Report of the

Independent Inquiry into the

Care and Treatment of

Kevin Hewitt

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Elaine Rassaby, Deborah Bull, Doreen McCollin and Dr Kevin Murray

Kevin Hewitt, aged 31, killed Wilfred Marchant, aged 72 and stabbed Brian Geeson and his son, Daniel, aged 12, in a Leicester street in August 1999. He was convicted of manslaughter on the grounds of diminished responsibility and two counts of attempted murder and was made the subject of a hospital order with restrictions (ss.37/41) in January 2000.

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PREFACE

We were commissioned in March 2000 by Leicestershire Health Authority to inquire into the care and treatment provided to Kevin Hewitt.

We present our report in accordance with the terms of reference which were specified to us.

Errata

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February 2001

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1. INTRODUCTION

1.1 On 11 August 1999 Kevin Hewitt killed Wilfred Marchant as he walked down East Park Rd in Leicester. Wilfred Marchant was a pensioner and was a stranger to Kevin Hewitt. Minutes before killing Wilfred Marchant, Kevin Hewitt had stabbed Brian Geeson and his son Daniel who were also strangers to him; their wounds were serious but fortunately both survived. The events occurred about an hour before the eclipse of the sun which, Kevin Hewitt believed, would signal the end of the world. When interviewed after his arrest, it was evident that Kevin Hewitt was suffering from a mental illness at the time of the offence. He was later convicted of manslaughter on the grounds of diminished responsibility and was ordered to be detained in Rampton Hospital under Sections 37 and 41 of the Mental Health Act 1983.

1.2 This inquiry was established by Leicestershire Health Authority in accordance with the guidance given in HSG(94)27. The terms of reference and procedures are at Appendix A. Our general purpose was to investigate the care and treatment which Kevin Hewitt had received from the mental health services before this offence. We are independent of the Health Authority and all mental health services involved in this case. Our inquiry followed two internal inquiries, one by the Leicestershire and Rutland Healthcare NHS Trust and the other by Leicester City Social Services Department, two of the major services involved in his care.

1.3 Kevin Hewitt's contact with mental health services dates back to 1986. From 1994 onwards there was continuous involvement with mental health services and we have focussed our inquiry on this period. We have tried our best to obtain all the relevant information from the various services over that period. Wherever possible we have cross-checked information across the services and with witnesses. While we believe that the chronology is an accurate reflection of that information, we have been unable to verify some matters and have indicated our uncertainty where it has been appropriate to do so. Various witnesses have had the opportunity to review those sections of the report relating to their work in order to make factual corrections. We accept responsibility for any remaining errors.

1.4 We have reviewed all available information. In addition to Kevin Hewitt's records from the various agencies involved in his care, we have reviewed a large number of documents, both clinical and managerial (see appendix B).

1.5 We have interviewed many witnesses (see appendix C) including Mr Marchant's family, Mr and Mrs Geeson and

Kevin Hewitt and his family. We wish to place on record at the outset our appreciation of the co-operation of the families in what were undoubtedly very difficult interviews. We are very grateful to the clinicians and managers who addressed us; no-one refused to co-operate with our inquiries. Sadly, however, Bob Hyams whom we had planned to meet, died before our inquiry began.

1.6 We have looked closely at the quality of Kevin Hewitt's clinical and social care. We have no doubt that any in-depth review of a patient's care of the sort that we have conducted will reveal areas of both good and poor practice. Where we have seen good practice we have highlighted it, but similarly we have indicated those areas where practice fell below an acceptable standard. Like all other inquiry panels, we have both the benefit and handicap of hindsight. We have tried to judge actions as they would have been seen at the time and in the context of local and national standards and expectations. Our starting point is that the Care Programme Approach is the 'cornerstone' of mental health practice and therefore a vital benchmark for assessing the delivery of mental health care.

1.7 There were major organisational changes in mental health services at a critical time during Kevin Hewitt's care which we have considered. Before 1 April 1999 Kevin Hewitt's care had been provided by the East Midlands Centre for Forensic Mental Health based at Arnold Lodge which was then part of Leicestershire Mental Health Service NHS Trust. On 1 April 1999 that Trust merged with the Fosse Health NHS Trust to become the Leicestershire and Rutland Healthcare NHS Trust. The inpatient services at Arnold Lodge were not included in this merger but, in accordance with a wider regional and national strategy, became part of the Central Nottinghamshire Healthcare NHS Trust. However, the new Leicestershire and Rutland Healthcare NHS Trust retained a local forensic service which had previously been provided by Arnold Lodge and which was 'disaggregated' from it and Kevin Hewitt's care from 1 April 1999 to the index offence, was provided by this local forensic service. It is beyond the remit of this inquiry to examine this reorganisation in depth. However, it was put to us by a number of witnesses that the local forensic service was not a viable service at this time and that this adversely affected the quality of Kevin Hewitt's care. This is clearly within our remit and, to this extent, the reorganisation has been the subject of our inquiry.

1.8 Finally we must record our gratitude to Melanie Sursham who ably and tirelessly supported our inquiry. Her knowledge of the mental health services in Leicester was invaluable to us and greatly enhanced the efficiency of the inquiry process.

2. EARLY LIFE

2.1 Kevin Hewitt was born on 17 March 1968 in Leicester. Reports suggest that the pregnancy and birth were uncomplicated and that he reached developmental milestones at the appropriate stages.

2.2 Kevin Hewitt's early life was uneventful in a stable family. His parents were both from Jamaica and he has two older sisters both of whom have children of their own. Mr Hewitt, who died in 1992 following a chronic physical illness, was described as a strict disciplinarian who was nevertheless respected by his children. The Hewitts see themselves as a close and caring family and all reports describe them in this way. There is a history of significant mental illness in one close relative.

2.3 Kevin Hewitt was described as a quiet child but with plenty of friends who got on well at primary school. He enjoyed secondary school less and left when he was 16 having achieved 3 CSEs in maths, chemistry and physics. He was reported to have been a successful student, 'the only black boy in the top set at school' and that this precipitated racial abuse from other students. Following an incident when Kevin Hewitt attacked a student who was being abusive to him and which was serious enough to require police intervention, Kevin Hewitt was moved to another class and subsequently lost interest in school. Although we could find no details of this incident Kevin Hewitt told a social worker subsequently that he had 'seen hell' at the age of 13 and he may have been referring to this event.

2.4 Kevin Hewitt was convicted of three offences as a juvenile, two of theft and the third involving an assault on an unknown 17 year old woman in a shopping centre in Leicester. The only details we could obtain about this incident suggest that Kevin Hewitt tried to engage the woman in conversation; she was not interested and he subsequently slapped her face. He was sentenced for all three matters together to 24 hours at an attendance centre shortly before his sixteenth birthday. He was also cautioned for two matters as a juvenile.

3. FIRST ADMISSION: 28 January to 3 March 1986

3.1 Kevin Hewitt was referred by his general practitioner (GP) to Leicester General Hospital at the age of 17. On 28 January 1986 he attended with his father and was seen by Dr Walker, a consultant psychiatrist. The notes state that his family was finding it difficult to cope with him; Kevin Hewitt's sister told us that his behaviour was 'hyper'. He presented with symptoms of overactivity, flight of ideas, pressure of speech and grandiosity. He had been sleeping poorly and eating little. He said that he had been smoking 'ganja' every day. Initially he agreed to informal admission to Leicester General under Dr Walker's care but later the same day declined treatment and was restrained following threatening behaviour. He was detained under Section 5(2) of the Mental Health Act (MHA or 'the Act') 1983 and an application completed on the following day for further detention for assessment under Section 2 of the Act. The differential diagnosis at this time was hypomania possibly secondary to cannabis abuse.

3.2 He was treated initially with haloperidol but suffered a dystonic reaction. He was subsequently given thioridazine but this was also discontinued and instead he was prescribed chlorpromazine with procyclidine for side effects. He was later given weekend leave and the Section 2 order was allowed to lapse on 25 February 1986. He was discharged on 3 March 1986 on 150mg chlorpromazine at night with outpatient follow-up. Dr Walker's discharge letter to Kevin Hewitt's general practitioner referred to the difficulty in deciding whether this was a drug-induced episode or an affective illness.

3.3 Kevin Hewitt was seen monthly as an outpatient. He stopped taking medication shortly after discharge. At the last outpatient appointment which he attended in September 1986, he denied that he had ever been ill and accused the services of messing up his life and job. A further appointment was offered which he did not attend.

Comment

3.4 With the benefit of hindsight it is possible to see that this episode rehearses a number of issues which become important in Kevin Hewitt's later psychiatric care, namely, the need for compulsory detention under the Mental Health Act, his denial of mental illness and resentment of the perceived consequences for his life, and failure to comply with medication and to co-operate with the services after discharge. Our view of this episode is that it was an unremarkable first contact with psychiatric services, that

the treatment that he received was appropriate and reasonable attempts were made to engage him in follow-up.

4. 1986-1992

4.1 We have little information about this period. The GP records show that he attended the same practice intermittently between 1986 and 1992 for minor physical complaints and it is likely that he lived in Leicester at the family home during this period, free of mental health problems.

4.2 We were unable to obtain a clear account of Kevin Hewitt's educational history after he left school but it appears that he was keen to obtain vocational qualifications. He began a course at Coalville Technical College doing electrical engineering but found it difficult to manage his time and gave up after a few months. Between 1987 and 1990 he passed a City and Guilds course in motor vehicle engineering.

4.3 Kevin Hewitt told us that during this time he worked for two companies as a fitter. The first was at a tyre and exhaust dealer for two years until the company closed. Kevin Hewitt had enjoyed this work. He then worked at another garage for about a year. Kevin Hewitt's sister said that he suffered racial harassment at work but Kevin Hewitt did not report this to us. He recalled various other short-term jobs including working as a driver and valet and as a painter-decorator. He told us that he 'did not like the environment' in this last post, although he did not elaborate on this.

4.4 Reports suggest that he had a number of brief relationships with women and a longer-term relationship for about 3 years. His family recalled that he was particularly distressed by the failure of one brief but intense relationship, and that this may have adversely affected his mental health, not long before his next contact with psychiatric services.

4.5 His criminal record shows a number of minor offences during this time. He was convicted of criminal damage in 1987, and given a conditional discharge with £42 costs, after an incident where he kicked and broke a door at college. He was convicted of theft from a vehicle in 1989, and fined £125. Finally, he was convicted of handling stolen goods, minor fraud and minor road traffic offences in 1991, and fined a total of £70 for these matters and £100 for driving without insurance. There were no offences of violence.

Comment

4.6 In our view this relatively stable period in his early life and absence of significant behavioural disturbance precludes a diagnosis of personality disorder, as is suggested at a later stage.

MR HEWITT'S DEATH

4.7 Mr Hewitt died in July 1992 after a long illness. At the time the family was housed in temporary accommodation while their house was being refurbished and Kevin Hewitt was alone with his father when he died. He was particularly distressed that his father had not died at the family home. All reports describe this as a significant event in Kevin Hewitt's mental health history. Kevin Hewitt told us, and his family confirmed, that he had been very close to his father.

4.8 After his father's death, Kevin Hewitt continued to live at the family home with his mother, his sisters having moved out. We were told that the relationship between mother and son was reasonably harmonious. Kevin Hewitt was interested in DIY and his sisters showed us examples of the high standard of his craftsmanship in the family home.

4.9 Reports describe Kevin Hewitt as a regular social drinker but there is no indication of more significant alcohol or other drug abuse at this time.

5. SECOND ADMISSION: 27 to 28 January 1993

5.1 In October 1992 Kevin Hewitt began an engineering course at De Montfort University but left after the first term. He attended his GP, Dr Newley, on 8 January 1993 complaining of personal problems and anxiety; he was prescribed sertraline. A reference in Dr Newley's notes suggests a referral to Relate and Cruise for counselling but there is no evidence that this referral was pursued.

5.2 On 27 January 1993 Kevin Hewitt attended The Leicester Royal Infirmary after taking an overdose of sertraline and other medication. He said that the reason he took the overdose was because he was depressed about his father's death and about college. He was admitted to a medical ward for observation.

5.3 The following day he was assessed by a social worker who elicited some paranoid ideas – *'being mocked and ridiculed by all and sundry, including close friends'* - and by Dr Drybala, a locum consultant psychiatrist who did not elicit these symptoms but was concerned at what Kevin Hewitt had revealed to the social worker. Kevin Hewitt refused any further treatment, denied any further intention of harming himself and insisted on leaving hospital. Dr Drybala wrote to Dr Walker, his previous consultant, on 1 February 1993 saying that he believed that Kevin Hewitt was suffering from a depressive illness and also questioned whether he was developing a psychotic illness. He asked Dr Walker to arrange urgent follow-up *'as I suspect that if a rapport can be established with him, his prejudices against antidepressant medication may be overcome and engagement in therapeutic relationship is also likely to be helpful in resolving issues pertaining to bereavement etc'.*

5.4 Dr Walker offered him two outpatient appointments which he did not attend. Dr Newley was informed.

Comment

5.5 In the circumstances this was a thorough assessment. The content of his psychopathology, such as feeling mocked by friends, was significant in view of the later attack on a friend in 1994. It is notable that although he initially sought medical treatment, he subsequently refused any psychiatric follow up; this pattern was to be repeated. His behaviour at this time was suggestive of the prodrome of a mental illness.

6. INCIDENT AT SHELTER HOUSING OFFICE: 11 November 1993

6.1 On 11 November 1993 Kevin Hewitt went to the local office of Shelter, the homeless charity, asking for help, although the records do not make clear what help he wanted. He was noted to be agitated on arrival and accused another client of laughing at him in the waiting room. He was seen briefly and given some information regarding rehousing. He asked to use a telephone and was allowed the use of one of the office telephones. When the female worker dealing with him returned a few minutes later Kevin Hewitt became more agitated and said that he felt trapped and closed in and that no-one was helping him. He threw a punch at the female worker who subsequently barricaded herself in the office, braced against the door to prevent him from entering. Kevin Hewitt smashed the glass panel of the door and the woman suffered a cut to her scalp and minor cuts to her fingers. He then left the premises saying *'that's what happens when you cage people in, they go mad'*. The incident was reported to the police.

6.2 Kevin Hewitt was arrested two months later at the family home and taken to the police station where he was interviewed, then charged with criminal damage and assault. He was given bail to appear at Leicester Magistrates Court on 16 February 1994. The statement made by the police constable who interviewed Kevin Hewitt makes no reference to mental illness and the transcript of the interview is more suggestive of non-co-operation than mental disorder. No appropriate adult was present.

6.3 Records show that Kevin Hewitt did not attend Leicester Magistrates on 16 February. The Police National Computer record shows that these charges were adjourned *sine die* (without a date) on 12 October 1994 at a time when Kevin Hewitt was detained in hospital.

6.4 Kevin Hewitt later disclosed to clinical staff at Arnold Lodge that in late 1993 he had felt under such threat from a number of (delusional) persecutors that he had left Leicester, travelling to Nottingham, Manchester and possibly elsewhere to avoid their malign influence. However, he was unable to escape their attentions, as confirmed to him by comments made by strangers in the streets, which had a particular significance to him. He therefore returned to Leicester. In one interview he suggested that this persecution had been going on for up to three years, beginning in about 1991.

Comment

6.5 This account is strongly suggestive of the development of a paranoid illness, possibly with intermittent symptomatology in the early stages, so that, for instance, he did not appear disordered when interviewed by police in January 1994, but was probably unwell for much of late 1993. This pattern of fluctuation of symptoms, at times intense but at other times in spontaneous remission, is common in the insidious onset of a major mental illness.

7. ASSAULT 23 February 1994

7.1 On 23 February 1994 Kevin Hewitt went to the flat of Michael Oshin, a friend, armed with a knife and intending to do him harm. Michael Oshin was not there but his girlfriend, Amanda Shelton who knew Kevin Hewitt well, let him in to wait. They sat and talked for some time. Then as she went to make coffee, Kevin Hewitt approached from behind and holding her around her neck, stabbed at her several times. During the attack he said that he intended to kill her. He forced her to the floor and then attempted to strangle her before she broke loose and ran from the flat. Kevin Hewitt said that he tried to telephone an ambulance but then left the flat. He subsequently approached a police vehicle, admitted his offence and was arrested. Amanda Shelton was treated for cuts to the head; she also suffered bruises and grazes to the head and bruising to the throat.

7.2 All reports suggest that the offence arose directly from Kevin Hewitt's delusions. When seen by the police surgeon, Dr Duxbury, at the police station, the assessment in the police custody record was *'Mr Hewitt has suffered from mental illness in 1986. At present, it is not possible to be sure whether he is suffering from a mental illness, although I strongly suspect that this is the case'.* Dr Duxbury also noted that at one stage Kevin Hewitt commented: *'I can't go home; they know where I am'.* He telephoned Dr Walker, who suggested that a full forensic assessment would be appropriate. Dr Duxbury also advised that, because of his history of mental health problems, an appropriate adult should be present at interview and this was arranged.

7.3 Kevin Hewitt subsequently explained that he thought Michael Oshin and Amanda Shelton had been trying to *'wind him up'* to the extent of having rented a house near to the post office where he cashed his giro in order to keep him under surveillance. He told the police that he had felt stressed and *'tortured'* with *'enemies all around'*, that he was *'not normal'* and that he had gone to Nottingham and Manchester to get away but had been followed there too.

7.4 He said that a few days before the offence he had gone to the nightclub where Amanda Shelton worked and, afterwards, felt unwell with gastro-intestinal symptoms. He said that he had not eaten for the previous four days although he continued to drink alcohol. He believed that his symptoms were due to a poisoned drink given to him by Amanda Shelton at the nightclub. Medical records from The Leicester Royal Infirmary show that on 21 February 1994, two days before the assault, Kevin Hewitt

attended complaining of abdominal pains. He did not wait for a full examination following the initial assessment when he was told that it was unlikely that he was suffering from food poisoning. In at letter to a Tribunal during a later admission Kevin Hewitt described how, when things were getting too much for him, he did try to obtain help. He said that the failure to admit him at this time contributed to the subsequent offence.

7.5 Kevin Hewitt was charged with attempted murder and appeared before Leicester Magistrates Court on 25 February when he was remanded in custody. When Dr Kaul, then senior registrar in forensic psychiatry at Arnold Lodge, saw him at Leicester Magistrates Court on 1 March 1994, he described him as *'almost mute, retarded, perplexed and scared'* and concluded that he was suffering from an acute mental illness. On 2 March 1994, Kevin Hewitt set fire to his cell at Leicester prison. The following day he was assessed by Dr Shapero, a consultant forensic psychiatrist at Arnold Lodge, the medium secure forensic unit serving Leicestershire. Kevin Hewitt told Dr Shapero that he had set the fire because God had told him that he was a bad person and that he had to kill himself. Dr Shapero concluded that he was suffering from a schizophrenic illness with symptoms that included thought disorder, thought blocking, thought broadcast, second and third person auditory hallucinations and passivity experiences. He considered him to be a 'considerable' risk to himself and to others and recommended urgent transfer to hospital under Section 48 of the Mental Health Act.

7.6 On 4 March 1994 he was assessed by Arnold Lodge nursing staff who supported admission to hospital. Section 48 medical recommendations were completed by Dr Shapero and Dr Sen from HMP Leicester; the transfer direction was issued by the Secretary of State on 21 March 1994 and Kevin Hewitt was transferred to Arnold Lodge on 25 March 1994.

Comment

7.7 **The involvement of mental health services in Kevin Hewitt's care in this episode was exemplary. Good advice was available to the police at the time of his arrest. At court, the case was identified as causing concern, and a prompt assessment was undertaken. The fire-setting in the prison was again brought to the attention of services so that an urgent review was completed. The outcome was the speedy transfer to an appropriate hospital placement for treatment.**

8. THIRD ADMISSION: 25 March 1994 to 3 January 1995

8.1 Kevin Hewitt was admitted under Dr Shapero's care to Helvellyn Ward, an admission ward in Arnold Lodge on 25 March 1994. He was prescribed chlorpromazine and procyclidine. A physical examination revealed no abnormalities.

8.2 Tracy Bestwick, a social worker from Arnold Lodge, visited the family home and interviewed Mrs Hewitt and Kevin Hewitt's elder sister Sharon. Although this was only a preliminary assessment, Ms Bestwick's detailed report of 28 April provides the basis of much of the later social work reports. Of significance is his mother's history of mental illness and the suggestion that Kevin Hewitt may have been under pressure to support her, both practically and emotionally, which may have been an additional stress for him.

8.3 The medical notes record Kevin Hewitt's experience of auditory hallucinations and delusions of passivity. He told Dr Shapero that these had been present for at least 3 years. He said that he had seen Sky Network presenters talking about and to him and telling him that he would be killed. He believed that he had to flee to Manchester to escape his killers. On the 3rd May Kevin Hewitt said that he was convinced that he would be followed when he left hospital.

8.4 By 5 May his mental state was noted to have improved, he was less perplexed and more confident; he said he was not mentally ill and would plead guilty in order to be returned to custody. He contacted his solicitor to ask that he be returned to prison. His solicitors made enquiries and were advised that Kevin Hewitt would be remaining at Arnold Lodge 'for some time'. Kevin Hewitt also asked to see his notes. The following evening, however, he was described as becoming increasingly hostile and paranoid. He was complaining of abdominal pain, and was suspicious of the medication which he had been taking. As his threats to "smash up" escalated, and he was refusing further oral medication, he was given zuclopenthixol acetate 100mg intramuscular injection and his chlorpromazine was increased to 150 mg three times daily. On 11 May he was unfit to attend court. At a ward round on 16 May Dr Shapero suggested that a hospital order would be the appropriate eventual disposal. On 13 June he was noted to be oversedated; as there was also continuing evidence of auditory hallucinations, trifluoperazine 10mg three times daily was prescribed instead of the chlorpromazine.

8.5 At about this time his care was transferred from Dr Shapero to Dr Kaul, who had been appointed consultant forensic

psychiatrist at Arnold Lodge in May 1994. Kevin Hewitt attended court on the 22 June where the attempted murder charge was reduced to wounding with intent to commit grievous bodily harm. By this time he had improved sufficiently for escorted leave in the hospital grounds to begin.

8.6 At a multidisciplinary team meeting at the end of June, the possibility of a 'non-custodial' order was considered. In early July, Kevin Hewitt was transferred to Pennine Ward, and it was suggested that he should take a depot preparation. After initially refusing, he agreed to fluphenazine decanoate 50mg intramuscular injection fortnightly and the trifluoperazine was stopped. He continued to improve.

8.7 On instructions from Kevin Hewitt's solicitors, Dr Kaul prepared a report for the Court on the 25 August. Dr Kaul's view was that Kevin Hewitt had been suffering from an active mental illness at the time of the offence and that 'his intention to commit the alleged offence was not a rational intent'. As to disposal, Dr Kaul's view was that Kevin Hewitt had improved to the extent that he no longer needed hospitalisation and would not be detainable under the Mental Health Act. If a non-custodial sentence was considered, he recommended a probation order with a condition of psychiatric treatment. On 16 September 1994 Kevin Hewitt attended Leicester magistrates' court and his case was committed to the Crown Court.

8.8 Throughout this admission there was regular social work input, firstly from Tracy Bestwick and later from Robert Nisbet, forensic social workers at Arnold Lodge. Robert Nisbet, who had been appointed only recently, acted in a co-ordinating role during the later part of the admission, liaising with probation, Kevin Hewitt's solicitors and others. On 31 August 1994 Robert Nisbet completed a community care assessment. He consulted Kevin Hewitt, medical and nursing staff and family members and concluded that a 6-12 month hostel placement was appropriate as a prelude to Kevin Hewitt gaining his own accommodation. He noted that family members acknowledged the importance of Kevin Hewitt receiving support for the transition into the community and that they would maintain contact with him.

8.9 In late 1994 Raju Chauhan, a social worker employed under Section 11 of the Local Government Act 1966 with special responsibility for supporting black service users, began working with Kevin Hewitt alongside Mr Nisbet. Her role, as described to us, was to complement other staff who were working with Kevin Hewitt and to support him in a more informal way in an attempt to promote trust and engagement with services. She later undertook a cultural needs assessment of Kevin Hewitt and concluded that he was aware of the effects of racism and felt

positive about his ethnicity. The assessment did not identify any unmet ethnic or cultural needs.

8.10 On 2 September 1994, Kevin Hewitt was transferred to Brecon Ward, a rehabilitation ward at Arnold Lodge. In early September 1994 he was seen by staff from Runcorn House and Ashcroft House. These registered care homes (hostels) were managed by Leicestershire County Council Social Services Department. Both specialised in the care of people recovering from mental illness. Kevin Hewitt was ambivalent about the proposal for hostel care and at times expressed a preference to return to the family home; he also suggested that he would stop taking medication some time in the future. At about the same time his case was allocated to Rose Kingham, an officer of the Leicestershire Probation Service, for a pre-sentence report.

8.11 In late October and early November, there appeared to be some deterioration in Kevin Hewitt's mental state with increasing paranoia. On 31 October when seen by Robert Nisbet he was showing *'some signs of paranoia'* and expressing a wish to discontinue medication. On 3 November he was involved in an argument during which he hit another patient and was briefly secluded. He was considered unfit to attend court on 4 November and, in Dr Kaul's absence, Dr Earp, another consultant forensic psychiatrist at Arnold Lodge, wrote to the Court to that effect. Kevin Hewitt was transferred back to Pennine ward and his fluphenazine decanoate injection was increased to 100mg fortnightly. Robert Nisbet subsequently spoke to Kevin Hewitt and Sharon Hewitt and contacted Kevin Hewitt's solicitor in order to advise them that Kevin Hewitt would not be fit to attend court. Robert Nisbet's notes state that Kevin Hewitt appeared angry, *'aloof with people and out of touch with his surroundings'*. He was asking to be returned to prison. Robert Nisbet also advised Rose Kingham of the apparent deterioration in his condition. However, there was a difference of opinion amongst ward staff about whether or not Kevin Hewitt was relapsing. Subsequently no further psychotic symptoms were observed and his depot medication was decreased to 50mg every 10 days on 16 November and every 2 weeks on 19 November.

8.12 Rose Kingham's pre-sentence report of 11 November 1994 did not refer to this apparent relapse. She reported that, in view of his improvement and remorse for the offence, *'he does not represent a substantial risk to the public, provided that his condition is monitored and his medication is administered regularly'*. She advised against a custodial sentence on the grounds that prison might compromise Kevin Hewitt's mental health. Rose Kingham supported the proposed probation order and advised the court that a place at Runcorn House, which was

staffed 24 hours a day, would be available immediately and that a condition of residence would be appropriate.

8.13 Following the adjourned Court hearing, Dr Perini, consultant psychiatrist at Rampton Hospital, was asked by the Crown Prosecution Service to provide an opinion to the Court. On 15 November, having evidently spoken to Dr Perini during his visit to assess Kevin Hewitt, Robert Nisbet contacted Rose Kingham. He explained that Dr Perini's view was that Kevin Hewitt continued to require hospital treatment. Dr Perini's report of 18 November 1994 concluded that *'Mr Hewitt would benefit from a further period of inpatient hospital treatment in order to stabilise his mental illness...at this stage he would be unlikely to co-operate with medication and out-patient follow-up.....'*. As to disposal, Dr Perini advised: *'The Court could consider the imposition of a hospital order under s37 of the Mental Health Act on the grounds that Mr Hewitt suffers from a mental illness, namely schizophrenia, which is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment.'* Dr Perini recognised that beyond discharge co-operation could not be guaranteed *'unless or until his mental state deteriorated to the point where he could be readmitted under a Section.....An alternative approach might be to consider the imposition of a probation order with a condition of psychiatric treatment....which would allow for greater control as breach of the conditions would result in a return to court for resentencing.*

8.14 Having seen Dr Perini's report, Dr Kaul wrote to Kevin Hewitt's solicitors on 1 December 1994 saying that he thought that Kevin Hewitt needed no more than one month in hospital. He also explained that he felt that a hospital order would not benefit Kevin Hewitt as he would soon be well enough for discharge and would have access to a Mental Health Review Tribunal (MHRT) which would *'almost definitely discharge him'*. This would leave no control over his medication in the community. *'Hence the hospital order would not assist us in keeping Mr Hewitt well in the community and thus preventing any risk of further serious offence'*. His advice to the court was therefore unchanged, that a probation order was more appropriate under the circumstances.

8.15 On 2 December 1994 Kevin Hewitt pleaded guilty to unlawful wounding, the charge having been reduced further from wounding with intent to cause grievous bodily harm. He received a two year probation order with a condition of psychiatric treatment and residence as directed by the probation officer. The plan was that he should remain at Arnold Lodge for a further period of 6-8 weeks so that accommodation at Ashcroft or Runcorn House could be finalised.

8.16 On 11 December Amanda Shelton contacted the ward but no information was given to her. She contacted the police who also telephoned the ward and were given Dr Kaul's contact details. Following discussion with them Dr Kaul arranged a meeting for 21 December at which Amanda Shelton, her mother, Dr Kaul and Robert Nisbet were present. Miss Shelton expressed concern that Kevin Hewitt had *'got off'* with only a two year probation order; she was also worried that he might pursue her after his discharge. She described the terrible effect that the attack had had on her and her concern that he had *'selected'* her as his victim. Robert Nisbet told us that this interview was *'one of the most salient and most emotional experiences I recall'.* With Kevin Hewitt's prior agreement the nature of his psychotic illness was explained to her. She was also told about the conditions of the probation order and it was agreed that Kevin Hewitt would be advised not to go to the nightclub where she still worked. She was assured that the assault had been taken seriously, that there was no wish to place anyone at risk and was advised to make contact again if she had any further concerns.

Comment

8.17 **We were told by Robert Nisbet that there was no policy about talking to victims at this time and that it was not usual practice to do so. In the circumstances, the initial hesitation by ward staff was perhaps understandable. Ultimately however we felt that the team's approach to the interview with Amanda Shelton was a reasonable one which balanced the duty to protect Kevin Hewitt's confidentiality with an appreciation of Amanda Shelton's concerns as the victim of a very serious assault.**

8.18 Kevin Hewitt was discharged to Runcorn House on 3 January 1995. There is no record of a Care Programme Approach (CPA) meeting prior to his discharge. The discharge summary for Kevin Hewitt's new GP, Dr Rackham was eventually completed by Dr Janas, registrar to Dr Kaul, on 17 February 1995 after a reminder from the medical secretary. It may be that the delay was the responsibility of Dr Janas' predecessor, but it is not possible to determine this from the records. Dr Janas described a care package which included supervision by probation, monitoring of medication by Dr Kaul, social work input from Robert Nisbet and Community Psychiatric Nurse (CPN) support from Susan Tookey. His medication on discharge was fluphenazine decanoate 50mg intramuscular on a fortnightly basis with procyclidine as required.

Comment

INTERAGENCY WORKING AND AFTERCARE ARRANGEMENTS:

8.19 We are aware from other inquiries and from witnesses to this inquiry that the introduction of CPA progressed slowly in Leicestershire and that in late 1994/ early 1995, it had not been implemented. Even so, it would have been good practice to hold a predischarge meeting and this was not done. This would have provided an opportunity to discuss the care package with Kevin Hewitt, his family and the multidisciplinary team and to make explicit the expectations in relation to the probation order and how they might best support him. Nevertheless, we felt that the care package which was devised, was a comprehensive one which would provide him with a wide range of professional support at Runcorn House. We were impressed by the considerable efforts made by Robert Nisbet to effect good communication between the agencies involved.

8.20 We consider it unacceptable that the discharge summary was not sent to the GP until six weeks after discharge. Kevin Hewitt's discharge had been anticipated for some weeks, and arrangements had been confirmed following the final court appearance. In this instance, this failure did not appear to make any material difference, but as will be evident below, following the next admission the delay was much more important.

8.21 We considered Raju Chauhan's contribution. We are aware that the use of workers employed under the provisions of Section 11 has been the subject of controversy, including suggestions of tokenism. The expectation in this case that, an Asian woman would be well placed to undertake a cultural needs assessment of a young man of African-Caribbean heritage is questionable and indeed was described by one witness as having been '*naive*'. We share this view.

THE PROBATION ORDER:

8.22 We discussed the appropriateness of the disposal with Dr Kaul, staff from Arnold Lodge and Ms Kingham. The offence was potentially extremely serious, with Kevin Hewitt admitting that he had intended to injure Michael Oshin and subsequently Amanda Shelton. Despite this, the charge was ultimately reduced to unlawful wounding, and the advice from Dr Kaul was for a probation order with psychiatric follow-up. Dr Perini's report appears to be more cautious, suggesting a further period in hospital

before discharge, with a hospital order under Section 37 of the Mental Health Act 1983 as an option. Dr Kaul's additional comment, that Kevin Hewitt would have been discharged by a Mental Health Review Tribunal, appears to be mistaken: Kevin Hewitt would not have had access to a Mental Health Review Tribunal until 6 months after the date on which the order was made. It appears that he was confusing the appeal arrangements for Sections 3 and 37.

8.23 While we think that a psychiatric probation order was not an unreasonable disposal and a hospital order without restrictions would have had little advantage, the possibility of a hospital order with restrictions does not appear to have been considered. This, in our view, would have provided a more robust means of maintaining his care after discharge. We have no doubt that the nature of the offence was such as to warrant consideration of the imposition of a restriction order. So far as we could ascertain, there are no studies of the use of psychiatric probation orders in these circumstances and we therefore accept that there is no evidential basis for concluding that the disposal recommended was outside the usual range of disposals by a court in 1994 for an offence of this nature. However, we think that this offence was at the extreme end of the spectrum of seriousness which would allow for a community disposal. Ultimately, of course, we recognise that the decision as to disposal lay with the Court.

8.24 We also recognise, as will be made clear below, that the probation order was successfully completed and that the arrangements served to maintain Kevin Hewitt in good mental health and free of offending for the duration of the order.

9. RUNCORN HOUSE: 3 January to 25 August 1995

9.1 During Kevin Hewitt's time at Runcorn he received at least monthly supervision visits from Robert Nisbet and some further visits by Raju Chauhan. Robert Nisbet also liaised with Rose Kingham and the hostel and effectively co-ordinated his care. There are detailed records of each visit and many telephone calls on file.

9.2 Rose Kingham visited Kevin Hewitt at Runcorn House on a weekly or sometimes fortnightly basis, and spoke regularly with Robert Nisbet and the CPN. There are detailed records of contacts.

9.3 In the event CPN input was provided mainly by Shirley Butler during Kevin Hewitt's stay at Runcorn with occasional input from Susan Tookey. Shirley Butler visited Kevin Hewitt every 10 days to 2 weeks to administer depot medication and attended all reviews as is documented in the CPN records

9.4 From early in his stay, concerns were expressed by Runcorn House staff that Kevin Hewitt remained aloof from other residents and from staff, divulged little about himself and avoided forming relationships with others. He was described as minimising the seriousness of the offence and appearing resentful about remaining at the hostel and accepting medication. Rose Kingham told the panel that *'he did the letter of the order, but really not the spirit'*. She also said that *'he became more uncooperative as time went on'*. He frequently complained of boredom but refused to participate in hostel activities. Efforts were made to involve him in a centre for African Caribbean people with mental health problems and this achieved some limited success.

9.5 Kevin Hewitt saw Dr Kaul on 6 February 1995. He appeared over-medicated and complained of difficulties with sleeping. Dr Kaul reduced his depot to 25 mg fluphenazine decanoate every 10 days and advised him to take 100mg chlorpromazine at night to help him sleep which Dr Rackham was asked to prescribe. Kevin Hewitt subsequently refused the chlorpromazine.

9.6 On 21 February 1995 Kevin Hewitt was involved in an incident with another resident who sustained superficial cuts to his fingers as a result. It appeared that Kevin Hewitt had been *'larking about'* with a kitchen knife and he insisted that the injuries were accidental. The incident was taken seriously by staff who warned Kevin Hewitt of the risks of this behaviour. Robert Nisbet interviewed Kevin Hewitt closely about the

incident. Kevin Hewitt gave an account of what he considered to be his main relapse indicators i.e. feeling that people were out to get him. These feelings were not currently present but he did complain of insomnia.

9.7 The first review of his case was on 28 February 1995. Kevin Hewitt attended along with CPN Shirley Butler, Rose Kingham, Robert Nisbet, Justin Hebron (social work team manager) and Raju Chauhan, his key worker at Runcorn, Erskine Cave and another Runcorn House worker. It is not clear whether Mrs Hewitt or Kevin Hewitt's sisters were invited to or were made aware of this review. Kevin Hewitt stated that he would prefer to leave Runcorn and live independently. In preparation for future independence he was offered the chance to participate in the self-catering programme at Runcorn House but he declined to do so. He continued to complain of sleep difficulties. In his extensive contemporaneous notes Robert Nisbet discussed the continued presence of both positive and negative symptoms of psychosis and also suggested the possibility of a concomitant depressive disorder.

9.8 The Runcorn notes recorded concern about Kevin Hewitt's attitude: *'It does appear that Kevin is using Runcorn as a soft option to prison and has very little commitment to any care programme.'* He was also resentful at having to pay hostel costs from his benefits. Justin Hebron questioned whether the probation order was still tenable in view of Kevin Hewitt's attitude and the level of risk he presented. The question of possible breach of the probation order was raised. Later that day Robert Nisbet discussed these concerns with Dr Kaul and suggested that the supervision might be a futile exercise. Dr Kaul agreed to liaise with Shirley Butler about medication.

9.9 On 6 March 1995 Robert Nisbet was advised of a further recent incident at Runcorn House. Kevin Hewitt had reportedly challenged another resident about his table manners; the other resident then made racist comments towards Kevin Hewitt and threatened him with a chair. Kevin Hewitt responded by striking the other resident twice about the face. The staff present felt that Kevin Hewitt had been provoked by the other resident, who was already *'on notice'*, and did not propose taking any action over Kevin Hewitt's actions.

9.10 The following day Robert Nisbet accompanied Kevin Hewitt to his outpatient appointment with Dr Kaul who commented that Kevin Hewitt was minimising the seriousness of his offence. The viability of the probation order was discussed and Kevin Hewitt was asked to consider the issues which had been raised in the review. In order to reduce side effects, Dr Kaul reduced the depot to 25mg fortnightly and substituted

temazepam 10mg at night to help with insomnia, writing to the GP to request these changes to Kevin Hewitt's prescription. Dr Kaul and Robert Nisbet reviewed Kevin Hewitt's diagnosis: Robert Nisbet recorded in his notes *'It may be that we have achieved a successful treatment of his psychosis and we are now dealing with the underlying personality problems.'* Later that month the review reconvened to consider whether Kevin Hewitt should remain on the probation order. It appeared that Kevin Hewitt had changed his view and had agreed to comply with the requirements. However the team remained concerned about his lack of engagement with them and apparent lack of remorse about the offence and the effects on his victim. Kevin Hewitt did not attend the review and asked not to attend them in future. When Raju Chauhan visited on 30 March 1995, Kevin Hewitt refused to discuss the past and made it clear that he did not feel that the clinical team could help him.

9.11 Kevin Hewitt's second review took place on 16 May 1995. All professionals attended apart from Dr Kaul; Kevin Hewitt declined to attend and there was no family involvement. His non-co-operation with care plans and reluctance to participate in hostel activities were again noted. It was agreed that Kevin Hewitt would meet informally each week with his probation officer and social worker. By this time, he was spending one night each weekend at his mother's home.

9.12 An incident occurred on 6 June 1995 in which Kevin Hewitt became angry with a member of staff who admonished him for changing TV channel while he was watching. This incident, together with other concerns about his intimidating behaviour, lack of concentration and slow responses prompted a request for review by Dr Kaul, who saw Kevin Hewitt on 27 June 1995. Apart from the negative symptoms of schizophrenia, Dr Kaul could not detect any deterioration in his mental state. Dr Kaul noted that Kevin Hewitt had applied to begin a BTEC course in engineering technology the following September.

9.13 In June 1995 Kevin Hewitt's social work supervision was temporarily transferred to Norma Bailey while Robert Nisbet attended a training course. She appears to have had close contact with Runcorn House during the period of her involvement and on 23 June noted that Kevin Hewitt's behaviour was causing them concern, with other residents saying they were finding him intimidating. Kevin Hewitt was also noted to have severe sleeping problems and failing personal hygiene.

9.14 Kevin Hewitt's case was reviewed for the third time on 29 June 1995. It was noted that positive feedback had been received from probation, his CPN and the Moat House Community College, an African Caribbean community group which he had

begun to attend. Hostel staff felt however that their view of him was quite different. His Runcorn House keyworker, now Nick Jordan, stated that it was clear that Kevin Hewitt hated being at Runcorn: *'we have offered Kevin time and support and are getting nowhere'.* As for the prospects of going home, Mr Jordan reported that he had told Kevin Hewitt that *'the reality of that happening would be slim (at least two years).'*

9.15 Nevertheless, by the time of the next review on 13 July, the possibility of moving back to his mother's home was being seriously considered. It was agreed that Rose Kingham would visit Kevin Hewitt's mother to establish what her views were, and that, if his move home was agreed, Kevin Hewitt would continue to be seen every 2 weeks by his probation officer and by the CPN. There is a brief note of a home visit on 19 July by Rose Kingham and CPN Susan Tookey who impressed upon Mrs Hewitt the need to contact them if she had any concerns about Kevin Hewitt. Rose Kingham agreed to make contact with Kevin Hewitt's sisters to ascertain their views although there is no evidence that this happened.

9.16 We asked Rose Kingham why Kevin Hewitt had not been considered for independent accommodation as that had been the intention expressed in her pre-sentence report. Ms Kingham said that a return to his mother's house was regarded as the best option as it would provide a degree of monitoring; also that he was likely to comply as this was what he wanted. *'...it was felt that that was the best that could be achieved at that point'.*

9.17 In early August Robert Nisbet reviewed Kevin Hewitt at Runcorn House. Although he did not detect any significant change in his own interaction with Kevin Hewitt, he was told by the staff at Runcorn that they felt that Kevin Hewitt was now far more open and more willing to engage in meaningful activities, having successfully enrolled on a BTEC course at a local college. Robert Nisbet noted that Kevin Hewitt was reluctantly compliant with medication.

9.18 A review took place on 21 August. It was agreed that he would return to live with his mother on 25 August 1995. In his note to the file Robert Nisbet recorded his concern that Kevin Hewitt *'is lacking now in the insight towards his offending behaviour and therefore may still remain a considerable risk of further offending and dangerousness'.* At this point the input of Social Services formally ended. This decision was taken on the basis of the ending of the *'statutory obligation'*; the panel was told that this probably referred to the ending of the tenancy at Runcorn House. It was also clear that Kevin Hewitt did not want further contact. Although social workers from the multidisciplinary team were present at subsequent reviews, there was no further formal

contact with Social Services until Kevin Hewitt's next admission at the end of 1997.

Comment

INTERAGENCY WORKING AND AFTERCARE ARRANGEMENTS:

9.19 CPA had still not been formally implemented in the Trust at this time. Nevertheless, there was good coordination of agencies and regular case reviews were held with contributions from all involved professionals including the probation service. Determined attempts were made to involve Kevin Hewitt in the reviews and his non-attendance was not for lack of trying.

9.20 The records do not include any copies of letters of invitation to the Hewitt family to case reviews, although Mrs Hewitt was contacted when a return home appeared imminent. We were told that Robert Nisbet had made personal contact with Kevin Hewitt's mother and sister during this period; they did not recall this and were generally dismissive of the efforts which had been made to consult them. We recognize that, without records, recall of conversations which took place six years ago may be unreliable. Certainly, if such contacts were made, they were not sustained and did not become a significant part of care planning.

9.21 Social services casenotes prepared over this period by Robert Nisbet and others were full and perceptive, acknowledging the difficulties of Kevin Hewitt's attitude to treatment and his lack of remorse for the offence against Amanda Shelton. The social work department made clear its decision to end social work involvement at this time on the grounds that it could not add anything further to the care package following discharge from Runcorn House. This decision seemed a reasonable one, and was clearly recorded and circulated within the full care team, removing any possible ambiguity.

10. COMMUNITY CARE 10 August 1995 to December 1997

10.1 It appears that Kevin Hewitt dropped out of the BTEC course around the end of 1995. Over the following two years he worked briefly but the jobs did not last more than a few weeks.

10.2 Initially Shirley Butler visited Kevin Hewitt every two weeks. In early 1996, Carey Maisey replaced her as CPN and Kevin Hewitt's depot medication was reduced to once every 3 weeks. Kevin Hewitt made it clear that he did not wish to take the depot, and only complied because of the probation order and in order to claim benefits.

10.3 Rose Kingham also visited him, initially every two weeks, and later monthly, usually on a prearranged basis, and maintained contact with the CPN service. Rose Kingham told us that, due to his attitude, her visits were perfunctory and were largely to ensure that the probation conditions were met. Although occasionally Kevin Hewitt came to the probation office, more often she visited him at home as this allowed some monitoring of Mrs Hewitt's health as well. Rose Kingham also said that Kevin Hewitt had become threatening at the office and this did not happen on home visits. She said that he appeared resentful of the visits and that they were, as a consequence, gradually reduced. She said that the main focus was on CPN involvement which was expected to continue after the expiry of the probation order. Rose Kingham's repeated risk assessments put him at level 3 on a 4 point scale indicating a low likelihood of a further offence but high seriousness if it occurred. She told the panel that she considered that compliance with medication was critical to containing the risk; this was clearly recorded on her risk assessments and in case summaries.

10.4 Dr Kaul reviewed Kevin Hewitt on 13 September 1995 and 30 November 1995 and his mental state was stable. At around this time, Kevin Hewitt registered with another GP, Dr Roshan. The first CPA documentation was completed on 4 December 1995 although there is no record of a meeting with Kevin Hewitt on that day. The CPA form was completed by Susan Tookey and, according to the documentation, only she and Dr Kaul were present. A review date was set for 3 June 1996.

10.5 Rose Kingham's entry of 14 February 1996 is illustrative of his attitude to care during this period: *'As ever Kevin is willing to co-operate with the statutory part of this Order but will do nothing above that. All I can do is liaise with the Community Psychiatric Nurse re medication and maintain regular contact'.*

10.6 The next review was held on 4 June 1996. Dr Kaul, Carey Maisey, Robert Nisbet, Rose Kingham and a registrar were present. There was no change to the care plan. Kevin Hewitt continued to be *'difficult to engage'* and *'resentful to staff support'*. It was agreed that Rose Kingham should remain in a *'low key'* role, that Carey Maisey would continue as primary worker and would inform Rose Kingham of progress. A further review date was set for 3 December 1996.

10.7 On 28 August 1996 Amanda Shelton reported to the police that she had seen Kevin Hewitt in the Evington area of Leicester, that he had been looking at her strangely and that she was worried. This information was passed to Carey Maisey and Dr Kaul. Carey Maisey subsequently discussed the incident with Kevin Hewitt and was satisfied that the contact was accidental. No further action was taken and Amanda Shelton received no response from them. The entries in the notes record the reluctance of the clinical team to share information about Kevin Hewitt with the police.

Comment

10.8 We recognise that the balance between public interest and patients' privacy has moved in the direction of greater disclosure since 1996. Nevertheless, we think that this episode did not fulfil the assurances of continued support that Amanda Shelton had been given at the earlier meeting on 21 December 1994. We consider this matter later.

10.9 It appears that the next CPA review was brought forward to 21 November 1996 and Carey Maisey, Robert Nisbet, Rose Kingham, Dr Kaul and Sharon McNulty were present. No changes were made to the care plan and a review date was set for 21 May 1997.

10.10 On 30 November 1996, the probation order expired and Rose Kingham had no further contact. This concluded the probation service's involvement in Kevin Hewitt's case.

Comment

PROBATION ORDER:

10.11 Despite our reservations about the appropriateness of the probation order for the offence against Amanda Shelton, it was clearly effective. Although Kevin Hewitt did not gain insight into his mental illness or the need for medication, he complied with supervision and took medication as prescribed. He made it clear that he did so largely because of the formal requirement upon him to do so and he was

aware of the risk of breach of proceedings if he failed to comply.

10.12 Rose Kingham's records were detailed and complete. We felt that her input was diligent, perceptive and exemplary in many ways. She appreciated the complexities of interagency working and maintained close links with other services. At the same time she was conscious of Kevin Hewitt's resentful attitude to supervision and attempted to accommodate it as best she could. Although qualified only 3 months before taking on Kevin Hewitt's case, she told us that she was well supported by means of supervision with a senior probation officer and this was apparent from her case notes.

10.13 Over the two years of formal supervision, despite Kevin Hewitt's ambivalence, Dr Kaul maintained a good therapeutic relationship with him. He arranged regular outpatient appointments, was sensitive to Kevin Hewitt's views on medication and was successful in avoiding further episodes of illness leading to readmission. There was never any suggestion of breach proceedings for problems with medical management. Consistent CPN input and care co-ordination by Carey Maisey was fundamental to this success. Most significantly, at the end of formal supervision in December 1996, it was possible for Dr Kaul and Carey Maisey to maintain a continuing informal clinical relationship with Kevin Hewitt for a further year before the situation failed.

10.14 Kevin Hewitt saw Dr Kaul on 8 January 1997 complaining of weight gain which he attributed to the medication. Dr Kaul agreed to a further reduction of depot to 25mg monthly but increased the frequency of contact with Carey Maisey to every two weeks in order to detect signs of relapse. At a clinical review on 4 February 1997, Carey Maisey reported an improvement in their relationship with Kevin Hewitt *'showing more spontaneity and motivation'*. However, at his visits in March and early April, Kevin Hewitt told Carey Maisey that he did not wish to continue taking the depot. Carey Maisey arranged for Kevin Hewitt to see Dr Kaul on 15 April to discuss this further.

10.15 On 4 April 1997 Kevin Hewitt was arrested. He had been seen urinating in a public place in the late evening by police officers who stopped him and, asked him to take a breathalyser test before driving further. It was alleged that Kevin Hewitt grabbed the intoximeter and assaulted two police officers who tried to retrieve the meter and restrain him. Kevin Hewitt claimed that one of the officers hit him on his upper leg with his baton during the struggle. With the assistance of other officers, Kevin Hewitt

was restrained and taken to Charles St Police Station and charged with affray. The matter was eventually heard at Leicester Crown Court on 7 April 1998. By this time Kevin Hewitt was detained in hospital. A note from the Court states: *'Judge feels that defendant is best left "in hands of the Psychiatric Services"'* and the matter was left to lie on file.

10.16 It is not clear how or when Dr Kaul came to know of this incident. However Dr Kaul informed Carey Maisey about it on 8 May 1997 and Carey Maisey's entry of that date states that he could find no evidence that this incident was associated with a relapse in his mental state.

10.17 Kevin Hewitt attended the prearranged outpatient appointment on 15 April. He told Dr Kaul that he wanted the CPN visits to continue but did not wish to take depot medication. At the same time, he was concerned that his income support would be affected. He was eventually persuaded to continue with the depot. This meeting was recorded as a CPA review and Carey Maisey was also present. A review date was set for 21 November 1997.

10.18 On 21 July 1997 Kevin Hewitt told Carey Maisey that he had been to his GP for sleeping tablets and was concerned that he had been prescribed an antipsychotic. Carey Maisey contacted Dr Mansingh – a new GP at Dr Roshan's practice – and informed him of his monitoring role. Dr Kaul was also informed of this conversation.

10.19 On 9 September 1997, Kevin Hewitt saw Dr Kaul and asked to come off depot and to start oral medication. Dr Kaul wrote to Kevin Hewitt's GP in the following terms: *'I am sceptical about his reasons for coming off the depot and I suspect he would stop taking his oral medication. Unfortunately we do not have much of a choice in this matter at this juncture and would have to go along with his wishes. However, I have insisted, and he has agreed, that he would continue to see my CPN colleague Carey Maisey'.* Dr Kaul asked the GP to prescribe trifluperazine tablets 5mg at night.

10.20 At around this time, Kevin Hewitt sought Dr Kaul's and Carey Maisey's support for a Local Education Authority grant to study electrical engineering at Charles Keene College. Carey Maisey wrote him a letter of support. It appears that he subsequently began an engineering course at the De Montfort University.

10.21 On 29 September 1997 Kevin Hewitt rejoined his original GP's list, a single-handed practice run by Dr Newley. After seeing the practice nurse, Kevin Hewitt saw Dr Newley and complained

that he could not take the medication which had been prescribed for him by Dr Kaul. Dr Newley told the panel that the only information he had about Kevin Hewitt at this stage was the brief history he had given to the practice nurse. These notes include reference to Dr Kaul as responsible medical officer (RMO) and Carey Maisey as CPN, to a 4 year history of schizophrenia and to the fact that he had *'tried to kill someone'*. Despite this history, Dr Newley did not contact Dr Kaul but changed his medication from trifluoperazine tablets to fluphenazine tablets 1-2mg daily and gave him a 30 day supply. Kevin Hewitt told Carey Maisey subsequently that the new medication suited him better and he attended for a further prescription on 31 October 1997.

10.22 Also unknown to Dr Kaul's team, Dr Newley supported an application by Kevin Hewitt for council housing. The housing records reveal that on 4 December 1997 Kevin Hewitt was offered an unfurnished flat in Beaumont Leys. Kevin Hewitt did not inform Carey Maisey or other members of the clinical team about the tenancy for some months following re-admission to hospital later that month. In the event, because of this admission, Kevin Hewitt never lived at the flat although he had apparently moved some of his possessions there.

10.23 A CPA review was held on 2 October 1997. Carey Maisey, Dr Davies a senior registrar, and Robert Nisbet were present. There was no change to the care plan and a review date was set for 2 April 1998. Carey Maisey continued to visit Kevin Hewitt at home and noted that he was unusually sociable and in good humour. He had returned to college and had also begun some voluntary work in a private home for residents with mental health problems. He subsequently complained to Carey Maisey that one of the female residents had been behaving sexually inappropriately towards him, but refused to give any further information.

10.24 On 24 November 1997 Kevin Hewitt again attended Dr Newley who was concerned that Kevin Hewitt might be developing a manic illness and prescribed risperidone 2mg daily. Dr Newley told the panel it was probable that he had received Kevin Hewitt's previous medical notes by that time. He said that risperidone was a new drug at that time and it was unlikely that he would have prescribed it without specialist advice.

10.25 In the early hours of the 25 November Kevin Hewitt telephoned Pennine ward in a distressed state. Carey Maisey was informed and spoke to Kevin Hewitt later that morning. He complained of sleep difficulties and stress and asked for an appointment with Dr Kaul as he felt his sleeplessness was becoming a problem. Carey Maisey arranged to visit him on 1 December; he also

made an outpatient appointment for him with Dr Kaul for 2 December 1997.

10.26 On his visit on 1 December 1997, Carey Maisey found Kevin Hewitt to be elated, stressed and complaining of poor sleep and wanting access to his previous prison notes. He was seen the following day by Dr Kaul who considered that he was probably developing a manic illness. Kevin Hewitt agreed reluctantly to informal admission on 5 December. In the meantime Carey Maisey visited Dr Newley and warned him of the possibility of detention if Kevin Hewitt refused admission. Carey Maisey obtained a prescription of risperidone which he took to Kevin Hewitt and arranged to pick him up to take him to hospital on 5 December.

Comment

INTERAGENCY WORKING AND CPA

10.27 Although CPA had been formally implemented in the Trust during this time and CPA documentation for Kevin Hewitt was being completed, this did not appear to reflect a substantive change in practice in relation to interagency working. Carey Maisey told us that reviews were not always prearranged but were often done 'on the hoof'. Since they were not prearranged, they did not provide a forum for coordinating services with other agencies, nor did they provide a means for involving Kevin Hewitt and his family in reviewing and planning his care.

10.28 Nevertheless, we recognize that, without a statutory basis for ensuring contact after the ending of the probation order, there was notable success in engaging Kevin Hewitt with mental health services, as we have noted above.

GENERAL PRACTITIONER:

10.29 In September 1997 Kevin Hewitt was new to Dr Newley's practice and Dr Newley did not have access to his previous GP records which would have suggested caution in changing medication. Nevertheless, the notes recorded by his practice nurse gave an indication of the seriousness of his offending history and the name of his responsible medical officer. In the circumstances we think it was unwise to have changed the medication without first consulting Dr Kaul.

10.30 Similarly, we felt the change of medication to risperidone in November 1997 should not have been made without consulting Dr Kaul. Although Dr Newley believes that he

would not have prescribed this treatment without first seeing the notes, we cannot find any evidence that risperidone had ever been prescribed for Kevin Hewitt previously and we think it more likely that this change was initiated by Dr Newley in an attempt to find a more suitable medication for him. We appreciate the view that Dr Newley expressed to us that it was preferable to ensure that patients with schizophrenia should receive some anti-psychotic medication rather than none. However, in our opinion, his willingness to prescribe useful treatment did not preclude him taking the initiative to contact Dr Kaul and his team. We also note that the general level of support available to Dr Newley from the mental health services was poor - with no linked CPN / psychiatric social work service, which might have been of assistance in establishing better links with both general and forensic mental health services.

10.31 Similarly, we think that Kevin Hewitt's housing application should have been made known to the mental health services. In fact, Dr Kaul's team was made aware of it only after Kevin Hewitt's compulsory admission some 3 months later. While this information was unlikely to have altered the course of subsequent events, it should have been known to Carey Maisey who was Kevin Hewitt's keyworker at the time and therefore responsible for co-ordinating his care. We give further consideration to matters relating to liaison between GPs and mental health services later.

11. FOURTH AND FIFTH ADMISSIONS: December 1997 to 14 December 1998

11.1 When Carey Maisey went to collect Kevin Hewitt on 5 December 1997 he was not there although he had packed his belongings and informed his mother that he was going to hospital. When he returned, he was initially irritated with Carey Maisey but was persuaded to accompany him. He reiterated that he would stay only until the following Monday ie. 8 December. He was admitted to Beaumont ward, an acute admission ward.

11.2 The notes indicate that he was seen by the duty doctor on 5 December who did not consider that Kevin Hewitt's mental state was such as to warrant compulsory detention if he wished to leave the ward. On 6 December he agreed to start treatment with lithium, then he went on leave overnight, returning the following day. He again took leave and refused to return to hospital, saying that as an informal patient he could come and go as he liked.

11.3 He agreed to attend an outpatient appointment on 8 December with Carey Maisey and Dr Kaul. Carey Maisey noted that he had been drinking and a later report suggested that he had stopped medication to enable him to drink alcohol during the Christmas period. When seen by Dr Kaul he was talkative, elated and verbally hostile; he refused to continue with the lithium, but agreed to take risperidone. It was suggested to him that his behaviour was similar to that which preceded the offence against Amanda Shelton. Another outpatient appointment was arranged and the notes record that Dr Newley and Beaumont ward staff were told that detention may be necessary in the near future. Dr Newley did not recall this message, nor was any written summary of this brief admission sent to the GP.

11.4 Carey Maisey called on Kevin Hewitt on 12 December, without prior arrangement, but he was not in. He visited again on 15 December as previously arranged. By this time Kevin Hewitt had stopped taking the risperidone and was complaining of many physical symptoms, and that his food and drink may have been *'laced'* by his mother, sister or Carey Maisey himself. In a later report for a managers' hearing social worker Tracy Cooke (formerly Tracy Bestwick) makes reference to Kevin Hewitt's reported belief at this time that girls were joking and laughing about him. He refused to see Dr Kaul and arrangements were made to assess him for compulsory admission on the following day.

11.5 On 16 December Carey Maisey went to Kevin Hewitt's home with Dr Kaul, Dr Newley and the duty approved social worker (ASW) Sue Talbut but no one was at home. They returned the following day and assessed Kevin Hewitt who was particularly angry with Carey Maisey. The medical recommendations for Section 3 were completed but the application did not proceed at that point. The Social Services notes are ambiguous: the file note of 17 December stated that *' ongoing work is to be carried out to support in the community'*; however there is also a suggestion that the approved social worker had intended to complete an application for compulsory admission but could not do so because of Mrs Hewitt's objections as nearest relative. In her report of this assessment Sue Talbut wrote that due to her lack of acquaintance with Mrs Hewitt it would be difficult to make a case for removal of the nearest relative under Section 29 of the Mental Health Act. She also wrote that, although Kevin Hewitt was *'hyper'*, he was not worryingly so and that it was *'borderline whether the risk outweighs the "agro" in a sect 3'*. Mrs Hewitt told Sue Talbut that the family would encourage Kevin Hewitt to take his prescribed medication and to refrain from alcohol. It was agreed that Sue Talbut would discuss this with her managers.

11.6 Bob Hyams, social work team manager, asked Carol Williams, a forensic social worker, who worked largely in the magistrates' court, to liaise with Kevin Hewitt's relatives. In his later affidavit to the Court Bob Hyams explained that it was normal practice to allocate cases of this nature to social workers employed within the forensic services. Ms Williams consulted the Arnold Lodge file and telephoned Kevin Hewitt's sister, Sharon, to discuss the situation. Ms Williams explained to Sharon Hewitt that those professionally involved with the case thought that Kevin Hewitt posed a risk to his mother and to the public. She asked Sharon Hewitt to explain this to her mother, presumably with a view to inducing her to remove her objection to Kevin Hewitt being taken into hospital. Sharon Hewitt told Carol Williams that she was reluctant to intervene for fear of criticism by the family; she thought that her mother would not listen to her in any case. She also mentioned that she was moving into her mother's house with her young children on 19 December for the Christmas period.

11.7 Carol Williams also consulted Carey Maisey who advised her not to visit Kevin Hewitt alone as he considered him to be dangerous. Nor would Carey Maisey accompany Carol Williams

to see Mrs Hewitt because Kevin Hewitt saw him as the instigator of the assessment. Carol Williams telephoned Mrs Hewitt who did not think that Kevin Hewitt was unwell and who remained adamantly opposed to Kevin Hewitt's admission, even though the prospect of Section 29 displacement was explained. Carol Williams subsequently spoke to team leader, Bob Hyams, who initially expressed the view that the grounds for obtaining a Section 29 displacement appeared *'thin'*. However having consulted with Dr Kaul, who felt that Kevin Hewitt posed a *'substantial risk'*, Bob Hyams changed his view and prepared an affidavit in support of the Section 29 application.

11.8 The ASW report form completed on 29 December by Sue Talbut recorded the intervening events and making of the s3 application. Bob Hyams and Dr Kaul applied to Leicester County Court on 22 December for Mrs Hewitt's displacement and this was granted on an interim basis for 24 hours.

11.9 On Tuesday 23 December Sue Talbut attended the Hewitt's home with a view to serving the papers on Mrs Hewitt that would advise her of her displacement as Kevin Hewitt's nearest relative and in order to admit Kevin Hewitt to hospital under Section 3 of the Mental Health Act. In addition to arranging for an ambulance to take Kevin Hewitt to hospital, Ms Talbut arranged for police attendance, anticipating that Kevin Hewitt might refuse to go to hospital despite the Section 3 order. Only 2 police officers attended; Ms Talbut recorded that neither was big built, that they were unable to get reinforcements, and that the ambulance men had *'physical frailties'*. She noted that 3 young children (Sharon and Erma Hewitt's children) would be staying at the house over Christmas, which increased the need for urgent intervention under Section 3 of the Mental Health Act. Kevin Hewitt was extremely angry, in part because he had understood that action before Christmas was unlikely, but he did not put up any substantial resistance. He asked to call his solicitor but was advised to do this from the hospital. Mrs Hewitt was very distressed and attempted to stop Kevin Hewitt being taken. She told Sue Talbut that Kevin Hewitt posed no threat to her or the children. For reasons that are not apparent from the ASW's notes, the police felt it necessary to use CS gas on Kevin Hewitt. Ms Talbut wrote: *'Perhaps matters might have been negotiated but anxiety levels had been raised'*.

11.10 Although Kevin Hewitt was admitted to Belvoir ward, a locked intensive care ward, in handcuffs, on admission these were removed without any further problems. He immediately made a formal complaint about the police action and applied to the Mental Health Review Tribunal (MHRT) for discharge. Dr Meakin, the Belvoir ward RMO, recorded injuries consisting

of superficial bruising and tenderness. Sharon Hewitt subsequently saw this incident as indicating 'institutional racism.'

11.11 Sue Talbut explained to Mrs Hewitt that the full Section 29 proceedings would be held the following day and Mrs Hewitt attended court with her *'very angry daughter'* but without a solicitor. The Court granted a further interim order appointing Leicester City Council as nearest relative and the Section 3 application was completed by Sue Talbut. On 6 January 1998 the Section 29 proceedings were concluded and the local authority confirmed in that role. Carol Williams confirmed that Mrs Hewitt had been represented at that hearing and that her solicitor had expressed the view that the family was, in reality, frightened of Kevin Hewitt and were relieved that displacement proceedings removed that responsibility. This view was not expressed to the panel by other witnesses or by the family who indicated only their anger and distress at this event.

Comment

ASSESSMENT AND ADMISSION:

11.12 We have looked carefully at the circumstances of this admission as we were told that they had a profound adverse impact on Kevin Hewitt's attitude to mental health services subsequently.

11.13 We recognise that this was a difficult decision which was likely to have been influenced by staff shortages over the Christmas and New Year holiday period, the limited support that might have been available to him at that time, and to the need to ensure the safety of his sister's children who were staying in the house. On the other hand we heard from Sharon Hewitt that, although Kevin Hewitt was not taking medication, there was no urgency to admit him; also from Dr Newley who said of his interview that Kevin Hewitt *'made a very reasonable case concerning how he felt.....He appeared frightened, more than anything else.'* Bob Hyams too felt, at least initially, that the case for displacing Mrs Hewitt as nearest relative was *'thin'* – perhaps reflecting an uncertainty about the need for compulsory admission.

11.14 We found no discussion of alternatives to admission in the documentation although we acknowledge that he had recently discharged himself from a brief voluntary admission. The possibility that Mrs Hewitt might have been willing voluntarily to relinquish her position as 'nearest relative' does not appear to have been explored.

11.15 We think it is regrettable the ASW's role was shared between two ASWs each acting alone rather than the tasks being co-ordinated by one person. The Code of Practice to the Mental Health Act makes it clear that it is the responsibility of the ASW to co-ordinate the assessment and admission of the patient, including ensuring the appropriate conveyance of the patient to hospital. In this case it appears that the ASW, perhaps preoccupied with giving Mrs Hewitt information about the Section 29 proceedings, did not moderate the behaviour of the police during the process of removing Mr Hewitt from the home and only later discovered that handcuffs had been used. We think that in the circumstances, where police felt it necessary to use CS spray, it would have been preferable for the ASW to have accompanied Mr Hewitt in the police vehicle. Further, given the complexity of the assessment, it would have been better conducted throughout by two ASWs with clearly defined and coordinated roles. We think that, if this had happened, Kevin Hewitt's removal from his home to hospital might have been less traumatic.

11.16 The ASW assessment report form was completed by Sue Talbut, one week after the assessment. Although it provided a detailed account of the events, it was not available to the staff who cared for Kevin Hewitt over the holiday period, nor does it appear that Ms Talbut made an entry on the ward file as good practice would require.

11.17 The available evidence does not amount to a clear and compelling case for compulsory admission and treatment but neither does it demonstrate that admission was unjustified. Ultimately, we accept the views of those members of the clinical team, particularly Dr Kaul and Carey Maisey, who knew him well. Kevin Hewitt's recent suspicions that he was being poisoned by members of family were treated with proper gravity by those undertaking the assessment. The presence in the home over the Christmas period of Sharon's young children added to the concern.

11.18 What is clear is that this event had an adverse impact on Kevin Hewitt and his attitude to the clinical team and on his family who were distressed by these events. The use of handcuffs and CS spray was unnecessary and inappropriate. We note that guidance issued by the Association of Chief Police Officers in 1999 advises, in relation to mentally ill people, that alternatives to CS spray should be considered and that relatives and professionals are consulted before it is used. We were pleased to hear

that the Leicestershire Constabulary no longer uses CS spray in these circumstances.

11.19 We are concerned that no attempt was made to support the family immediately following these events and over the holiday period. The first formal discussion with them (by another social worker, Tracy Cooke) about the admission took place almost three weeks after the event and its primary purpose was to obtain information in relation to Kevin Hewitt's application to the Mental Health Review Tribunal. The family told us of their extreme distress at this time about the way in which Kevin Hewitt had been admitted and the distrust that this had engendered in mental health services. It appears there was no thought given to re-establishing supportive contact with Kevin Hewitt's family after the Section 29 order was invoked despite the fact that the local authority was in effect his 'nearest relative' for the remaining period of Kevin Hewitt's detention.

11.20 It appears that no national statistics exist and little information is available on the use of Section 29; it is therefore not possible to state with certainty how this episode compares to models of practice elsewhere. It is however apparent that Section 29 is used very infrequently – as is clearly the intention of the Mental Health Act. As a rare event and complex intervention it would have merited greater managerial guidance than is apparent from the Social Services notes.

ADMISSION TO BELVOIR WARD:

11.21 Dr Kaul suggested to us that Belvoir ward was an inappropriate setting for a patient like Kevin Hewitt who did not require intensive care but who was potentially dangerous: *'Because he was not obviously disturbed, or because he was not openly expressing hallucinations, delusions....my concern was that there might be an underestimation of risk'.* We heard from clinical staff on Belvoir ward that the philosophy of the ward was and is that of an intensive care ward and that the admission of forensic patients who required a longer period of secure care is strongly resisted. We share Dr Kaul's view that, in view of its operational policy and philosophy, Belvoir ward was not an ideal environment for Kevin Hewitt's care at this stage and that a low secure facility, had it existed, might have managed this early stage of his admission more appropriately. This view should be seen in the context of the wider debate about forensic services in Leicestershire which we consider later.

11.22 Admission to Belvoir ward resulted in a temporary change of RMO from Dr Kaul to Dr Meakin although Dr Kaul continued to oversee his care during his stay on Belvoir. The potential confusion in these arrangements was reflected in the evidence we heard from Dr Page (a senior registrar on Dr Kaul's team) who believed that Dr Kaul was Kevin Hewitt's RMO during this period. Similarly, correspondence from Kevin Hewitt suggested that he thought Dr Kaul was his RMO at this time. We considered it beyond our remit to explore this model of care in any depth but we should point to the absence of any apparent conflict between Dr Kaul's and Dr Meakin's team about Kevin Hewitt's care while on Belvoir. We were also impressed with the high level of input from Dr Kaul's team during this period.

11.23 Kevin Hewitt was seen briefly on admission; the first full entry was dated 28 December by Dr Nielsen, senior house officer (SHO) to Dr Kaul. The medical notes record that he was considered to have residual symptoms of a hypomanic episode, with some pressure of speech and grandiose assessment of his own abilities, but that anger about the circumstances of his admission was the most prominent finding. He refused lithium but accepted risperidone. Kevin Hewitt was permitted escorted leave and; within a week of admission, unescorted leave in the hospital grounds. Dr Kaul saw him a few days after admission when he had started to default on taking risperidone. He agreed to starting depot fluphenazine and was prescribed 25mg as an initial dose.

11.24 Shortly after admission Kevin Hewitt revealed that he had the flat in Beaumont Leys which he had been decorating. This was not previously known to Carey Maisey or the clinical team.

11.25 In order to prepare her report to the Mental Health Review Tribunal, Tracy Cooke visited the family home on 12 January 1998. Sharon Hewitt was angry about the admission, that her brother had been *'dragged off'* two days before Christmas. At the same time she expressed anger towards Kevin Hewitt for stopping medication and for the subsequent effects on the family. Tracy Cooke concluded that Kevin Hewitt had limited insight into his mental illness and the need for medication: *'In the past he has been ostensibly 'compliant' as a placatory exercise to effect his desired 'outcome' but it seems unlikely he would continue his medication regime were he able to make a choice.....If Kevin does not receive treatment he is likely to deteriorate and the level of risk could be substantial'.*

11.26 By 8 January 1998 Kevin Hewitt was considered ready for transfer to the ordinary open ward dealing with patients from his area, Beaumont Ward, but an episode of threatening behaviour towards a member of nursing staff led to seclusion and delayed the transfer. On 14 January Tracey Cooke described his attitude as *'belligerent'* and commented that Kevin Hewitt had said that he thought staff were *'spiking'* his drinks. When reviewed on the ward by Dr Kaul, Carey Maisey, Dr Page, Tracey Cooke and ward staff on 22 January he expressed his anger that mental illness had damaged his life and continued to deny that he had suffered from a mental illness. He was also angry with both Dr Kaul and Carey Maisey. In Tracey Cooke's note of the meeting she stated: *'Quite clearly Kevin will disengage with follow-up if left to his own devices. This raises the question of a s25 with the need for a named supervisor. Carey would not feel comfortable in this role and he feels it would be contra-indicated for a female to visit alone'.* By this time, he was having 4 hours of unescorted leave per day and it was agreed that he should be given more leave and transferred to Beaumont ward as soon as a bed became available.

11.27 On 29 January his case was considered by the hospital managers who decided that he should continue to remain subject to compulsory detention but recommended that he should be transferred to an open ward and that *'a care plan for this patient's discharge should be developed at an early opportunity..'*

11.28 On 30 January 1998 Kevin Hewitt was given weekend leave. The following day he was brought back to the ward by the police with burns to his face, head, arms and hands. It appears that, in order to claim insurance and deal with debts, he had doused his car in petrol and attempted to set fire to it. As he lit the petrol, the vapours ignited and he suffered burns as a result. We were told that this incident was not driven by psychotic symptoms but that his poor judgement was probably influenced by his mental state.

11.29 He was transferred to the burns unit at The Leicester Royal Infirmary for a week, with 24 hour psychiatric nursing supervision, before returning to Belvoir ward. On his return he was more disturbed, irritable and suspicious of the food provided for him, eating only from sealed containers. He remained under Dr Meakin's care, with intermittent reviews from Dr Kaul. His depot medication was increased to fluphenazine decanoate 75mg fortnightly. By 26 February 1998 he was well enough to be transferred to Beaumont ward. At this point he gave Tracey Cooke the address of his flat.

11.30 Carey Maisey's notes reflect Kevin Hewitt's continuing distrust of him and the breakdown of their previously good relationship. Carey Maisey told us that Kevin Hewitt often refused to make eye contact with him or to acknowledge his presence when they met; he described being *'cold-shouldered'* by Kevin Hewitt. On 2 March 1998 Kevin Hewitt was introduced to Nigel Parr who was to take over from Tracey Cooke as his social worker.

11.31 On 4 March 1998 his case was considered by the Mental Health Review Tribunal. In an addendum to her medical report Dr Page, senior registrar to Dr Kaul since January 1998, stated that Kevin Hewitt had improved since admission but continued to require detention because of his lack of insight into his illness and concerns about compliance with medication. She added that supervised discharge might need to be considered. Kevin Hewitt's own submission to the Tribunal reflected his view that he did not require the rehabilitation that could be offered by mental health services. A social work report by Tracey Cooke also opposed discharge of the Section 3. Although Kevin Hewitt's solicitors submitted an independent report from Dr Ola Junaid which supported discharge, the Tribunal decided that detention should continue. At about this time Nigel Parr took over from Tracey Cooke as Kevin Hewitt's social worker. This was his first forensic post.

11.32 Dr Kaul was Kevin Hewitt's RMO on Beaumont ward and he was seen on a weekly basis. Although often irritable and lacking insight into his mental illness, he was permitted daily leave of up to 6 hours. He continued to dispute the need for depot medication. A CPA review form was completed on 26 March and recorded the attendance of Dr Kaul, Dr Page, Carey Maisey and a staff nurse; this would appear to refer to a ward round held on 25 March rather than any prearranged meeting; a review date was set for 2 October.

11.33 As Kevin Hewitt was not consenting to his treatment, he was referred for an independent second opinion. He was seen on 26 March by the independent doctor, who authorised a treatment plan including continuing depot anti-psychotic medication. Kevin Hewitt was angry and left the ward before receiving the depot. He remained AWOL until 3 April 1998 despite attempts by the police to locate him. He did, however, telephone the ward at times.

INCIDENT 4 April 1998

11.34 When he did return to Beaumont ward on 3 April he refused to accept his depot injection. On 4 April he again refused depot medication and was restrained by nursing staff. Reports suggest that Kevin Hewitt may have told another patient that he

intended to harm nursing staff with a screwdriver which he was carrying. Because of his threats of violence towards them, nursing staff sought help from two police officers who were on the ward for other reasons. We were told that reinforcements were called and 7 policemen in riot clothing were involved in the incident during which Kevin Hewitt produced the screwdriver with which he threatened them. He was eventually restrained by police officers, and then given the depot and other medication including zuclopenthixol acetate 150mg before being taken in handcuffs to seclusion on Belvoir Ward. Five of the policemen suffered minor injuries.

11.35 Kevin Hewitt claimed subsequently that he had been using the screwdriver to remove the boarding on the front door to his flat in Beaumont Leys, which had been secured by the housing department following a number of break-ins. On 8 April Trisha Flewd from the Housing Office contacted Nigel Parr to say that the flat was secured. Housing benefit was discussed and it was agreed that they would keep in contact.

Comment

11.36 It seems likely that police involvement in this incident arose largely because of their presence on the unit in relation to a different matter and then escalated. This is clearly an unusual incident. Those witnesses who gave evidence to us who were directly involved at the time were firmly of the view that there was no alternative. Other witnesses expressed concern about the way this incident was handled, particularly the police involvement in it. We felt that other strategies for de-escalating this situation should have been tried prior to involving police in this way.

11.37 Within a few days of the incident Kevin Hewitt was assessed by staff from Arnold Lodge and it was agreed that he should be transferred there as soon as a bed became available. Kevin Hewitt told the assessing staff that he had not wanted to take the medication because of side effects and that he had acted properly in defending himself against the police officers. Until transfer, he was nursed on the highest level of observations (one nurse observing, with two more available and specifically assigned to his care) which he complained was intrusive.

11.38 On 14 April his mother attended the ward round with Dr Meakin and Kevin Hewitt asked to tape the discussions. He also asked to see his medical records. On 18 April he made further threats to three nurses which were regarded as serious and he was secluded overnight. Statements were made by each of the nurses and it was agreed that, although this should not be

treated as a *'reportable incident'*, its seriousness should be conveyed to Arnold Lodge staff. Dr Meakin wrote accordingly to Dr Kaul.

TRANSFER TO ARNOLD LODGE: 22 April 1998

11.39 On 22 April 1998 Kevin Hewitt was transferred to Pennine admission ward under Dr Kaul's care. He settled quickly on the ward without change to his medication of 75 mg fluphenazine decanoate depot every two weeks. Observations were reduced to level 2 (every 15 minutes).

11.40 Weekly risk assessments were completed. Concerns were expressed about his relationship with women and female staff and these were closely observed. Nigel Parr attended regular ward rounds and maintained a separate record of his visits.

11.41 Kevin Hewitt's mother made regular visits to the ward although there were no apparent attempts to engage her in discussion. The family told the panel that they would have attended meetings if they had been invited, as for the Mental Health Review Tribunal, but that they did not generally receive invitations.

11.42 In early May 1998 Kevin Hewitt refused his depot medication but stated his willingness to try risperidone or another of the newer antipsychotics with fewer side effects. He was noted to be more irritable and had significant akathisia. In discussion with Dr Page he agreed to try a reduced dose of 25mg fluphenazine decanoate two weekly in the first instance; an oral antipsychotic might be tried at a later stage. He was also given propranolol for akathisia. With further observation there was concern that his mood was becoming elevated and, on 22 May 1998, he agreed to try carbamazepine 100mg twice daily, subsequently increased to 300mg daily. This medication was not authorised on the existing form 39 and not approved until he was seen by a Second Opinion Appointed Doctor (SOAD) on 6 June 1998; because of the unavailability of the statutory consultees, the treatment was not formally authorised until 11 June.

11.43 On 8 June, Dr Kaul and the multidisciplinary team reviewed the evidence and suggested that Kevin Hewitt probably suffered from a bipolar disorder. Dr Saju's (the SHO) note of that review stated: *"Depot neuroleptics was started due to his noncompliance. Does he need neuroleptic? 1st episode was manic. 2nd episode started with depression, later with paranoid ideas. 3rd episode (worst) was again manic. He was well in between. Overall evidence was for bipolar disorder. If this is the case there is no need for neuroleptics if he was on carbamazepine."* On the basis of this revised diagnosis it was decided to increase the carbamazepine and to stop the depot.

Comment

11.44 The logic of this diagnosis is questionable. Kevin Hewitt's first admission in 1986 was prompted by an acute and short-lived psychotic illness which was considered at the time to be either a drug induced or an affective (abnormality of mood) episode. In February 1993 Kevin Hewitt took an overdose which could be seen as depressive but the assessment by the social worker included the record of paranoid ideation – the concern that people were mocking him. Kevin Hewitt's behaviour over the next year – the incident at the Shelter office, the attempt to escape delusional persecutors in Leicester, Nottingham and Manchester and the delusional motivation for the assault on Amanda Shelton - and his own account of having been unwell for the previous 3 years suggest a primary paranoid illness rather than a mood disorder.

11.45 During the sustained remission from late 1994 to late 1997, Kevin Hewitt was treated with depot antipsychotic medication alone; no antidepressants or mood stabilisers were prescribed. His depot was discontinued on 9 September 1997, and as he had been taking depot medication for three years it would have remained in his system for some considerable time after stopping the injections; he subsequently accepted oral fluphenazine then risperidone prescribed by his GP through September to November, until his rapid relapse at the end of that month. In our view the mass of recorded evidence does not support the review of diagnosis and the subsequent importance given to treatment with a mood stabiliser rather than an antipsychotic. We consider that the appropriate diagnosis would have been schizoaffective illness, with particular concern attaching to the return of paranoid symptoms.

11.46 On 12 June Nigel Parr spoke to Tracy Reece at the Beaumont Leys Housing office to discuss Kevin Hewitt's circumstances. He also contacted the Housing Benefits Office concerning the cessation of benefits. He was told that an application was needed together with an explanation as to why Kevin Hewitt could not return to his flat. Nigel Parr confirmed Kevin Hewitt's benefits position in writing to the Housing Benefits office by letter on 12 July. Despite this, Housing records reveal that further notifications of rent arrears were sent to his flat in Beaumont Leys during June and July.

11.47 Dr Kaul completed the statutory form authorising the renewal of Kevin Hewitt's detention under Section 3. Nigel Parr and Dr Page prepared reports for consideration by the hospital managers and referred to the improvement in his mental state, his limited insight into his mental illness, the likely failure to comply with treatment and the need for discharge to be preceded by planned leave from the unit. These reports were considered at a CPA review on 15 June 1998 attended by Dr Kaul, Dr Page, Nigel Parr an occupational therapist and a member of nursing staff, but not, apparently by Kevin Hewitt. Subsequently, the hospital managers reviewed the case and decided on 17 June 1998 not to discharge the Section. On 18 June Nigel Parr noted that Kevin Hewitt had received a summons for a drugs related offence. We have no further details of this allegation.

11.48 During this period Kevin Hewitt's leave was restricted to the enclosed courtyard within Arnold Lodge. He was transferred to a rehabilitation ward on 9 July. On admission the staff nurse noted that he showed no remorse for the offence in 1994 - *'Kevin feels he needed to stab his friend or be poisoned'*; that he preferred to speak to women than to men and liked flirting with female staff and that he did not accept the labels of mental illness or manic-depressive illness. It was agreed that he could have escorted leave outside the unit.

11.49 On 31 July 1998 Kevin Hewitt attended an interview at Southfields College for a computing course beginning in September which would involve attendance 3 days per week for 5 hours per day. Nigel Parr also helped him make contact with the tutor at Southfields with responsibility for students with mental health problems and arranged for a meeting to discuss *'identified problems which may point to issues of mental health deterioration'*. At a ward round on 23 July Nigel Parr agreed to be 'keyworker' after Kevin Hewitt was discharged from hospital.

11.50 At about the same time Kevin Hewitt asked to be prescribed risperidone as an *'insurance policy'* in the event of relapse; the notes record that in more than one discussion with staff he said that in his view he did not suffer from a manic-depressive disorder but from schizophrenia. He was prescribed risperidone 1mg twice daily initially, increased on 17 August to 2mg twice daily. He was also granted 2 hours unescorted leave per day and 4 hours unescorted leave to his home twice weekly with a view to extended leave in about 3 weeks time.

11.51 On 25th August 1998 Kevin Hewitt visited the Housing Office seeking the keys to his flat, which had been secured by the housing department. He was advised that the property had been surrendered earlier that month, after it had been burgled

several times and nothing of value was left in it. At the point that the flat was surrendered, the rent account was in fact in credit as Kevin Hewitt has received backdated housing benefit. The Housing records reveal that despite having been informed of Kevin Hewitt's detention in hospital, notification of arrears and correspondence regarding the surrender of the flat continued to be sent to the Beaumont Leys address. Kevin Hewitt was offered the chance to resume the tenancy but indicated that he would not *'feel safe'* there, instead he completed an application form for rehousing on medical grounds in which he admitted his mental health history.

11.52 Nigel Parr subsequently contacted Leicester City Council about possible insurance as did Kevin Hewitt's solicitors. Nigel Parr also wrote to Touchstone Housing, a housing association, about a possible tenancy and completed an application form. His letter of application read as follows:

'Thank you for dealing with Kevin's application to be housed. Kevin has been treated for mental illness under Section 3 of the Mental Health Act 1983.

He has now been treated and well enough to be discharged, into the community.

Kevin wishes to be housed as soon as possible. He has a place at Southfields College starting soon. On discharge Kevin will be supported by regular monitoring from health care professionals from Arnold Lodge and myself as Kevin's Social Worker.

Kevin is requesting a one bedroomed flat. He has stated that he has felt claustrophobic in a bedsit or small spaces. We as his carers feel that a facet of Kevin's illness is feeling claustrophobic.

I look forward to hearing from you when a vacancy has been found.'

11.53 A simultaneous application was considered by the Leicester City Housing Department which also approached Touchstone and another housing association under its 'nomination' system. Touchstone offered Kevin Hewitt a tenancy at 283 East Park Road, a low rise non-estate property. He accepted and was interviewed by Mara Forana of Touchstone Housing Association for his suitability, before the tenancy commenced on 9 November. We were told that the application had been accepted under the nominations system and that, although Touchstone was not a mental health specialist, it had had experience of housing mentally ill clients.

Comment

HOUSING:

11.54 We agree with Pat Hobbs, Assistant Director of Housing at Leicester City Council, who told us candidly that the Housing Department had handled Kevin Hewitt's case badly. Despite Nigel Parr's efforts to inform the Housing Department of Kevin Hewitt's admission to hospital, notices of rent arrears continued to be sent to him at the Beaumont Leys address and the tenancy was eventually terminated because it was unoccupied. Kevin Hewitt was informed about this only after a visit to the Housing Department in late August. Although he was later compensated by the Council, in our view these events inevitably discouraged subsequent engagement with mental health and other statutory agencies.

11.55 We are also concerned about the very limited information that was made known to Touchstone Housing Association about Kevin Hewitt. Ordinarily a doctor's report would have been required to support an application on medical grounds but Kevin Hewitt's parallel application proceeded quickly in advance of this process so that by the time that Dr Page was asked to provide a report, a housing offer had already been made. She returned her form incomplete in the face of this news, inviting the housing department to contact her if they still required information. No further information was requested. Although Nigel Parr assured us that he provided Touchstone with 'in depth information' about Kevin Hewitt, this does not appear on the otherwise comprehensive notes held by Touchstone and the Housing Department. It appears that, apart from details volunteered by Kevin Hewitt at interview, Nigel Parr's letter was the only source of information prior to the offer of a tenancy. In our view, the information provided to Touchstone and the Housing Department was inadequate. No mention was made in this letter of known problems of non-compliance, the risks associated with non-compliance, the indicators of relapse and the action that should be taken in the event. We are unsure why Nigel Parr's letter gave so little detail, particularly as Kevin Hewitt himself appeared to have been willing to make full disclosure to the Housing Department of his illness and associated difficulties.

11.56 It is notable that neither the Housing Department nor the Housing Association was involved in the CPA process for Kevin Hewitt which should have provided an opportunity to share information; we consider this matter later.

11.57 In early September, Kevin Hewitt complained of bilateral breast enlargement (gynaecomastia), an uncommon but well recognised side-effect of treatment with anti-psychotic and mood-stabilising medication. It was unclear when this problem started as it was not recorded in the admission physical examination notes. Stopping treatment would have been impractical and was thought unlikely to reverse the problem, so a referral for a surgical opinion was made.

Comment

11.58 It seems inevitable that this condition would have further increased Kevin Hewitt's reluctance to accept treatment as prescribed.

11.59 Leave was extended to cover the times of attendance at college and, following discussion between Nigel Parr and Mrs Hewitt, Kevin Hewitt started occasional overnight leave to his mother's home. In a comprehensive risk assessment completed at the end of September, Nigel Parr noted *'his reluctance to accept others points of view'* and the absence of any symptoms of psychotic or paranoid illness.

11.60 On 5 October 1998 a CPA meeting was held attended by Dr Kaul, Dr Page, Dr DiLustro (senior registrar), Dr Ley (Senior House Officer), Nigel Parr, Carey Maisey and staff nurse Sue Murphy. The meeting considered progress reports by Dr Ley, Nigel Parr and a nursing report and another comprehensive risk assessment by Sue Murphy. It was noted that Kevin Hewitt remained angry about *'racial issues'* and that Nigel Parr would explore this. Sue Murphy's risk assessment stated that Kevin Hewitt showed no remorse for his previous offence and continued to believe that his victim had tried to poison him. There was no evidence that Kevin Hewitt's attitude towards women, which had been a concern on his previous admission, was a cause for continuing concern. Although Kevin Hewitt recognised that his behaviour was impulsive, he denied that he suffered from a manic depressive illness and regarded his behaviour as *'stress-related'*. It was agreed that, because of the mistrust Kevin Hewitt felt towards Carey Maisey, no CPN would be allocated. It was agreed that Nigel Parr would be the care co-ordinator with Dr Page and Nigel Parr seeing Kevin Hewitt weekly until discharge. Weekly leaves would be granted to allow a period of extended leave of about 3 months before discharge of the Section. Section 25 was not considered appropriate and it was noted that Kevin Hewitt regarded this as an unnecessary infringement of his rights.

Comment

ENDING CPN INVOLVEMENT AND APPOINTMENT OF THE CARE COORDINATOR:

11.61 It was made clear to us by a number of members of the multidisciplinary team that the relationship between Kevin Hewitt and Carey Maisey was considered to have broken down irrevocably. Whilst there is little evidence of a formal strategy to address this relationship, we heard from several witnesses of incidental contacts between Carey Maisey and Kevin Hewitt which Carey Maisey sought to exploit in an attempt to re-establish a relationship with him. We acknowledge that, even if concerted attempts had been made to address this relationship, it may have proved irreparable. However we do not accept the view that the breakdown in Carey Maisey's relationship with Kevin Hewitt made any subsequent relationship with a CPN untenable. We have seen no discussion within the clinical notes of assigning Carey Maisey's CPN colleague to Kevin Hewitt's care although we were told that there were concerns expressed about the appropriateness of a female CPN in view of Kevin Hewitt's *'attitude'* towards women. We note, however, the working relationships which Kevin Hewitt formed with Rose Kingham and Dr Page and we saw no evidence to suggest that his attitude to community staff of either gender would have presented any particular difficulties. In any case, concerns about safety may have been addressed through joint visiting with Nigel Parr; there was no documented consideration of this option although Dr Kaul suggested to us that resources would have been insufficient to permit joint visiting. We are aware that Kevin Hewitt declined the offer of referral to the Intensive Community Support Team.

11.62 We do not think that the management arrangements for Carey Maisey enabled this matter to be properly considered. Carey Maisey told us that he had chosen to have his clinical supervision from Mary McMurran, a senior psychologist within the service. While this type of supervision arrangement is not unknown, it is the UKCC's advice[1] that this should run concurrently with supervision from fellow nursing practitioners. There are good reasons for this, not least to ensure that actions in individual cases are in accordance with the principles and practices that underpin the CPN service and that may not be familiar to supervisors

[1] Position statement on clinical supervision, United Kingdom Central Council, 1995

from other professions. There are recognised benefits from such supervision. Yet Victor Patino, Clinical Services Manager at Arnold Lodge, with responsibility for managing the CPN service at the time, told us that the ending of CPN input was decided and managed by the multidisciplinary team and did not come to his attention. We do not think that this was an adequate supervisory or managerial arrangement. The apparent inability of the multidisciplinary team to consider input beyond their own resources demonstrates a hazard of the development of consultant-led multidisciplinary teams in the absence of strong and proactive professional service management. In particular, we RECOMMEND that procedures for supervision are reviewed to ensure that they comply with UKCC guidance and that all decisions about input and termination of a service are agreed by the relevant service manager.

11.63 Further, from the evidence that we heard, there appeared to be a belief within the team that the role of CPN and social worker were largely interchangeable. Nigel Parr's later records indicate that, during home visits, he regularly enquired about Kevin Hewitt's treatment and medication and, if not by plan then by default, appears to have taken a primary role in monitoring compliance. In our view the team failed to appreciate the distinct and complementary roles of these two disciplines and, in particular, failed to consider the consequences of not providing robust mechanisms for monitoring treatment compliance.

11.64 In the absence of CPN involvement, Nigel Parr was the obvious candidate for care co-ordinator. We examine the care co-ordination in this case later. However, we note here that Nigel Parr had limited forensic experience. He had joined the forensic services on secondment in March 1998 and this was his first experience of supervising the aftercare of a patient with a forensic history; he had been authorized as an ASW since 1997. Dr Kaul told us that there were good reasons for choosing Nigel Parr for this role including his '*knowledge of ethnic and cultural issues*'; also that he had developed a good relationship with Kevin Hewitt. While we do not doubt this, we consider that Nigel Parr's appointment as care co-ordinator in the absence of CPN support was inappropriate for a social worker with his limited experience in forensic work. We are not convinced that resource constraints prevented the appointment of another CPN to assist Nigel Parr. The evidence suggests that the matter was not considered. Nigel Parr told us that he had discussed with Bob Hyams, his supervisor, his sense of isolation in dealing with Kevin Hewitt and the lack of CPN support. As noted, we were unable to speak to Bob Hyams to ascertain his view but

we note that there are no supervision records which addressed this issue. We support the recommendation made by the Leicester City Social Services Department in its internal inquiry in this case that all supervision should be recorded on the case file; such records should accurately reflect any concerns raised. Such practice should be in line with guidance provided by the Department of Health[2].

11.65 Throughout this period there was a particular sensitivity attaching to the relationships between Kevin Hewitt and the staff with immediate responsibility for his care. It is apparent that Kevin Hewitt was capable of forming quite intense but fragile relationships with those involved in his care and treatment. At times particular emphasis was placed on the need to preserve this fragile trust and that concern intensified following his compulsory admission to hospital in December 1997. We recognise the need to develop and maintain therapeutic alliances with patients as a mainstay of successful community aftercare, particularly in the absence of legal means to enforce treatment after discharge. While we do not criticise the emphasis on the therapeutic alliance, it may have deterred the team from adopting a more robust approach to his management.

AFTER CARE UNDER SUPERVISION:

11.66 The possible use of a Section 25A supervised discharge order had been considered earlier in this admission.

11.67 There were different views amongst members of the clinical team as to whether it was appropriate. Carey Maize told us that supervised discharge was not an option that Dr Kaul favoured *'for whatever reason'*. He said that, personally, he could see both sides of the argument: *'If you are hearing someone who is saying he is compliant....would there be any need to go down the supervised discharge route? On the other hand, with a history of non-compliance, for someone who is quite apt at giving lip service until we moved him on to the next stage, he would maybe come to a bit of a stumbling block somewhere along in the future...'* We did not find evidence to suggest that Carey Maize argued either for or against the use of the order at the time.

11.68 Nigel Parr argued for supervised discharge and compared it to the probation order which had been used with apparent success. He told us that *'it would have been a robust use of the Mental Health Act to support Kevin in the community'*. He

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[2] 'Recording with care'. An inspection of case recording in Social Services Departments, DOH, January 1999

disagreed with the decision not to invoke the supervised discharge order. However the SSD internal inquiry noted that, contrary to CPA guidance, this disagreement was not recorded in Kevin Hewitt's notes.

11.69 We considered the possible benefits to Kevin Hewitt of a supervised discharge order. The limitations of this provision are clear as it does not provide clinical teams with a robust framework to enforce treatment after discharge. On the other hand there may sometimes be value in a statutory framework even if it lacks enforcement provisions and there is anecdotal evidence of the efficacy of Section 25A in maintaining compliance with medication in similar circumstances. Recently published research[3] describes a low rate of utilization of Section 25A amongst forensic and general adult psychiatrists with many taking the view that the legislation is inadequate; there is also a minority of consultants who have found it to be useful. We conclude therefore that Dr Kaul's views on the lack of utility of Section 25A were in no way idiosyncratic and were broadly representative of professional opinion at the time.

11.70 Although initially angry at not being discharged at this point, Kevin Hewitt complied with the leave requirements. Nigel Parr, and occasionally in his absence, Tracy Cooke, visited him each week at his mother's home during this period of leave and helped him with an application for a community care grant and other practical matters. On 20 October Kevin Hewitt told Nigel Parr that the college course was not appropriate to his needs and that he was considering another course starting in April 1999 which might suit him better; it seems that he stopped going to his computer course at about this time. They also discussed his medication and his continuing supervision through outpatient appointments. On 19 November 1998 Nigel Parr visited him at his new flat at 283 East Park Road which he was in the process of decorating. The refusal of a community care grant delayed this process and Nigel Parr supported appeals to the Social Fund and to a Leicester Charity Organisation. Subsequent visits took place at Kevin Hewitt's mother's home where he was staying until the flat was furnished and decorated.

11.71 Kevin Hewitt saw Dr Page for weekly out-patient appointments through October; his case was discussed at weekly ward rounds with Dr Kaul and he continued to collect medication on a weekly basis. On 22 October, another patient reported that Kevin Hewitt had offered to supply drugs but there was no corroboration of this. Kevin Hewitt was assessed by the surgical team on 26 October in

[3] 'Consultant psychiatrists' experiences of using supervised discharge', Franklin et al, Psychiatric Bulletin, 2000, 24, 412-5

relation to his gynaecomastia; he was advised to lose weight and arrangements were made for a follow-up appointment in January. He discussed this advice with Dr Page, and his concerns about scarring after surgery if this was to proceed. On 17 November he saw Dr Ley and on 24 November he saw Dr Page again. At his next appointment on 1 December, Dr Page was late and Kevin Hewitt left without seeing her. However staff reported to Dr Page that he appeared to be low in mood. He saw Dr Ley on 8 December and was gloomy about his financial circumstances as he had been refused a grant or a loan for furnishing his flat. Dr Page wrote to him to apologise for the missed appointments.

11.72 A CPA/Section 117 review was held on 14 December 1998. It was attended by Dr Kaul, Dr DiLustro, Dr Ley and Nigel Parr and considered a medical report from Dr Ley, nursing report from Sue Murphy and social work report from Nigel Parr. The reports noted that he denied that he had been mentally ill, although he admitted to suffering from a stress-related illness, and that he had a continuing sense of grievance about his treatment by the police. It was agreed that the Section should be discharged that day. The plan was that Nigel Parr would visit Kevin Hewitt weekly, consider early relapse indicators with Carey Maisey, refer him to the Community Support team and include him in the community patients' CPA review schedule. Kevin Hewitt would see Dr Page monthly. Dr Ley would give Kevin Hewitt two weeks medication on discharge and liaise with the GP over future prescribing and the treatment of the gynaecomastia.

11.73 Dr Ley's discharge summary was dated 16 December 1998. The diagnoses given were bipolar disorder, manic type and paranoid personality disorder. Dr Newley did not, in fact, receive the discharge summary until 12th January, by which time Kevin Hewitt had already attended his surgery for a repeat prescription.

Comment

DIAGNOSIS:

11.74 We have indicated earlier our disagreement with the diagnoses of bipolar disorder, manic type. We have also indicated that the evidence does not justify the diagnosis of personality disorder.

11.75 We find it surprising that, if the personality disorder diagnosis had been accepted, there was no assessment or intervention from the psychology services. We were told that psychology services were well provided at Arnold Lodge and a wide range of services were offered including symptom identification, relapse prevention, compliance issues, and supportive psychotherapy. Dr Patrick Sims, the psychologist

who worked with Dr Kaul's team, told us that Dr Kaul was 'psychology-friendly', implying that he would readily refer patients to the psychologists if he felt it appropriate to do so. Although Dr Sims took part in multidisciplinary discussions about Kevin Hewitt's care, he was not asked to provide services to him and did not consider it his place to offer them.

11.76 The accuracy of the diagnosis is important. Firstly, the diagnosis of personality disorder may have allowed evidence of paranoid illness to be construed as personality traits rather than symptoms in need of treatment. We acknowledge, however, that Dr Kaul did not treat Kevin Hewitt as if a personality disorder was a major element in his difficulties, and in his note of his last assessment of Kevin Hewitt on 7 July he recorded explicitly "no PD" (personality disorder). Secondly and more importantly, the diagnosis of bipolar disorder allowed the mainstay of treatment for a paranoid psychosis in the context of proven poor compliance – depot antipsychotic medication – to be discarded in the hope that treatment with mood stabilisers would be adequate.

DISCHARGE ARRANGEMENTS:

11.77 The review meeting on 14 December took place in the absence of some key players in Kevin Hewitt's aftercare. Kevin Hewitt did not attend, although it may have been mentioned to him by Nigel Parr during a home visit but this was not recorded. Neither was Mrs Hewitt invited nor were her views sought despite the fact that Kevin Hewitt had been living in the family home for the previous 3 months. Dr Newley was not invited nor were his views sought, although the discharge summary indicates that he would assume responsibility for prescribing for Kevin Hewitt. Dr Page was absent though her views may have been represented by Dr Kaul, her supervisor. No contact was made with Mara Forana at Touchstone Housing Association either by way of consultation or to inform her of his likely discharge. Although called a 'CPA/s117 review', it was in our view little more than a clinical review and did not provide an opportunity to coordinate input from the family, external agencies and to provide an interagency care package. We consider this and matters relating to liaison with the GP later.

12. COMMUNITY CARE 14 December 1998 to 11 August 1999

December 1998

12.1 Nigel Parr visited Kevin Hewitt at his mother's home on 18 December and Kevin Hewitt was seen at outpatients by Dr Page on 22 December. Both record his concern about his financial position and the refusal of the community care grant. Nigel Parr made further telephone contact with Kevin Hewitt about his arrears during this period. Kevin Hewitt told Dr Page that he didn't want to see anyone apart from a doctor. Dr Page made an appointment to see him on 19 January.

January 1999

12.2 Dr Newley's records show that he did not receive a copy of Dr Ley's discharge summary until 12 January. There was no other contact from Dr Ley that Dr Newley had documented or could recall. On 5 January, Kevin Hewitt saw Dr Newley who gave him a prescription for a month's supply of carbamazepine 300mg twice daily and risperidone 2 mg twice daily. Dr Newley told us that the medication would probably have been prescribed on the basis of Kevin Hewitt's previous supply which he had brought with him.

Comment

12.3 As with his discharge in early 1995 there was an unacceptable delay before the GP was notified of the change of circumstances. We were unable to discover why Dr Ley's discharge summary was not received by Dr Newley until almost a month after it was dated. It may be that it was dictated on 16 December but not typed until some time later and that the Christmas/New Year period further delayed the process. Whatever the explanation, Kevin Hewitt attended Dr Newley's surgery before Dr Newley even knew he had been discharged. This is clearly unsatisfactory. We RECOMMEND that early notification to GPs should be a quality standard in the Trust's CPA policy and that practice should be audited against it. We are aware of the recommendation made by the internal inquiry into the Paul Hundleby case that discharge letters should be faxed immediately to GPs and support the use of this and other information technology eg email, as a means of ensuring timely communication between agencies.

12.4 Nigel Parr visited Kevin Hewitt on three occasions and also accompanied him to the DSS to appeal against the decision

concerning the community care grant. On 21 January Nigel Parr visited Kevin Hewitt at his flat on East Park Rd which he had fully furnished and decorated with the help of some funds from the Leicester Charity Organisation. Nigel Parr expressed concerns about Kevin Hewitt's alcohol consumption and noted his guarded responses to various inquiries about his mental health. He felt that these matters should be explored in outpatient meetings. Nevertheless on 29 January he agreed with Kevin Hewitt to reduce his visits to once every fortnight. This decision was conveyed to Dr Page who subsequently confirmed it to Dr Newley.

12.5 Kevin Hewitt did not attend his appointment with Dr Page on 19 January but attended a week later on 26 January. Dr Page explored his alcohol consumption and again his guarded responses were noted and his distrust of the social work and other input. He told Dr Page that he had decided not to proceed with surgery for the gynaecomastia. Dr Page summarized the interview in a letter to Dr Newley and arranged to see Kevin Hewitt again on 23 February 1999.

February 1999

12.6 Kevin Hewitt collected a repeat prescription from Dr Newley's surgery on 11 February. Nigel Parr tried to visit Kevin Hewitt at the family home on 12 February but there was no reply. He spoke to Kevin Hewitt by telephone later that day and was told that he had forgotten the arrangement. Another appointment was made for 26 February but again there was no reply when Nigel Parr called. In a later telephone call Kevin Hewitt told Nigel Parr that he had been asleep and a further appointment was made for 4 March. Nigel Parr wrote to Dr Page about his concerns that two supervision visits had been missed.

12.7 Kevin Hewitt attended his outpatient appointment with Dr Page on 23 February 1999. He again expressed his reluctance to see psychiatrists as they were *'too dangerous'* and was worried about becoming too close to his social worker and spoke about severing all links. Dr Page informed him that she was leaving the service in April and that he would have an appointment to see Dr Kaul after that. Dr Page asked him to have a blood test from his GP to check his carbamazepine level - and so to check his compliance with treatment; she noted that he was not psychotic and was reluctantly complying with medication. Dr Page wrote to Dr Newley summarizing the interview. He was given a further appointment for 23 March 1999.

March 1999

12.8 On 4 March Nigel Parr visited Kevin Hewitt at the family home where it appears he still spent most of his time. Nigel Parr confirmed with Mrs Hewitt that she was happy with this arrangement and had no concerns.

12.9 On 11 March Nigel Parr attended a CPA review at which Dr Page and Dr Kaul were present. There is no information to suggest that Kevin Hewitt or his family or Touchstone Housing Association had been invited. It was agreed that Nigel Parr's visits would be reduced to monthly and that, after Dr Page left, Kevin Hewitt would see Dr Kaul every 2-3 months with the long term aim of returning him to general psychiatric services. It was agreed that Dr Page would check with Dr Newley to confirm that Kevin Hewitt was collecting his prescriptions.

12.10 Kevin Hewitt did not attend his outpatient appointment with Dr Page on 23 March. Dr Page telephoned the GP surgery and confirmed that he had collected prescriptions for carbamazepine in January, February and March but had not attended for the blood test for carbamazepine levels. Dr Page was unable to recall whether she spoke to Dr Newley or only to the practice nurse. Dr Page sent Kevin Hewitt another appointment for 30 March which he also did not attend. Dr Page wrote to Dr Newley informing him of this and of the report of an incident at a nightclub. She also sent Kevin Hewitt an appointment to see Dr Kaul on 14 April.

12.11 On 26 March Arnold Lodge received a telephone call from a member of the public stating that Kevin Hewitt had been thrown out of a nightclub and had been very paranoid.

12.12 Nigel Parr saw Kevin Hewitt on 26 March on a second visit after receiving no reply to a visit earlier in the day. He was accompanied by CPN Sharon McNulty because of concerns about Kevin Hewitt's mental state following the telephone call about his behaviour in the nightclub. Although Kevin Hewitt had a hangover and admitted to drinking too much during his birthday celebration, Nigel Parr did not detect any deterioration in his mental state. Nigel Parr's notes suggest that he attempted to see Kevin Hewitt on 31 March but without success.

Comment

REDUCED VISITS:

12.13 By the end of January Nigel Parr's visits had been reduced from once weekly to once every two weeks and by March this had been further reduced to once monthly. Thus within 3 months of discharge of the Section, his weekly follow-up by Nigel Parr had been reduced to monthly follow-up. (In practice, Nigel Parr was forced to make many more visits to Kevin Hewitt in a vain attempt to establish contact but the plan for monthly visits was not revised). The SSD internal inquiry considered whether it was premature to reduce the frequency of visits in view of the history of non-compliance. That inquiry noted that this was a multi-disciplinary decision; it also noted Bob Hyams' view that this was in line with practice when there is no 'statutory involvement'. In fact Kevin Hewitt continued to be subject to aftercare provisions of S117 of the Mental Health Act which confers statutory responsibility on both Health and Social Services (although Kevin Hewitt was under no obligation to accept the help offered or to comply with any part of the aftercare package.)

12.14 In his evidence to us Nigel Parr explained that this stepwise reduction in the frequency of visits was usual practice in the supervision of patients discharged from Arnold Lodge into the community. The pattern of this reduction reflects that recommended by the Home Office[4] as representing the minimum acceptable contact with a restricted patient where there are no grounds for concern about the patient's circumstances or mental state. In Kevin Hewitt's case there were already grounds for concern about his degree of insight and his willingness to engage that should have alerted the team to the risk that he would cease accepting medication and disengage completely from services. It is clear that the decision to reduce the level of contact was endorsed by Bob Hyams. It was not suggested to us that the reduction of contact was in any way resource driven.

12.15 We are of the view that the decision to reduce the level of contact was ill-conceived and failed to give adequate consideration to the management of known risks. Rather than reducing the level of contact the team might have chosen to take a more assertive approach in a positive attempt to engage Kevin Hewitt. In reducing the contact

[4] 'Notes for the guidance of social supervisors: Mental Health Act 1983: supervision and aftercare of conditionally discharged restricted patients', Home Office, Dept of Health and Welsh Office, 1997, para 44

with Kevin Hewitt, Nigel Parr also lost opportunities to engage Kevin Hewitt's mother and sisters.

OUTPATIENT APPOINTMENTS:

12.16 It is likely that one of the factors which reduced Kevin Hewitt's commitment to continuing psychiatric supervision was the termination of the good relationship which he had developed with Dr Page. She had supported him through the periods of increasing leave from the late summer onwards, and her notes record his willingness to discuss sensitive matters with her. Her departure from the service in April 1999 was therefore likely to be of concern to Kevin Hewitt. We acknowledge that Dr Kaul had successfully supervised Kevin Hewitt in the community from December 1994 until December 1997, and that he and Kevin Hewitt knew each other well. In our view, however, the CPA arrangements both before discharge and subsequently should have provided an opportunity for discussing such issues with the staff concerned and Kevin Hewitt in order to ensure that all necessary support was available for him when Dr Page left.

April 1999

12.17 On 12 April Dr Kaul's secretary wrote to Kevin Hewitt saying that Dr Kaul was unable to see him on 14 April and would send another appointment. We could find no evidence that another appointment was sent until 28 June, when Kevin Hewitt was offered an appointment for the 7 July.

12.18 Nigel Parr visited Kevin Hewitt at his mother's home on 6 and 9 April but received no reply on either occasion. He eventually met Kevin Hewitt on 16 April. He was noted to be spending some time at his flat and some time at his mother's home. Nigel Parr's note of that meeting expressed his concern about the pattern of failed appointments. Nevertheless, he found Kevin Hewitt to be well and willing to comply with medication. Kevin Hewitt said that he had forgotten the previous appointments and gave an undertaking to try to remember future meetings, which they agreed would be every 4 weeks. An appointment was made for 13 May.

12.19 At this time, and unknown to Nigel Parr, Kevin Hewitt met with Mara Forana at Touchstone Housing Association to discuss a move from Leicester, possibly to Derby, Nottingham or Tamworth. He completed a transfer form in which he gave the following reasons: *'I wish to move out of Leicester because I need to make a fresh start, and also to increase job prospects and to be comfortable in my surrounding because I wish to*

forget certain things and have come to a decision that this can not be achieved while I remain in the place of my birth'. He added by way of postscript that this information should *'be kept totally confidential'.* In a subsequent discussion with Mara Forana, Kevin Hewitt said that he felt the police in Leicester were harassing him and had stopped and questioned him several times. When Mara Forana asked him whether his social worker knew he wanted to move, he became agitated and explained that his social worker was one of those harassing him. Kevin Hewitt refused to allow Mara Forana to discuss this with Nigel Parr and so the information was not passed on to him. Mara Forana told us that she had no grounds for breaching Kevin Hewitt's right to confidentiality in these circumstances and this was in accordance with Touchstone Housing Association's confidentiality policy which was current at the time.

Comment

12.20 The effect of the decision by Mara Forana not to inform Nigel Parr left the clinical team ignorant of important information about Kevin Hewitt's mental state. The paranoid views Kevin Hewitt expressed to her were indicative of his deteriorating mental state and early signs of relapse. We consider this in a later section.

12.21 A neighbour and close childhood friend of Kevin Hewitt subsequently described to the police how Kevin Hewitt's behaviour changed at around this time: *'He also started to become paranoid, thinking that people from Arnold Lodge were following him…..that people were getting into his flat and moving things round, and he thought this was being done by people from Arnold Lodge, because they wanted to get him back inside there'.*

Comment

12.22 We discussed with Dr Kaul the failure to send Kevin Hewitt a further appointment at this stage. While not seeking to excuse this apparent oversight, Dr Kaul told us that every case in the community was considered on a monthly basis and that he would have discussed developments on Kevin Hewitt's case with the multidisciplinary team in this forum. Unfortunately, no notes were kept of those meetings. Nevertheless, Nigel Parr kept detailed notes and we believe that he would have recorded any significant decisions or concerns that had been raised at those meetings. None were recorded. In our view the fact that Kevin Hewitt was not seen and assessed by a psychiatrist between 23 February and 7 July was critical in the failure to monitor his mental health over this period.

May 1999

12.23 When Nigel Parr visited on 13 May, Kevin Hewitt was not at home but his mother reported no problems. Nigel Parr arranged to call on 17 May but when he did so there was no reply. Nigel Parr's report stated *'I strongly feel this situation needs to be reviewed'* and this was copied to Dr Kaul and to Dr Newley. Nigel Parr spoke to Dr Kaul on that day. Nigel Parr's entry states *'Dr Kaul has spoken to Dr Newley, GP – who stated that Kevin is still collecting his prescription'*. In fact, the GP records show that Kevin Hewitt collected his last prescription for risperidone and carbamazepine on 9 March.

Comment

12.24 It is likely that Dr Kaul was referring to the earlier conversation between Dr Page and Dr Newley. Had Dr Kaul spoken to Dr Newley at this time, his concern should have been raised since he would have learnt that Kevin Hewitt had not collected his prescription since early March ie that he had not collected a prescription for over two months and so could no longer have been taking his medication; nor had he attended for the blood test arranged by Dr Page.

12.25 On 19 May Nigel Parr tried to contact Mrs Hewitt by telephone but there was no reply.

12.26 At about this time Kevin Hewitt received £2500 compensation from the Council for the failure to observe the agreed procedures for terminating the Beaumont Leys tenancy and for wrongly removing his goods.

June 1999

12.27 Nigel Parr decided to bring forward the CPA review to 24 June and wrote to Kevin Hewitt asking to see him on 4 June. When he visited on that day, there was no reply.

12.28 On 17 June, Nigel Parr saw Kevin Hewitt in the street holding a bunch of flowers and waiting to board a bus. He was reluctant to engage in discussion and said that he did not want to see Nigel Parr and would contact him if he needed to. Nigel Parr wrote to Dr Kaul expressing the view that CPA had broken down. He said that it would be useful if the professionals involved in his care kept each other informed of any visits and contacts and this letter was copied to Dr Newley.

12.29 Unknown to the clinical team, Kevin Hewitt approached Mara Forana again with a request to be rehoused. On this

occasion his application stated that the main reason for moving was *'to escape harassment'*.

12.30 Dr Kaul, Dr Di Lustro and Nigel Parr met for a CPA review meeting on 24 June to discuss the difficulties in supervision. It was agreed that Dr Kaul would write to Dr Newley to find out if Kevin Hewitt was taking medication. Nigel Parr's note of the review also states that Dr Kaul *'would enquire if Dr Newley would take over the role of supervision due to the difficulties with my fulfilling this role due to Kevin's recent non-co-operation in keeping appointments'*. A review date was set for 9 September 1999.

12.31 Nigel Parr visited East Park Rd on 28 June but Kevin Hewitt was not there and a note was left for him. On the same day Dr Kaul wrote to Kevin Hewitt and set up an outpatient appointment for 7 July.

July 1999

12.32 Nigel Parr was concerned about the difficulty in meeting with Kevin Hewitt and on 1 July made an unannounced visit to East Park Road and then to the family home. Kevin Hewitt was at neither address although Nigel Parr noted *'some movement behind the curtains'* at the family home.

12.33 On 6 July Kevin Hewitt saw Dr Newley to complain of excessive sweating and insect bites. This was his first contact with a doctor since seeing Dr Page on 23 February. Dr Newley's notes contain no reference to his mental state.

12.34 Dr Kaul saw Kevin Hewitt on 7 July as arranged; this was his first psychiatric review in 4½ months. Kevin Hewitt told Dr Kaul that he had not been taking medication for over 6 months although he had been collecting it. He insisted that he did not wish for any follow-up as treatment had harmed him physically in the past. He was noted to be mentally well. Dr Kaul's note stated: *'Risk of violence low at the moment. Is not impulsive. Does not abuse substances. Manages anger reasonably well when not ill. No PD. Relapses slowly. Risks would significantly increase as he becomes mentally unwell.'* Dr Kaul decided to write to the GP *'to seek his positive contribution in his supervision'*, and to send him another appointment after this. He also recorded that he had obtained the advice of the Medical Protection Society (MPS) and was advised to keep maintaining contact through family and GP.

12.35 Dr Kaul told the internal Trust inquiry that he recognized that things were beginning to go wrong and that he called the MPS to seek assurance that there were no other statutory powers

available to him in the circumstances. He told us that this was the first time he had taken such action in his clinical practice. We were surprised that a clinician with his experience of the use of statutory powers should have needed advice of this sort; further that he had not sought advice from professional colleagues before approaching the MPS. We believe that this was indicative of his lack of professional peer support at the time, which we consider later.

12.36 Dr Kaul wrote a long letter to Dr Newley on 12 July in which he set out the difficulties of maintaining contact with Kevin Hewitt and the nature of his relapses. He wrote:*'Mr Hewitt is not one of those patients who rapidly relapses after stopping taking medication. His relapse takes place gradually over a number of months and it takes a similar period before he becomes potentially dangerous to others. My view is that as long as he is being supervised, even if he is not taking medication, we can pick up the early indicators of a relapse and treat him when he is becoming ill, even if this needs to happen through detention under the Mental Health Act. Unfortunately despite being assertive in our follow up it is proving almost impossible to maintain contact with him. Hence we are somewhat struggling as to how we can ensure that he remains mentally well and thus minimise any potential risk to others'. 'The fact that he holds me and my team responsible for his detention in hospital further compromises our ability to maintain a therapeutic alliance with him. As he seems to have a better relationship with you than he does with us I wondered if you had any suggestions as to how we find a way ahead through this impasse.'*

Comment

12.37 We think that Dr Kaul's advice to Dr Newley about the timing of a relapse was misleading. By this time Dr Kaul was aware that Kevin Hewitt had not taken medication for some 6 months and therefore relapse was likely to be sooner rather than later. Further, we do not agree that his follow-up at this point could be described as assertive since there was no psychiatric follow-up between 23 February and 7 July. We accept, however, that there were similarities between the circumstances in July 1999 and December 1997, and that Dr Kaul had some justification for believing that the situation might be resolved as it had been previously, ie. by a compulsory admission under the civil provisions of the Mental Health Act. The critical difference was that in 1999 there was no regular therapeutic contact of the kind provided by Carey Maisey previously, which had allowed close monitoring of Kevin Hewitt's mental state.

12.38 Dr Kaul's letter to Dr Newley was interpreted differently by Dr Newley, Nigel Parr and Dr Kaul. Nigel Parr's notes indicate clearly his understanding that, in writing this letter, it was Dr Kaul's intention to ask Dr Newley to become care co-ordinator. Dr Newley also believed that he was being asked to take over primary responsibility for Kevin Hewitt's care but felt that he could not do so without discussing it with Kevin Hewitt and asked his secretary to make an appointment. Dr Kaul, however told us that was not his intention at that time and that he was seeking suggestions as to how opportunities for monitoring him could be maximized. At this distance it is impossible for us to know the intention behind this letter but we note the ambiguity in its interpretation. Further, we think it highly unlikely that a GP with minimal contact with the psychiatric services, no training or regular involvement in CPA and no forensic experience would be in a position to take on the care co-ordinator role without considerable support from the forensic team.

12.39 In July the DSS main office in Blackpool received a number of letters from Kevin Hewitt asking for cancellation of his benefits as he considered himself to be well and not entitled to them. The DSS office contacted Nigel Parr at the beginning of August who felt that this may indicate a relapse in Kevin Hewitt's mental state.

12.40 On 30 July Kevin Hewitt went to the hospital medical records department requesting sight of his notes. His behaviour frightened the medical records officer and the Unit Co-ordinator attended. This event did not come to light until after the index offence and there is no record of it in any contemporaneous notes.

August 1999

12.41 Kevin Hewitt's case was considered at the monthly team meeting on 2 August. Dr Kaul recorded that he had sought the advice of the medical records officer who advised that there were no powers under s117 to enforce supervision. It was agreed that Nigel Parr should make contact with Kevin Hewitt's sister, that Dr Kaul would follow up the letter to Dr Newley of 12 July to which no reply had been received and that Kevin Hewitt would be referred to the Public Protection Panel (PPP) in September 1999.

Comment

12.42 The Public Protection Panel was established on 1 May 1998 to consider the registration of people who present a serious

risk of harm to others and where a multi-agency approach is needed to manage the risk. We consider the PPP later in this report. As a founding member of the Panel and Panel advisor in relation to mental health referrals, Dr Kaul would have been aware of the stringent panel criteria in relation to risk and to the need for multiagency action. While referral is no guarantee of registration (only about 30% of those referred to the Panel have been registered), we regard this referral as an indicator of the level of risk that Dr Kaul considered Kevin Hewitt might pose to the public. Nevertheless, the evidence we have seen regarding Kevin Hewitt's presentation does not convince us that his registration would have been agreed.

12.43 On 4 August, Dr Newley received a letter from Kevin Hewitt asking to see his medical records and an explanation of his previous medication. Dr Newley asked Kevin Hewitt to come into the surgery to discuss the request, which he did later the same day. Kevin Hewitt said that he intended to apply to university or pursue a career and was concerned to remove any reference in his history to mental illness. Dr Newley advised him to discuss his supervision with Dr Kaul and to ask Dr Kaul for copies of his hospital records which were not held in the surgery. Dr Newley told us that Kevin Hewitt appeared well and that he showed *'normal anxiety over his past history holding him back'*. Dr Newley's contemporaneous notes stated *'review – wants medical records – OK'* and did not indicate any other concerns.

12.44 At 8.45am on 6 August Kevin Hewitt presented himself to Charles Street Police Station and was interviewed by two police constables. Kevin Hewitt told the officers that he had been a detained patient at Arnold Lodge, that he had been discharged the previous December and that he was being followed by Arnold Lodge staff who he felt were blocking his application for a house move. One of the police constables made enquiries with the Police National Computer. In a witness statement the police constable said:

'He was known, not currently wanted. He had warning markers for mental, schizophrenic, violent, assault Police.
I advised Hewitt to contact his Doctor, to make enquiries into his medical history. I advised him that the Mental Health Service do not tend to follow patients who have been released around the town.
Hewitt appeared paranoid about the Mental Health Service.'

It appears that the police officers did not take any further action on this matter.

Comment

12.45 With the benefit of hindsight this was an important encounter which was revealing of Kevin Hewitt's deteriorating mental state at this point. However Kevin Hewitt was not registered on the Public Protection Register and, without registration, the police would not have had any reason to make further enquiries or to contact a key worker, despite the warning markers.

12.46 On the same day, Kevin Hewitt telephoned Dr Kaul and asked him for assistance in gaining access to his medical records. Dr Kaul advised him to put his request in writing, so that a formal reply would be forthcoming. Kevin Hewitt also asked for confirmation that he was not on any treatment order. He complained of side effects in the past but would not accept Dr Kaul's offer to discuss this further, agreeing to go to the GP instead. Dr Kaul's entry noted: *'sounded reasonably calm with no pressure of speech, as has been the case when he was relapsing last year.'*

12.47 Kevin Hewitt wrote to Dr Kaul on 9 August, setting out his requests as Dr Kaul had advised. The letter was coherent and there was no indication of thought disorder or paranoid beliefs other than his insistence that he wanted nothing further to do with the psychiatric services.

12.48 On 9 August, Dr Newley returned Dr Kaul's call. Dr Newley confirmed that Kevin Hewitt had attended the surgery and was seeking access to his medical records but that he did not detect any signs that Kevin Hewitt was relapsing. It was noted that Kevin Hewitt was not living at home any longer. Dr Newley told Dr Kaul that he had sent him a further appointment and it was agreed that he would contact Dr Kaul if there were concerns. Dr Newley told us that Dr Kaul did not express urgency about Kevin Hewitt's situation. Dr Kaul, however, told us that he was surprised that his level of concern, indicated by the telephone calls to him, was not apparent to Dr Newley. The same day Dr Kaul and Nigel Parr agreed that Dr Kaul would contact the Leicestershire Constabulary and Nigel Parr would try to contact Sharon Hewitt.

12.49 Later that day, Kevin Hewitt requested an urgent appointment with Dr Newley. He was given the last appointment of the evening. Dr Newley spent half an hour with Kevin Hewitt discussing his concerns, stomach problems and stress. Kevin Hewitt was initially fearful of being compulsorily admitted

to hospital and calmed down when he realised that no-one else was present. Dr Newley felt that his symptoms were psychological in origin and prescribed flupenthixol 1mg twice daily which would be reviewed in two days time. Later that evening, Kevin Hewitt contacted the GP deputising service, to speak to Dr Newley who returned his call. Kevin Hewitt had read the possible side effects of flupenthixol and did not wish to take it; instead he asked for a medicine 'to cover the more physical reasons for indigestion'. Dr Newley persuaded Kevin Hewitt to try the flupenthixol and arranged to see him the following day before morning surgery.

12.50 On the morning of 10 August, Kevin Hewitt saw Dr Newley and reported feeling somewhat better. Dr Newley prescribed zolpidem to help him sleep and it was agreed that Kevin Hewitt should keep the appointment arranged for the following day.

12.51 As agreed, Nigel Parr tried to contact Sharon Hewitt, but the telephone number he had was no longer valid. He decided to try to contact Kevin Hewitt at his flat some days later. Dr Kaul attempted to discover the name of the police liaison officer. An entry on 10 August stated that the officer was Ian Coulton and that Dr Kaul would contact him the next day.

12.52 We were told that on the evening of 10 August, Kevin Hewitt went to the family home. His sister subsequently described his appearance as *'menacing'* and *'wild eyed'* but he refused to enter the house.

12.53 At 4am on 11 August, Kevin Hewitt went to The Leicester Royal Infirmary and was seen by the reception triage nurse. He complained of hyperactivity and being unable to sleep. He said that he had been a patient at Glenfield Hospital and Leicester General Hospital but could not remember when. The record suggests that he was asked to wait but did not do so. Kevin Hewitt told us that he left because he was fearful of being detained again.

12.54 The index offence occurred later that morning.

12.55 Dr Kaul attempted to interview Kevin Hewitt on 11 August 1999 but was unable to do so due to his mental state. He was interviewed by the police on 12 August 1999 with Nigel Parr acting as 'appropriate adult' but was thought disordered and incoherent. He appeared at Leicester Magistrates Court and was remanded to prison on 13 August where he was assessed on a number of occasions. He was thought to be psychotic and his behaviour was unpredictable and violent at times. Because of serious concerns about his mental health, he was transferred

to Rampton Hospital on 7 September under Sections 48/49 of the Mental Health Act 1983.

12.56 Subsequently Kevin Hewitt told clinical staff that on the day of the offence, which was the day of the eclipse, he believed the world would end and that he would be killed. He said that he had been influenced by media coverage of the eclipse. He said that he intended to kill others before they killed him. Dr Gunawardene, his RMO at Rampton, told us that Kevin Hewitt found it very difficult to discuss the offences with clinical staff and that he had expressed extreme guilt and remorse.

12.57 Medical opinion to the court was that at the time he committed the offences, he was suffering from a mental illness which impaired his responsibility for his actions. He pleaded not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility and to two counts of attempted murder. The pleas were accepted by the court without trial on 10 December 1999 and, after further reports were prepared, he was sentenced on 28 January 2000 to return to Rampton Hospital to be detained under Sections 37 and 41 of the Mental Health Act, the restriction order being without limit of time.

Comment

MENTAL HEALTH MANAGEMENT:

12.58 It is not in dispute that Kevin Hewitt was well at the time of discharge in December 1998 and that his mental state at the time of the offences in August 1999 was grossly disturbed. The chronology shows that this deterioration was not simply a sudden, catastrophic change. Whilst there were incidents of disturbed behaviour and the intermittent expression of paranoid delusional beliefs which were indicative of relapse from at least April 1999 onwards, Kevin Hewitt was asymptomatic when assessed by Dr Kaul and Dr Newley on four occasions in July and early August.

12.59 We recognise that the symptoms of deterioration were not known to the clinical team at the time and that he was, in any case, good at concealing them. We also recognise that Kevin Hewitt was reluctant to co-operate with follow-up, as had been the case in late 1997 after the expiry of his probation order. The evidence that Kevin Hewitt specifically identified those responsible for him as his persecutors, with delusionally elaborated beliefs regarding their purposes in supposedly following him around, compounded their difficulties in his follow-up. However, these difficulties were to some extent foreseeable:

Kevin Hewitt's lack of commitment to psychiatric follow-up and his lack of insight into his continuing severe mental illness were well known to the clinical team.

12.60 The medical supervision of the early part of this period went well. Kevin Hewitt had regular appointments with Dr Page, most of which he kept, and her recorded comments illustrate that they had a good therapeutic relationship. However, Kevin Hewitt began to default on his appointments in March at a time when both medical and social work input had been reduced. In our view, the handling of this period was crucial. Although the reduced level of medical input was broadly similar to that provided in 1996 - 97, the critical difference was the absence of CPN contact on a two weekly basis to administer depot medication and monitor mental state; it is notable that when this was withdrawn in August 1997, compulsory admission followed within four months, despite evidence that Kevin Hewitt was taking at least some oral antipsychotic medication prescribed by his GP.

12.61 In the circumstances Dr Kaul's failure to offer a further appointment following the cancellation of the April appointment was unacceptable. It was not until July, when there was incontrovertible evidence of the breakdown of follow-up arrangements, that a further appointment was offered. The result was that Kevin Hewitt was not medically reviewed for some four and a half months after his last appointment with Dr Page. The evidence suggests that it was during this interval that he had stopped collecting his prescription from the GP and that his mental state was relapsing.

12.62 By early July, it had become evident that the care plan was not sustainable. At this point, the issue of legal intervention was considered. The only realistic intervention would have been a formal assessment for admission under the Mental Health Act. Although there were grounds to suspect that Kevin Hewitt would relapse, the hard evidence available to the clinical team was largely of non-co-operation rather than symptoms of illness. We accept Dr Kaul's conclusion from the interview on 7 July, that Kevin Hewitt was not then detainable.

12.63 The next contact was in August when Kevin Hewitt met with Dr Newley on three occasions prior to the offence. We think that Dr Newley's care for Kevin Hewitt over this time was commendable; he made considerable efforts to see Kevin Hewitt at short notice and outside surgery hours and his attempts to reintroduce antipsychotic treatment were

appropriate. We agree with Dr Newley that there were no apparent grounds arising from those interviews to seek a Mental Health Act assessment.

12.64 For similar reasons, we do not criticise the clinical team for its failure to seek Kevin Hewitt's compulsory detention on the evidence which was available to it in August 1999. Although, without medication, his relapse was predictable, there was no actual evidence of relapse available to the clinical team other than his non-co-operation. Such contacts as he had, with Dr Kaul on 7 July, by telephone on 6 August, and with Dr Newley on 4, 9 and 10 August, did not indicate that compulsory admission was warranted. We note that the previous compulsory admission had been made on tangible evidence of a deteriorating mental state.

12.65 We do, however, believe that with more assertive clinical management before this point, Kevin Hewitt's eventual relapse could probably have been avoided. The failure to involve a CPN and to monitor his mental state and his compliance with medication between March and July represents a critical lapse in his management. At the same time we recognise, that even with better clinical management, without legislative powers for compulsory treatment in the community, there may have been little that could have been done to ensure compliance.

CARE COORDINATION AND MANAGEMENT:

12.66 As care co-ordinator Nigel Parr was the primary contact with Kevin Hewitt and from May 1999 he recognised that supervision was failing and alerted Dr Kaul. Without a CPN, Nigel Parr was, in effect, responsible not only for the social care arrangements but also for monitoring Kevin Hewitt's compliance with medication. We have indicated earlier that we believe that this responsibility was excessive.

12.67 Nigel Parr was relatively inexperienced in forensic work and Kevin Hewitt was the first forensic client for whom he had taken on care co-ordinator's duties. Nigel Parr said that, before Bob Hyams' absence, he had had monthly supervision from him and access at any time to discuss difficult cases. Nigel Parr felt that the level of supervision was satisfactory, although the records in the 'supervision file' were scant and did not reflect the depth of discussions nor was a record kept of informal discussions about the case.

12.68 Due to Bob Hyams' absence, Nigel Parr received no formal supervision between 21 April and 27 July 1999 when

Carol Williams took over this role. This was the time when Nigel Parr was becoming increasingly worried about the breakdown of the care package. At the same time, he was covering the post of his Leicester City colleague Tracy Cooke, who had been absent on long-term sick. He told us that colleagues used to call him 'the forensic service'. The pressure on this service was expressed in a letter written on behalf of the social work team to service manager Lennie Sahota on 2 June 1999: *'We have reached a point where most team members feel that they cannot adequately deal with their own case loads, let alone cover for absent colleagues and managers, or provide duty cover for the increasing numbers of unallocated cases. We urgently need full cover for those staff on long term sick and an overall increase in the team establishment'.*

12.69 At the same time the forensic social workers were under further pressure as a result of the disaggregation of the local forensic services from Arnold Lodge on 1 April 1999, a matter which we consider in more detail later.

12.70 We think that the absence of both Bob Hyams and Tracy Cooke and the fundamental reorganization of services in April 1999 placed an unduly heavy burden on a social worker who was relatively inexperienced in forensic work and left him with inadequate support. However, at the same time, we must express our concern that, when it had been available, supervision had failed to address issues of liaison with the GP and with Touchstone Housing Association.

GENERAL ISSUES

13. VICTIMS

13.1 We referred earlier to two occasions when Amanda Shelton, victim of Kevin Hewitt's earlier assault, sought support from mental health services. We stated that at that time the Trust did not have a policy in relation to supporting victims.

13.2 The Victim's Charter[5] established the rights of victims of crime and sets out the help that is available from the police and victim support units. The Marchant family told us how well they were supported by the police following Mr Marchant's death. Mrs Marchant and her daughter were accompanied to the inquiry by the family liaison officer, Detective Constable Tracy Colman, and it was clear to us that DC Colman's assistance and that of the police service generally had been a valued support to them.

13.3 Sadly, the same cannot be said of the health and social services following the incident. The Marchants told us that their first contact was the letter from the panel inviting them to attend the inquiry. Similarly the Geeson family's only contact had been in relation to the inquiry and there had been no expressions of sorrow or offers of assistance to them. We have seen correspondence from Michael Howlett of The Zito Trust to the Chief Executive of the Leicestershire & Rutland Healthcare NHS Trust dated 26 August 1999 in which Mr Howlett said that 'They [the Marchants] have received numerous cards and flowers expressing condolence and sympathy but not one word from anyone connected to Leicestershire's mental health services. We think this is a regrettable lapse but one that is very common in the NHS'. We could find no response to that letter but more importantly no action was taken to contact the victims, which reflects poorly on health and social services. We felt compelled to draw this to the attention of the Health Authority which led to a prompt, if belated, response from the Trust and Social Services.

13.4 Sharon Hewitt also told us that she felt 'abandoned' by mental health services following the offence. We recognise that there was a need for sensitivity to the police investigations at the time. Nevertheless there was no subsequent offer of support, to the family and it was left to them to seek explanations and help. The Hewitt family are, in our view, also victims of this offence and deserve

[5] The Victim's Charter,, Home Office 1996

support. We RECOMMEND that the Trust and Social Services develop a policy which ensures that support is available to all victims of serious incidents perpetrated by current or recent patients.

13.5 Both the Marchant and Geeson families were understandably concerned about Kevin Hewitt's future care and his possible eventual transfer and discharge back into the community. The principles expressed in the Victim's Charter in relation to information for victims of mentally disordered offenders have been enshrined in the Mental Health Act 1983 Code of Practice[6] at para 1.9 and we were able to refer them to those principles. We welcome the proposals in the recent White Paper on the Mental Health Act[7] to expand the provision of information to the victims of mentally disordered offenders who have committed serious violent or sexual offences.

[6] Mental Health Act , Code of Practice DOH, 1999
[7] Reform of the Mental Health Act: Part II, High Risk Patients, DOH, 2000, para 4.23-25

14. COMMUNICATION BETWEEN GENERAL PRACTITIONERS AND MENTAL HEALTH SPECIALIST SERVICES

14.1 We have commented critically elsewhere in this report on the liaison between Dr Newley and Dr Kaul's team in the months prior to Kevin Hewitt's admission in December 1997. We have also commented on the need to expedite the conveyance of discharge summaries to GPs.

14.2 Our overall view is that, despite Dr Newley's responsibility for prescribing medication after Kevin Hewitt's discharge, Dr Kaul's team did not see Dr Newley's role as central to Kevin Hewitt's care; further, that they did not use CPA as a means of facilitating liaison with Dr Newley. Dr Newley told us that he was sometimes copied correspondence regarding arrangements for CPA meetings, but this was not, to his mind, an invitation to attend. He was never personally invited to attend, and told us that the usual timing and the short-notice provided for such meetings would preclude his attendance in any case. He had received no training in CPA and, as pointed out previously, had no CPN liaison nurse in the practice. This situation was not unusual. We are aware from other inquiries of the practical difficulties of involving GPs in CPA meetings.

14.3 In the circumstances, and in view of Kevin Hewitt's history of non-compliance and the critical link between non-compliance and relapse, we think it was inappropriate to delegate the prescribing of medication to Dr Newley following Kevin Hewitt's discharge. This practice led to the situation in early to mid 1999 in which there was no mechanism to alert either Dr Kaul or Dr Newley to Kevin Hewitt's failure to collect his prescriptions.

14.4 We were told that, at the relevant time, the Trust did not have a policy on responsibility for out-patient prescribing, but that it was common practice that in-patients would be given two-weeks supply of medication on discharge and that their further prescriptions would normally be provided by their general practitioner. We were also told of significant variations in practice between different clinicians some of whom only rarely asked a patient's GP to take over prescribing. We contacted both the Royal College of GPs and the Royal College of Psychiatrists; neither knew of any guidance on this matter, which we find surprising and regrettable. We welcome the Trust's recent draft guidance on FP10 prescribing and endorse the advice that, where compliance is a problem in a patient with serious mental illness, FP10 prescribing by psychiatrists should be

the preferred practice. We RECOMMEND that this guidance is adopted by the Trust.

15. INTERAGENCY WORKING AND THE CARE PROGRAMME APPROACH

15.1 CPA is regarded as the cornerstone of mental health practice. It was launched by the Government in 1991. As in other Trusts, implementation of CPA in Leicestershire was slow. It is acknowledged that in general CPA formalized what was generally accepted to be good practice and that, even without an explicit policy, adherence to its basic principles could be expected. The four main elements of the CPA are:

- systematic arrangements for assessing the health and social needs of people accepted by the specialist psychiatric services;
- the formulation of a care plan which addresses the identified health and social care needs;
- the appointment of a key worker to keep in close touch with the patient and monitor care;
- regular review and if need be, agreed changes to the care plan

15.2 The Government issued further guidance in 1995, "Building Bridges," which emphasized the principles of inter-agency working in the commissioning and provision of services. The guidance stressed the need for consultation with service users and carers.

15.3 CPA was formally launched in Leicestershire in 1995 and some details of this policy are given in the Stemp and Sears-Prince Inquiries. The policy was revised in December 1997 and December 1998.

15.4 The 1997 revised policy applied to Kevin Hewitt's care during his last admission and until April 1999. Some relevant provisions are:

- a distinction between high dependency (level 3) and medium dependency (level 2), the latter requiring intervention from a smaller number of providers who will usually be in the same multidisciplinary team;

- Section 7 gives guidance on patients who decline care packages. Para 7.4 states that if the patient rejects the programme 'the team should offer where appropriate to keep in contact on a regular basis, in consultation with the patient's GP'. Para 7.5 states further that patients who decline a Care Programme

should be considered for inclusion on the Supervision Register.

- Section 10 addresses the choice and allocation of the co-ordinator and sets out the matters that should be taken into account. The guidance in this Section states that the choice of co-ordinator might take into account the wishes of the patient as well as the balance of health and social care needs.

- While the policy refers to the need to consider the perspectives of clients, it does not suggest that the client should attend each review. Carers are listed among the possible 'disciplines' that might be invited to a review.

15.5 A revised policy was issued in December 1998 for implementation on 1 April 1999 and it effectively integrated the systems of Care Programme Approach and Care Management. The Sections of the policy described above were not materially changed except that, for those who reject a Care Programme, a range of alternative interventions should include a consideration of supervised discharge, assertive monitoring and referral to the PPP as well as the supervision register.

15.6 The first formal reference to CPA in Kevin Hewitt's case was in 1996 and CPA review records were completed at varying intervals from that time onwards. According to CPA records he was considered to be a medium dependency (level 2) patient although, on a list of district forensic patients which was prepared in about April 1999, he was recorded as a high dependency (level 3) patient. This change in dependency level was not reflected in the CPA review forms which, in any case, were often only partially completed. Some review forms recorded dates for subsequent reviews but many did not; in any case dates for prearranged reviews were often changed.

15.7 Through the chronology of his care, but particularly from December 1997 onwards, we have pointed to fundamental failures in the operation of CPA and, consequently, failures of good practice:

User and carer involvement

15.8 We consider that, after his admission in December 1997, insufficient attempts were made to involve Kevin Hewitt in discussions about his care package. We recognize that, from his time at Runcorn House in 1995 onwards he had

avoided attendance at case reviews. It appeared that, on this basis, efforts to involve him in discussions about his care had ceased: he was not invited to review or pre-discharge meetings, nor apparently was he forewarned of them. Similarly, we found little evidence of attempts to involve his mother or sisters in these discussions although Nigel Parr told us that informal discussions were held with them during home visits. We did not find a single written invitation to them on the file nor any notification following review meetings. There is no note of any consultation with Kevin Hewitt or his family to be found in any of the CPA records, nor is there any note that either Kevin Hewitt or his family were advised of the outcome of any reviews. Nigel Parr told us that Mrs Hewitt was offered but declined a carer's assessment, although we found no reference to this in any of the records.

15.9 We do not think that the practice in Dr Kaul's team was markedly different from that of other local teams at the time. We note in particular the second independent audit of CPA which was commissioned by the Leicestershire Health Authority in 1999 and which found little evidence of user and carer participation within CPA*: 'Users and carers frequently do not attend CPA Planning or Review Meetings, rarely sign and agree their Care Plan or receive a copy....'*

15.10 Even if there had been a commitment to the attendance of users and carers, the local forensic service would have had difficulties achieving it after its disaggregation from Arnold Lodge in April 1999. The action plan following the Trust's internal inquiry in this case noted:

'Whilst the service supports the principle of the involvement of patients and their carers in the CPA meetings, this is currently not possible due to constraints on office accommodation. However if the patient wishes to attend, then attempts are made to arrange alternative venues. The views of the patient and their carers are sought prior to the review.....'

15.11 Para 2.4.5 of Building Bridges states *'A fundamental principle of mental health care is that users of services should be involved as far as possible in the care process'.* We do not think that this principle is properly reflected in the Trust's CPA policy nor in practice in this case. We RECOMMEND that the Trust's CPA policy is revised to reflect the priority of involving users and carers in CPA; that the CPA review forms are revised to reflect this and that practice is audited against this standard.

Liaison with other agencies

15.12 We think that there was a fundamental failure to recognise CPA as an opportunity for liaising with agencies other than health and social services who were involved in Kevin Hewitt's care. As a consequence, the vital roles played by the Touchstone Housing Association and by Dr Newley as prescriber were not recognized.

Housing

15.13 We have discussed the failings of the Housing Department in relation to maintenance of the Beaumont Leys tenancy and the minimal information provided by Nigel Parr to the Housing Department and to Touchstone in relation to the application for rehousing. This gave no indication of any risk. We were told that at the relevant time (1998-99) there was very little liaison between the mental health services and Leicester City Council Housing Department over the rehousing of patients on discharge from hospital, although we heard of 'pockets' of good practice.

15.14 The circumstances of this case reflect the poor state of communication between these services at that time. Touchstone received no more information from the mental health services about Kevin Hewitt's circumstances than did the Housing Department. Even after the tenancy on East Park Rd was agreed, Touchstone was not invited to review meetings nor informed subsequently about Kevin Hewitt's care. Mara Forana of Touchstone told us that Kevin Hewitt had volunteered some information about the 1994 offence when he was interviewed prior to the offer of the East Park Rd tenancy. Nevertheless she told us that Kevin Hewitt's case did not raise serious concerns and this is unsurprising given the minimal information conveyed by Nigel Parr in his referral letter and subsequently. Ms Forana said that, in the circumstances, she felt that she had no reason to know that Kevin Hewitt's concerns were suggestive of a relapsing mental state nor grounds for revealing Kevin Hewitt's request for transfer to Nigel Parr without his consent. Ms Forana referred to Touchstone's confidentiality policy which only allows staff to initiate contact with, among others, a social services department or health authority, *'where there is evidence to suggest the welfare of an individual or individuals is being abused or is at risk'*. In view of this policy and the minimal information she had been given, we cannot criticize her actions although we believe that the policy did not reflect current views on the balance between rights of privacy and disclosure in the public interest. Further, in our view, the

failure to inform Nigel Parr of Kevin Hewitt's deteriorating mental state in April 1999 was highly significant in the light of subsequent events.

15.15 We heard evidence to suggest that liaison between housing and mental health services is now improved. Pat Hobbs told us that it is now more common for representatives of the Department's Community Care Team which specializes in housing vulnerable clients, to be invited to case conferences and reviews. Moreover, since autumn 1999 a confidentiality 'template' has been agreed by the housing associations in relation to the exchange of information about the rehousing of high risk offenders.

15.16 Nevertheless, we believe that the mechanism for achieving proper communication is dependent on proper implementation of the CPA process. We RECOMMEND that the operation of CPA within the Trust is reviewed to ensure that it provides a proper means for achieving interagency liaison with all partnership agencies.

Risk assessment and management:

15.17 The assessment of risk is a key component of CPA. Para 7.9 of Leicestershire's 1998 CPA policy includes the following: 'Care programmes should include details of relapse indicators and the steps taken should these arise.' In this case we saw no systematic multidisciplinary method of assessing and reassessing risk in Kevin Hewitt's case although various schedules were completed by different professionals in the course of his care [eg. Honos scale, comprehensive risk assessment by Robert Nisbet]. The evidence from clinical records suggests that those involved most closely in Kevin Hewitt's care (Dr Kaul, Carey Maisey, and Nigel Parr) were conscious at material times of the risk that he posed and were aware of the relapse indicators such as non-compliance with medication, fears of poisoning, attempts to seek medical records etc. However there was no agreed means for recording those indicators and for reassessing them and, consequently, no mechanism for informing those outside the multidisciplinary team (Dr Newley and Mara Forana representing the key agencies). Further, we could find no evidence of an agreed risk management plan following his discharge from hospital in December 1998 although various strategies such as supervised discharge had been considered. The supervision register was not discussed but its limitations were widely recognised and it had fallen into disuse. Critically, there was no agreed strategy for dealing with problems of non-compliance with the care plan

which were likely to arise. We RECOMMEND that a clear statement of relapse indicators and associated management responses should be made in the care programme, that it should be regularly reviewed and the statement should be circulated to all involved agencies, the user and carers at each review.

A note on the Leicestershire Public Protection Panel:

15.18 We referred earlier to the work of this panel which was established to facilitate a multi-agency approach to the management of people who present a serious risk of harm to others. The panel, which consists of senior representatives from probation, police, Social Services, housing and health, meets once a month to consider referrals and to review cases. It has a dedicated manager from the police service and a formal commitment of resources by all the partnership agencies. We were told that about 30% of the referrals have a significant mental health dimension, although only 7 referrals have been made by the health services since it began. Between one quarter and one third of those referred to the panel are subsequently registered; as we have suggested earlier, it is possible that Kevin Hewitt would not have been accepted for registration.

15.19 Had Kevin Hewitt been registered on the Public Protection Register, his management by the different agencies would have been co-ordinated; for example, his attendance at the police station on 6 August would have been reported to Nigel Parr and might have prompted a formal Mental Health Act assessment; the risks would also have been made known to Touchstone Housing Association. However on the basis of the information known to the clinical team at the time, we do not think that there should be any criticism of the failure to make an earlier referral.

15.20 We were impressed with the Leicestershire PPP as a mechanism for achieving multi-agency co-operation in high risk cases. Its procedures are clear and well formulated and it retains the flexibility to act with speed where urgent action is required. The resourcing by all agencies and the appointment of a dedicated manager are essential components of its efficacy. The very small number of referrals from psychiatric services, in comparison to the recorded numbers of referrals from other agencies with known mental health needs suggests that the agency should have a higher profile within the health service.

16. MANAGEMENT REORGANISATION 1 APRIL 1999

16.1 On 31 March 1999 the existing mental health provider, Leicestershire Mental Health Service NHS Trust, ceased to operate and was replaced by a new organisation, Leicestershire & Rutland Healthcare NHS Trust. The reasons for the re-organisation are beyond the scope of this Inquiry; however, as part of the process there were major changes in the management and provision of forensic services for Leicester.

16.2 The forensic services at Arnold Lodge had been the subject of a major inquiry in 1996/97 which resulted in far-reaching changes to the medium secure services. The inquiry acknowledged that Arnold Lodge provided two complementary services: the East Midlands Centre for Forensic Mental Health (EMCFMH) which provided in-patient medium secure services to ten health districts across the Trent Region and the Leicestershire District Forensic Service (DFS) which primarily provided aftercare and rehabilitation for Leicestershire's mentally disordered offenders. The inquiry focused on the EMCFMH and did not address the structural relationship between the two services. However we were told that the two services were so 'entangled' that Leicestershire patients who did not require medium secure services were sometimes admitted to Arnold Lodge. As a consequence, the Leicestershire use of medium secure beds was excessive and we were told that this created inequity of access for patients from elsewhere in the region.

16.3 The organizational changes on 1 April 1999 provided an opportunity to disentangle these two services. From that date, the in-patient service at Arnold Lodge (EMCFMH) became part of another NHS trust - Central Nottinghamshire Healthcare - whilst the district forensic service became part of the new Leicestershire & Rutland Healthcare NHS Trust. It was suggested to us by a number of witnesses that this "disaggregation" of local and regional forensic provision on 1 April 1999 left the local forensic services under-resourced and that, as a patient of this service, Kevin Hewitt's care was compromised at a critical time. We considered these changes and their likely effect on his care.

16.4 We heard little disagreement with the overall strategy but considerable concern about the manner and speed with which it was accomplished. Planning began in about mid 1998 and a feasibility report was prepared. It was not until December 1998 - four months before the new services

would be operational - that a project group was established to manage the disaggregation of the DFS. Minutes of the Division of Psychiatry and Medical Staff meetings at Arnold Lodge from January 1999 onwards record concern about the viability of the local forensic service from the proposed start date. We were told that there was no further work, with a clinical focus, which clarified the question of the adequacy of the available resources for the clinical task.

16.5 On 1 April 1999 the resources for the local forensic service fell far short of the Trust's service specification. A position statement issued on 1 April 1999 stated: *'It is recognised that a stand alone DFS will require additional resources if it is to provide a safe and appropriate service'.....It is recognised that the resources available to the DFS are inappropriate if an enhanced and a safe local forensic service is to be provided for the people of Leicestershire and Rutland'.*

16.6 There was a considerable level of uncertainty in this service. Although the service specification was for two consultant-led teams, we understand that until 31 March there was no confirmed agreement between Dr Kaul and the Trust of his secondment to lead the single consultant team which assumed responsibility for the local forensic services the following day. A bid for a second team was submitted against Modernisation Fund monies but was unsuccessful. Although Dr Kaul relinquished his inpatient sessions at Arnold Lodge and his contract became full time with the local forensic service, there was no transfer of junior medical posts into the local forensic service. We were told that the psychologists were unhappy about their proposed input to the local service and the psychologist who was due to transfer to the service found employment elsewhere before 1 April. In the absence of funding for the second consultant-led team, it was decided that the monies for the psychology post would be used to fund a consultant psychiatrist on a locum basis. It was agreed that Dr Enda Hayden, who was working in general adult psychiatry, would be transferred to the local forensic service on 1 July 1999. However, because of pressures in adult psychiatry services, the transfer was not effected until October that year.

16.7 In the meantime, the handover of local forensic patients from other consultants to Dr Kaul was completed by June 1999 while Dr Kaul's medium secure patients were transferred to consultants remaining at EMCFMH. We heard differing accounts of the number of patients who remained with the local forensic services but the balance of

evidence was that the distribution was inequitable and left Dr Kaul with a heavy caseload.

16.8 The local forensic service, as constituted on 1 April, had no dedicated specialist in-patient beds and was reliant on beds in open wards in the Trust, as with Kevin Hewitt's admission in December 1997. This was clearly unsatisfactory and a bid was submitted against Modernisation Fund money. In the meantime, a contract was agreed for two low secure beds at the Francis Willis Unit in Lincoln. The initial bid to the Modernisation fund for the low secure facility was unsuccessful. This process was taking place at the time that Dr Kaul failed to send a further outpatient appointment to Kevin Hewitt after he cancelled the appointment for 14 April.

16.9 Although the shortfall in resources for this service was known to the Health Authority, the Authority accepted that the service could become operational on 1 April. We consider that the Health Authority should have been more cautious in the circumstances, and should have sought a more critical appraisal of the clinical demand and the service capacity. This was in the context of considerable public concern following a series of well-publicised incidents. We have seen copies of correspondence between The Zito Trust and Leicestershire & Rutland Healthcare NHS Trust shortly before the 11 August 1999 attesting to such concern. In this context, the Regional NHS Executive was represented on the working party which set out the strategy for the development of secure services across the Trent region. We have seen correspondence from the Regional Office in July 1999 suggesting that the Health Authority might review the adequacy of forensic services in the light of the recent changes in service arrangements. This letter was not answered until after 11 August.

16.10 Further it appeared that the future of social work input to the local and medium secure services was, on 1 April, unresolved. Initially there was no representative from Social Services on the project team. The first formal communication about the proposed disaggregation arose, as an apparent afterthought, in late January 1999 and representatives from the two SSDs were subsequently invited to join the project team. No formal discussions were held between City SSD, which had lead responsibility for patients at Arnold Lodge, and either the Leicestershire & Rutland Healthcare NHS Trust or Central Nottinghamshire Healthcare until after the disaggregation had occurred. Due to the delay in notifying the Social Services of the proposals, the matter was not raised at a relevant Leicester

City Council Social Services subcommittee until mid-March of 1999 - just prior to the actual disaggregation of the forensic services and correspondence available to us suggested that there had been no other formal consultation with Social Services about social work input prior to 1 April 1999. A decision was taken by the City SSD to provide, pro tem, an allocation of three social workers to cover both Arnold Lodge and the local forensic service while a joint review was carried out with other SSDs. On 8 April 1999 Nigel Parr wrote to Sandra Taylor, Director of Social Services at the time, about the disaggregation in the following terms:*'I am concerned that the needs of those clients who require a high level of supporting and monitoring in the community will be compromised by a service which has ever greater demands placed on it. This client group in particular needs a great deal of input especially when in the community and if not managed properly will pose a great deal of risk to themselves and to others'.*

16.11 Despite undertakings of continued support for the local forensic service, by the summer of 1999 relations with EMCFMH had become strained, so that, for instance, there was acrimonious correspondence about the continued use of office facilities at Arnold Lodge by the local service. Overall, we believe that the local forensic service was not well supported by EMCFMH and that Dr Kaul lacked the support of his former colleagues in leading this service. Witnesses told us of low morale amongst staff within the local forensic service.

16.12 Several months after the offence, a quality monitoring visit on 16 December 1999 stated: 'There is currently only one team which means that there is a strain on the workload and a difficulty in assertively following up patients.'

16.13 We do not question the strategy of disaggregation, only the extent to which it impacted on the care available to Kevin Hewitt. In our view, the loss of support from the larger service, the departure of senior clinical staff, recruitment difficulties, the acknowledged failure to achieve adequate initial funding and the evident tensions between medium secure and local forensic services after April 1999 are likely to have adversely affected the care that was available to patients of the local forensic service, including Kevin Hewitt.

16.14 Having taken evidence in the summer of 2000 on these matters we were advised that the resourcing of the local forensic services was a continuing problem. We felt

compelled to express these concerns in a letter to the Health Authority, and subsequently met with representatives of senior management of the Trust who gave us details of the developments which have been made to address these concerns.

17. ETHNICITY

17.1 **We have commented earlier on the role of Raju Chauhan. While we expressed scepticism about the underlying assumptions of her role, she was able to involve Kevin Hewitt, albeit for a brief time, in an African-Caribbean community group and made some attempts to take his ethnic needs into account in providing his care. There is evidence that Kevin Hewitt experienced racial abuse from other residents during this period and that the staff at Runcorn House were supportive of him and dealt firmly with those responsible for the abuse.**

17.2 **By contrast, in Kevin Hewitt's later admission during 1997/98 it does not appear that his cultural and ethnic identity was seen as an important factor, either in delivering inpatient care or arranging aftercare. During this admission reference was made to the difficulties in communicating with Kevin Hewitt's mother due to her strong West Indian accent. The records do not indicate that any attempt was made to address these difficulties which may, in part, explain the family's lack of involvement in the CPA process.**

17.3 **During the same admission there were documented references to racial abuse towards Kevin Hewitt by other patients. Again, there was no evidence of a strategy for addressing this with Kevin Hewitt or with the other patients. Dr Ley's reference in his discharge summary to Kevin Hewitt as a 'coloured man' suggests a lack of sensitivity to matters of race and culture. We note the conclusions of the Woodley report:**

'Racial harassment remains a serious problem and includes not only physical attacks, but verbal and more covert or surreptitious gestures such as exclusion. If this is not dealt with effectively and fairly, an environment conducive to recovery and good health can never be achieved for black and minority ethnic people'[8]

17.4 **Mara Forana appears to have been the only person involved in Kevin Hewitt's aftercare from the similar ethnic background. She told us that she thought that Kevin Hewitt had felt able to discuss with her his feelings of discrimination. It is notable that during the spring of 1999 Kevin Hewitt told her that he was being followed and persecuted by the police and by the mental health services.**

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[8] Woodley team Report (1995) East London & The City Health Authority and Newham Council p137

We do not have data on the ethnic mix of care staff but our impression from the witnesses we spoke to was that significant ethnic minority groups may be under-represented in the staff complement. We RECOMMEND that the Trust, Health Authority and SSD review the ethnic make-up of their work force in order to ensure that they are able to respond appropriately to the needs of ethnic minority patients and that practice is compliant with the Health Service guidance on this matter[9].

17.5 **Sharon Hewitt told us that she felt that her brother had suffered as a result of 'institutional racism'. There is evidence to support the view that black male psychiatric patients are often perceived as being more threatening and more dangerous than their white counterparts and that this perception can materially affect the type and quality of interventions offered. While it goes beyond the scope of this inquiry to examine this issue in detail, we draw attention to the manner in which Kevin Hewitt's compulsory admission to hospital was executed in December 1997. We are also concerned that he does not appear to have been assessed for or offered non-pharmacological interventions or therapies, despite the presence of both psychologists and occupational therapists within the multi-disciplinary team. We RECOMMEND that care planning, both for inpatients and outpatients, should routinely consider issues of race and culture.**

[9] Health Service Circular 1999/060, 12 March 1999

18. INTERNAL INQUIRIES

18.1 Two separate internal inquiries were carried out following the index offence, one by the Leicestershire and Rutland Healthcare NHS Trust and the other by Leicester City Council Social Services Department. Both were completed in November 1999. It had been agreed that the inquiry reports would be jointly reviewed, but for reasons that were not clear to us, this did not happen.

18.2 The terms of reference of the internal Trust inquiry overlapped to a significant degree with the terms of reference of the independent inquiry. They included for example *'the quality and scope of his health, social care and risk assessments', 'the extent to which his care and treatment reflected the relevant statutory obligations', 'the collaboration and communication between the agencies who were or could have been involved..'* etc. This overlap was acknowledged, and in view of the likelihood of a subsequent independent inquiry, the authors *'concentrated on those issues on which early action may be required'*. This seemed to us to be a sensible approach.

18.3 However, we do not think that the focus on issues requiring early action was maintained. The three recommendations made by the internal inquiry largely concerned record-keeping practices within the forensic services. While we accept that record-keeping is vitally important, in our view the record-keeping practices in this case were more a hindrance to the conduct of the inquiry than a matter which concerned the care and safety of other patients and members of the public. In our view, matters concerning risk and clinical practice are those of immediate concern which should have been addressed.

18.4 There was no protocol for the Social Services inquiry and, in the circumstances, the Department of Health guidance on 'Working Together under the Children Act' was adopted. We have not established the extent to which this guidance was followed by Leicester City Social Services Department in this instance. However we have serious concerns about the appropriateness of an internal inquiry conducted solely by a Social Services manager.

18.5 Moreover, in our view, there is no advantage and may be significant disadvantage in conducting separate Health and Social Services inquiries. The Trust inquiry did not have access to the Social Services notes and was unable to consider the critical role played by Nigel Parr as care co-

ordinator in this case. The Social Services manager did not review the medical and nursing records and was unable to consider the work of Dr Kaul, Dr Newley and Carey Maisey in relation to Nigel Parr's input. In an era of multiagency work, it is our view all serious untoward incident inquiries should normally be conducted on a multiagency basis. We RECOMMEND that internal inquiries following serious untoward incidents should be multiagency and should address matters of practice of direct and immediate concern to the care and safety of patients, staff and the public.

19. SUMMARY OF RECOMMENDATIONS

We RECOMMEND that procedures for supervision are reviewed to ensure that they comply with UKCC guidance and that all decisions about input and termination of a service are agreed by the relevant service manager (para 11.62).

We support the recommendation made by the Leicester City Social Services Department in its internal inquiry in this case that all supervision should be recorded on the case file; such records should accurately reflect any concerns raised. Such practice should be in line with guidance provided by the Department of Health[10](para 11.64).

We RECOMMEND that early notification to GPs should be a quality standard in the Trust's CPA policy and that practice should be audited against it. We are aware of the recommendation made by the internal inquiry into the Paul Hundleby case that discharge letters should be faxed immediately to GPs and support the use of this and other information technology eg email, as a means of ensuring timely communication between agencies (para 12.3).

We RECOMMEND that the Trust and Social Services develop a policy which ensures that support is available to all victims of serious incidents perpetrated by current or recent patients (para 13.4).

We welcome the Trust's recent draft guidance on FP10 prescribing and endorse the advice that, where compliance is a problem in a patient with serious mental illness, FP10 prescribing by psychiatrists should be the preferred practice. We RECOMMEND that this guidance is adopted by the Trust (para 14.4).

We RECOMMEND that the Trust's CPA policy is revised to reflect the priority of involving users and carers in CPA; that the CPA review forms are revised to reflect this and that practice is audited against this standard (para 15.11).

We RECOMMEND that the operation of CPA within the Trust is reviewed to ensure that it provides a proper means for achieving interagency liaison with all partnership agencies (para 15.16).

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[10] 'Recording with care'. An inspection of case recording in Social Services Departments, DOH, January 1999

We RECOMMEND that a clear statement of relapse indicators and associated management responses should be made in the care programme, that it should be regularly reviewed and the statement should be circulated to all involved agencies, the user and carers at each review (para 15.17).

We RECOMMEND that the Trust, Health Authority and Social Services Department review the ethnic make-up of their work force in order to ensure that they are able to respond appropriately to the needs of ethnic minority patients and that practice is compliant with the Health Service guidance on this matter[11](para 17.4).

We RECOMMEND that care planning, both for inpatients and outpatients, should routinely consider issues of race and culture (para 17.5).

We RECOMMEND that internal inquiries following serious untoward incidents should be multiagency and should address matters of practice of direct and immediate concern to the care and safety of patients, staff and the public (para 18.5).

[11] Health Service Circular 1999/060, 12 March 1999

20. OTHER MATTERS

20.1 In the course of this inquiry we have referred to a number of matters upon which further action is needed but which are beyond the remit of the Trust and Social Services Department and other agencies involved in this case. We list them here.

20.2 We referred to the lack of available information on Section 29 displacements and lack of guidance in this area, which we find surprising in view of the distressing consequences of displacement for those involved. We note that the proposed revision of the Mental Health Act will effectively do away with the existing role of the 'nearest relative'. We think it likely however that similarly complex issues may arise under the proposed system which will require the social worker to consult with the family and significant others before nominating a person to assume a broadly similar role to that held by the 'nearest relative'. We believe that guidance is needed on how consultation with families should proceed where there are differences of opinion between the family or carer and the professional care team. In particular, such guidance should address the issue of how families and carers should continue to be included and consulted where a decision has been taken to nominate a person other than a carer or family member.

20.3 We referred to the lack of guidance to GPs about their role in relation to CPA, particularly in relation to prescribing. We believe that this matter should be referred to the Royal College of General Practitioners and the Royal College of Psychiatrists so that national guidance may be provided.

20.4 We referred to the problem for inquiry panels in obtaining access to information without the patient's agreement to disclosure. We are aware that similar problems have arisen in other inquiries and we believe that the Department of Health needs to issue unambiguous guidance on this matter.

APPENDIX A

LEICESTERSHIRE HEALTH AUTHORITY

The Independent Inquiry pursuant to HSG (94) 27 into the Care and Treatment of Kevin A Hewitt

Remit for Inquiry

1. To examine all the circumstances surrounding the care and treatment of Kevin Alderton Hewitt by the mental health services, including primary care, up until the manslaughter of Mr William Marchant and attempted murders of Mr Brian Geeson and his son, Daniel, on 11 August 1999 . In particular:

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

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

        i. his assessed health and social care needs and
        ii. his assessed risk of potential harm to himself and others
        iii. the role of informal carers and in particular Mr Hewitt's mother

        Taking account of any previous psychiatric history, including drug and alcohol abuse and the number and nature of any previous court convictions,

    c. the extent to which Mr Hewitt's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC(90)23, LASSL(90)11, Supervision Registers HSG(94)5 and Discharge Guidance HSG(94)27 and local operational policies,

    d. the extent to which his prescribed care plans were:

        i. effectively drawn up

        ii. delivered and

        iii. complied with by Mr Hewitt

2. To consider the appropriateness of the professional and in-service training of those involved in the care of Mr Hewitt, or in the provision of services to him.

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

   a. the agencies involved in the care of Mr Hewitt or in the provision of services to him and

   b. the statutory agencies and Mr Hewitt's family, taking particular cognisance of the need for sensitivity in regard to any dealings with his family and/or the victim Mr W Marchant and his family and Mr B Geeson and his family.

4. If matters are identified during the inquiry related to agencies other than health and social services, they are to be regarded as outside the scope of this inquiry, and referred to the Director, Primary Care & Corporate Services (DPCCS).

5. To refer all matters related to children at risk, suspected or established child abuse, or child protection, regarded as outside the scope of this inquiry, to the chairman of the appropriate Area Child Protection Committee (ACPC)

6. To consider practice in regard to available evidence and current expectations, and identify sources of support and/or evidence of good practice which will assist service and/or professional development.

7. To prepare a report with recommendations to Leicestershire Health Authority by November 2000. If during the course of the inquiry it becomes clear that this timescale cannot be met that the Panel Chairman informs the DPCCS.

8. To provide a report on progress within 3 months of the establishment of the Inquiry.

9. To consider such other matters as the public interest may require.

PROCEDURE ADOPTED BY INDEPENDENT INQUIRY

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

   a. of the terms of reference and the procedure adopted by the Inquiry; and
   b. of the areas and matters to be covered with them; and
   c. requesting them to provide written statements to form the basis of their evidence to the Inquiry; and
   d. that when they give oral evidence they may raise any matter they wish, and which they feel might be relevant to the Inquiry; and

e. that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness; and
f. that it is the witness who will be asked questions and who will be expected to answer; and
g. that their evidence will be recorded and a copy sent to them afterwards for them to sign.

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

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

4. Any other interested parties who feel that they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

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

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

7. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as is disclosed within the body of the Inquiry's final report.

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

APPENDIX B

Documents reviewed by the Panel

A note: we had access to all the information we requested apart from Kevin Hewitt's current clinical records at Rampton Hospital which he refused to disclose to us, although he agreed to meet us and gave us his account of his circumstances. We do not think that the information in those records is likely to change our conclusions to any significant degree. While we understand Rampton Hospital's decision not to disclose his records without his consent, we must state our concern that such refusal potentially undermines the ability of an inquiry to conduct a proper investigation.

Records relating to KEVIN HEWITT:
Hospital records, 1986 - 1999
General Practice records to 1999
Medical records from HMP Woodhill, 1999
Medical records, A&E Dept, Leicester Royal Infirmary 1994 - 1999
Leicestershire Social Services records 1994 - 1999
Leicestershire Probation Service records, 1994 - 1996
Crown Prosecution Service records, 1994; 1997; 1999
Leicester Housing Department
Touchstone Housing Association
Previous Leicestershire Homicide Inquiry reports
Richard Burton – Oct 1996
James Stemp – Nov 1997
Sanjay Patel – March 1998
Bradley Sears-Prince – March 1999
Paul Hundleby – draft report, late 2000
Internal inquiry Kevin Hewitt – L&R Healthcare NHS Trust
Internal inquiry Kevin Hewitt – Leicester City SSD
Miscellaneous
Full Independent Review of Arnold Lodge, March 1997
District Forensic Service Review, June 1998
A strategic approach to secure psychiatric services in the Trent Region - a report of the Task Group on secure psychiatric services, June 1998
Trent Region: strategic plan for high and medium secure psychiatric services, 2000
Annual report of Director of Public Health, Mental health in Leicestershire, 2000.
Leicester, Leicestershire and Rutland, National Service Framework local development plan
DFS Transfer – position statement 1 April 1999
Notes of District Forensic Service transfer project meetings

Revised service specification, DFS
Leicestershire Mental Health Service NHS Trust: list of serious incidents 1997 – 2000
Trust procedure for Serious Untoward Incidents
Audit of CPA, Jan 1997
Second independent audit of CPA, Aug 1999
CPA – guidelines, Dec 1997
CPA – guidelines, Dec 1998
Protocol of joint working between forensic mental health and probation services
Protocol for social work provision to Forensic MH services
Interagency agreement on client confidentiality and interagency transfer of personal information
Risk assessment and risk management documentation, Forensic Service 2000
Guidance for risk assessment
Belvoir ICU ward operational policy, Oct 1999
Beaumont Ward operational policy
Selected minutes, Division of Psychiatry
Selected minutes, medical staff committee, Arnold Lodge
Housing department, confidentiality and other policies
Touchstone Housing Association, confidentiality policies
CS spray: increasing public safety? – report by the Police Complaints Authority, March 2000
The Victim's Charter and extracts from Victim Support newsletter Dec 1999
Public Protection Panel documentation
FP10 prescribing guidelines 27/7/00

APPENDIX C

WITNESSES AND INTERESTED PARTIES

Witness/party*	Relevant position+
John Barnes	Primary nurse, Beaumont ward 1998
John Boyington*	Chief Executive, Leicestershire Mental Health Service NHS Trust, April 1997 – April 1999; Chief Executive, Leicestershire and Rutland Healthcare NHS Trust, April 1999 - February 2000
Dr Deborah Chaloner*	Chair, Division of Psychiatry, Jan 1997 – August 2000
Janet Davies*	Project Manager, Trusts merger, 1997
Paul Dempsey*	Senior nurse and ward manager, Belvoir ICU
Det Sgt Chris Dixon*	Police investigation team, index offence
J Dobbie	Duty triage nurse, 11/8/99, A&E Dept, The Leicester Royal Infirmary
Dr Sue Eason*	Medical Director, Leicestershire Mental Health Service NHS Trust, April 1993 – April 1999
Mara Forana*	Housing Officer, Touchstone Housing Association
Kevin Hewitt*	
Mrs J Hewitt*	Kevin Hewitt's mother
Sharon Hewitt*	Kevin Hewitt's sister
Erma Hewitt*	Kevin Hewitt's sister
Pat Hobbs*	Assistant Director of Housing, Leicester City Council
Dr Adarsh Kaul*	Consultant psychiatrist and Kevin Hewitt's RMO May 1994 - August 1999
Jacqueline Keogh*	Clinical manager, A&E Dept, The Leicester Royal Infirmary
Rose Kingham*	Probation Officer
Dr Emmet Larkin*	Consultant forensic psychiatrist and Service Director of EMCFMH
Dr Roderick Ley	SHO to Dr Kaul
Mrs I Marchant*	Wilfred Marchant's wife
Jeanette Marchant*	Wilfred Marchant's daughter
Carey Maisey*	Community psychiatric nurse

Cathy McCargow*	Chief Nursing Advisor Leicestershire Health Authority, lead responsibility for mental health strategy to Nov 1999
Jim McDonald*	Operational Director, EMCFMH
John McFadyen*	Commissioning and Development Manager for mental health, Leicestershire Health Authority
Dr Christopher Meakin*	Consultant psychiatrist, Belvoir ward
Det Ch Insp Craig Moore*	Panel member PPP
Sue Murphy	Named nurse, Snowdon ward, 1998
Dr Kevin Newley*	General practitioner
Robert Nisbet*	Forensic social worker
Sonia Oliver	Senior social worker, Rampton Hospital
Dr Kim Page*	Senior registrar to Dr Kaul
Nigel Parr*	Forensic social worker
Victor Patino*	Clinical services manager, Arnold Lodge
Bob Petrie	Manager, PPP
Colin Pinfold*	Assistant Chief Probation Officer, Leicestershire & Rutland Probation Service
Robert Richardson*	Senior staff nurse, Arnold Lodge
Dr Simon Shaw*	Clinical Director, West Sector, General Adult Psychiatry
Dr Patrick Sims*	Clinical psychologist
David Snowdon*	Director of mental health services, Leicestershire & Rutland Healthcare NHS Trust
Andy Stanley*	Service manager mental health, Leicester City Social Services Dept
Martin Taylor*	Chief Executive, Leicestershire & Rutland Healthcare NHS Trust, April 2000 - -
Dr Peter Turner*	Head of Service, adult mental health, Leicestershire & Rutland Healthcare NHS Trust
Ian Whitehead	Assistant Director (Commissioning), Leicester City Social Services Dept
Carol Williams*	Forensic social worker Team manager

*indicates witnesses who gave oral evidence.
+indicates position held at the time of involvement in the matters under inquiry