatment had to come from her.

The Guidance Document we have referred to above very appropriately advises:

> 'The two most important elements in effective supervision are the development of a close relationship with the patient and the maintenance of good liaison with the social supervisor. However often the Supervising Psychiatrist decides he needs to see the patient, he should see him in a situation in which he can detect deterioration in the patient's mental health or behaviour at an early stage. The doctor/patient relationship may be made more difficult by the fear of resentment of a conditionally discharged patient that he is being 'policed' by his supervisors'.

The Changing Scene

However, the situation with regard to Dr Brown's post and role which we have described as in 1987 changed very substantially when in 1989, following the appointment of a further Consultant at St George's, Dr Brown became a full time Psycho-geriatrician at the hospital, and lost her responsibility for the acute and disturbed wards. This was a very substantial change in her former role but she continued (in circumstances which we examine further below) looking after approximately 40 patients under the age of 65 from her previous service, advising us that these patients were gradually discharged into community or returned to the acute service. She was therefore no longer in the role of an Acute Adult Psychiatrist with responsibilities for disturbed wards - which position had led initially to her allocation to the role of Psychiatric Supervisor to Richard Stoker. This change of her position and role at St George's has given rise to one of our greatest concerns and anxieties in this case - namely as to whether from that time onwards Dr Brown was the appropriate Consultant to remain in the role of Supervising Psychiatrist to a person with the history background and circumstances of Richard Stoker. Dr Brown told us, however, that from the beginning of the 1990's she herself recognised that problem, and that she therefore sought to be relieved of that role and responsibility. She went on to tell us that she made a verbal request to her colleagues at St George's to consider being replaced but that she 'made no progress there', and she sought guidance from the Home Office. She raised the issue in one of her reports to the Home Office in a letter dated 1 November 1991 when she indicated her 'intention to request that Dr WG in whose geographical catchment area (Richard Stoker) resides to take over the case'. She told the Home Office that she would inform them when this occurred - but we see no evidence or documentation in the papers before us that she then took any further steps in this regard, and indeed we see no evidence of anything further until October 1994 when in a letter to the Home Office dated 18 October Dr Brown wrote, 'as explained several years ago (presumably referring to the 1991 Report), I as a Psycho-geriatrician, no longer have immediate call on acute psychogeriatric beds in this hospital, and as such, cannot always access such places in an emergency situation'.

She added that this had resulted in Richard Stoker being admitted during a crisis to inappropriate accommodation, and that she had not been able to hand over Richard Stoker's case to Dr WG, because of his conflicting commitment with the case of Sarah S. She, therefore, formally requested 'that an alternative RMO be sought to continue supervision of this gentleman, as I feel my useful intervention is now severly handicapped by my own clinical responsibilities and lack of appropriate facilities'.

The Home Office replied on 16 November telling Dr Brown that she 'would wish to know that any arrangements for such a change would need to be undertaken by you rather than by the Home Office: paragraph 44 of the Notes for the Guidance of Supervising Psychiatrist refers'. They added that 'the consent of the Secretary of State to such a change was not required, but they would wish to be informed of any change. Although the name of the Supervising Psychiatrist is not usually entered on a warrant of discharge, it would be helpful if the Home Office were notified as soon as possible of any change of Supervising Psychiatrist. If a Supervising Psychiatrist moves from a post and is unable to continue supervision of the patient, he or she should make arrangements for another suitable consultant to take over the case.'

A Change of Consultant?

Although the responsibility for initiating any change of Consultant was therefore firmly placed on the Consultant herself and those at St George's, nothing at all eventuated, although it is perhaps ironical (and Dr Brown herself describes it as such) that the issue was in fact to be in included in the agenda for the Medical Staff Committee of the hospital at the very time of Halina S's death. Dr Brown reflected this in the periodical Report she wrote to the Home Office on 17 May 1995, and in which she recorded that 'it has been agreed that my continuing involvement with Richard Stoker is inappropriate'.

Our clear concern is, that while this issue was being considered - apparently over a fairly long period of time - the fact that the 'wrong' Consultant was in the 'wrong' role must have had adverse implications for the proper care and treatment and management of Richard Stoker's case. Dr Brown very frankly underlined these concerns in her evidence to us and she highlighted some of the problems it created in her management of the care of Richard Stoker, explaining to us that difficulties were created because of her lack of contact with the acute wards; that she no longer had an allocation of beds at Otterburn House for acute patients and this created problems of accommodation; and that, in effect, from the time she became a full-time Psycho-geriatrician she should not have had control of Richard Stoker's case, which remained with her despite some efforts by her to the contrary.

We were very anxious to examine with the employing Trust, therefore, these issues raised by Dr Brown concerning her workload, her role at St George's Hospital and the appropriateness of her continuing role as Supervisor to Richard Stoker.

We, accordingly, took evidence at a later Hearing from Mr D M Anderson, Chief Executive of Northumberland Mental Health NHS Trust, in order to raise these issues with him. It is entirely right that we should record at the outset, and with necessary emphasis, that he spoke highly of Dr Brown's clinical competence and the extent of the workload that she was carrying. He told us that, like all the consultants at St George's Hospital, Morpeth, she was a very busy consultant with a heavy workload and that in the relevant period (between say 1990-1995) she was a full time consultant covering a population of probably 150 000 (this, of course, in the field of psychogeriatrics only). He went on to tell us:

> 'Her patients think the world of her and that even if there was delay in the outpatients department, the patients remained more than happy to wait and the relatives as well. When asked if because of delays they would prefer an alternative appointment they had replied "No, no, we are more than happy. We know Dr Brown is very busy. We know she takes time, but she gives us the absolute attention that we need".'

He went on to confirm his entire satisfaction with her clinical competence, and that he had never heard anyone say anything adverse about it.

He had to tell us, however, that so far as Dr Brown's continuing care of the case of Richard Stoker was concerned, that Dr Brown had been urged at the time of the appointment of the other acute Consultant Psychiatrist and her transfer into the role of Psycho-geriatrician, (and more than once subsequently) to transfer all of her under 65 cases and patients to another appropriate consultant, 'but she chose not to do so'. We were advised that the decision to retain certain acute patients under her own control and management (although that was no

longer her principal hospital role) was her own decision, and that although there were sensible reasons for this in certain cases, it was not believed to be so in the case of patients who were still under Restriction Orders where there was seen to be no logic whatsoever in her retaining responsibility for them. Her approaches to the Home Office in the 1991 letter and again in October 1994 had not we were told, been copied to the hospital authorities and she had not notified the hospital authorities at all of the concerns that she was expressing in both of those letters as to her continued suitability for her role. On the contrary, we were told, she continued her personal management of Richard Stoker's case, and the hospital was not aware of her taking or seeking to take any active steps whatever to alter that position. The hospital appeared to have viewed such decisions as matters of the clinical responsibility of a Consultant in which the Consultant had control, and not as a matter for administrative oversight by the hospital. It must be a matter of great regret that where everyone appeared to agree that the transfer of Richard Stoker's case to another Consultant was appropriate, it did not take place, and it concerns us that there was no system in place to monitor and ensure that the case was in fact transferred.

In our consideration we believe there must be a role for the intervention of the hospital authority in this kind of issue, and that if it was deemed appropriate for the 'hand over ' of certain patients following the change of a Consultant's position and role in the hospital (and such patients would have included Richard Stoker), the hospital had the right to be more interventionist and to insist upon this being done without being thought to breach in anyway the clinical independence of a Consultant.

Be that as it may, no change in the Supervising Consultant of Richard Stoker ever took place and it is our view that Dr Brown (despite her statements in evidence to us) chose to continue with Richard Stoker as one of the cases in her management, no doubt because of her contact with and interest in the case since the late 1980's.

The effect of the Changing Scene

We were satisfied that the change in Dr Brown's role at St George's Hospital to the field of Psychogeriatrics meant that she was becoming increasingly 'out of touch' with the type of issues which affected the management in an acute patient's case such as Richard Stoker. When, for example, we raised the question of 'risk assessment', she advised us and confirmed that there had been no risk assessment in formal terms and explained this by adding 'I think to some extent (as to formalised risk assessment) I had lost my contact, going into psycho-geriatrics on a full time basis'. There were many more observations from Dr Brown - put before us with frankness and without reservation - which reflected her view that in the 1990's she was increasingly an inappropriate person to have the care and management of the case of a conditionally discharged patient with the background of Richard Stoker. This must concern us to the extent that it was bound to have had an overall effect on the motivation and management techniques applied in this case, and the making of decisions as to what at all times and in all and changing circumstances were the right decisions to make about his care and treatment, and his suitability for continuance in the community. More especially is this so when Dr Brown herself recognises that she was the 'lead' member of the care team and the one therefore guiding and initiating major management and clinical decisions - a view which, we have indicated was also held by other members of the team. By way of underlining all we have said above we record the final observation from Dr Brown at the end of her evidence to us when we considered the question as to the extent which things might have been different,

and she replied 'I wish that I had been able to hand over the case when I felt it was appropriate'. We must entirely agree with that - but all we have heard suggests that it was she herself who was mainly responsible for that continuing position.

Communication between the Consultant Psychiatrist and other members of the Care Team

We have already indicated the serious shortcomings in the quality and extent of communication between Dr Brown and other members of the Care Team and other agencies in general which were, of course, bound to impact adversely on management and decision making. These continued without improvement despite misgivings constantly voiced by the Home Office, the Probation Service and the CPN and indications from the GP whose expressions of concern were not acknowledged, and with whom there was initially no communication. We learned, also, this was a matter which had considerably concerned the hospital management as a general issue.

Here again Dr Brown very frankly told us 'I have impressed that I had a lot of difficulties with communication' and she explained to us that this was partly due to an excessive workload that she felt she was carrying and to secretarial and office management problems. She acknowledged that contact was 'limited' with the Probation Service and the CPN and that she had difficulty 'in letter writing', adding 'I am a person who prefers to do rather than write, and I have no illusions about that'. We could well understand to some extent her own view of priorities when she indicated 'I am very much a clinical psychiatrist, not an academic - and if there is a choice between a patient and a letter then I will see the patient no doubt'. However, there is equally no doubt that her role as a Supervising Psychiatrist necessitated a very high level indeed of communication, exchange of views, reporting and letter writing so that all those involved in the care of Richard Stoker and the Home Office and other supervising authorities knew what was going on. There was no issue at all at the hearing between any of the parties that Case Conferences were inadequately convened and, when convened, were very much late in the day; and that Reports to the Home Office (which should have been on a regular three monthly basis) were not being sent in on time, necessitating reminders and a formal complaint by the Home Office.

When we proceeded to talk to the Trust's Chief Executive about these matters of communication and correspondence, we learned that this had been a longstanding issue and one of considerable concern to the Trust. This was the 'other side' of Dr Brown that Mr David Anderson had referred to - what was frankly lack of administrative efficiency, and her inability to administer her caseload properly, to manage her time and particularly to deal with correspondence. We were advised of constant problems of an administrative nature and of repeated efforts to cure these by counselling, advice and assistance. There seems to us to have been an almost surprising forebearance shown to her shortcomings in this regard because of the high regard in which she was held as a Clinical Psychiatrist and her clinical competence.

Speaking in general terms (not related directly to the case of Richard Stoker) we were told by the Chief Executive that he frequently needed to review matters with Dr Brown and to urge that spending 100% of her time with her patients was one thing but not letting the rest of the Care Team know what was happening was another thing because 'if she did not get that balance right then she actually was not doing good to anybody'.

This is a view with which we are bound to agree entirely, because although the hospital management took the view that there was a high degree of clinical competence on the one hand and unacceptable administrative problems on the other - we consider that these two aspects could not be viewed separately and apart. In our view it was inevitable that administrative inefficiency on the one hand was bound to impact on clinical effectiveness on the other -and that in our view this was exactly what had been happening in the case of Richard Stoker.

Following a run of administrative problems during 1992, the hospital management arranged a meeting with Dr Brown at the beginning of December 1992 to review a range of matters including the case of under 65 patients, outpatient clinics, correspondence, secretarial support, meetings and communications with other staff and set out a protocol of requirements in a letter to her of 23 December 1992. The letter was very positive in its tone, but we do not see evidence of any effective 'follow-up' to monitor if what was then very properly being required was in fact later being achieved. The issue of secretarial support was very positively addressed by the hospital management who dealt with new provision and replacements but later found little course for dissatisfaction with the previous postholder.

It is fair to say that few if any, of the administrative problems which were highlighted over the years may have had any direct bearing on the case of Richard Stoker himself save for the overriding fact that he continued to be included in the list of patients which Dr Brown continued to manage personally. Whilst, to some extent, these administrative issues might therefore be considered to be 'peripheral matters' in the case of Richard Stoker, compared with the day-to-day management and treatment of his case in the community and the making of decisions as to his appropriate care and treatment - we are compelled to the view that all of the issues and problems which we have outlined in this section must have had an adverse effect on the management of the case and the decisions made about his care management - and our major concerns and criticisms must lie in this area.

Members of the Panel during the course of the Inquiry were concerned to note the lack of communication at all stages with Richard Stoker's General Practitioner who could well have had - and we feel sure did have - a useful contribution to make regarding his day to day management, care and, above all, of the circumstances in which he was living. This is perhaps just another example of the communications 'issue' which we have already sufficiently highlighted.

SECTION SEVEN

A. ISSUES OF RISK ASSESSMENT

What is Risk Assessment?

'Risk Assessment' is the method and procedure by which the risks perceived to attend a given situation, a given person, a given set of facts, or some proposed course of conduct in connection with these are considered, measured, assessed and recorded, so that the appropriateness of a present situation or a proposed course of conduct can be the better measured and determined.

In the case of Richard Stoker, given his background and problems, it was clearly appropriate that there should be ongoing risk assessment in respect of his continuing care and residence in a community situation, and in relation to any proposal or decision about his care arrangements.

From the evidence we heard it was clear that all disciplines had differing concerns and so differing problems in connection with Richard Stoker - but they were not adequately and collectively formulated or addressed because there was never any collective sharing or discussion of these issues amongst members of the Care Team. Thus there appears never to have been any collective 'Risk Assessment' which would, we feel, have been extremely helpful - if not essential - in the Richard Stoker situation. This is not to say, of course, that the question of risks associated with his care and treatment or arising from it were not being considered - indeed the risk and the measuring and extent of it was regularly referred to by the members of the team in their individual notes, comments and reports but never, as we say, addressed on a collective basis. Views expressed reflected, particularly, the concern that the risk from Richard Stoker was of self-harm and self injury and there was little - if indeed any - concern that there could be a risk to outsiders. Dr Brown was very confident indeed in her view - expressed in such reports as she sent, in her notes and in her evidence to us - that Richard Stoker posed no risk at all to anyone but himself. The other members of the team were not so sanguine about this - but again their concerns in this area were not high.

Although Probation Officers, acting as the Social Supervisors, of Richard Stoker and their managers, voiced concerns about Richard Stoker's deteriorating situation, the major focus of these concerns was invariably the possibility that he would continue to self-harm. This is in spite of the fact that many of the circumstances which existed prior to the events when he killed his mother-in-law in 1976 (severe debt, heavy drinking, difficulties in relationships with women, stress and problems in coping) were also present in the 1990s when the Probation Services were expressing concern about Richard Stoker's situation to the psychiatrists, the Home Office and others. However, on no occasion was any pattern between the situation of Richard Stoker prior to his original offence, and his personal situation from 1992 onwards perceived or expressed in any report to the Home Office.

Following referral of Richard Stoker's case to the CPN and the additional involvement therefore, of the CPN service in the Care Team, while no formal risk assessment again was completed at that stage, the CPN did express her concerns about Richard Stoker's behaviour and the risks which it might entail - views echoed by the caseload supervisor and CPN manager. The reports and papers before us indicated that from the outset the CPN had adopted the practice of being accompanied whenever she went to visit Richard Stoker at his home, and the reason put forward for joint visiting was that because of the overall concerns about his self-harming she was apprehensive about being faced, alone, with an episode of self-harming or its consequences which would have required urgent intervention. However, during the hearing of evidence at Morpeth, the CPN indicated that the reason - or perhaps an additional reason - for joint visiting was because of concerns about her own safety in dealing with Richard Stoker - although it was clear that such concerns had never been voiced in any early reports, notes or correspondence. Such a difference in emphasis might perhaps be explained or seen in the context of views expressed by Dr Brown on several occasions that she did not view Richard Stoker as any danger at all to others - and as the CPN was a junior and inexperienced Community Psychiatric Nurse and may have felt unable to challenge such an expression of opinion.

The Absence of Risk Assessment

The opportunity for a formal risk assessment to have been taken would obviously have been when there had been a multi-disciplinary meeting or review and at which all disciplines would have considered and contributed to an assessment of up-to-date risk issues. However, our consideration of all the papers and reports suggests that when multi-disciplinary reviews were held they appear to have been called in response to a particular crisis. The consequence of this was that the crisis tended to dominate the review and there is no evidence that the whole picture offered by events or the assessment of future prospects was ever taken fully into consideration.

In February 1993 there was such a review - and 4 days later Richard Stoker had a brief admission to a ward at St George's but was then allowed to take his own discharge. Contrary to hospital discharge policy at that time, no further review was arranged - nor indeed was it held. In September 1994 a multi-disciplinary meeting was held. At this, a plan was formulated that Richard Stoker would go into a residential home (at Innisfree) for people with mental illness - a view supported by all members of the team. When, unfortunately, he was rejected for this placement, the review was not reconvened - apparently because the immediate crisis was over and, indeed, no further review or multi-disciplinary meeting took place between then and the events which gave rise to Halina S's death in May 1995.

In our view, if a comprehensive and overall view of Richard Stoker's care and the issue of risk assessment and risk management had been taken at these or any other multi-disciplinary meetings, it would have been clear that he was increasingly failing to cope with independent living, resorting to increased episodes of self-harm, alcohol abuse and substantially in debt. Whilst he had been living in fully supported accommodation (such as the Sweethope Hostel) none of these behaviours were apparent, but they increasingly arose after that period and no comprehensive risk assessment appears to have been taken to address those issues.

When Dr Brown was asked what she would now have considered the risk factors to have been, she identified primarily the risk of self-harm and, more generally, a potential for violence - but did not consider that this was directed to others. We feel we must take the view that episodes of violence were minimised by Dr Brown who had, throughout, a very confident and supportive attitude towards Richard Stoker's progress, and felt that any violence was attributable to periods of alcohol intoxication. She felt that many patients were verbally abusive and threatening when drunk and there was, therefore, perhaps a failure to acknowledge that Richard Stoker was not a 'usual patient' in that context, and that therefore the issues of self-harm, threatening and abuse during period of alcohol excess needed to be more specifically addressed and assessed and the issues of corrective action more specifically targeted.

As we have indicated above, there was no evidence in the medical information - or indeed any other documentation - of there having been any formal risk assessment. Dr Brown agreed that this was the case but emphasised that there had been regular consideration of risks - in particular the risk that Richard Stoker represented to himself. Perhaps the reason - or one of the reasons - for the lack of the kind of formal risk assessment which would now properly be expected in such cases, lies in the appropriateness of the role of Supervising Psychiatrist for Dr Brown which we have previously addressed. In further addressing the absence of formal risk assessment she said ... 'To some extent it is my being out of touch now ... I think risk management and the type of clients the acute psychiatrist deal with has been much better developed over recent years and to some extent I have lost contact with that (by going into psycho-geriatrics)'. She added 'The type of risk assessment that I do with the elderly is very different to this type of case'.

We are not suggesting, of course, that the problems inherent in Richard Stoker and his community living were overlooked or that the Care Team members did not recognise them. However it is clear to us that the concerns in the Care Team were at a differing levels and in differing degrees, and that it is a matter of regret that those differing views were not brought together and collectively assessed, weighed and discussed so that an agreed assessment of risk and how to manage it might the better have been developed and formulated which in turn, in our view, may well have led to the recognition of the need for more active intervention in the management of his case. This in turn could have had a substantial bearing on whether the events of May 1995 could have been avoided.

B THE QUESTION OF PREDICTABILITY

Inevitably, one of the issues highlighted and raised from the inception of this unhappy case and our consideration of the issue of 'risk assessment', is whether or not the events leading to the killing of Halina S were unpredictable or otherwise - and whether, if they were unpredictable they might nevertheless have been avoided.

We find it difficult to assess and judge the facts and circumstances in such absolute terms. However, in our judgement, the fact that on 25 May 1996 Richard Stoker would stab Halina S to death in her flat could not, in fairness, have been as such predicted. In that sense, therefore, the term 'unpredictable' is appropriate to this event and in reviewing all the papers we do not see that any contrary view has indeed been expressed.

However, it is our view, on a judgement of all the facts and circumstances surrounding this case, that from the end of 1992 onwards and increasingly during 1993, the circumstances in which Richard Stoker was living and the pattern of his conduct and behaviour during that period was such that there must have been an increasing risk that an event of some violence would occur - more particularly might this be so towards women in his association. Accordingly, we ask ourselves whether or not such a subsequent event of violence might have well have been avoided. We have given the most careful consideration to this aspect of the issues raised by this case and we all take the view that such violence might well have been avoided if there had been different handling of the regime of treatment and management of Richard Stoker. We believe that if in addition to the recognition by those managing his care that matters were reaching something of a critical stage when corrective and different steps needed to be taken (and to which we refer later) that such steps had in fact been taken, and if the problems in providing a means of transferring, at that stage, Richard Stoker out of the community and into a more sheltered and protected environment had been effectively addressed.

We raised these issues specifically with Dr Brown when she gave evidence before us at Morpeth and we put before her the proposition that although the event might well have been unpredictable, it might never the less have been preventable. She was entirely frank in expressing her own concerns on this aspect of the matter, but explained that she still had difficulty in understanding why the event occurred when it did 'When we probably had had three months (of his behaviour) of what was the most stable three months he had in the last two years'. However, pressed as to whether she shared the view that the event might have been 'preventable' her response was 'If he had been at Hexham (Innisfree) it most certainly would have been preventable ..... If he had been here (St George's) presumably either in rehabilitation or he came in some other setting it would have been preventable. It is always easy to see things in retrospect'.

We do of course accept that the benefit of hindsight and retrospect are easy to claim and previous events are then the more easily reviewed and assessed, but we are never the less driven to the conclusion that as expressed in more detail in Chapter Five of this report the problems created by Richard Stoker's behaviour in May of 1995 might well have been avoided if his care and treatment during the months preceding those events

had been handled differently. In summary, therefore, while the death of Halina S in these circumstances might have been unpredictable, it might well have been avoided by different handling of his care and treatment at that time.

SECTION EIGHT

SPECIFIC ISSUES - INTRODUCTION

By our Terms of Reference we have been asked, amongst other issues, to examine and report our views and findings on certain specific aspects of Richard Stoker's case. These include:-

(a) The professional qualifications and in service training of members of the Care Team;

(b) The extent to which statutory obligations (both national and local) and local operational policies were complied with;

(c) The delivery of and compliance with Care Plans;

(d) The history of Richard Stoker's medication and his compliance; and

(e) The adequacy of the collaboration and communication between those concerned in Richard Stoker's care.

Before we deal with our overall findings and recommendations, we therefore address the specific issues in the following paragraphs.

(A) PROFESSIONAL AND IN-SERVICE TRAINING OF CARE TEAM MEMBERS

In earlier sections of this report we have already expressed our views on the qualifications and in-service training of Dr Brown who was the Consultant Psychiatrist appointed as Supervising Psychiatrist in the case of Richard Stoker and the senior member of his care team. In this section, therefore, there is nothing further we wish to add under this heading in respect of Dr Brown and we accordingly deal with our views on the professional qualifications and training of the other members of the team, namely, the Probation Officer and the Community Psychiatric Nurse.

All the Probation Officers dealing with Richard Stoker's case were qualified, and as such, were competent to fill the appointed role of Social Supervisor. The most recent Social Supervisor was a trained and qualified Probation Officer with four years experience and one well able to fulfil the basic role of Social Supervisor. However, it must be added that his specific training in relation to mentally disordered offenders and the provisions of the Mental Health Acts was limited and it would be important, therefore, that he should be able to rely on the advice and judgement of the Consultant Psychiatrist in this case.

Even in an ideal liaison situation - which this, unfortunately, was not - it would have been useful for the Probation Officer and any other colleagues in the Probation Service asked to be Social Supervisors in such a case, to have received more specific preparation and training in an area of work which, although having strong similarities with the supervision of life sentence prisoners, also had some significant differences in relation to the mental health background. The Probation Officer told us that in

addition to his training and service as Probation Officer he had attended a specific course on 'Working With Mentally Disordered Offenders' - but that was the extent of any specific training for this type of case. He pointed out to us that it was mainly Social Workers who tended to hold the role of Social Supervisor in hospital or in the community. He had seen, read and considered the Home Office 'Notes for the Guidance of Social Supervisors' and in general terms felt confident of his ability to discharge that role properly, although he recognised that more detailed knowledge of and experience with the Mental Health Acts would have been an advantage.

In respect of the Community Psychiatric Nursing Service the CPN was allocated to the charge of Richard Stoker's case and was eventually the Care Manager in respect of that role, qualified as a Mental Nurse in July 1985. She was employed as a Registered Mental Nurse on the inpatient facilities at St George's Hospital, Morpeth until February 1993. In that month she undertook a five week training programme in preparation for her work as a Community Psychiatric Nurse at 'E' Grade. She also undertook four days training in care management in April 1993. However, it appears that she holds no formal qualification for working as a Community Psychiatric Nurse, nor had she undertaken any training with regard to risk management or risk assessment situations.

The provision of Community Psychiatric Nursing services to Richard Stoker followed a referral from Dr Brown to the Community Rehabilitation Team in August 1993. The referral letter makes reference to Richard Stoker 'as a conditionally discharged patient from Rampton Hospital' and indicated that he was 'subject to the usual license conditions'. However, the CPN, in evidence before us stated that she was unaware of the detail of the Mental Health Act provisions other than those sections which she would come across in working in a hospital situation. In her referral letter to the Team Dr Brown adverted to the level of risk which she saw posed by Richard Stoker (which she saw mainly at a low level and directed to the problem of self- harm) but there is no evidence of a formal risk assessment ever taking place, although Dr Brown felt able to discount entirely the risk of a further offence occurring.

It would appear to us that in the provision of CPN services not enough attention was directed to the particular issues surrounding Richard Stoker's case and the reasons why he was on a Section 41 order. In the light of the situation and previous history of Richard Stoker the allocation of his case of a Community Psychiatric Nurse on 'E' Grade and with no formal training in community nursing - and who was eventually appointed Care Manager for him - invites overall consideration as to the policy to be adopted in allocating such cases within the Service. The CPN had no previous experience of a patient under such an Order, and indeed on the occasion of the original referral Richard Stoker failed to attend appointments as a result of which the action taken was to discharge the case - when a more positive reaction would have been appropriate. In the course of her evidence to us we all discussed in detail with the CPN the appropriateness of her allocation to this case and her ability to carry out the role required of her. She confirmed to us that in Northumberland it was accepted that 'E' Grade staff would be caseload holders and have responsibility for a case, and that throughout her appointment and whilst carrying out that role she felt the responsibility was right for her and that she was able to deal with it. She added, however, that 'on hindsight, probably it was not wise' - this because of the extent of her experience and

training at that time. She was strongly of the view, however, that the outcome was in no way affected by this because (within the Service) they worked as a team and made team decisions, and there was supervision from her Line Managers. She did not think things would have been done differently under a different officer or that there would have been different outcomes.

These, of course, are extremely difficult areas to assess, even with hindsight, but perhaps the best course would be to always have regard, as far as possible, to recommended practice and principles. We were advised that in the report issued by the Department of Health/Home Office in 1992 by the Academic Development Advisory Group (in respect of their view of services for Mentally Disordered Offenders and others requiring similar services) there was a recommendation that for both Social Workers and Probation Officers additional specialist training be available for those working with mentally disordered offenders and similar patients. There was also a suggestion that a small number of Probation Officers should receive training as Approved Social Workers so as the better to undertake their role in regard to the Mental Health Acts. This is, perhaps, an overall consideration and a much wider training issue to be borne in mind for the future.

(B) THE EXTENT TO WHICH MR STOKER'S CARE CORRESPONDED TO STATUTORY OBLIGATIONS AND LOCAL OPERATIONAL POLICIES

In our Terms of Reference we have been specifically required to examine and consider the extent to which Richard Stoker's care corresponded to Statutory Obligations and to Local Operational Policies. We have, therefore, given detailed consideration under both of these headings and first, in connection with Statutory Obligations, we have considered the application to this case of:

The Mental Health Act 1983 - Sections 37 -42
The Mental Health Act 1983 - Section 117 (After Care Arrangements)
Department of Health Guidance HC(90)23/LASSL (90)11 Care Programme Approach
Department of Health Circular HSG (94)5 (Supervision Registers)
Department of Health Circular HSG (94)27 (Guidance on the Discharge of Mentally Disordered People and their Continued Care in the Community)

We have the following comments and observations to offer.

(a) The Mental Health Act 1983

(i) Sections 37 - 42

Section 41 of the Act is the provision under which a Restriction Order is made when it is necessary to protect the public from serious harm, and re-enacts the provisions under which the original Order under which Richard Stoker was detained in Rampton Hospital following his first conviction was made.

The Act empowers the Home Secretary to discharge a patient in hospital subject to conditions. Here again, these provisions were properly applied when Richard Stoker, following the Hearing and determination by a Mental Health Review Tribunal, was granted his discharge to allow him to live in the community subject to the conditions imposed in the Discharge Order. The Home Secretary, of course, retains under the Act a discretion to recall a patient at any time, and the recall need not be triggered by a breach of the patient's conditions of discharge but, indeed, on any grounds which the Home Secretary considers in the circumstances to be appropriate.

In order that the Home Secretary may be kept fully in touch with all and any circumstances which may warrant the exercise of this power of recall, a report to the Home Office is required to be made, not only on a regular periodical basis, but also whenever:

(a) there appears to be an actual or potential risk to the public; or
(b) contact with the patient is lost or the patient is unwilling to co-operate with supervision; or
(c) the patient's behaviour or condition suggests the need for further inpatient treatment in hospital; or
(d) the patient is charged with or convicted of an offence.

It is also important to remember that if a Conditionally Discharged Restricted patient requires hospital admission or treatment, it is not always necessary for the Home Secretary to recall the patient under the original Order for:

(a) The patient may be willing to accept treatment informally; or
(b) In some cases it may be appropriate to consider admitting the patient under Part II of the Act as an alternative; or
(c) It may not always be necessary to recall a patient to the same hospital from which he was conditionally discharged. In some cases recall to a hospital with a lesser degree of security would be appropriate.

Comment and observations

While we are satisfied that Richard Stoker's care corresponded to the statutory obligations in principal, we are nevertheless quite concerned that the reporting to the Home Office, did not at all times sufficiently emphasise the extent of the problems which Richard Stoker was from time to time experiencing and upon which the views of the Home Office might more particularly have been sought. Nor do we think there was a sufficient recognition of the fact that there were available under the powers of the Mental Health Act 1983 and the initial Conditional Discharge Order, opportunities for dealing with Richard Stoker otherwise than by what was considered to be the 'draconian' option of recalling him back to Rampton Hospital. In our view a wider appreciation of these

alternatives may well have been helpful in considering other ways of dealing with Richard Stoker's problems.

(b) **Section 117 - After Care Arrangements**

Section 117 of the Mental Health Act 1983 requires Health Authorities and Local Authorities, in conjunction with the voluntary agencies, to provide after care for certain categories of detained patients - which would include patients detained under Sections 37 -41 of the Act. Where a decision has been taken to discharge a patient, whether conditionally or otherwise, it is the responsibility of the Responsible Medical Officer to ensure that a discussion takes place to establish a Care Plan to organise the management for the patient's continued health and social care needs.

Although in Richard Stoker's case plans were conceived and put in place which were deemed appropriate to manage his health and social care needs, we would observe that there does not appear to have been any formal discharge meeting involving the professions recognised as appropriate by Section 117 of the Act. Community Psychiatric Nursing involvement did not occur until 1993 and there is no record of any Section 117 aftercare meeting. We cannot trace that at any time a formal Risk Assessment process was in place - although, of course, views on the risk or otherwise presented by Richard Stoker were regularly considered by individual members of the Care Team. The quarterly reports requested by the Home Office from the Supervising Psychiatrist were generally late in being completed, although when duly prepared and delivered they provided her general overview of the care. We further note that the GP was not involved in any Section 117 proceedings.

(c) **Care Programme Approach - Circular HC(90)23/LASSL(90)11**

The Care Programme Approach outlined by the above circular was to be implemented by 1 April 1991. The Care Programme Approach was developed to ensure that patients treated in the community received the health and social care appropriate to their circumstances and needs, and in order for this to occur, systematic arrangements were to be in place for assessing health and social needs, appointment of a Key Worker to monitor the agreed health and social care, and that such a Key Worker would advise professional colleagues of changes in circumstances which would require review and modification of the care programme. Particular emphasis was put on inter-professional working, involving patients and carers keeping in touch with the patient in ensuring that the agreed service was provided and in highlighting the role of the Key Worker.

In the case of Richard Stoker, all of the above arrangements would have also been covered by the after care arrangements as laid out in Section 117 of the Mental Health Act. However, following his referral to the Community Psychiatric Nursing Service in 1993 and the appointment of a Key Worker there does not appear to have been any formalisation of the Care Programme Approach in his case, and indeed the CPA in Northumberland was not

implemented until 1994. There would have been clear advantages if the Care Programme Approach set out in the Guidance had been followed, and the absence of formalisation of the health and social care arrangements which were being made for Richard Stoker must have had some bearing on the eventual outcome.

(d) **Supervision Registers for Mentally Ill People - HSG(94)5**

The provision of a Supervision Register took forward the policy of a Care Programme Approach to ensure that those patients who posed more risk to themselves and others received special care support and supervision within the community to assist in preventing them from falling through the care network. References to the question of the Supervision Register and Richard Stoker's appropriateness for inclusion in it, occurred more than once throughout the documentation which we have considered.

Three categories are noted for inclusion in the Supervision Register and these are:

(a) Significant risk of suicide;
(b) Significant risk of serious violence to others; or
(c) Significant risk of severe self-neglect.

Inclusion on the Supervision Register entails a review of the community psychiatric care arrangements for the patient occurring at least every six months.

Richard Stoker was subject to the provision of the 1983 Mental Health Act with Conditional Discharge Restriction and a requirement for quarterly reviews by his Responsible Medical Officer. Against his background there is raised the question of whether or not it was appropriate that he should be placed on the Supervision Register. We were advised in evidence at our Hearing that this issue was fully considered by the Supervising Psychiatrist when raised by team members and it was decided that this would not be appropriate. The inclusion of his name on the Supervision Register would have made no difference to the management and care of his case in the community in the light of the conditions already imposed upon his conditional discharge but would have ensured that regular review meetings would have been held every six months. We note this is a view wholly endorsed by other independent psychiatrists who have also reviewed this case.

(e)` **Guidance on the Discharge of Mentally Disordered Patients and their Continued Care in the Community - HSG(94)27**

This Guidance published in 1994 seeks to ensure:

(i) that psychiatric patients are discharged early only when and if they are ready to leave hospital;

(ii) if there are any risks to the public or patients themselves, it is minimal and effectively managed; and

(iii) that when patients are discharged they get support and supervision they need from responsible agencies.

We are satisfied that the principles set out in this Guidance were, indeed, applied in Richard Stoker's case but as we indicate in the text and body of this report, it is the manner and detail of the application of them to the case of Richard Stoker which we believe was capable of more particular examination from 1993 onwards and we would refer far more detail to the later paragraphs of Section Five of this Report.

(f) Local Operational Policies

Richard Stoker was discharged from Ingram Ward, St George's Hospital, Morpeth in January 1988. From the evidence that we heard at Morpeth it was not clear what Local Policies were then in place with regard to discharge and after care prior to 1989. In the policy dated 1989, reference is made to patients under Sections 3 and 37 having an aftercare review following discharge, and which was to be recorded on an Aftercare Register. No mention is made in Richard Stoker's clinical notes of a Discharge Care Planning meeting or of a Discharge Plan. However, of course, the terms of his Conditionally Discharged Order made in 1988 establishing his health and social care needs were in place and implemented.

The later and more comprehensive Local Policy was the Care Programme Approach policy which was promulgated in 1994 and which was due to come into force in Northumberland on 1 April 1995. This local policy was designed to implement and make local application of the Care Approach Programme established under HC(90)23. In view of the timescale involved it did not have any specific application to the case of Richard Stoker - except that we would wish to observe upon the policy and procedure for the appointment of a Key Worker/Care Manager. The factors stated in the Local Policy which determine the appointment of a Key Worker states that the Key Worker/Care Manager must have the appropriate skills and experience to match the user needs and also that in cases with the most complex needs a Care Worker is required who has authority to call reviews. We are not confident that in the case of Richard Stoker this level of appointment and experience, in fact, existed. In the Guidance, reference is made to the fact that someone on a Supervision Register or Care Programme Approach level they would have a 'G' grade or equivalent professional allocated to the case.

We particularly note that when giving evidence at Morpeth, the Key Worker/Care Manager appointed in this case, felt that she may have been inappropriately allocated to the case because of her level of experience. We feel that had there been clear discussions amongst professionals at the outset, a more appropriate allocation would have been made.

(C) THE DELIVERY OF AND COMPLIANCE WITH CARE PLANS FOR RICHARD STOKER

The Original Plan

The basic care plan for Richard Stoker following his release from St George's Hospital, Morpeth was effectively that contained in the Order of the Mental Health Review Tribunal which gave him his Conditional Discharge. The terms of that Order were that 'he be discharged from St George's, Morpeth and that he be subject to the Supervision of the Responsible Medical Officer and the Probation Officer and that until the otherwise directed he should live at Sweethope Hostel, Ashington'. Those terms and conditions - which in effect constituted the initiation of a 'Care Plan', were amplified in more detail in a letter from the Home Office dated 30 November 1987 which provided:

(a) The patient shall reside at Sweethope Hostel, Sweethope Avenue, Ashington, Northumberland;

(b) The patient shall reside there under the supervision of a Probation Officer appointed by the Northumberland Probation Service;

(c) The patient shall keep in touch with and receive home visits from the Supervising Officer as directed by the officer; and

(d) The patient shall attend a Psychiatric Outpatient Clinic as directed by the Consultant Psychiatrist at St George's Hospital.

In November 1987 the admission panel to Sweethope Hostel wrote to the Consultant Psychiatrist confirming their acceptance of Richard Stoker as a resident subject to arrangements being made for his day time activities which were to be established, and confirmation that there was continued support to both Richard Stoker and Sweethope Hostel by the Probation Officer.

Arrangements were made in consultation with the RMO and the appropriate Consultant for Richard Stoker to attend sheltered employment facility at Coopies Lane, as part of his day time activities and this pattern took effect from the time of Richard Stoker's discharge from St George's to Sweethope Hostel in January 1988.

The above effectively constituted the 'Care Plan' and the care arrangements for Richard Stoker, subject to the comments of the Supervising Psychiatrist that the policy was then to be one of 'constraint and support' in that overall situation. We can trace nothing more specific having been promulgated and established as a Care Plan but the details above together constituted a plan to which members of the Care Team would work. It was essentially a plan which depended to a very high degree upon its acceptance by Richard Stoker and his co-operation throughout. Any variations or additions to the plan tended, thereafter, to be the result of reaction to dealing with crisis situations which had arisen and seeking to contain them.

Developments

There does not appear to have been any formal meeting involving the multi-disciplinary team to discuss aftercare arrangements and to agree a formal Care Plan. No Community Psychiatric nursing services were involved in the initial phase, and it is not clear whether the responsible Medical Officer, Dr Brown, and the then Social Supervisor, Mr Dunn, had discussions to clarify their role with regard to Richard Stoker's continuing support, needs and monitoring requirements in the Community. Dr Brown agreed in evidence to us that she could not recall any Case Conference to examine the continuing issues of the care programme, but was able with confidence to report to the then Department C3 at the Home Office in May 1988 her satisfaction with care arrangement progress to date.

The next significant variation in the care programme or pattern was noted in May 1989 and concerned Richard Stoker's proposed marriage to Ms SG (which occurred in October 1989) and his proposed move out of Sweethope Hostel into a sheltered flat with her by way of an agreed alteration in his care arrangement pattern. Although his work in the sheltered workshop scheme had been terminated following an incident (of dishonesty) there, Dr Brown was able to advise the Home Office that he continued to 'be a model patient'.

We take the view that the initial discharge arrangements outlined above would appear to have been sufficient for ensuring ongoing support in the community for Richard Stoker, and although loosely described as a 'Care Plan' they to some extent achieved that objective. However, as time progressed, more and more of the support framework fell away. This included his leaving Sweethope Hostel (where he had substantial support), leaving the placement at the sheltered workshop scheme; marital break-up resulting in him moving to live by himself and with his behaviour becoming more unpredictable with alcohol abuse and self-harming. The basic approach to continuing care in the Community appeared to have remained that of a 'containment and support', and there does not appear to have been a formal reappraisal of his care in the community and a plan formed within the agencies to ensure a better support framework in the light of the ever changing conditions. In November 1993, following referral of the case to the Community Psychiatric Service, an assessment was prepared by the CPN but that, of course was an assessment rather than a care plan or a variation of it. This overall situation was best summed up by the Social Supervisor, the Probation Officer, in his evidence to us when he said.... 'I think that's what we were really pushing for, a multi-disciplinary approach, really a co-ordinated way forward, really, rather than a reaction to crisis'.

Concerns

That must remain our main concern on the question of care arrangements - namely that although the elements of a Care Plan were in position as outlined above, they were indeed a general outline and did not have the benefit of a joint contribution from members of the multi-disciplinary team (especially from 1993 onwards when the community psychiatric nursing services were involved) so that all members could consider together collectively, how best to develop, formulate and apply a care

programme which would have addressed the increasing problems which were being experienced in the management of Richard Stoker's case from 1993 onwards.

(D) RICHARD STOKER'S MEDICATION AND COMPLIANCE WITH HIS REGIMES

It is clear from all the medical evidence over recent years included in the papers placed before us, and in the evidence which we heard, that Richard Stoker suffered from a learning impairment and from the history in his case records at no time was there any evidence of a psychotic illness nor was there at any time any identified need for prescribed medication. In terms, therefore, of treatment by way of medication there is nothing upon which we need observe.

We note further, that following his transfer to St George's Hospital, Morpeth, he was regularly seen in the outpatients department, and his attendance there was good until the 1990s when he failed several appointments; in early to mid 1993 such attendance dropped off very substantially. When Richard Stoker did not attend outpatients it was not noted in the case notes what action, if any, was then taken. Indeed, on one occasion during a review in February 1993, when a number of appointments had been missed, Dr Brown expressed the view that she was only willing to offer appointments to Richard Stoker 'if he was willing to keep them'. This underlined the difficulty of securing co-operation with Richard Stoker and, perhaps, the frustration felt by the Care Team of his unwillingness to respond positively - but this failed also to acknowledge that Richard Stoker remained, as a result of his Conditional Discharge Order, under compulsion and that therefore his failures may properly have called for more positive intervention.

Dr Brown's comment on Richard Stoker's treatment at Rampton was that he was being given increasing amounts of responsibility, and overall, the main strategy of treatment was containment whilst in hospital and support once in the community. It was felt by Dr Brown that his problems were mainly in the nature of 'inadequacy' and that a hospital admission (for treatment), would not have solved this.

From our interviews with the Care Team, it was understood that Richard Stoker had attended both literacy and numeracy training whilst an inpatient. On discharge from hospital these did not appear to continue, but at one stage he attended a rehabilitation workshop and it was said he did well there during a short period of time. Whilst he was at Sweethope Hostel, and in preparation for independent living in the community, budgeting and independent living skills were addressed.

However, in terms of treatment options - other than medication - such as alcohol education, literacy skills, relationship counselling, debt management and other treatment to assist his problems in the community, there is no great evidence that much was attempted in this field.

Once he was living un-supported in the community, the Probation Officer and the Community Psychiatrist Nurse offered budgeting advice to Richard Stoker - but it was clear he did not act upon this, and indeed, their view was that he ignored it. There is no evidence that Richard Stoker received any alcohol education despite it being known that he drank to excess - particularly in times of crisis. It was said that he was not

'receptive to this', given his personality and low intelligence, and although throughout the evidence we heard that the Team Members were only too aware of his excessive drinking problem (and the associated self-harm when in drink) they felt unable in view of his inadequacy and learning difficulties in making any progress in this field.

During the period when Richard Stoker was resident with his wife and there were matrimonial difficulties, we were advised that he received counselling and education on specific matrimonial topics, but no specific couple-work was undertaken and this again was because of the continuing problems of obtaining co-operation from him. It was clearly very difficult for the Care Team and its members to make progress with Richard Stoker on these various issues and that at the end of the day a policy of 'containment and support' represented the maximum that was felt capable of achievement in these areas.

(E) THE ADEQUACY OF COLLABORATION AND COMMUNICATION BETWEEN THE AGENCIES INVOLVED IN THE CARE OF RICHARD STOKER OR THE PROVISION OF SERVICES TO HIM

Joint Meetings

In light of what we have already found it necessary to say in previous Sections of this report, it will come as no surprise that the foremost area of our concerns that we are about to highlight is that of Communication and Collaboration - especially between the members of the Care Team involved in Richard Stoker's management. Since Communication and exchange and sharing of views, proposals and concerns must precede the determination and therefore the management of the case and the problems it raises, it follows that Collaboration - even where the participants are not only willing but indeed anxious to pursue a collaborative cause - it is rendered more difficult if not impossible, without adequate communication.

The Care Team was headed by the Supervising Consultant Psychiatrist and we have already indicated that she considered that her role was the 'lead role' and it is clear that other members of the Care Team shared that view. Difficulties in promoting communication and securing collaboration were therefore inevitable against the background in which Dr Brown frankly acknowledged that she had 'a lot of difficulties with communication' - attributing this partly to the excessive workload which she felt she was carrying and partly to secretarial and office management problems. She was undoubtedly a very busy Consultant, resulting in difficulty with letter writing, and adding to us 'I am a person who prefers to do rather than write; I have no illusions about that'. We have already examined these issues more fully in Section Six, and commented upon them.

The periodical reports to the Home Office from the Consulting Psychiatrist (which should have been on a regular three monthly basis) were perhaps in the circumstances viewed as something of a bureaucratic chore, especially in the case of a Psychiatrist who considered she had a very busy workload and secretarial problems and perhaps an understandable preference for 'doing rather than writing'. However, the absence of the discipline of preparing and despatching such regular Reports (which would be copied to

other members of the Care Team and those concerned) meant that an excellent opportunity of 'keeping in touch' and sharing views, proposals and concerns with other members of the Care Team was missed - which would, of course, have enabled them to make and share views and comments and either agree or disagree so as to promote a contribution to Care Plans and exchange of views. This kind of multi-disciplinary meeting and sharing their views never occurred - except on rare occasions, which was the more surprising because this was the single joint case this team were sharing.

Inter-Communication

Written communication from the Consultant to the Probation Officer and the Community Psychiatric Nurse was minimal and although those officers were meeting together and conducting joint visits they felt unable to move forward without wider co-operation involving the Consultant. Those officers expressed their concerns, - and to a certain extent frustration - in their evidence before us.

The Probation Service indicated that they clearly recognised the importance of regular and constructive liaison with the other professionals involved, and when the CPN was involved in working with Richard Stoker, liaison between the Probation Service and the CPN was effective and joint visits were made. However, liaison with the Psychiatrist remained limited. The measures taken by the Probation Service to improve this were to some extent to try to communicate this concern directly to the Psychiatrist, and to refer to it from time to time in the Probation Service's regular reports to the Home Office. Although there was evidence that, on at least one occasion, such a comment in the report to the Home Office did lead to an attempt by the Home Office to influence the Psychiatrist to liaise more effectively, many similar comments in other reports by the Probation Officer to the Home Office were rather too 'coded' to convey that concern in sufficient strength. It is likely, therefore, that the true weight of feeling from the Probation Service may not have been communicated on a sufficient number of occasions or with sufficient force.

Although Probation Officers did try to influence the Psychiatrist by some approaches to her, they did not take a further option which could have been to make a formal approach to the Chief Executive or Medical Director of the Mental Health Trust. It is recognised that this might have been an uncomfortable action for the Probation Service to take and one which they were not aware was available to them at the time, but it would have been a justifiable expression of the strength and concern being experienced by the Probation Service staff. The Panel understood that useful discussions have subsequently taken place between Northumberland Probation Service and Northumberland Health Authority.

The Community Psychiatric Nursing Service - from its involvement in 1993 - reported similar experience and similar concerns on the question of communication - and with it, therefore, reduced opportunities for collaboration. This appeared to result in a tendency to rely more upon contact with the Social Supervisor, who was the Probation Officer rather than the Consultant Supervising Psychiatrist. We have already indicated in previous sections of this report that the CPN allocated to the management of Richard Stoker's case, was relatively new to that post role and it is understandable,

therefore, that she did not feel in a position to be more forceful in pressing for multi-disciplinary involvement and action.

Concerns

We must therefore make very clear indeed in this Section our concerns that the level of Communication and therefore Collaboration in this case was unsatisfactory and unacceptable, and that lessons must be learned from it. Dr Brown was entirely forthright and frank with us in acknowledging that responsibility in this field was hers - but we would like to think that for the future other members of Care Teams would be encouraged to recognise that they act in a joint role in patient management and that they should be encouraged to recognise that they would be entitled themselves to propose and insist upon multi-disciplinary meetings and case conferences - and indeed to initiate these - if they felt that a sufficient lead was not coming from other members of the Team.

So far as any Communication or Collaboration with the members of Richard Stoker's family is concerned, we have already explained that position at the end of Section Four, and confirm our view that there were no practical options available there.

SECTION NINE

CONCLUSIONS AND RECOMMENDATIONS

We would not want to record the result of our deliberations in this case or set out our Conclusions and Recommendations without first recognising again the concern, ability and experience of all those in Health Service and the Probation Service who, over the years, devoted care and attention to Richard Stoker. That remains the position whatever the conclusions we have reached and whatever recommendations we make. We recognise also that we have the advantage of being able to review all the facts and circumstances with the benefit of hindsight and retrospect, and that it is sometimes all too easy to be wise after the event.

We have, in our review of the case to date, pointed to something of a 'watershed' in the management and treatment of Richard Stoker having been reached at about the end of 1992 and the beginning of 1993. We would here, again, reiterate our view that it was entirely proper for the authorities to have been satisfied with the progress of Richard Stoker's life in the Community and his integration back into society up to the end of 1992, and there was up to that period, every reason for satisfaction with his progress and there was no substantial cause for concern either in his own interests or in the interests of the Community at large.

We must, however, state our conclusion that from the end of 1992 onwards things 'began to go wrong' and were characterised from then onwards by a number of indications which were, in our view, 'warning signals' that his then current programme of Care in the Community needed to be reconsidered and reinforced. A series of problems were arising and persisting and we do not consider that these were at that time being effectively recognised and objectively and sufficiently addresssed. We do not think that the balance to which we have previously referred and which it was necessary to achieve between the personal interests and wishes of Richard Stoker on the one hand and the interests of the Community on the other - bearing in mind especially that he was a patient who was the subject of a Conditional Discharge Order under the Mental Health Acts which was designed to ensure the public interest - was at all times recognised and protected.

At the end of a full and far reaching examination of all the facts, papers and evidence, we confirm the view already originally expressed in this Report that although the killing of Miss Halina S in May 1995 was, - as a particular event - 'unpredictable', we do not consider that the circumstances were unavoidable. We believe that if there had been from 1993 onwards a more positive and more co-ordinated approach to the management of his care, it would have been recognised that steps to arrange and secure his transfer out of an uncontrolled Community setting and into a more controlled and managed environment were actively and urgently required, not only in the interests of his own care and rehabilitation but also for the better safeguarding of the Community in general. Had this happened, then the event of May 1995 could have been avoided.

The Case Conference (then long overdue) in September 1994 had confirmed that all disciplines shared the view that the time for his transfer out of the Community setting had arrived and that he should be placed in an appropriate Nursing Home - Innisfree having been selected. When that opportunity failed (although such a failure ought to have been

recognised as a possibility) we are satisfied that further steps ought then to have been taken actively to seek and to arrange an effective alternative which achieved the same objective - namely, putting Richard Stoker in a more controlled and managed environment and removing him from his lonely and separate existence in the Community. We accept that would not have been a simple task, but that was not sufficient reason for failing to pursue such a positive objective but rather simply to accept, so it seems to us, the continuance of the then highly unsatisfactory position.

The Alternative

Before we look at alternatives, we recognise that it is impossible to say - even with the benefit of hindsight - that any one single course of action would have created such a difference as to prevent the tragedy of May 1995. We are bound to observe, of course, that if Richard Stoker had not been and not able to be in that place and at that time when Halina S met her death, then the tragedy would have been prevented. That may seem a simplistic and obvious view, but it arises from our conclusion that if steps to correct and adjust the decline of the management and treatment of Richard Stoker had been taken sooner rather than later, then his removal from this environment would have been achieved, so that at the end of 1994 and the beginning of 1995 (at the latest) he should have been placed in a more controlled and managed environment for his own good and the good of the Community in which he was living.

Some of the alternatives which from the reports and evidence we know had been 'canvassed' by individual members of the Care Team but not adequately pursued included the alternatives of:

(a) Hospital admission - for reassessment of his needs and following assessment to await (in Hospital) appropriate resettlement proceedings - because it was clear he was not able to cope with independent living;

(b) The consideration of using and applying the provisions of the Mental Health Acts to detain him under Part II;

(c) Recall to hospital under the terms of the original Order; and

(d) Finding some other controlled residential home or hostel where he would have been under more regular supervision and management.

We consider that alternative (c) was certainly always available, and that grounds had arisen and were manifest over many months which would have justified that course, namely, of inviting the Secretary of State to exercise his powers. The Guidance Notes to which we have earlier referred point to the need to advise the Secretary of State whenever 'the Patient's behaviour or condition suggests a need for further inpatient treatment in hospital' - a stage which, in our view, had certainly been reached in 1994 at the latest. Although it is clear that some of the Agencies - in particular Dr Brown - considered that this would have been a 'Draconian' course, the Home Office had already made it clear in correspondence that recall need not be to Rampton but 'to any other suitable and appropriate hospital'; and that, therefore, must have remained at all times an alternative if all else had failed. It is clear that the view was taken that Richard Stoker might not have wanted or been prepared to accept any

of these alternatives - but again we reflect that perhaps too much consideration was being paid to his own views and preferences rather than what was the prime consideration in the circumstances, namely the safeguarding of the Community.

The Failure to Act

After the failure of the Innisfree proposal our conclusion is that the Care Team allowed hopes that some alternative solution would arise to be dominant in their minds. Matters were allowed to 'drift' instead of a positive course of action (given the Case Conference of September 1994 about Innisfree) being pursued.

We believe that there were a number of principle reasons why this happened:

(a) There was in our view throughout the management of Richard Stoker's case a marked failure to consider and produce a co-ordinated plan which would have been achieved by the holding of multidisciplinary meetings, Case Conferences and regular and better communication. This is a striking failure in the management of Richard Stoker's case, and from documents before us and the evidence we heard this issue has never really been contested. It was, rather accepted as an 'unfortunate' and long ongoing situation so much so that scarcely anything at all was done to correct it, and requirements for improvement were not adequately pursued;

(b) There was also in our view failure to approach the question of Risk Assessment and its management in a structured manner which would have enabled the members of the Care Team to have this aspect of the matter more focussed on their attention, and recognise that situations, problems and crises needed to be addressed against that background. If this had been done, the need for a much more proactive approach to Richard Stoker's care and treatment in 1994 and 1995 might have been better recognised;

(c) There was also failure to respond effectively to the fact that Dr Brown's role as a Consultant Psychiatrist had changed dramatically since her first appointment as Supervising Psychiatrist and, therefore, being no longer involved in Acute Psychiatry but rather in Psychiatry for the Elderly, she had long ceased to be an appropriate person for the role of Supervising Psychiatrist. Although it was clearly recognised that the case of Richard Stoker (with other cases) should be transferred to another Consultant, no sufficient action was taken to ensure that this in fact took place, whether Dr Brown wished it or not;

(d) Finally, we conclude that there seems to have been a tendency to treat Richard Stoker as just 'another' patient with problems, without continuing to recognise that there was in addition to his mental impairment a background of a violent incident which always had to be borne in mind and that he was subject to a Conditional Discharge Order.

The responsibility for these failings and shortcomings in the management of his care must lie with the Care Team - but primarily with the Supervising Consultant Psychiatrist who acknowledged herself to be - and was recognised by the other members - as being the 'Team Leader'. The failure - or rather her failure - to lead the Team and to enable a multidisciplinary approach with regular Case Conferences gave rise to constant concerns by the other Team members and their expressed 'frustration'. If there is any criticism to make of

those other members in this respect it is that, on reflection, they did not do enough to make their concerns and dissatisfaction sufficiently heard and known, although we do recognise that with a Consultant as the lead professional they perceived difficulties in this. A second and substantial course which perhaps lay behind the problems we have outlined in the management of Richard Stoker's case is the fact that during the 1990s it is probably the case that the Supervising Consultant Psychiatrist in charge of case leading the Team was not the right person for that role. In our section about the Supervising Psychiatrist we have examined this issue in detail and expressed our concerns about this, and we must record these in our conclusions as being one of the factors which went to any failures and shortcomings in this case, because it is inevitable that the concerns expressed about the continuing inappropriateness of Dr Brown's role as Supervising Psychiatrist must in our view have had an impact upon the management processes, and the effective guidance which a Supervising Psychiatrist would be expected to give in this area.

RECOMMENDATIONS

It is our duty to make some recommendations arising out of the Inquiry into this case in the hope that improvements or benefits for the future may arise. Some of our recommendations are, of necessity, of more specific rather than general application and we feel that all agencies should be encouraged to take all of these on board because the number of cases of this kind which each agency will experience will be just a small proportion of their total workload.

1. The Care Team
   Where there is such a case in which a Conditionally Discharged patient with this type of background is placed in the care and management of a multidisciplinary Team it is, in our view, important that members of that Care Team have the training, experience and background which suits them for such a role - and we refer particularly to the training recommendations and requirements for Probation Officers and Community Psychiatric Nurses who have to fill a role in such a Care Team and the need for the Consultant Psychiatrist to be an appropriately placed and experienced person as referred to below.

2. Communication and Collaboration are, of course, absolutely essential within a Care Team and there is no need for us indeed to make any recommendation on this - it is already, surely, established practice and case law - although there were particular issues and deficiencies in this case. We would, therefore, in the light of the circumstances of this case underline how absolutely essential it is to hold regular Case Conferences and always to communicate fully. We would add, that although one member of the Team (usually the Consultant Psychiatrist) would normally be recognised as the Team Leader, it must be made absolutely clear that any member of a Care Team can and is entitled to require (and if necessary, in default convene) a Case Conference or similar multidisciplinary meeting to ensure there is all times a co-ordinated approach to care and the regular exchange of views.

3. Communication
   The Trust should establish strict Standards for Reports, recording letters and other communications to be observed by all of its staff and the implementation of the Standards should be regularly reviewed and audited.

4. We consider that the General Practitioner will always have a role to play in the management of a case such as this, and should at the outset be identified and receive regular communication. A patient's General Practitioner should also be invited to contribute to multidisciplinary and CPA meetings and would, we feel sure, have a most useful contribution to make.

5. Risk Assessment and Risk Management
A protocol must be established and implemented to ensure that proper Risk Assessment and Risk Management proceedings are applied in all relevant cases and fully audited.

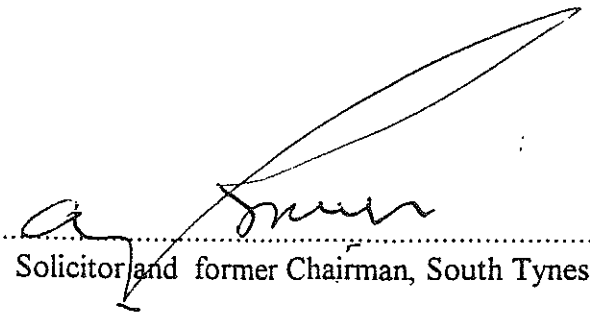
6. Patient Records
We would take the opportunity following the experience of examining records in this case to recommend that inpatient and outpatient records be amalgamated on the same file so that there is a single combined record of a patient always available.

7. Care Team Membership
Whenever there is a change in the employment or role of a member of a Care Team, this must immediately be reported and considered so that a positive and constructive assessment can be made as to whether that Officer ought to continue as a member of the Care Team or be replaced by another or more appropriate Officer. This is not any criticism of the quality and service of the Officer who will be replaced - but simply designed to ensure that persons in the right disciplines and roles contribute to the Care Team approach.

8. The above recommendation inevitably brings us to the question of the role of Dr Brown in the light of the concerns expressed in evidence to us about her continued role and the transfer of this case which should have occurred but did not occur. We would recommend, therefore, that within the limits of clinical independence of Consultants, an employing Trust should see part of its role as an employer in ensuring that the person in the role of Supervising Consultant Psychiatrist remains appropriate to that role and should assist (and where appropriate insist) in relocation and reprovision of that role in the event of changes occurring. It must be in everyone's interests to ensure that the person in that very important role remains the right and most appropriate person.

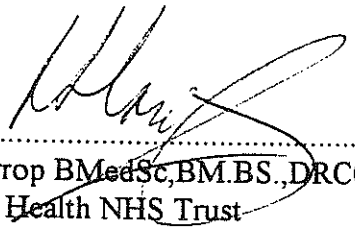
9. We consider additionally that the role of the Medical Director of the Trust should be extended/defined as including a specific audit programme of the cases of all Conditional Discharge Patients who are in the care of the Trust, to ensure that all proper procedures and practices in relation to such patients are being followed and audited and the proper management is in place.

DATED THIS NINETEENTH DAY OF DECEMBER 1996



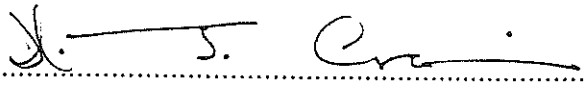
.....

Mr A G Brown, Solicitor and former Chairman, South Tyneside Family Health Services Authority



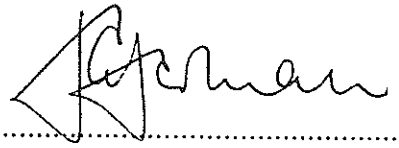
.....

Dr F M Harrop BMedSc,BM.BS.,DRCOG,MRC Psych - Consultant Psychiatrist, Bradford Community Health NHS Trust



.....

Mr H J Cronin RMN,CPN Cert - Area Manager, Wakefield & Pontefract Community NHS Trust



.....

Mr J C Harman MA, Deputy Chief Probation Officer, South Yorkshire Probation Service

APPENDIX A

NORTHUMBERLAND HEALTH AUTHORITY

TERMS OF REFERENCE

RICHARD STOKER: REMIT FOR INQUIRY

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MR R STOKER

1. To examine all the circumstances surrounding the treatment and care of Mr Stoker by the mental health services, in particular:

   (i) the quality and scope of his health, social care and risk assessments;

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

      (a) his assessed health and social care needs;
      (b) his assessed risk of potential harm to himself or others;
      (c) his psychiatric history, including alcohol and drug abuse;
      (d) the number and nature of any previous Court convictions;

   (iii) the professional and in-service training of those involved in the care of Mr Stoker, or in the provision of services to him:

   (iv) the extent to which Mr Stoker's care corresponded to statutory obligations, particularly the Mental Health Act 1983; relevant guidance from the Department of Health (including the Care Programme Approach HC(90)23/LASSL(90)11 and Supervision Registers HSG(49)5); and local operational policies;

   (v) the extent to which his prescribed care plans were:

      (a) effectively delivered, and
      (b) complied with by Mr Stoker;

   (vi) the history of Mr Stoker's medication and compliance with his regimes;

2. To examine the adequacy of the collaboration and communication between:

   (i) the agencies (Northumberland Mental Health NHS Trust, Northumbria Probation Service and Northumberland Social Services Department) involved in the care of Mr Stoker or in the provision of services to him; and

   (ii) the statutory agencies and Mr Stoker's family.

3. To prepare a report and make recommendations to Northumberland Health Authority.

APPENDIX B

COMPOSITION OF THE PANEL

MR A G BROWN - CHAIRMAN	Solicitor and former Chairman, South Tyneside Family Health Services Authority
DR F M HARROP	B MedSc,BM.BS.,DRCOG,MRC Psych Consultant Psychiatrist, Bradford Community Health NHS Trust
MR H J CRONIN	RMN, CPN Cert Area Manager, Wakefield & Pontefract Community NHS Trust
MR J C HARMAN	MA Deputy Chief Probation Officer, South Yorkshire Probation Service

APPENDIX C

BIBLIOGRAPHY

FILE PERIOD	FILES RECEIVED
1. 1987 - 1995	General correspondence received from Northumberland Mental Health NHS Trust regarding Richard Stoker including History Sheets - Clinical Notes
2. 1984 - 1994	Clinical correspondence received from Northumberland Mental Health NHS Trust regarding Richard Stoker including Clinical Notes
3. 1993 - 1995	Care Worker's notes and correspondence received from Northumberland Mental Health TNHS Trust regarding Richard Stoker
4	Extensive Probation Records and other documentation received from Northumbria Probation Service:
5. To May 1996	Northumberland Social Services file
	REPORTS RECEIVED
6. 12 July 1995	Internal Inquiry undertaken by Northumberland Mental Health NHS Trust
20 March 1996	Dr Stephen Singleton, Director of Public Health Northumberland Health Authority. Commentary provided for Northumberland Health Authority on Internal Inquiry:
7. 14 March 1996	Comments by Dr R J Turner, Consultant Psychiatrist, Nottingham Healthcare NHS Trust
8. 31 January 1996	Comments by Dr R J Turner, Consultant Psychiatrist, Nottingham Healthcare NHS Trust

9. 18 October 1995	Comments by Dr Don Grubin, Consultant Forensic Psychiatrist/Senior Lecturer in Forensic Psychiatry, Newcastle City Health NHS Trust	
	Additional policy information requested from Northumberland Mental Health NHS Trust	

DOCUMENTS RECEIVED

1. 1987 - 1995	Home Office Department of Health & Social Security	Mental Health Act 1983 Supervision and Aftercare of Conditionally Discharge Restricted Patients Notes for the Guidance of Supervising Psychiatrists
11. Sept 1989	Northumberland Mental Health NHS Trust	Discharge and Aftercare Policy - Mental Health Unit
12. 1990	Department of Health	HC(90)23/LASSL(90)11 Care Programme Approach for People with Medical Illness
13. February 1994	Department of Health	HSG(94)5 Introduction of Supervision Registers for Mentally Ill People from 1 April 1994
14. May 1994	Department of Health	HSG(94)27 Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community
15. 1995	Crown Prosecution Service	(i) Statements taken from Crown Prosecution Services file
16. 1995	Crown Prosecution Service	(ii) Regina v Richard Stoker - Exhibits
17.January 1996	Northumberland Mental Health NHS Trust	Addendum to Interim Report on a Confidential Internal Inquiry into the death of Ms Halina S on 25 May 1996
18.1 February 1996	South Tees Community & Mental Health NHS Trust	Regional Forensic Service Psychiatric Report prepared by Dr D D Kothari on Richard Stoker remanded at HM Prison Durham

19.May 1996	Northumberland Mental Health NHS Trust	Indicated Care Management and Care Approach Arrangements
20.May 1996	Northumberland Health Authority	Discharge and After Care Policy Section 117 (With Appendices) (May 1996)