

***A review of the circumstances leading up to  
and surrounding the care and treatment  
of Ms Sarah Lawson***

**REPORT SYNOPSIS**

*Commissioned by:  
Surrey & Sussex Strategic Health Authority  
West Sussex County Council*

**July 2004**

## Chair's Statement

In June of 2001 I was asked to chair the Review of the care and treatment of Ms Sarah Lawson. The Review Panel's composition and its Terms of Reference are outlined in Appendix 2 of this document. The Review Panel delivered its final report in August 2003.

The final report is the responsibility of the panel alone but the report was commissioned by West Sussex Health Authority<sup>1</sup> and West Sussex County Council social services department. The commissioners hold the copyright of the report and bear the responsibility for its publication or non-publication.

In its final report the Review Panel recommended that the report be published in full and that advance copies should be sent to witnesses and to Mr James Lawson and Ms Karen Lawson. This was done but following this limited circulation of the full report the commissioners received various submissions and decided against publication of the full report.

It remains the opinion of the review panel that the report should be published in full because no synopsis could reflect the totality of the report but the responsibility for publication rests with the commissioners and they have decided against full publication.

Under these circumstances I have reluctantly concluded, with the agreement of the commissioners, that it is better to put this synopsis into the public domain than to have no publication whatsoever.

Conducting this review has been a complex and time-consuming process. We are indebted to the many witnesses we saw who subjected themselves to our often searching questions and we regret that some, including Sarah Lawson's parents (James Lawson and Karen Lawson) chose not to meet with us.

The review panel concluded that while there were a few examples of good practice both within the Worthing Priority Care NHS Trust and in social services there were failures of management, of systems and in professional practice which adversely affected patient care particularly during the mid to late 1990s.

Some of the complaints made by Sarah's mother about her daughter's treatment were justified. But some of Karen Lawson's behaviour sought to influence the treatment her daughter received, sometimes succeeded in doing so and was not always in her daughter's best interests.

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<sup>1</sup> West Sussex Health Authority no longer exists. The Successor organisation within the NHS is the Surrey and Sussex Strategic Health Authority. For a glossary of organisations involved in the care of Sarah Lawson see appendix two.

The panel's findings are outlined below and we are pleased to note that our recommendations have been accepted and we have been told they have been acted upon by the Primary Care Trusts concerned, by the West Sussex Health and Social Care NHS Trust and by West Sussex Social Services.

We have agreed with the commissioners that six months from publication of this synopsis the panel will revisit the West Sussex Health and Social Care NHS Trust, Adur, Arun and Worthing Teaching Primary Care Trust and West Sussex Social Services to ensure that changes made as a result of this case are working effectively.

Peter Smallridge (Review Panel Chairman)  
On behalf of the Review Panel

## **Background**

On Monday 14 May 2001, at Maidstone Crown Court, James Lawson pleaded guilty to the manslaughter of his 22-year old daughter, Sarah. Sarah Lawson was killed by manual asphyxiation in April 2000. The Crown accepted Mr Lawson's plea and there was no trial before a jury.

The legal basis of the plea was of diminished responsibility, namely, that at the time of the homicide Mr Lawson suffered from such abnormality of mind as to substantially impair his mental responsibility for his acts leading to the homicide.

Mr Justice Nelson said, at the time of sentencing, "It is the psychiatrists' view, expressed by all of them, that your judgement was impaired by your depressive illness so that you believed the situation regarding your daughter was completely hopeless and there was no prospect of future recovery. Thus you shared your daughter's own beliefs that her life was futile and helped her to end it".

Mr Lawson was sentenced to a two-year suspended sentence supervision order. The judge argued that a non-custodial sentence was indicated on the following grounds: the facts of the case were so unique that they outweigh any public duty the Court may have to ensure that homicides of this kind are deterred; the risk of Mr Lawson harming others was very low; a custodial sentence would further isolate Mr Lawson from others and make him increasingly entrenched in his views about the offence.

At the end of August 1997 19-year old Sarah Lawson was referred to her local psychiatric services by her general practitioner who had seen her on several occasions over the previous month. The referral was prompted by Ms Lawson's covert discontinuation of her medication and an escalation of self-harming behaviour, both of which coincided in time with Sarah's mother, Karen Lawson, complaining about the GP's management of her daughter's case. This was a pattern of events which emerged frequently in this narrative and which were to prove so damaging to Sarah Lawson's mental health.

Over the course of the next three years Sarah Lawson had contact with facilities managed by Worthing Priority Care NHS Trust as well as several other providers of mental health services. The overall quality of care she received varied greatly, being poor in the first period (August 1997 to May 1998), generally of a high standard in the second (June 1998 to October 1999), and patchy in the third (16<sup>th</sup> to 21<sup>st</sup> April 2000).

Her treatment culminated in a short stay, as a voluntary patient, at Homefield Hospital in Worthing (managed by Worthing Priority Care NHS Trust) in April 2000. During her stay at Homefield she was found to be in possession of cannabis and was asked to leave the hospital. It was shortly after this incident that Sarah Lawson was killed.

The summary of the full report of the Independent Review into the Care and Treatment of Sarah Lawson concluded that, “In an atmosphere of a sometimes dysfunctional community mental health team and justifiable and unjustifiable criticism, the needs of Ms Sarah Lawson were often lost. On occasions, Sarah Lawson’s mental health was influenced negatively by her parents, and especially Ms Karen Lawson. She became a proxy for both her parents’ intense emotional interactions and disordered psychological functioning in the family, and was frequently manipulated into the role of a patient in a mental health service which was at times woefully inadequate.”

## Context

In drafting its full report the review panel took care to separate what information was available to health services at the time (although not necessarily accessed by them), and what was obtained during the course of the review. Nearly 50 witnesses were seen, a small number more than once. Some significant potential witnesses refused to give evidence at all.

The context in which Sarah Lawson's care was provided is addressed in the full report by looking at the development and disposition of services throughout the 1990s, particularly in the period from 1995. In addition the full report contains evidence from users, voluntary organisations, and professionals involved in service planning and delivery.

The review also examined the patchy uptake of guidelines from the Department of Health in 1989 aimed at addressing variations between trusts in the care given to those in contact with mental health services. In addition the review examined the promulgation of this advice in a series of initiatives by the Department throughout the 1990s and the gradual emergence of policies and procedures that led to the Care Programme Approach.

In this case the symptoms and signs of mental disorder can only be understood in the context in which they appear. In contextual terms, a central role is played by the personal and family histories, areas in which little was known in this case, particularly in the early period of care.

The narrative in Sarah Lawson's case begins with her seeing her general practitioner (GP) in August 1997. Later in the same month she was referred to her community mental health team (CMHT) in circumstances that included the transfer of primary care from one GP to another. The CMHT response was to allocate the case to a community psychiatric nurse.

When Sarah Lawson required admission to a psychiatric unit in September 1997 no places were available in Worthing (at Homefield) and so she was transferred to the Eastbourne Clinic. Dissatisfaction with the care and treatment provided there led to the first of two admissions to Marchwood Priory in Southampton, between October and December 1997, and a formal complaint against the Eastbourne Clinic.

Although a single nurse at The Acre Day Hospital attempted to provide care and treatment for Sarah Lawson, between late-December 1997 and May 1998, other members of the CMHT failed to fulfil any of the national and local requirements of the Care Programme Approach.

Admitted to Homefield after an overdose in May 1998, Sarah Lawson remained without a nominated consultant for a month, until, detained under the Mental Health Act, she came under the care of Dr Farsi who brought structure and organisation to her care. Later, she was transferred to a rehabilitation unit, Crescent House, from where she was discharged in September 1998.

For a year from October 1998, Sarah Lawson was managed as an out-patient by a consultant psychiatrist, Dr Angus, who provided a high standard of care. As happened previously, specialised interventions were recommended and tried but Sarah was not able to make the necessary commitment to seeing them through. Ms Lawson's failure to follow a treatment plan led to her discharge by the CMHT in late 1999.

Between October 1999 and April 2000, Sarah Lawson's only contact with health professionals was her GP. A family crisis was associated with her self-harming and being seen at Worthing General Hospital Accident and Emergency Department (A&E) in mid-April 2000 and later that month she was re-admitted to Homefield, to be discharged a day later after being found in possession of cannabis. A few hours later, her father killed her.

## Detailed findings & recommendations

### Findings

1. All senior managers in the authorities concerned underestimated the breadth and complexity of the investigation necessary to review the care and treatment of Ms Sarah Lawson.
2. Both the Trust and the Health Authority were unprepared for the intense media criticism and had not taken advice on how to manage it. The Trust had not informed the Health Authority about the killing.
3. The Health Authority risked a potential compromise of the independence of the independent review by permitting Ms Karen Lawson to have an influence on the panel's composition.
4. Given the important positions held by Mr James Lawson and Ms Karen Lawson in the whole of the narrative outlined here, their decisions not to attend the review as witnesses have severely limited the panel's understanding of their daughter's care and treatment.
5. The panel concurs with one witness's opinion that the Worthing CMHT was 'dysfunctional' and concludes that this was so in August 1997 when Ms Lawson was referred to it. The reasons why this was so are complex, but were nevertheless influenced by the actions and inactions of individuals.

The panel believes that responsibility for recognising these deficiencies, and for taking action to remedy them where possible, lay with senior Trust management and senior professionals, particularly psychiatrists and nurses.

6. The above comments (at 5) were supported by evidence from a number of voluntary organisations, the community health council and the visits of the Mental Health Act Commission.
7. The above comments (at 5 and 6) provide a context for many of the deficiencies in the care provided to Ms Lawson by the Worthing CMHT between August 1997 and May 1998.
8. Department of Health guidelines on the Care Programme Approach have existed for more than a decade and have been regularly updated. While for many trusts the system was not fully operational until the mid-1990s the basic elements of the Approach (a care plan, keyworker, systematic assessment, regular review and full assessment of risk prior to any discharge) should have applied to all cases accepted by specialist psychiatric services.

9. Worthing Priority Care NHS Trust endorsed national guidelines by producing its own document on CPA policy and procedure in 1995. Again its applicability to all patients was emphasised. This policy was augmented with guidelines on a case register, tiered CPA, the Supervision Register, links with social services community care management plans, the role of keyworkers, reviews, discharge procedures, documentation, and the importance of training and audit.

No CPA process was initiated for more than a year after Ms Sarah Lawson's first contact with the CMHT.

10. In good clinical practice, a full knowledge of the family history is considered essential if an accurate diagnostic formulation is to be made. The diagnostic formulation is the narrative that describes the formation, precipitants, maintenance and modifying factors in relation to a mental health problem, and indicates treatment approaches. The formulation plays a critical part in risk assessment and management. Where disorders of personality and substance misuse are diagnosed, a family history is very important because research indicates the influence of both genetic links and exposure within the family to 'maladaptive' strategies for coping with distress.

The panel believes that Ms Lawson's parents did not disclose relevant information concerning their own backgrounds. This non-disclosure of important information had a significant effect on the CMHT's ability to properly formulate Ms Sarah Lawson's case and to manage any risk associated with it.

11. The GPs did not communicate vital background information to the CMHT both at the time of the initial referral in August 1997, and subsequently.
12. Other professionals did not adequately assess and formulate the needs of the family. As a result, steps were not taken to address the separate needs of Ms Sarah Lawson and her parents as carers.
13. Interventions for families involving one or more members suffering from mental illness in general practice are often difficult, time consuming, and open to manipulation. It would be in the interests of both patients and doctors to manage these cases more effectively, and for practices involved formally to decide who should deal with them and how they should be dealt with.

14. In addition to shortcomings in the GP's referral, the Worthing CMHT did not have an effective process for handling new cases, mainly because of failures of medical leadership at the time.

There was no evidence of a triage system in operation in mid-1997. An acceptable triage service would consist of a doctor, nurse and social worker, and if possible other professions would be part of this service. The purpose of a triage service is to ensure that appropriate professionals properly assess urgent and non-urgent cases. They would consider the appropriateness of the referral and its adequacy, the history and risk factors, who needs to respond and when. The triage system would be set up by the consultant psychiatrist, be managed on a day-to-day basis by the team leader or an administrator, and rotate between members of the community team. Its deliberations would be recorded.

15. Within a month of a GP referral to specialist psychiatric services Ms Lawson had four meetings with two CPNs, and the case was discussed at one CMHT meeting. The failure of a psychiatrist to become involved in the case led to one CPN being responsible for dealing with Ms Lawson's parents' complaints about the care provided for their daughter.
16. Ms Sarah Lawson continued to self-harm and health care workers from two professions were subject to further criticism. Complaints about both the GP and one CPN resulted in their withdrawal from the case; there were also threats of legal action. The Lawson parents' extreme concern for their daughter was experienced as hostility by the professionals.
17. From the beginning, Ms Karen Lawson reported feeling concerned that she was being, and would be, excluded by the professionals from whom her daughter had sought help.
18. Ms Sarah Lawson's stay at the Eastbourne Clinic in September and October 1997 was the subject of independent review after a complaint was made by Ms Karen Lawson.
19. While initially the Eastbourne Clinic admission appears to have been helpful, at the end the necessary relationship of trust between the Lawson family and the Clinic staff broke down. From Ms Karen Lawson's perspective the admission, like the previous period of community mental health team CPN involvement, had served only to make matters worse.
20. Ms Sarah Lawson's admissions to Marchwood Priory between October and December 1997 were time-limited because of the way in which they were funded. At the end of the first admission clearer pictures were emerging of Ms Sarah Lawson's reactions to conflict and stress, of the relationship between mother and daughter, and of the consequences of enduring stress for both of them.

21. It would be difficult to envisage a more unsatisfactory situation in late 1997. No care was provided by the Worthing CMHT following Ms Lawson's discharge from the Marchwood Priory in early November 1997. Her re-admission to the Priory two weeks later was arranged by Ms Karen Lawson through the GP and was in the context of the Lawson family's expressed concern at the absence of a CMHT care plan.
22. Whatever the benefits of the admissions to both Marchwood Priory and the Eastbourne Clinic, they also served to facilitate the distancing of Ms Sarah Lawson from the Worthing CMHT. This state of affairs existed because of a combination of related factors including: the CMHT's failure to initiate the CPA process in August/September 1997; the shortcomings in Dr Fernando's professional practice; Ms Karen Lawson's aversions to the Worthing CMHT and Homefield.
23. The CPA meeting held on 17<sup>th</sup> December failed to undertake any of the functions which were required of it.
24. In the first few months of 1998 Ms Sarah Lawson withdrew from her Acre Day Hospital programme despite concerted attempts to engage her.
25. Ms Sarah Lawson failed to take up the offer of a place at St George's Hospital, London in early 1998. She secretly discontinued her medication and also withdrew from analytical psychotherapy.
26. In early 1998 Ms Lawson's treatment was completely fragmented. In the absence of CMHT involvement, Ms Lawson's mother became the driving force of her daughter's care. She objected to, proposed, and rejected various treatments. Some of these treatments had (in the past) or had the potential (in the future) to help her daughter.
27. Ms Sarah Lawson remained outwith her CMHT and the CPA processes, and without a consultant until May 1998.
28. The panel concludes that the failure of the Trust to provide an accessible psychology service led to self- and other referrals to Hythe House.

The panel has been unable to judge the therapeutic impact of the Hythe House interventions, but therapists' practices in other areas (note keeping, communication, and in-service audit and supervision) lead us to have serious concerns regarding professional competence.

29. So far as the panel can tell, communication between the three Hythe House therapists then in post appears not to have taken place. Highly significant clinical information was not passed on to the CMHT, or the GP, with whom there was no written correspondence. Therapists appear to have depended on memory rather than written records to recall sessions.

30. Ms Lawson was on a treatment order under the Mental Health Act for six weeks in mid-1998. The panel concludes that this order made an important contribution to both the stabilisation of her mental state and the introduction of meaningful care planning at both Homefield and Crescent House.

31. At the time of her discharge from Crescent House in September 1998 both Crescent House staff and Dr Angus and his colleagues from Greenacres and the Acre Day Hospital had put a lot of effort into engaging with Ms Lawson.

A varied care plan was put in place but Ms Lawson's commitment to it was never strong and she eventually stopped attending the Acre Day hospital, Greenacres occupational therapy (OT) programme, and Dr Angus' outpatients.

32. Throughout 1999, insights into the level of distress in the Lawson household emerged through sessions with the pastoral counsellor, through Dr Angus, and through the occupational therapists (OTs). The panel believes that, as on other occasions, this understanding could have been seen as very threatening by both Ms Sarah Lawson and her mother.

33. Those responsible for Sarah Lawson's care sought specialist advice but no member of the family took up the offers made by Options to provide individual substance misuse counselling.

Ms Sarah Lawson did not attend her appointment at the Cassel Hospital which *could* have provided family psychotherapeutic treatment in an in-patient setting.

34. When Dr Angus discharged Ms Sarah Lawson from CMHT follow-up at the end of October 1999, he did not know that her mother had been an in-patient at the Priory Hospital, Roehampton, for two weeks receiving treatment for conditions similar to those presented by her daughter.

At the time of the discharge, Dr Angus anticipated that Ms Sarah Lawson would return to the service and indicated a clinical pathway in the event of relapse.

35. Between November 1999 and April 2000, Ms Sarah Lawson was in contact only with primary care, namely her GP.

36. A family crisis in mid-April 2000 coincided with Ms Sarah Lawson self-harming and presenting at Worthing General Hospital A&E. The decision by a psychiatric liaison nurse to provide follow-up, and the inability of a social worker to make contact with the CMHT led to disorganised and inadequate care over the subsequent three days.

37. On Thursday 20th April 2000, a social worker, who had been contacted by Mr Lawson and acted commendably in the case, insisted that the GP refer Ms Lawson to the CMHT through the Rapid Response Team.
38. Panel members are not clear as to how Ms Lawson came to be in possession of cannabis.
39. In making the discharge decision, the alcohol/illicit substance agreement was not interpreted literally but in the light of the information provided to the duty consultant.
40. Had the duty consultant been in possession of a full picture (knowing of family discussions, the degree of family pathology and events leading up to the admission), he would not have recommended discharge.
41. The duty consultant's discharge decision was contingent on Ms Lawson being examined by the ward doctor before she left. This did not happen.
42. The nature and degree of Ms Karen Lawson's mental disorder at this time was not a factor considered in the risk assessment. Furthermore, the level of anger being expressed by Mr Lawson was not addressed by staff or included in the risk assessment. In summary, the most clinically important purpose of the admission, namely to provide respite for her family, was lost sight of.
43. A nurse at Highdown, who had limited knowledge of Sarah Lawson's case, gave inappropriate advice. The advice was not necessarily correct, and was not that given by the Homefield team at the time of the discharge decision.
44. The panel believes that following the homicide the Trust's judgement regarding its own role and that of the criminal justice system was flawed and its failure to undertake a thorough internal inquiry may well have contributed to the lack of preparedness of both the Trust and the Health Authority for what followed.
45. A chain of events emerged: media criticism of the Trust fuelled by Ms Karen Lawson's sometimes misleading accounts of her daughter's care; some national organisations climbing on the failure-of-care-in-the-community bandwagon; the Trust constrained in its response by issues of confidentiality; a Trust and Health Authority ill-prepared for the trial; the facts of the case in Court being presented in a way which criticised mental health services and portrayed them as responsible for what happened; a policeman indicating his preferred sentencing option to the media before sentencing.

46. The failure of the responsible consultant psychiatrist to fulfil his consultant responsibilities led to the CPNs managing Ms Sarah Lawson without medical input. His absence from a crucial meeting brought to a head the family's reasonable concerns about the lack of medical input to the case. Both these matters contributed significantly to the lack of trust between the Lawson family and the CMHT.
47. The complaint against the GP and the CPN made in September 1997 lapsed in July 1998. The complaint against the Eastbourne Clinic made in October 1997 was not decided by the Health Authority until late-1998. Overall, these complaints contained many matters of substance.
48. On the basis of their meeting in December 1997, Ms Karen Lawson put her concerns about the competence and inter-personal style of her daughter's consultant psychiatrist in writing.

According to a professional witness, also present at the December meeting, some of Ms Karen Lawson's comments reflect inaccurate recall of some aspects of the meeting, while others were not corroborated. However, in many respects the complaint has resonances with evidence given to the panel by other CMHT members.

49. Separate from Ms Karen Lawson's complaint against her daughter's consultant psychiatrist there was significant evidence of malpractice from multi-disciplinary team (MDT) colleagues. Although in the end the consultant psychiatrist resigned from the service, the panel believes that the Trust's senior management failed to take seriously enough, and act quickly on, the reports presented to them of unsafe clinical practice.
50. The management of psychiatrists should have been no different from that of other staff. Had the consultant psychiatrist been effectively 'line' managed by the medical director, proper attention would have been paid to the information made available to him by other professional managers, which would in turn have led to a much earlier grasp of the difficulties his behaviour was causing. While the ultimate responsibility rests with the chief executive, she was almost totally dependent on the medical director to obtain information regarding concerns about consultants. It is clear that the medical director should have informed her, but failed to do so.
51. These concerns were well known to many of the consultant psychiatrist's colleagues and to members of the community mental health team, many of whom were trying to show proper concern for the care of their patients, and to ensure the effective working of the team. Worse, it appears that some of the responses to Ms Lawson and her family's requests for assistance were made in order to compensate for the consultant psychiatrist's shortcomings.

52. It is impossible to know what difference the presence of clinical psychologists in the community team might have made to the care and treatment of Ms Sarah Lawson. However, the majority opinion of professionals and users interviewed concurs in lamenting the comparative absence of an integrated service, and the absence of effective provision for those with complex and enduring needs. It seems likely, at least, that both professionals in psychology and their counterparts in the mental health teams would experience a degree of isolation in consequence. Working independently, opportunities for multi-disciplinary support and peer supervision are lost, both of which might make an important difference to the endurance and flexibility that professionals can bring to bear on problems such as personality disorder.

53. In addition, there is clear evidence that psychology staff were over-burdened and unable to meet the population's needs. The Trust must be in a position to account for this situation, and, in particular, to satisfy itself that allied services (such as counselling) are appropriately regulated. Such services cannot be relied upon as a reasonable or evidence-based alternative for patients with complex needs.

### **Recommendations**

1. The Department of Health should clarify the categories of homicide referred to in HSG(94)27 (*Guidance on the discharge of mentally disordered people and their continuing care in the community*).
2. The Healthcare Commission should issue guidance on the requirement, nature, and establishment of inquiries and reviews. It should also clarify the distinction between an inquiry and a review and indicate the circumstances in which each is recommended.
3. Where it is not possible to fill consultant posts with adequately qualified and otherwise suitable psychiatrists, locums and others acting as consultants should receive regular and recorded supervision under the oversight of the medical director.
4. A triage system should be established to process referrals.
5. Regular and patient-focused GP practice meetings would provide a forum for peer group advice and support thereby making it more difficult to form collusive, and potentially detrimental, alliances.
6. It is necessary to acknowledge that the appetite for news and speculation about cases such as this is almost insatiable. The Health Authority and the Trust should consider seeking professional public relations advice when very serious untoward incidents occur, and always do so when there is a homicide.
7. Trusts should seek advice on the procedures to adopt immediately after a homicide (e.g., sequestering all records, and the composition of the internal inquiry/review team). Such advice could be obtained from Strategic Health Authorities or independent experts.

8. The panel believes that all referrals should go to full (i.e., multi-professional) CMHT meetings, that every case should have a nominated consultant, and that the CPA process should be instituted with a nominated (if only provisional) key worker.
9. Underlying the Trust's approach should be the principles that whistle-blowing is taken seriously, staff are provided with support where necessary, and safe clinical practice is promoted.
10. There is an urgent need for the Trust to review its CPA documentation and to ensure that what one witness described as, '**a workable and resourced CPA policy**' is developed. This must take into account staff's concerns about accountability and equity. Account must be taken of key workers' experience, seniority, caseload and mix, and professional affiliation.
11. Copies of all CPA documentation should be held at a central point, either with the Trust's case register, or by the clinical audit co-ordinator.
12. There is an urgent need for the Trust to fund psychology posts and ensure that psychologists have a role in the CMHTs.
13. A system of registration and inspection of counselling services needs to be put in place, not least to ensure adequate supervision and monitoring of cases referred to counsellors. Such a system should include ensuring that policies are in place concerning the recording of interviews and record keeping generally, confidentiality (and necessary disclosure), regular reporting to referring agencies, keeping GPs and other professionals informed when matters of concern are noted, the appropriateness of counsellors qualifications and the suitability of buildings.
14. CMHT case discussions should be recorded in a similar manner to CPA meetings. Particular note should be taken of action plans and naming those responsible for their implementation.
15. The training of social workers should re-emphasise the therapeutic nature of their practice, and equip them to intervene in family and relationship matters as well as helping them to function as 'care managers'.

16. An annual audit should be undertaken on the functioning of CMHTs. A minimum requirement would cover the following areas:

- minutes of CMHT meetings;
- who and what professional groups were represented at meetings;
- how new cases were allocated;
- how urgent referrals were managed;
- the CPA process;
- links with in-patient, day-care and specialist services;
- the management of complaints with a trend analysis of those complaints.

The findings of the audit should be reported to the Trust board on at least an annual basis. Where appropriate, action plans will be drawn up to identify shortfalls in service delivery. Careful monitoring of the implementation of action plans is essential.

17. A Trust policy steering committee should, in conjunction with representatives of local services and the voluntary sector, draft policies and procedures, and oversee their amendment, implementation, and audit. All documents should contain a précis of how they have been drawn up and ratified, and when they will be reviewed.

18. It is recognised that in reality there will be minor variations in the implementation of policies (although all should be ratified). However, as far as possible, all extant policies and procedures should be reviewed to avoid duplication, contradiction, and 'unauthorised' documentation.

19. The medical director and director of nursing should assume overall responsibility for implementing policies and procedures on behalf of the Trust board.

20. The Trust should have a monitoring system in place to ensure that it is complying with Departmental guidelines on complaints procedures. Where the 85% target is not being met action should be taken to resolve delays.

The response from the chief executive officer should outline the process the complainant may undertake if s/he is unhappy with the outcome of the Trust investigation. In addition a leaflet explaining the complainant's right to an independent review should be included with the letter.

A system should be in place to ensure that complaints' reports are fed back to relevant staff at all levels, and that a summary of the complaint and the result of its investigation are accessible in the current case files.

21. The Trust requires the services of trained family therapists. Clinical psychologists and social workers can provide assessments, some treatments, and supervision for other professionals in the CMHTs.

22. Policies concerning the identification, care and treatment of 'vulnerable adults' should be in place in all NHS trusts.
23. The care and treatment of people diagnosed with personality disorder has long presented problems to local psychiatric services.  
  
The Trust needs to identify its own 'product champion' team for personality disorder, with lead roles for clinical psychologists, psychiatrists, nursing staff, social workers and family therapists who could design treatment programmes, undertake therapy, and train and supervise other staff.
24. As a starting point, training on personality disorder would seem essential for staff across the Trust. This is currently available via organisations such as the Association for Psychological Therapies, based in Leicester.
25. The Trust may well not have the critical mass of patients necessary to provide viable specialised services for sub-groups of individuals with personality disorder (there are ten recognised sub-types of personality disorder, including the 'borderline' type). These patients may also continue to be provided for by out-of-area tertiary services.
26. Training in issues of confidentiality need to focus on *necessary disclosure*, an essential element of risk assessment and management.

## **Appendix 1: The Panel and its Terms of Reference**

This appendix describes how the review panel members were appointed and how they approached their task. Two related matters had a significant influence on the panel's work: firstly, media coverage of the death and subsequent Court proceedings; secondly, Ms Sarah Lawson's parents decisions not to give evidence to the panel and Ms Karen Lawson's repeated challenges to its independence.

West Sussex Health Authority and West Sussex County Council Social and Caring Services agreed to jointly commission the review and prospective panel members were approached in June 2001, after the completion of criminal proceedings. A panel was confirmed in mid-July 2001. The membership was:

- Mr Peter Smallridge (chair) was director of social services in Warwickshire and Kent from 1983 to 1998 and non-executive chair of West Kent Health Authority from 1998 to 2002. He is currently non-executive chair of Ashford Primary Care Trust in Kent.
- Mr Cedric Frederick (independent sector member, nominated by Worthing voluntary organisations) is chief executive of a London-based voluntary organisation and a non-executive director of a partnership NHS Trust, both of which support people with mental health problems, learning disabilities and autism. He is a Mental Health Act manager.
- Mr Peter Walsh (nursing member from January 2002) is director of nursing practice at a London mental health trust. He is responsible for the overall clinical practice of about 1,100 nurses covering a range of services including acute and community mental health teams, and rehabilitation.
- Dr Paul Bowden (medical member) is a forensic psychiatrist. He worked as a consultant at a south-London hospital where he had an in-patient unit, and at a London prison. Other major areas of his work were teaching trainee psychiatrists, establishing a community outreach service, and editing a journal.

Dr Estelle Moore (psychologist adviser to the panel) is a consultant clinical and forensic psychologist. She is an associate fellow of the British Psychological Society, currently based in a forensic service (high security) with responsibility for providing group and other therapies for offender patients with personality disorder. The review manager was Mrs Sandra Peloquin.

Terms of reference and the review procedure were agreed in August 2001.

The terms of reference were:

1. *To examine the circumstances leading up to and surrounding the care and treatment of Ms Sarah Lawson by those relevant public and private agencies throughout her contact with those agencies.*

*In particular:*

- i establish the sequence of events leading up to the death of Ms Sarah Lawson by the relevant public and private agencies throughout her care with those agencies;*
  - ii the quality and scope of her health, social care and risk assessments;*
  - iii the appropriateness of her treatment, care and supervision in view of the patient's history and in respect of:*
    - her health and social needs as assessed by the relevant agencies;*
    - her risk of potential harm to herself and others, as assessed by relevant agencies;*
    - her history of prescribed medication and compliance with that medication;*
    - her involvement in, and compliance with, the care and treatment plan based on those assessments;*
    - the extent to which Ms Lawson's care corresponded to the statutory obligation, particularly the Mental Health Act 1983, Code of Practice and relevant other guidance from the Department of Health (Care Programme Approach (HC(90)23/LASSL(90)11), supervision registers (HSG(94)5), Discharge Guidance (HSG(94)27); and local operational policies.*
2. *To examine the adequacy of the collaboration and communication between NHS trusts, social services, primary care and private agencies involved in the care and treatment of Ms Lawson or in the provisions of services to her family.*
3. *To identify any steps to be taken to improve local services and where possible reduce the risk of further such incidents.*
4. *To report on the findings of the review and to make recommendations, if appropriate to the West Sussex Health Authority and West Sussex County Council Social Services Department.*
5. *The report's findings and recommendations will be published by the commissioning agencies in full subject to any issue of confidentiality. Prior to publication the report will be shared by those people who have contributed to the review process, including immediate family members and their representatives.*
6. *Consequently on the panel's deliberations, to identify any matters arising that may require further investigation in the public interest.*

Panel members met for the first time in early October 2001. Visits were made to some Trust and community-based locations and a chronology was prepared.

The first half of 2002 was taken up with receiving evidence, and the second, with preparing a draft report. The first draft report, dated January 2003, was used as a feed back to witnesses in line with the assurance given in the review procedure.

Panel members informed themselves as comprehensively as possible about the background to the case by obtaining health and other statutory services' records, and the policies and procedures which underwrote that care. They also read the documents which formed the basis of the formal complaints, and police witness statements and court papers relating to the criminal proceedings. They then took written and oral evidence as both a means of gaining further information and a way of seeking an understanding of judgements and practices.

Interviews were recorded and draft transcripts sent to the interviewees for corrections of fact. When a first draft of the whole report was completed in January 2003, witnesses were sent those parts of the report which referred to their own evidence in order for them to have an opportunity to comment on the manner in which their evidence had been represented and the judgements made by the panel in relation to it. The panel considered all the responses and amended the report in the light of witnesses' comments of fact and opinion.

In March 2003 a second draft report was completed and in late April 2003, West Sussex Health and Social Care NHS Trust and Adur, Arun and Worthing Primary Care Trust gave a written response to the summary of recommendations. Both Trusts accepted the findings of the review panel in full. The review panel and the commissioners of the report then met with legal advisers and the final report was sent to the Strategic Health Authority in August 2003.

The panel sought both to maintain the independence and objectivity necessary to give a balanced account of the issues involved and to produce an informed set of recommendations for the commissioning authorities to consider.

Mr James Lawson and Ms Karen Lawson were invited on nine occasions to meet the panel; their decisions not to give evidence as witnesses have added immeasurably to the difficulties we have in understanding many of the events and judgements made by the individuals with whom this report is concerned.

The position of Ms Sarah Lawson's parents in this process cannot be underestimated. Their decisions not to attend the review as witnesses have limited our understanding of their daughter's care and treatment.

## Appendix 2: Glossary of Organisations

- Surrey & Sussex Strategic Health Authority – successor organisation to West Sussex Health Authority, co-commissioner of the review into the care and treatment of Sarah Lawson.
- West Sussex County Council social services department – co-commissioner of the review into the care and treatment of Sarah Lawson.
- West Sussex Health Authority – predecessor organisation to Surrey & Sussex Strategic Health Authority, co-commissioner of the review into the care and treatment of Sarah Lawson.
- West Sussex Health and Social Care NHS Trust – successor organisation to Worthing Priority Care NHS Trust and current provider of mental health services in West Sussex.
- Worthing Priority Care NHS Trust – predecessor organisation to West Sussex Health and Social Care NHS Trust and former provider of mental health services in west Sussex.
- Adur, Arun and Worthing Teaching Primary Care Trust – successor organisation to West Sussex Health Authority as local commissioner of mental health services in the relevant part of West Sussex.
- Homefield Hospital (Worthing) – mental health hospital (closed in 2000) formerly managed by Worthing Priority Care NHS Trust.
- Acre Day Hospital – day hospital formerly run by Worthing Priority Care NHS Trust and the location of the Greenacres occupational therapy team.
- Crescent House – a rehabilitation unit formerly run by Worthing Priority Care NHS Trust. Crescent House closed in 2002 and services are now provided in the community.
- Hythe House – a private counselling service.
- Eastbourne Clinic – private hospital for patients with mental health problems.
- Highdown – rehabilitation unit. Now closed.
- Cassell Hospital – specialist hospital for people with personality disorders.
- Marchwood Priory (Southampton) – private hospital for patients with mental health problems.
- Priory Hospital (Roehampton) – private hospital for patients with mental health problems.
- St George’s Hospital (London) – general hospital in south London where Sarah Lawson received psychiatric support.

- Worthing General Hospital – general hospital where Sarah Lawson received treatment in the A&E unit.
- The Healthcare Commission – successor organisation to the Commission for Health Improvement.