Report of the Independent Inquiry into the Treatment and Care of

Bradley Sears-Prince

A report commissioned by

Leicestershire Health Authority

March 1999

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Preface

The Panel wishes to place on record its gratitude to the people who contributed so conscientiously to its work. This has enabled the Panel to be satisfied that it has been able to work properly to its remit (see Appendix A for the remit of the Inquiry). In particular, the Panel wishes to express its thanks to the very many people who attended to provide the Panel with information orally and/or who supplied the Panel with information in writing (see Appendix B for a list of people who appeared before the Panel and a list of other contributors to the work of the Panel). The work of the Panel was clearly supported not only by the Leicestershire Health Authority that established it, but also by the Leicestershire Mental Health Service NHS Trust. Homicide Inquiries are not a pleasant experience for anyone involved, but the commitment and the level of contribution of those who appeared before us is to be commended.

The Panel also wishes to record its thanks to the people who worked directly with the Panel, in particular the stenographers and, of course, Melanie Sursham. Melanie worked as a dedicated professional with sensitivity and care. Her support was invaluable to us all.

Finally, we wish to commend this Report to the Authority and the Trust. We hope that it can assist these organisations in progressing the delivery of mental health care within Leicestershire.

May 1998

The Panel received some comments in late November 1998 on the draft of its final Report and has taken full account of them. The Leicestershire and Rutland Probation Service drew our attention to work that is relevant to some of the issues in this Report. First, the Leicestershire and Rutland Probation Service Public Protection Panel (established in January 1998) provides a facility for any agency to initiate a multi-disciplinary review of people who are thought to represent a significant threat to the public or themselves. Secondly, the Probation Service has prepared a Confidentiality Policy which is designed to ensure that such information can be released in appropriate circumstances, whilst protecting the individual's right to confidentiality. Thirdly, the Leicestershire Prisoners' project is a research project into the needs of mentally disordered prisoners in Leicestershire.

January 1999

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May 1998

1 *Introduction*

1.1 Mr Bradley Sears-Prince is a young man with a history of offences, including many offences of violence that commenced at an early age. He has a reputation for violence. He began drinking alcohol at an early age, and has a history of drug abuse, primarily involving the taking of cannabis, but including other drugs such as LSD. He was diagnosed as suffering from insulin dependent diabetes mellitus at the age of 11. Later (that is in his late teenage years and subsequently), Mr Sears-Prince was largely homeless after his prison sentences, although his mother remained prepared to house him in extremis. In recent years he had expressed concern about his violence and sought help.

1.2 Mr Sears-Prince's offending history culminated in the murder of Adil Butt on 22 June 1996. This was a tragedy for the family of Mr Butt. We extend our deepest sympathies to them. The tragedy has also been a cause of great distress to the family of Mr Sears-Prince to whom we also extend our sympathies.

1.3 Mr Sears-Prince's contact with mental health services was limited. His first contact arose from accessing the general practitioner service that is offered to people who are homeless in Leicester at the Y Centre. This resulted in an out-patient appointment. Subsequently, he presented himself to the mental health services on three occasions for informal admission to hospital. He, and his family, perceived that there was something wrong with Mr Sears-Prince. Their concerns may be, and should have been, interpreted as a cry for help. However, on no occasion was he thought to have a mental illness. On no occasion was it thought appropriate that he be compulsorily admitted under the Mental Health Act. On no occasion was it thought necessary to evaluate and assess carefully this young man's condition and needs. If anything, he was thought to be suffering from a personality disorder that was not treatable, or at least not treatable within the services available. Mr Sears-Prince did report, on a number of occasions, that he had a psychiatric illness, referred to as schizophrenia or paranoid schizophrenia. It is not clear from where this came, but it probably arose coincidentally with the time of his detention in H.M.Y.O.I. Glen Parva. As he self reported this condition, it did influence some decisions made with regard to him, e.g., it was providing this information to a locum general practitioner that precipitated the admission to hospital in November 1995. This information was also repeated by Mr Sears-Prince to the police at the time of his arrest for the murder, and appears to have been the motivating reason for him having an assessment of his fitness to be detained and interviewed. We repeat that no mental health workers who assessed Mr Sears-Prince found him to be presenting with symptoms that warranted a diagnosis of mental illness.

1.4 The function of the Independent Inquiry, in broad terms, was to ascertain whether anything more should have been done with, and for, Mr Sears-Prince by the mental health services that he accessed

1.5 The Panel has made a number of recommendations, most of which are rather specific. The overriding message that it derives from this inquiry is that, whilst no action might have avoided the tragic consequences that led to the establishment of the inquiry (paragraphs 4.1 and 9.1) and the health service does not offer a service solely on the basis of a prediction of dangerousness (paragraph 2.11), action should have been taken in the form of further assessment of the needs of Mr Sears-Prince (see, e.g, paragraph 6.12). There was an informal care plan that reflected the concern for the patient, but it did not comply with the procedures available nor did it identify all relevant and sufficient action (paragraphs 4.3.7, 4.4.7 and 6.9). The most appropriate step to achieve this would have been via a multi-disciplinary meeting, and this would have been triggered had the Care Programme Approach been actioned in a different way in the case of this man. Whilst this can be stated briefly, the Panel discusses these points in considerable detail at most stages of the following report. An indicative summary follows.

1.5.1 The Panel took the view that more could have been investigated about the physical health of Mr Sears-Prince (paragraph 2.7).

1.5.2 More of the criminal history of Mr Sears-Prince might have been revealed had there been a multi-disciplinary meeting which had one of its objectives as the gleaning of information about him (paragraph 2.12, see also paragraph 2.13).

1.5.3 There is considerable debate amongst clinicians as to the propriety of providing a service for people with psychopathic disorder. But it must be recognised that Parliament has provided for the compulsory admission of people with psychopathic disorder and there is an expectation that hospital can be a resource for at least some people diagnosed as having that condition. We do not agree with the approach of the clinicians in Leicester in not assessing the case of Mr Sears-Prince fully. Less criticism can be directed at individual clinicians in relation to the provision of a service, though a proper assessment of the needs of Mr Sears-Prince might have led to proposals that could usefully have been considered. However, it is essential to recognise the professional debate as to the treatability (in the true sense rather than that imported by the Mental Health Act 1983) of persons with psychopathic disorder (paragraph 3.5).

1.5.4 Mr Sears-Prince may have been sincere in his continued expressions of concern about his violence and the impact that it has on himself, his family and others, including its victims. There are issues here that deserved full consideration through a thorough assessment of the condition of Mr Sears-Prince and any treatment needs that he might have had (paragraph 4.3.2).

1.5.5 A full assessment through a multi-disciplinary meeting would have enabled a thorough professional view to have been taken of the condition and prospects for treatment of Mr Sears-Prince. This meeting would have occurred as a result of application of the Care Programme Approach (paragraph 4.3.8).

1.5.6 Given what was known at the time of his second admission to hospital about Mr Sears-Prince's previous behaviour and his own acknowledgement that something was wrong, even greater care should have been taken to obtain the widest possible consensus on how best to deal with someone who was a major problem to the community and to himself (paragraph 4.4.2).

1.5.7 It is not the view of the Inquiry that there is an obvious treatment option, but a full multi-disciplinary meeting, as triggered through application of the Care Programme Approach, ought to have ensured that the matter was thoroughly debated and, perhaps, specialised services might have been accessed for advice and assistance, for example, the local forensic psychiatry service or the personality disorder service at a hospital such as Rampton High Security Hospital (paragraph 4.4.5).

1.5.8 The Panel suggests that a more appropriate response to the letter written by Dr McMurran than that provided by Dr Walker (which displayed, at the least, unacceptable professional discourtesy) would have involved establishing a CPA or multi-disciplinary meeting (paragraphs 4.6.4 and 4.6.5).

1.5.9 It should now be clear that we believe that application of the Care Programme Approach would have been appropriate. This should have resulted in the calling of a multi-disciplinary meeting that would have resulted in the more thorough assessment of Mr Sears-Prince that clearly was warranted (paragraph 6.1).

1.5.10 Having considered this case carefully, the Panel takes the view that there is a value in that including people with personality disorder in the Care Programme Approach enables the collation and consideration of more information about such an individual than would otherwise be available and brings the knowledge and skill of practitioners from a number of professions to bear on the matter in hand. This will lead to more appropriate decisions and strategies being adopted (paragraph 6.3).

1.5.11 The Panel takes the view that a multi-disciplinary meeting concerned with the problems that this man presented would have been good practice, regardless of any debate about the applicability of the CPA (paragraph 6.4).

1.5.12 The Panel is not clear whether the consequence of determining that a patient was "not for CPA" was that the staff assumed that he was a low dependency patient or whether the staff were, in effect, discharging him completely from any further contact with the service (paragraphs 6.7 and 6.8).

1.5.13 An indication of what a multi-disciplinary meeting might have achieved is provided at paragraph 6.15.

1.6 The Panel has made a number of recommendations and also posited a number of ideas that it believes worthy of further consideration.

1.6.1 Consideration should be given by the Trust as to how it seeks advice and contributions from the Housing Department to the benefit of the health care team, without imposing burdens that are excessive or disproportional on it. Nor should this be an overly bureaucratic exercise (paragraphs 2.6 and 5.3).

1.6.2 In the above context, the Panel has considerable interest in the project concerned with the sharing of information between different agencies. The Panel believes that, provided the obvious concerns around confidentiality and access can be overcome, notification that someone has had contact with another agency could be of real value in cases such as that presented by Mr Sears-Prince (paragraph 2.6). There is a difficult balance to be drawn between the sharing of information on the basis of need and the public interest on the one hand, and the need to respect the confidentiality of individuals, on the other hand. We, therefore, commend the work of the group looking at the sharing of information on an inter-agency basis (Leicestershire Joint Strategy Group (Mental Health), "JSG Topic Group on Inter-Agency Confidentiality (1997)). We believe that this approach could have a significant role to play in the future care and treatment of people with mental health needs (paragraph 7.1).

1.6.3 Where there have been psychiatric opinions of an individual, it is absolutely vital that such views be kept under review and that their validity be scrutinised at subsequent assessments (paragraph 2.16).

1.6.4 We recommend that the Authority and the Trust give specific consideration to the peculiar problems presented by people with personality disorder and, pending the outcome of the Ashworth Inquiry and in line with the recommendations by such bodies as the Reed Committee, arrive at an agreed position on what, if any, services are to be offered locally and what action local professionals should take when presented with the case of a person with personality disorder, which can include referral to other agencies (paragraphs 3.9 and 3.6, see also paragraph 6.19). We recommend that the Authority and Trust, in conjunction with the relevant social service authorities as lead assessors of community care needs, together should review the services that could and should be provided for people with personality disorder. They may decide that a service should not be provided, in which case we believe that a clear statement to that effect should be made with clear guidance to staff who have to deal with people with that diagnosis, including to which services outside the Trust such patients are to be referred as referrals will often be necessary. It is not a

service decision which we would applaud. This is a difficult group of patients. It is entirely possible that helpful guidance will be forthcoming from the current Ashworth Inquiry (paragraph 8.2). Neither the Trust nor the Authority have any specific strategy for dealing with people with personality disorder, by way of explicit integration within existing services, the development of a specific local service, referral on to other specialist services or by virtue of a policy decision whereby a service is not offered to people with personality disorder except where a clear treatment can be successful (paragraph 4.4.3). However, whilst there is no overall strategy and co-ordination of services, service provision to some people with personality disorder was provided by the therapeutic community at Arnold Lodge and other places in the Trust.

1.6.5 At a national level, it is necessary for a policy decision to be taken as to whether there should be any therapeutic solution to the problem presented by dangerous people with a personality disorder (paragraphs 3.8 and 4.4.4).

1.6.6 If a service is to be provided to people such as Mr Sears-Prince, there needs to be greater clarification as to what is available and from whom (both within and outside the Trust) (paragraph 4.2.8).

1.6.7 Whilst an informal care plan was, in effect, drawn up, more can be done, which would have been achieved by proper application of the Care Programme Approach (paragraph 4.3.7 and section 6).

1.6.8 We recommend that the process be amended so that there is a requirement for reasons to be given for decisions taken about applying the Care Programme Approach to any individual (paragraph 4.3.11).

1.6.9 It is recommended that the failure to action the decision for referral to a Community Psychiatric Nurse be considered very carefully by the Trust and that a system to ensure that such action is taken be either introduced or re-emphasised and that quality audits should be enabled to assess whether decisions are actioned appropriately (paragraph 4.4.6).

1.6.10 We wonder whether it would not be possible to have a system, sensitive to changing facts and conditions, whereby people known to the service, and known not to be people that the service can assist, are not normally admitted inappropriately. There was some evidence offered to the Panel that there are many night time admissions that result in immediate discharge the following day. Of course, the vast majority of these will have involved entirely appropriate and consistent actions (paragraph 4.5.1).

1.6.11 The Panel recommends that decisions under the Care Programme Approach that a patient is "not for CPA" should fall within the audit process and provide a valuable learning tool in the application of CPA (paragraph 6.10).

1.6.12 The Panel believes that there was a failure to own the Policy and that the then senior management commitment to CPA was not sufficient, thus producing what might be termed a cavalier attitude, amongst some professionals, to what might have been perceived as a merely bureaucratic exercise (paragraphs 6.20, 6.21 and 6.24). The Panel believes that improved documentation, coupled with adequate training and effective managerial oversight, would have avoided some of the confusion associated with the application of the CPA to the case of Mr Sears-Prince (paragraph 6.22).

1.6.13 Our final comments on the Care Programme Approach are to draw attention to the findings of the "Audit of the Care Programme Approach I LMHS NHS Trust" undertaken by J S Forbes and L J Edwards of the University of Leicester and to confirm that much of what we identified confirms those findings. Whilst we are not in a position to endorse all that is said in the Report, we endorse many of the findings, and we support the recommendations made (paragraph 6.25).

2 *Mr Sears-Prince's relevant life history prior to his contacts with mental health services*

2.1 According to his own and his mother's versions of his early history, Mr Sears-Prince had been a happy young boy, with no problems, but that he had then gone off the rails for some reason. We have reason to believe that his early life was not idyllic and that some of his problems might have their origin then. Indeed, if the diagnosis of a personality disorder is sustainable, it is likely that there would be evidence of a dysfunctional family. We had some evidence of this from the construction of the immediate family unit in which Mr Sears-Prince grew up, from the contacts that the family had with the Social Services Department and from the evidence surrounding the diagnosis and treatment of his diabetes. On the other hand, his mother and maternal grandparents presented to us as a mutually supportive unit, concerned for the welfare of the one member who was different in behaviour from the rest.

Diagnosis of diabetes

2.2 At the age of 11, Mr Sears-Prince was diagnosed as having Insulin Dependent Diabetes Mellitus (IDDM). From the totality of the evidence before us, the diagnosis and initial response were not handled well by either Mr Sears-Prince or his family. There is documentation making very clear the frustration felt by the diabetologist of the time. This is in language stronger than would normally be expected. It should have informed the family about the serious consequences of poor control of IDDM. The failure to attend meetings and appointments, that is indicated in the initial stages of the diagnosis of IDDM, is a matter that litters Mr Sears-Prince's history of contact with the various agencies with which he was engaged. When he could see the clear benefit of contact with any given agency, attendance was not as much of a problem as on other occasions. Evidence for this

lies, for example, in the accessing by Mr Sears-Prince himself of housing and homelessness services in his later teenage years and early twenties.

2.3 Despite the history of the diagnosis of diabetes, it would appear that Mr Sears-Prince did understand the condition. Certainly, both his brother (who was particularly helpful from an early age) and his mother were aware of the needs associated with it. The impression of the ward staff during Mr Sears-Prince's hospital admissions (see below) was that his diabetes was well controlled. The evidence for this was his management of the condition whilst being a hospital patient. There was no investigation of the state of his diabetes during his contacts with the mental health services. There was no concern expressed about it.

2.4 However, some of the evidence before the Panel suggested that Mr Sears-Prince's diabetes control continued to be poor, or at least that his control was not consistent. It is also possible that the diabetes might have a connection with the violence that Mr Sears-Prince presents. There are two indications of such a connection. The first appears in a letter from Mr David Bate, acting as Solicitor Advocate for Mr Sears-Prince, dated 1 November 1994. In that letter, Mr Bate states that Mr Sears-Prince had informed him that "After the attacks, he frequently drifts off due to his lack of sugar/insulin and when he awakes, is totally unaware of the damage he has caused." The impression of a connection was confirmed by his family. We are not in a position to offer a clinical view of this information, but its careful analysis might have been of assistance in assessing what help could have been provided to Mr Sears-Prince. The second indication appears in the records of the Housing Department. When Mr Sears-Prince made his first homelessness application on 21 August 1995, he stated, in the course of the interview, that his diabetes produced fits that led to very aggressive behaviour just before, during and after fits. Whether this is true, or added colour for the benefit of the application, is not possible for the Panel to determine. We do not rule out the possibility that it was invention on the part of someone who is capable of manipulation for his own benefit. Nor do we rule out the possibility that there was a real connection between the diabetes and the behaviour.

2.5 The contribution of the diabetes to his propensity for violence was not investigated further as a consequence of his subsequent contact with mental health services. In the light of other relevant factors, we suggest that, at some stage, this could have been a valuable exercise. The letter from Mr Bate was on file before the out-patient appointment that Mr Sears-Prince attended with Dr Khoosal in November 1994. Dr Khoosal was aware of the letter. Had a multi-disciplinary team meeting been called then, or later, it is possible that the homelessness team would have been asked to contribute to the discussion and it is possible that this piece of information would have been revealed. The more general importance that we place on such a meeting will become increasingly apparent during the course of this Report. At present, it is important to stress that it might have resulted in greater flow of information between those who needed to know, even though there is no guarantee that Mr Sears-Prince would have attended or contributed. It should have produced the comprehensive assessment that was necessitated in this particular

case. It will become apparent that the (then) Leicestershire Social Services Department had little input in the case of Mr Sears-Prince. Therefore, it had no opportunity to carry out its functions under section 47 of the National Health Service and Community Care Act 1990 to assess need for community services, which include housing.

2.6 It would appear that the Housing Department is prepared, even keen, to contribute to discussions wherever possible. It is likely that the Department would often have something of value to contribute. Consideration should be given by the Trust as to how it seeks advice and contributions from this agency to the benefit of the health care team, without imposing burdens that are excessive or disproportional on the Housing Department. Nor should this be an overly bureaucratic exercise. In this context, the Panel has considerable interest in the project concerned with the sharing of information between different agencies (see paragraph 7.1). The Panel believes that, provided the obvious concerns around confidentiality and access can be overcome, notification that someone has had contact with another agency could be of real value in cases such as that presented by Mr Sears-Prince.

2.7 There was some evidence before the Panel that Mr Sears-Prince might have had epilepsy, but no clinical evidence of this has emerged during his several periods of observation as a prisoner. Nevertheless, descriptions of some of his uncontrollable behaviour at home would be more consistent with epilepsy than diabetes, and he has occasionally been in receipt of anti-convulsants. It is not possible for the Panel to assert that this is a likely diagnosis, but there are indicators that suggest that investigation would have been valuable. The Panel is well aware of the results of the EEG (see paragraph 4.3.6), but this would not entirely exclude the possibility of complex partial seizures. A primary source for investigation would be the evidence of the family. More could have been investigated.

Offending history

2.8 Mr Sears-Prince's criminal history commenced as a young boy. It would appear that it started in 1986, the year in which he was thirteen. In December 1986 he was convicted of taking a motor vehicle without the owner's consent, criminal damage and an assault occasioning actual bodily harm. In 1990 he was convicted of a further assault occasioning actual bodily harm and a further instance of taking a motor vehicle without the owner's consent. In February 1991, he was convicted of burglary, criminal damage, theft and threatening behaviour, for which he was sentenced to 120 hours community service. Mr Sears-Prince's compliance with the order was poor. In March 1992, he was convicted of wounding, assault occasioning actual bodily harm, attempted theft, robbery, burglary and breach of the community service order. For these offences, he was sentenced to two years' imprisonment, which was served in H.M.Y.O.I. Onley. On his release he was under licensed supervision for the remainder of his sentence. Whilst on licence, he was charged with aggravated burglary and was remanded in custody. In October 1993, he was convicted of violent disorder, and sentenced to two years' imprisonment. As he had been remanded in custody, he served only a short

subsequent period in H.M.Y.O.I. Glen Parva and was released on licensed supervision. As a consequence of this criminal history, Mr Sears-Prince had contact with the probation service. This contact terminated at the end of the licensed supervision, for which he reported regularly. We received considerable assistance from the probation service in gaining a clear picture of Mr Sears-Prince's history and in formulating some of our conclusions.

2.9 Mr Sears-Prince was charged with further offences in November 1994, but these were subsequently discharged. In October 1995, a further charge of assault occasioning actual bodily harm was dropped when the complainant withdrew the complaint. In January 1996, he was remanded on bail when charged with an offence contrary to section 18 of the Offences Against the Person Act 1861. He was on bail for this offence when he committed the murder, of which he was subsequently found guilty, on 22 June 1996. We are not in a position to comment on the fact that he was granted bail for this offence, other than to note the preference for bail established by the Bail Act 1976.

2.10 This is a significant criminal history. There is a large number of serious offences involving harm to the person. Looking back at the offences, as we had the advantage of doing, it can be interpreted as a series of offences that increased in severity. Further, the police were well aware of this young man. There were incidents involving Mr Sears-Prince that did not result in charges. He was arrested on a number of occasions for offences of dishonesty and offences of violence. He was known as a violent young man. It is said that he was also known often to be armed with a knife. With the benefit of hindsight, it might be suggested that an offence of the tragic proportions that did occur was one simply waiting to happen.

2.11 One of the major components of a prediction of the dangerousness of an individual is that person's history of violent behaviour. There is a pattern of behaviour in the case of Mr Sears-Prince that would have informed an assessment of his dangerousness. We should make clear that many of the medical personnel were of the view that Mr Sears-Prince was indeed dangerous, but that there was, nevertheless, nothing that could be done for him by the mental health services. The health service does not offer a service solely on the basis of a prediction of dangerousness, but some of its patients are indeed people who present a real risk of danger to others. Clearly many people with psychopathic disorder may present such a risk. For the purposes of assessment, detention under the Mental Health Act 1983, section 2 is possible for a maximum of 28 days. However, the Mental Health Act 1983 only permits the compulsory admission of a person with psychopathic disorder (for a potentially longer period) if that person satisfies all the necessary requirements for admission to hospital including the requirement that is loosely (and often misleadingly) known as the treatability requirement (see, further, section 3.5 below). Section 3(1)(b) of the Mental Health Act 1983 provides one of the criteria that needs to be established and it is this provision which is known as the treatability requirement:

"in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition...."

2.12 Whilst the medical staff were aware of a criminal history, they were not aware of all the details. Mental health services were not party either to the information held by the police or to the, admittedly small amount of, information held within the child protection unit of the social services department. This is information to which the Mental Health Service Trust was not entitled. Some of it might, however, have been revealed, if relevant, had there been a multi-disciplinary meeting which had one of its objectives as the gleaning of information about Mr Sears-Prince. Certainly a response to the letter of Dr McMurran, in which she raised real concerns as to the level of dangerousness presented by Mr Sears-Prince, (see paragraph 4.6) by calling a multi-disciplinary meeting would have provided clearer information about the degree of dangerousness presented by Mr Sears-Prince.

2.13 If more information of the type indicated had been available, further consideration of the case of Mr Sears-Prince might well have taken place. In this Report, we are particularly concerned to determine whether a greater sharing of information might have occurred in the case of Mr Sears-Prince. We believe that it could have done, and that that would have been a valuable exercise.

Drug and alcohol use

2.14 The main source of information about alcohol and drug use is Mr Sears-Prince himself. It is, though, not in doubt that he abused both alcohol and drugs. The extent of that abuse is difficult to judge. He had begun drinking alcohol at a very young age – from somewhere around the age of 13. What Mr Sears-Prince regards as a sociable amount to drink is often, as he is aware, out of line with what most people would accept.

2.15 Mr Sears-Prince had also, at about the same age, begun experimenting with drugs. His primary illicit drug of use, according to him, was cannabis, although he did indulge in others, including LSD, amphetamines, ecstasy and heroin. The Panel is not in a position to judge the extent of his drug abuse. It appears to have been significant.

2.16 It is entirely possible that many, if not all, his problems of inappropriate response to unwelcome stimuli might be related to illicit drugs and alcohol. That was the view of Dr J D Earp, a consultant forensic psychiatrist, who interviewed Mr Sears-Prince whilst he was detained at H.M.Y.O.I. Glen Parva in 1993 whilst awaiting trial. Dr Earp formulated the opinion that his behavioural problems were a product of drug and alcohol abuse and thus any condition that he might suffer from was a product of them and so was not a mental disorder because of the effect of section 1(3) of the Mental Health Act 1983. Section 1(3) states:

"Nothing in subsection (2) above shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."

There was, therefore, no psychiatric disposal recommendation that Dr Earp could make during Mr Sears-Prince's wait for trial. This is a significant view, and had an impact on the thinking of psychiatrists that saw him subsequently. It is absolutely vital that such views be kept under review and that their validity be scrutinised at subsequent assessments. Indeed, in this case Dr Earp now takes a different view from that which he took in 1993. He is now of the opinion that Mr Sears-Prince has a seriously disordered personality that fulfils the diagnosis of psychopathic disorder as defined in the Mental Health Act 1983.

3 Personality disorder

3.1 It is clear from our consideration of this case that Mr Sears-Prince's diagnosis is, if anything, that he suffers from a personality disorder. It is a factor of real significance.

3.2 We have decided to offer some thoughts on personality disorder even though we are well aware of the major inquiry taking place that is concerned with events in the Personality Disorder Unit at Ashworth Hospital. We anticipate that that inquiry will examine all issues surrounding personality disorder and we hope that what we offer may be a contribution to its work.

3.3 It is clear that the aetiology of personality/psychopathic disorder is uncertain and unclear (for a recent summary of some of the research papers, see Jones et al (1998), at p. 59). For obvious reasons, this presents difficulties and controversies in diagnosis of the condition. The term personality refers to enduring qualities of an individual shown in their ways of behaving in a wide variety of circumstances. Personality disorder is diagnosed when enduring or habitual ways of behaving give rise to suffering on the part of the patient, or others directly affected by their actions. The view of personality disorder as a category of psychological disability distinct from mental illness is an enduring and established feature of western psychiatry. It finds its most recent formal, professional expression in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders – DSMIV (American Psychiatric Association, 1994) where a multi-axial classification is proposed. Under this scheme clinical disorders and personality disorders are listed as separate categories of potential disability, as are medical conditions, and psychosocial and environmental problems. Personality disorders are defined by the World Health Organisation as "a variety of clinically significant conditions and behaviour patterns which tend to be persistent and are the expression of an individual's characteristic lifestyle and mode of relating to self and others" (World Health Organisation 1992). These can take a number of distinct forms which differ from one another on the basis of the particular pattern of social dysfunction the

patient exhibits. It also appears as a category within the Mental Health Act 1983 where it is termed psychopathic disorder, and is defined, at section 1(2), as follows:

> "psychopathic disorder' means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned...."

It is our view that Mr Sears-Prince most probably suffers from the personality disorder sub-classified by the International Classification of Diseases and Disorders of the World Health Organisation (ICD-10) as "Emotionally Unstable Personality Disorder; Impulsive Type; Coded F60.30, but a prolonged and detailed assessment would be required to confirm this opinion of the sub-type.

3.4 It is also the case that there is a major professional debate as to what treatments are viable for people so diagnosed (see, e.g., Jones et al (1998)). Drug treatment, which is often viable for people with mental illness, has little impact on people with psychopathic disorder. It must also be recognised that people with this diagnosis often present a real danger to others.

3.5 Psychopathic disorder, as defined at 3.3, is one of the four specifically recognised mental disorders within the Mental Health Act 1983 and is a disorder upon which a compulsory admission may be based (be it through the criminal courts or otherwise). The legislation requires, amongst other things, that the treatment in hospital will "alleviate or prevent a deterioration of" that condition. This meaning is obviously not the same as would be expected from a common sense view of a treatability requirement. The concept is so widely interpreted that providing a secure and controlled environment is now accepted as satisfying the legislative requirement (see the decision of the Court of Appeal in *R* v *Cannons Park Mental Health Review Tribunal, ex parte A* (1994) and commentaries on the case including that by Baker and Crichton (1995)). Clearly, this extended meaning is more applicable where detention (often relatively long term) is contemplated in a secure environment. The local facilities in Leicester would neither be able to provide a secure nor a long term environment. There is considerable debate amongst clinicians as to the propriety of providing a service for people with psychopathic disorder. But it must be recognised that Parliament has provided for the compulsory admission of people with psychopathic disorder and there is an expectation that hospital can be a resource for at least some people diagnosed as having that condition. We do not agree with the approach of the clinicians in Leicester in not assessing the case of Mr Sears-Prince fully. Less criticism can be directed at individual clinicians in relation to the provision of a service, though a proper assessment of the needs of Mr Sears-Prince might have led to proposals that could usefully have been considered. However, it is essential to recognise the professional debate as to the treatability (in the true sense rather than that imported by the Mental Health Act 1983) of persons with psychopathic disorder.

3.6 The varying opinions held by clinicians that inform their decisions about service provision to particular clients do not absolve Trusts from the need to recognise this difficulty and to provide either a service or some guidance to its clinicians as to how to deal with referrals of patients with psychopathic disorder. This is particularly important where the individual clinician may believe that there is nothing in theory, never mind in practice, that can be done for such people (as Dr Walker, Mr Sears-Prince's last responsible medical officer, believed was the case with some patients with psychopathic disorder) even though they may fall within the definitions of the Mental Health Act 1983.

3.7 We are clear that people like Mr Sears-Prince present a real difficulty. It is reasonable to expect as constructive a response as possible. If an individual is not treatable (and this phrase, as we have indicated, has a range of meanings dependent upon the statutory or clinical interpretation and also dependent upon the local services that are actually available for people with that condition), we repeat our view that it is reasonable to expect that a thorough assessment has been undertaken in reaching that conclusion.

3.8 At a national level, decisions have to be made as to what services, if any, should be offered to and for people with a personality disorder. It is by no means clear that these services should be primarily medical. A policy decision must be made as to whether there should be any therapeutic solution to the problem presented by dangerous people with a personality disorder.

3.9 Clinicians in cases such as that of Mr Sears-Prince need to have a clear lead as to the expectations that society has of them. A lead could have been provided by the Trust and the Authority had the care and treatment of people with a personality disorder been addressed by them. We recommend that these two organisations give specific consideration to the peculiar problems presented by people with personality disorder and, pending the outcome of the Ashworth Inquiry and in line with the recommendations by such bodies as the Reed Committee, arrive at an agreed position on what, if any, services are to be offered locally and what action local professionals should take when presented with the case of a person with personality disorder, which can include referral to other agencies.

4 *Contacts with mental health services*

4.1 At all points in the chronology of Mr Sears-Prince's contact with mental health services, it is necessary to consider whether the gravity of his situation was recognised and, if so, whether there was more that could have been done in terms of treatment and care. It is important to stress here that, where the Panel has identified action that could have been taken that was not taken, the Panel is not asserting that a different outcome would have been produced. The nature of the condition and the behaviour of Mr Sears-Prince make it entirely believable that improved action in his case might well have made no difference. However, the Panel is clear that more could have been done, taking into account local and national resources. In particular, it is clear that further assessment of the case of

Mr Sears-Prince was called for. This could have been expected even while respecting the treatment perspectives of individual clinicians. It is why there is considerable discussion in this Report of the importance of a multi-disciplinary meeting and of the Care Programme Approach.

4.2 *First contact: out-patient appointment with Dr Khoosal*

4.2.1 Mr Sears-Prince was first seen by Dr N Hewett, the general practitioner operating at the Y Centre (for homeless people), in October 1993. The objective of Dr Hewett's work is to provide a general practitioner service where necessary, but to sign post homeless people to other services. He is not supposed to become the homeless person's general practitioner, although he may be the doctor who has most contact with a particular individual, as was indeed the case with Mr Sears-Prince from October 1993 until February 1996. Shortly after that date, Mr Sears-Prince's accommodation situation was resolved by the tenancy of a flat in which the murder subsequently took place. He was not homeless for the entire period in question. It is not the case that Dr Hewett was the only doctor seeing Mr Sears-Prince, but he saw him most often. Much of the contact between the two was concerned with prescriptions for insulin and, more importantly for Mr Sears-Prince, for the provision of certificates of incapacity to work on the basis of his diabetes.

4.2.2 In late October 1994, Mr Sears-Prince told Dr Hewett that he was, as Dr Hewett has recorded it, "frightened to go out, anxious and argumentative. He wanted to stop his behaviour because of the problems he was having at home which he said made him feel 'paranoid'." In consequence, Dr Hewett wrote a letter of referral, marked "moderately urgent", to the Department of Psychiatry at Leicester General Hospital on 26 October 1994. In that letter, Dr Hewett refers to Mr Sears-Prince's homelessness status, his diabetes, his having been "in and out of prison" and his "previous history of LSD and amphetamine abuse", though he was denying a current drug problem. Dr Hewett drew attention to the fact that Mr Sears-Prince had been seen by Dr Earp and provided a brief summary of the outcome of that meeting. He then described the presenting complaint around anxiety, 'paranoia', and what Mr Sears-Prince had told him as recorded and referred to above.

4.2.3 As a consequence of this referral, Dr Khoosal saw Mr Sears-Prince on 15 November 1994 as an out-patient. Mr Sears-Prince informed Dr Khoosal that he, Mr Sears-Prince, had a problem with 'nastiness'. It seems possible that the use of this expression indicated some concern on the part of Mr Sears-Prince about his own behaviour and a glimmer of willingness to try to change. It is a pity that it was not found possible to explore this more fully in an attempt to engage more constructively with Mr Sears-Prince. The information available to Dr Khoosal at that time was the letter of reference from Dr Hewett, the interview with Mr Sears-Prince, an interview with his mother, Mrs Sears-Prince, and an assessment made of Mr Sears-Prince when he was detained in Glen Parva by Dr Earp. As a result of that assessment,

Dr Earp had formed the view that Mr Sears-Prince had no mental illness or mental impairment. He also felt that there was insufficient evidence to support a diagnosis of psychopathic disorder as the irresponsible and aggressive behaviour identified was "invariably associated with drug abuse" and this led Dr Earp to conclude that, in accordance with section 1(3) of the Mental Health Act, there was no mental disorder within the meaning of the Act (see also paragraph 2.16).

4.2.4 As a result of the out-patient appointment, Dr Khoosal wrote a letter to the referring general practitioner (Dr Hewett), advised Mr Sears-Prince to seek help with his diabetes from his general practitioner, referred Mr Sears-Prince to Paget House for his drug problem, and discharged him.

4.2.5 It appears that Dr Khoosal did not fully understand the consequences of the referral to Paget House. Two organisations operated within the physical environs of Paget House. One was the medical drugs service; the other was a front-end, drop-in service provided by a charitable organisation. Referrals to Paget House that were not specific would result in the person being assessed by the charitable organisation. That organisation might involve the health service, dependent upon the assessment of the person referred and their willingness to be involved. The confidentiality policy of the organisation meant that it did not feed back to the person making the original referral without the consent of the person involved, unless exceptional circumstances existed, which was not the case with Mr Sears-Prince. Dr Khoosal received no information and the referral was not followed up. In part, this was also because Dr Khoosal was absent from work for the best part of a year from a time shortly after he had seen Mr Sears-Prince. As Dr Khoosal commented to the Panel, it would have been better had this referral been followed up. However, it was, it would appear, assumed by the medical team that Mr Sears-Prince did access the service offered and that the nub of the problem was, therefore, being dealt with. In fact, Mr Sears-Prince did not access the service. He missed the appointments that were made for him, though he may have called in on at least one occasion. This disorganised pattern of behaviour appears to be characteristic of him.

4.2.6 Dr Khoosal also had a letter from the Solicitor Advocate then working for Mr Sears-Prince, David Bate, who has sadly since died and whose records no longer exist. Mr Bate took the view that there was something very wrong with Mr Sears-Prince and that action needed to be taken to help him. We have already referred to Mr Bate drawing the attention of mental health services to the possible interconnection between violence and diabetes in the case of Mr Sears-Prince (see paragraph 2.4). In his letter, Mr Bate drew attention to the violent nature of Mr Sears-Prince's offending behaviour and stated that they were mainly "cases of extreme violence." Mr Bate also stated that "Bradley is desperately seeking help."

4.2.7 Dr Khoosal did not consider that a referral to another specialist service, such as the forensic psychiatry service was appropriate. This decision was made partly because he had taken a professional view of Mr Sears-Prince's problem. He had determined that it did not demand the specialist services offered through forensic psychiatry. However, there is also the impression that this was informed by a view of forensic psychiatry as being a service that was then difficult to contact and access, and that therefore a referral was not worth making anyway. This is not consistent with the view of the Forensic Psychiatry service as expressed by its then manager and the then clinical co-director. Dr Khoosal's view is consistent with that of Dr Walker, the consultant who took over responsibility for the care of Mr Sears-Prince. Perceptions, whether accurate or not, are almost as important as realities. We note that there is an inconsistent picture presented by these views. The most likely explanation surrounds personal relationships, personal experience of perceived or real difficulties in contacting specialist agencies on an individual rather than systematic basis, and a failure, on the part of general psychiatrists (which may be an understandable confusion), to understand the nature of the forensic services provided. Only a small part of the forensic services provided in Leicester is the District Forensic Service; the greater portion of the work is concerned with the work of the Medium Secure Unit at Arnold Lodge and consequent out-patient work. The former does have some beds on the Glenfield Hospital site. As indicated in the contract specification for 1995/96, the focus of the District Forensic Service would suggest that the case of Mr Sears-Prince would not clearly fall within the work of the Service as he was not currently before the courts nor being interviewed by the police as would seem to have been required (see Appendix C, at paras. 1.1.1, 1.2.1, 1.2.2, 1.2.3 and 3.0). This delineation of the work of the forensic psychiatry service is not a surprising one. We have had our attention drawn, by the Leicestershire Mental Health Services NHS Trust, to the fact that there is a difference between the guiding principles that were framed for the creation of the District Forensic Service and the contract specifications upon which we have relied. Clinicians, it was suggested, who were likely to refer patients to the service would have had in mind the guiding principles rather than the contract specification. Whilst the Trust does not disagree with the perception of inaccessibility of the District Forensic Service at the time, it would seem that there was also a discrepancy between the original proposals for the service and the service that was actually offered under the contract specification. This would have added to the sense of confusion and to the sense of inaccessibility evident at the time.

4.2.8 If a service is to be provided to people such as Mr Sears-Prince, there needs to be greater clarification as to what is available and from whom (both within and outside the Trust). The intention was not that the District Forensic Service was to provide a service to patients with personality disorder per se. Whether a service should be provided is a matter which the Trust and the Authority need to consider, and which we discuss elsewhere (see paragraphs 3.6, 3.9 and 8.2).

4.3 *Second contact: first hospital admission August 1995*

4.3.1 On 15 August 1995, Mr Sears-Prince presented himself at the Accident and Emergency Department of The Leicester Royal Infirmary. He was expressing suicidal ideas for the first time in his life, though he later denied that. He said that he was afraid that he would harm himself or other people. Because of the nature of his earlier contact with mental health services, there was doubt in the minds of the ward staff as to the propriety of this admission and whether there was anything that could be provided for him. Mr Sears-Prince settled quickly on the ward and presented no management problems.

4.3.2 There is a consistent theme that Mr Sears-Prince presented as being concerned about his own violence. It is a moot point whether this was treated sufficiently seriously by those who heard him express his concerns. It is entirely believable that staff who heard him dismissed his claims. From what we have been able to glean, it appears plausible to suggest that he is capable of deception and manipulation. If so, that is a capacity that is consistent with the view that he has a personality disorder. Words of concern and remorse might then be viewed as the mere use of words that he knows will have impact without necessarily reflecting their true meaning. On the other hand, he may have been sincere in his continued expressions of concern about his violence and the impact that it has on himself, his family and others, including its victims. There are issues here that deserved full consideration through a thorough assessment of the condition of Mr Sears-Prince and any treatment needs that he might have had.

4.3.3 His family clearly were very concerned about the behaviour and degree of violence presented by Mr Sears-Prince. They are deeply concerned that their cries for help on behalf of Mr Sears-Prince were not, as they perceive, heeded. From a lay perspective, it is difficult to know what agency can best help. Whilst it may not have been the health service in this particular case, that service does, or should, have the capacity to refer the case of an individual to a more appropriate agency. Again, this reflects the need for a careful assessment of this particular case.

4.3.4 There was a suspicion that he may have accessed mental health services as a means of avoiding other issues or of seeking benefits for himself.

4.3.5 At a time when, for various unforeseen reasons, there was little in the way of consultant cover, Mr Sears-Prince was admitted to Knighton Ward, nominally in the care of Dr Khoosal, who was not, at that time, back at work. In fact, Mr Sears-Prince was admitted under the care of Dr Chakrabarti, a registrar (receiving supervision from Dr Warrington the only consultant out of a team of three then in post and available). We have

considerable sympathy with the difficult general position in which Dr Chakrabarti must have found himself. As a junior doctor, he was expected to take considerable responsibility because of the difficulties that some have alleged were management failings in recruiting to a vacant consultant post.

4.3.6 On seeing Mr Sears-Prince on 16 August 1995, Dr Chakrabarti noted that the major issue was the inability to control his anger outbursts, for which Mr Sears-Prince often subsequently felt remorse. Dr Chakrabarti recorded that Mr Sears-Prince informed him of a history of conduct disorder in childhood and of a head injury in childhood that had precipitated many headaches. Mr Sears-Prince's history of cannabis abuse/dependence was noted, as was his history of use of opiates and LSD. It was this history that resulted in Mr Sears-Prince spending his longest period in hospital at this time. Dr Chakrabarti wondered if there might be some seizure phenomena behind the violent outbursts and so decided that it would be appropriate to carry out an EEG. This took some time to organise. It appears that this is the only reason why this admission lasted for as long as it did. The EEG result was normal. Mr Sears-Prince was then discharged.

4.3.7 On discharge, Dr Chakrabarti referred Mr Sears-Prince to the Forensic Psychology Service based at Arnold Lodge for anger management. Whilst in hospital, Mr Sears-Prince had been put on a trial of carbamazepine. It is not clear that it was intended that this medication be continued after discharge. The discharge plan, noted on 21 August 1995 prior to the results of the EEG, states that, on reviewing the EEG, it would be necessary to "decide on medication". Mr Sears-Prince was able to continue to receive carbamazepine on prescription after his discharge. He was given an out-patient appointment. The conclusion appears to be that Mr Sears-Prince did not have a mental illness and that his major problem surrounded drugs and anger control. It is important to note that a care plan was established, even if it might be argued that at this (or other stages) more could have been done. However, greater clarity as to the final decision is necessary, in particular where interim decisions are recorded.

4.3.8 A full assessment through a multi-disciplinary meeting would have enabled a thorough professional view to have been taken of the condition and prospects for treatment of Mr Sears-Prince. This meeting would have occurred as a result of application of the Care Programme Approach. Whilst some appropriate action was taken in terms of referral to the drug advice centre (after the initial out-patient appointment) and subsequently to anger management therapy (after the first hospital admission), both of which may be seen as appropriate responses to the problems with which he was presenting, whatever might have been thought about his sincerity or motivation, a full assessment was not carried out. There is, therefore, a strong argument in favour of having considered that Mr Sears-Prince might have been suitable for the Care Programme Approach at the time of this, his

first, admission to hospital. Whilst there appears to have been agreement that there was little that could be done for this man who appeared to have a personality disorder (which would appear to satisfy the definition of psychopathic disorder within the Mental Health Act), a treatment plan (perhaps better described as a care plan) was devised for him.

4.3.9 It had been decided, upon admission that Mr Sears-Prince was "not for CPA", that is it was determined that he was not for the Care Programme Approach. The Trust's policy adopted was that screening should be undertaken by the first mental health professional who had contact with a patient: this would ordinarily be the admitting nurse. At the time of this admission there was no expectation of a further consideration of the desirability of applying the CPA during the hospital stay, although it was, according to the then procedure, possible. The nurse conscientiously, within the advice that she had been given at this very early stage of the Trust's implementation of the Care Programme Approach, determined that Mr Sears-Prince did not fit the criteria for the CPA. This nurse graphically explained the difficulties of determining the propriety of the CPA for an individual not already well known to the mental health services.

4.3.10 Despite the fact that the Care Programme Approach was announced in 1991, it appears that it was not until early 1995 that any documentation was produced to secure its implementation within the Trust. That documentation was sparse and difficult to use. It was replaced by more comprehensive documentation in October 1995, after Mr Sears-Prince's first admission.

4.3.11 We should emphasise, however, that, at the time of the first admission, ward staff may have taken the view that the Care Programme Approach was not for people with psychopathic disorder, though this point was not made by those giving evidence to the Panel. Ward staff may also have taken the view that this man did not fall into the high dependency category, which was all that the then documentation referred to. It is not possible to determine the extent to which this factor had a role to play as full reasons for screening someone out of the Care Programme Approach were, and are, not required, and it was not possible to determine the extent to which this had an influence upon the decision-making. We recommend that the process be amended so that there is a requirement for reasons to be given for decisions taken about applying the Care Programme Approach to any individual.

4.4 *Third contact: second admission to hospital – November 1995*

4.4.1 On 17 November 1995, Mr Sears-Prince presented himself for admission again. Again it was decided, on admission to hospital, that he was "not for CPA". This decision was undertaken, as per the Policy, by the first mental health professional with whom he was in contact. It would appear that, once it was determined that he was "not for CPA", there was no re-consideration, during his hospital stay, of this assessment. Reconsideration was expected

by the policy that had been introduced since the first admission of Mr Sears-Prince to hospital. That policy had been introduced in October 1995. Staff have reported that they had no training and that their only introduction was a leaflet explaining the procedure. The Panel's impression was that, although there was real commitment on the part of many people within the Trust to the CPA, this was not reflected in management commitment and delivery.

4.4.2 The doctor responsible for the care of Mr Sears-Prince at this time was Dr Walker, a consultant. He has taken the very clear view that Mr Sears-Prince was a person suffering from a personality disorder for whom there was no treatment available. It seems most likely that Mr Sears-Prince does indeed have a personality disorder (see paragraphs 3.1 and 3.3), though sustained assessment had not then been undertaken to confirm this diagnosis. It is possible that there is little, if any, treatment locally available that would have been worth undertaking. Indeed, Dr Walker was highly sceptical of the referral to anger management and it may well be that no psychotherapeutic work with Mr Sears-Prince has any chance of success. However, that stance cannot be sustained as an acceptable reason for failing fully to explore every possibility. Given what was known at that time about Mr Sears-Prince's previous behaviour and his own acknowledgement that something was wrong, even greater care should have been taken to obtain the widest possible consensus on how best to deal with someone who was a major problem to the community and to himself.

4.4.3 It should be understood that the service within which Dr Walker was a consultant was established to concentrate, primarily, on people with severe mental health problems. All diagnoses (other than learning disability) could be handled, but there was no particular expertise in handling people with personality disorder. Further, neither the Trust nor the Authority have any specific strategy for dealing with people with personality disorder, by way of explicit integration within existing services, the development of a specific local service, referral on to other specialist services or by virtue of a policy decision whereby a service is not offered to people with personality disorder except where a clear treatment can be successful.

4.4.4 The treatment and care of people with personality disorder is a matter that is much greater than can be addressed in a report of a Homicide Inquiry. What is clearly demanded is a debate as to how society and professionals view the care and treatment of such people and a clear strategy must be agreed at a national level (see also paragraph 3.8).

4.4.5. As regards this particular case, it is clear that little investigation had been undertaken into the potential treatability of Mr Sears-Prince. It is not the view of the Inquiry that there is an obvious treatment option, but a full multi-disciplinary meeting, as triggered through application of the Care Programme Approach, ought to have ensured that the matter was thoroughly debated and, perhaps, specialised services might have been accessed for advice and

assistance, for example, the local forensic psychiatry service or the personality disorder service at a hospital such as Rampton High Security Hospital.

4.4.6 It is interesting to note that a decision was made at the end of Mr Sears-Prince's November 1995 admission, at Dr Walker's ward round on 20 November, that he was for discharge that day and that his case be referred to a Community Psychiatric Nurse (the file note states "arrange CPN"). It is not clear what this referral was intended to achieve, nor is there any evidence that it was ever made. Systems must be in place to ensure that, when decisions are made, they are actioned. This is the responsibility of both the consultant and the ward staff. It is recommended that the failure to action the decision for referral be considered very carefully by the Trust and that a system to ensure that such action is taken be either introduced or re-emphasised and that quality audits should be enabled to assess whether decisions are actioned appropriately.

4.4.7 Of course, one interesting thing that arises from the decision to refer the case to a C.P.N. is to consider its implications in the light of the decision that Mr Sears-Prince was "Not for CPA" and the view of Dr Walker that there was nothing that could be done for him. The juxtaposition of these factors presents an inconsistent picture. It displays a team wishing to follow up on its patients, and to have an appropriate care plan. But it also displays a team that deliberately or through ignorance or whatever did not wish to "play the game" by applying the rules relating to the implementation of the Care Programme Approach. A multi-disciplinary team meeting should have taken place.

4.5 *Fourth contact: third admission to hospital – February 1996*

4.5.1 Mr Sears-Prince was admitted for the last time, for an overnight period, on 5-6 February 1996. Mr Sears-Prince's admission followed the referral to the Leicester General Hospital by an on-call general practitioner. Had Dr Walker been on duty, it is quite clear that Mr Sears-Prince would have been turned away. The staff suspected that he did not really wish for help from psychiatric services but had other reasons for setting in motion the process that led to his admission, such as securing accommodation. On this occasion, he had just been ejected and banned from a local hostel, and he had no other accommodation available to him. It seems quite likely that this stay was motivated simply by a desire to have a bed for the night. We wonder whether it would not be possible to have a system, sensitive to changing facts and conditions, whereby people known to the service, and known not to be people that the service can assist, are not normally admitted inappropriately. There was some evidence offered to the Panel that there are many night time admissions that result in immediate discharge the following day. Of course, the vast majority of these will have involved entirely appropriate and consistent actions.

4.6 *Fifth contact: anger management therapy*

4.6.1 Whilst the February admission adds to the existing picture, it does not really make a significant addition. What is additional information about Mr Sears-Prince came, shortly after this admission, from Dr McMurran, a forensic psychologist, who was seeing Mr Sears-Prince as a result of the referral of him for anger management therapy. The referral was made to Dr McMurran by Dr Chakrabarti after Mr Sears-Prince's first admission to hospital in August 1995. Dr Chakrabarti wrote to Dr McMurran on 31 August 1995 making the referral. Dr McMurran was first able to see Mr Sears-Prince on 1 February 1996 and saw him on two occasions. By the time that she decided that it was necessary to contact Dr Chakrabarti, the referring doctor, she had offered Mr Sears-Prince two further interviews. One he cancelled, the other he did not attend. She wrote to Dr Chakrabarti on 26 March 1996. It is this letter which was passed to Dr Walker who was, by then, the doctor responsible for the treatment and care of Mr Sears-Prince.

4.6.2 In that letter, Dr McMurran raised very serious concerns about Mr Sears-Prince. She made clear that he had presented as very distressed, that he had problems with temper control and that his violence was "extremely worrying". She stated that he was "on bail for assault with intent to endanger life", which is a reference to the section 18 charge that he was then facing. She related the information that he was banned, for life, from a night shelter. She relayed the information that he was "extremely angry with Dr Walker". In conclusion, Dr McMurran took the view that she was "concerned that Mr Sears-Prince is a risk to the public and I should like to ask your advice on the appropriateness of a Care Programme Approach with this man."

4.6.3 It seems clear, from the policy, that Dr McMurran could have initiated such a meeting, though she was not aware of it at the time. Subsequently, she sought the introduction of an extra policy about the role of the Psychology Service in the Care Programme Approach. In the light of the CPA Policy, this seems to be unnecessary.

4.6.4 Of much greater significance is the approach that Dr Walker took to this letter. It seems to us that his response displayed, at the least, unacceptable professional discourtesy. The letter was a clear indicator of concern that Mr Sears-Prince presented a serious threat to others (of which Dr Walker was well aware) and that a professional colleague took the view that it was worth discussing his case. At the least, the Panel takes the view that Dr Walker should have talked in detail with Dr McMurran about her concerns and about his approach to Mr Sears-Prince; and that they should have agreed (even if very reluctantly on the part of Dr Walker) that a CPA or multi-disciplinary meeting be held. That meeting would, we are sure, have enabled many, if not all, the agencies with which Mr Sears-Prince was involved being invited and attending the meeting (see below).

4.6.5. By this time, there is a man with a history of contact with mental health services, who is thought to have a personality disorder; he has a significant forensic history; he has had diabetes since the age of 11, which has often been poorly controlled. Does this concatenation of factors merit or demand a different medical response than that hitherto? We suggest that there are many practitioners who would indeed have revisited their earlier conclusions and reconsidered the case.

5 Contact with the Housing Department of Leicester City Council

5.1 Mr Sears-Prince was well known to the Housing Department of Leicester City Council. It was one of the agencies that had considerable information about Mr Sears-Prince. That information would have been valuable to the mental health services. Some at least of that information might have been available through application of the Care Programme Approach.

5.2 Mr Sears-Prince made his first housing application in October 1992. He commenced his first tenancy in May 1994, which was a joint tenancy with his then partner. He had been assisted in getting the tenancy by the report of Dr Hewett (the Y Centre General Practitioner) about his diabetes, amongst other matters, and the need for a regular lifestyle. His partner gave notice to quit because she said that Mr Sears-Prince was assaulting her. He was given notice to quit and disappeared from the tenancy.

5.3 Mr Sears-Prince made a second housing application and presented as homeless in August 1995. He made the application, in effect, from the first stay in hospital. At the interview to assess his needs, the Housing Department gained considerable information about Mr Sears-Prince that included his claim that he had been having mental health problems for a few years, that his diabetes gave rise, on occasion, to fits (as we report elsewhere), that he had violent behaviour that could be triggered by anything or nothing, (he said that his admission to hospital had been triggered by him having suicidal thoughts). He made a request for temporary accommodation. Because he was not prepared to accept the hostel accommodation that was available, Mr Sears-Prince indicated that he would be able to stay at home for a few days. In the meantime, Mr Sears-Prince was seen by the social worker working at the Y Centre. She took the view that his problems were drug related, and saw no evidence that would raise in her concerns about his mental state. The Housing Department contacted the doctor on the ward, but did not receive a reply. It is clear that the Housing Department feels that contact with such a large organisation as a health service trust can be difficult. We formed the opinion that the Housing Department is keen to liaise with health and other colleagues whenever possible, indeed that is necessary to fulfil their statutory duties with regard to the provision of housing and responding to the needs of homeless people. We feel that there is an issue here which would repay further consideration. We are sure

thatthere is a commitment on all sides to improve communications for the benefit of all concerned, and we have no doubt that there would be a positive outcome to such consideration (see also paragraph 2.6).

5.4 Mr Sears-Prince was found hostel accommodation at the end of September 1995. His case was closed because he had left the hostel in mid-October and was not in contact with the Housing Department.

5.5 Mr Sears-Prince made his second homelessness application, a joint one with his then partner, at the end of January 1996. At the time of this application, he appeared to be much less vulnerable than at the time of his earlier application. It was decided, therefore, that he was homeless but not in priority need. Eventually a flat was made available in consequence of this application. There were no concerns about him as a tenant of this, the flat in which the murder took place.

6 Care Programme Approach

6.1 It should now be clear that we believe that application of the Care Programme Approach would have been appropriate. This should have resulted in the calling of a multi-disciplinary meeting that would have resulted in the more thorough assessment of Mr Sears-Prince that clearly was warranted. Indeed, one benefit of the Inquiry, and of hindsight, has revealed a young man in contact with many agencies. It also reveals that many of those agencies were unaware of the involvement of others. We, therefore, consider this matter in further detail.

6.2 The Care Programme Approach at its heart merely requires the placing on record of what is regarded as good practice. It requires an identification of the needs of all the people presenting to psychiatric services and a determination, at a multi-disciplinary meeting, of what, if anything, can be offered to each individual person. The Care Programme Approach was launched by the Government in 1991. The Mental Health Trust had documentation in place from February 1995 and a full policy from October 1995. The initial documentation, that indicates the step by step process to be followed, may be found at Appendix D. The various forms were in use, or at least the Panel can confirm that the Screening Form was in use.

6.3 From the Trust's step by step process document (see Appendix D), it will be noted, in so far as is relevant to the care and treatment of Mr Sears-Prince, that personality disorder is included as a condition for which the Care Programme Approach is relevant in the notes on the reverse of the form. Nevertheless, there is a debate, similar to that in relation to the treatability of personality disorder, as to whether much, if any, purpose is served by applying the CPA to people with personality disorder. Having considered this case carefully, the Panel takes the view that there is a value in that it

enables the collation and consideration of more information about such an individual than would otherwise be available and brings the knowledge and skill of practitioners from a number of professions to bear on the matter in hand. This will lead to more appropriate decisions and strategies being adopted.

6.4 The confusion about the applicability of the CPA to people with personality disorder is contributed to by the government advice, which is clearly primarily aimed at people with (severe) mental illness. Indeed, the original CPA policy documentation referred only to mental illness, as does the supervision register circular and "Building Bridges," which is the Government's guide to arrangements for inter-agency working for the care and protection of severely mentally ill people, published in 1996. Thus it is understandable for people to take the view that personality disorder does not fit well with the objectives of the CPA However, in HSG(94)27 on discharge procedures, the CPA is said to apply to people with personality disorder, but only where that can be done "safely and suitably". It may well be argued that this could not have been achieved in the case of Mr Sears-Prince. We do not agree, but recognise that this is a credible perspective. In any case, we take the view that a multi-disciplinary meeting concerned with the problems that this man presented would have been good practice, regardless of any debate about the applicability of the CPA

6.5 From the Trust's step by step process, it will also be noted that the primary focus of the form is on those who are assessed as having high level dependency needs. A "high dependency client" is defined as someone who displays "significant mental disturbance associated with psychosis, organic illness or damage, personality or affective disorder, or phobic symptoms and/or will be debilitated by the long term effects of their mental illness The debilitation will be in relation to the clients biological/psychological/social/spiritual ability to function independently. They will also be people who will require a package of multi-agency support in order to function within the community." One question that we will address is whether Mr Sears-Prince could have been regarded as a high dependency client. The process made clear that assessment for CPA should take place at the first formal contact and be undertaken by a mental health professional (that is a doctor, qualified nurse, qualified occupational therapist, psychologist or suitably qualified social services staff). The process also makes clear that "screening can take place at any point if a mental health professional feels it is required". It is this system that was in place at the time of the first admission to hospital of Mr Sears-Prince in August 1995.

6.6 The level of knowledge about the CPA in August 1995 seems to have been very sparse, according to the evidence that we received. There was a clear view that there had been no training and that people were having to endeavour to work the system without, they felt, having any clear guidance.

Several witnesses told us that a good deal of effort had gone into CPA training at all levels of staff, across disciplines and between local authorities and health authorities and trusts. Leicestershire Social Services Department in particular, as the relevant local authority before the reorganisation of local government which took effect in April 1997, invested considerable energy in developing and conducting training programmes for its own and NHS staff. The successor County Council and the Leicester City Council appear equally committed to joint training. In fact, the audit undertaken by the NHS Care Programme Approach manager in 1997 reports that there had been a training programme in early 1995.

6.7 The Screening Form is to be completed at the time of the initial admission. This form (see Appendix E) requires little to be filled in when a patient is not suitable for the Care Programme Approach. At this stage, the Panel needs to draw attention to a confusion that dogged the Panel and seems to have existed both before and after the introduction of the Policy in October 1995. The agreed policy appears to be that all patients in contact with the mental health services should be assessed for CPA If they are high or medium dependency clients (though the latter are not referred to on the step by step process document), the CPA is to be utilised fully. If they are identified as being low dependency clients, they will not have a care programme but will have a care plan. A care plan involves a procedure that operates locally without the involvement of the Trust's CPA office. The first level of confusion is when statements appear on the patient's record, as they did with regard to Mr Sears-Prince, that a person is "not for C.P.A". It was difficult to resolve exactly what this phrase was intended to mean. Within the Policy it should have meant that the patient was low dependency and therefore that there would be a care plan. However, an alternative view is that it meant that the service should have nothing further to do with the patient. We can well imagine that there may be inappropriate admissions to hospital that result in an assessment that the mental health services should have no contact with the person in the foreseeable future. Such a decision could not be made without a careful, multi-disciplinary assessment of the needs of the individual in question, in the light of currently available local and national facilities, and in recognition of the fact that circumstances change thus potentially undermining the basis for such decisions.

6.8 Mr Sears-Prince clearly was not regarded by the ward staff as satisfying the criteria for high or medium dependency. We are not clear whether the consequence was that the staff assumed that he was a low dependency patient or whether the staff were, in effect, discharging him completely from any further contact with the service.

6.9 There are also inconsistencies revealed by what we heard. There is a clear view, most eloquently and forcefully expressed by Dr Walker, that there was absolutely nothing that could be done for Mr Sears-Prince. Not only were there no local services suitable (indeed Dr Walker suggested that he was

having to protect the Community Mental Health Teams from too many such referrals because of excessive workloads), but also there were no treatment options at all available for a patient like this, who Dr Walker regards as a severe case of personality disorder (see paragraph 4.4.2). However, care plans (in effect even if not so called) were drawn up for Mr Sears-Prince, or, rather, action was identified and, usually, taken that was consistent with the creation of a care plan. If we include the initial out-patient appointment, this action involves: referral to the drugs advice service, referral to anger management therapy, a trial of carbamazepine (though it was not clear that it was intended that this continue when living in the community), and referral to a community psychiatric nurse (though this was not actioned). Whether this is sufficient identified action in the case of Mr Sears-Prince, we doubt, even despite the credibility of the view expressed in regard to the possible responses to personality disorder.

6.10 Care Programme Approach screening was always done in the case of Mr Sears-Prince. When the screening was done, we are not entirely clear how the staff were able to make the decisions (see paragraph 4.3.9). It seems that the Roy Assessment Tool was in use. Nevertheless, if the decision was "not for CPA", it is difficult to assess the basis on which that decision was made. This means that an Inquiry like ours finds it difficult to investigate the decision. Much more importantly, it is difficult to audit and learn from such decisions. At present, the audit process is not aimed at assessing decisions that are made. We believe that a valuable learning opportunity is thereby being missed. It is only by careful reflection on actual decisions that have been made that staff can develop their expertise and conform their approach to a common norm.

6.11 It will have been noted that Mr Sears-Prince was screened for the Care Programme Approach on admission only. This was consistent with the Policy at its inception, although the version of the Policy that came into force in October 1995 expected that this decision be reviewed. The rationale for this position is eminently sensible, since it reflects the need to be planning for discharge from the time of admission onwards. In a service in which the average stay is relatively short, this is essential. However, that decision should not then be taken as writ in stone. It is important that staff understand why they are asked to screen for the CPA on admission and why it is necessary to evaluate that decision in the view of information acquired during the case of a person's stay in hospital. Where there is a screening process on admission, there is the real risk that it will become a paper exercise only.

6.12 In summary, when looking at the operation of the Care Programme Approach as a whole in relation to Mr Sears-Prince, it seems clear that staff took the view that there was nothing that could be done for this man either within or outside hospital and that, therefore, applying the Care Programme Approach in relation to him was a waste of time, and would merely be an ineffectual

and bureaucratic exercise. There are three levels at which this must be considered. First, it needs to be considered whether Mr Sears-Prince could have been argued to have satisfied the definitions sufficient to warrant the CPA in his case. Secondly, if he was not for CPA, it needs to be considered what more could have been done within the care plan approach for people classified as low dependency patients. Thirdly, consideration must be given to the view that Mr Sears-Prince should not even have fallen within care planning.

6.13 We have reproduced the initial definition of a high dependency patient above at paragraph 6.5. This was expanded upon in the policy that was adopted in October 1995. The new definitions, and the definition of medium dependency, are to be found at Appendix F. It seems to us that Mr Sears-Prince could have been seen as falling within one of these two definitions.

6.14 The consequence of placing him in the high dependency category would have been the application of the principles of the Care Programme Approach. The one that we feel might have been most suitable is, as stated in the Trust's policy, the "development of a package of care, within available resources, agreed with the patient, their carers and the members of the multi-disciplinary team involved with her/his care" (emphasis added). We place considerable importance on the advantages that would have followed from the holding of a multi-disciplinary meeting.

6.15 If we believe that a multi-disciplinary meeting, produced by application of the CPA, would be an example of good practice, it might well be asked what might it have achieved. First, we are not in a position to say that it would have prevented this tragic incident. Indeed, little, apart from incarceration might have prevented it. However, certain positive outcomes would have been achieved. These would have included a clearer picture of the problems presented by and facing Mr Sears-Prince; a clearer view of an appropriate care plan to assist with addressing those problems where possible; a more cohesive and coherent view of the limitations of what could be achieved with and provided for Mr Sears-Prince, indeed this should have involved a decision to make a fuller assessment of his condition (including the contribution of his diabetes); and a clearer assessment of the risks presented by him, that could have resulted in a variety of strategies being adopted including hospitalisation either locally or elsewhere.

6.16 The clearest means to achieve these outcomes would have been through as broad an invitation list and attendance of various staff as possible at such a meeting. With hindsight it is clear that the following could have made a valuable contribution. The responsible medical officer, ward staff, a social worker from the relevant Community Mental Health Team (perhaps also the social worker who had had brief contact with Mr Sears-Prince in the Y Centre or at least contact with her to inform the social worker that did attend, and also that social worker might have been able to access the information on

record about Mr Sears-Prince and his family), a representative from the Housing Department (see section 5), his general practitioner (this could refer either to Dr Hewett or to the registered general practitioner on whose list Mr Sears-Prince appeared as a child), the police, someone from the probation service, representatives from Paget House (perhaps both arms), Dr McMurran (the forensic psychologist to whom Mr Sears-Prince was referred for anger management), Mr Sears-Prince, Mrs Sears-Prince (his mother), his partner, and a Community Psychiatric Nurse (especially if a referral had been made after the November 1995 admission).

6.17 If invitations had been issued, it is likely that some agencies would have felt that their engagement with Mr Sears-Prince was not sufficiently recent to enable them to make a valuable contribution and some, by the very nature of such meetings, would not have been able to attend. Nevertheless, we believe that a sufficiently broad-ranging group would have met to enable a careful consideration of the case of Mr Sears-Prince.

6.18 Even if the view is that he was not either high or medium dependency, it then follows that it must be considered whether he was a low dependency client. The definition is to be found at Appendix F. It seems difficult to place Mr Sears-Prince in this category.

6.19 If it is acceptable to place certain people outside CPA (other than those who obviously have no need for future contact), it would then have to be accepted that mental health services are entitled to reject someone from their service. This is certainly one interpretation of the view of Dr Walker. The special difficulty with this view is that, as we have mentioned at paragraphs 4.3.7, 4.4.7 and 6.9, there was action taken that might be regarded as inconsistent with the view that there was nothing that could be done for him. On a more general level, it would appear that rejection of patients with personality disorder deemed not to be treatable should be one that is either accepted or rejected at Trust and Authority level, if not at a national level. We have considered this point further at section 3.

6.20 It is easy to make the Care Programme Approach a bureaucratic, administrative process. The view of many of the staff accords with that view. It would seem that the view was being taken about CPA that it was a national initiative and was not specifically related to local implementation. This is a view that still prevails to some extent, and has been evidenced in the Audit undertaken by the University of Leicester. The failure to own the policy and believe in it meant that it was not regarded as a high priority. In consequence, it could even be said that some attitudes to CPA were cavalier.

6.21 It is important that the Trust constantly bears the over bureaucratisation of Policies in mind. The Care Programme Approach only works where those implementing the Approach value it and believe that it has a role to play in the delivery of care and treatment to their patients. We suggest that there is

an extent to which the CPA implementation within the Trust had become overly bureaucratic. It is the task of senior managers in any organisation to ensure that clear policy is developed, put into action and that there is compliance with it. The Panel is left in some doubt that this process was applied by the senior managers of the day in this case.

6.22 If staff are to believe in the Care Programme Approach at a local level, it is important that the documentation be clear and short. The documentation that was presented to the Panel was of an acceptable quality, in so far as it went. Its clarity could be improved. This is particularly so of the only documentation that was in use (the step by step process reproduced at Appendix D) between February and October 1995. As documentation for the Trust management, the Policy adopted in October 1995 has a clear role to play. However, it would seem to be too long for staff to read and digest it or to make use of it on a daily basis. Documentation that is too brief is likely to obscure the issues that staff need to consider. We believe that improved documentation, coupled with adequate training and effective managerial oversight, would have avoided some of the confusion associated with the application of the CPA to the case of Mr Sears-Prince.

6.23 It was disturbing to hear that ward staff were expected to implement the policy without any training. Initially the only guidance was the two page documentation reproduced at Appendices D (pages 2) and E (page 1). This is not easy to follow. We strongly recommend that consideration be given to a review of the documentation accompanying CPA.

6.24 We conclude from our perspective that there was insufficient management interest, ownership and drive behind the Care Programme Approach and its implementation. This is reflected in the time that it appears to have taken to implement CPA, the lack of training that appears to have been associated with CPA and the general malaise that is apparent to us in the attitude towards it. The Trust has commented that it has no disagreement that the process took an inordinately long time to implement (and that only partially). However, one of the problems, it said, with CPA implementation was the opposition of some clinicians to its implementation. Management at that time was presented with a problem, therefore, and decided to take an essentialist and, perhaps, dogmatic approach to implementation. As the Trust goes on to point out, this in turn led to further resentment on the part of some senior medical staff and the descent of the COA management into bureaucracy, with many clinicians at best observing the letter of the guidance but with little commitment to its spirit.

6.25 Our final comments on the Care Programme Approach are to draw attention to the findings of the "Audit of the Care Programme Approach I LMHS NHS Trust" undertaken by J S Forbes and L J Edwards of the University of Leicester and to confirm that much of what we identified confirms those findings. Whilst we are not in a position to endorse all that is said in the

Report, we endorse many of the findings, and we support the recommendations made.

7 Liaison between agencies

7.1 Liaison between various agencies can play a critical role in how people with mental health needs, which for present purposes may be assumed to include a personality disorder, are provided with treatment and care. Many reports have commented on communication difficulties. We would remind the various agencies within Leicestershire of this aspect of many Homicide Inquiry Reports and ask them to reflect upon the systems and means that they have adopted for ensuring that information is shared as and when necessary. We were impressed by the commitment of the Housing Department to being involved with clients/patients as and when necessary, but were also struck by the difficulty it reported in ensuring contact was successful when attempted. We are fully mindful of the need to respect confidentiality in this regard. There is a difficult balance to be drawn between the sharing of information on the basis of need and the public interest on the one hand, and the need to respect the confidentiality of individuals, on the other hand. We, therefore, commend the work of the group looking at the sharing of information on an inter-agency basis (Leicestershire Joint Strategy Group (Mental Health), "JSG Topic Group on Inter-Agency Confidentiality (1997)"). We believe that this approach could have a significant role to play in the future care and treatment of people with mental health needs.

8 Final comments

8.1 We must make very clear that, whilst we have some criticisms of some aspects of the service which is highlighted by the case of Mr Sears-Prince, we met some very good staff. Indeed, our general opinion was of high quality staff doing their jobs often in very difficult circumstances. For example, Ward 36, is a ward with a high admission and throughput rate that serves an area making considerable demands upon it. It is designed to offer a service primarily to people with severe mental health needs, as understood by the staff who work on it, although there is an expectation on the part of the Trust that it will take, and endeavour to help, a wider range of patients, including people with personality disorder.

8.2 For people with personality disorder, the Trust does not offer a particular service. There may be some confusion as to whether the phrase "severe mental health needs" is intended to include personality disorder. We recommend that the Authority and Trust, in conjunction with the relevant social service authorities as lead assessors of community care needs, together should review the services that could and should be provided for people with personality disorder. They may decide that a service should not be provided, in which case we believe that a clear statement to that effect should be made with clear guidance to staff who have to deal with people with that diagnosis,

including to which services outside the Trust such patients are to be referred as referrals will often be necessary. It is not a service decision which we would applaud. This is a difficult group of patients. It is entirely possible that helpful guidance will be forthcoming from the current Ashworth Inquiry. (Note that the Inquiry team has now reported: *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (January 1999, Cm 4194-II)).

9. Satisfaction of the remit of the inquiry

9.1 Our general conclusion is in relation to the Care Programme Approach. The patchy implementation of this scheme is already well known to both the Trust and the Authority. In the case of Mr Sears-Prince we believe that the Care Programme Approach could have been used more effectively and that this would, in our opinion, have resulted in a multi-disciplinary meeting at which there would have been a significant sharing of information otherwise not known to all the parties. It is worth emphasising that Mr Sears-Prince might have been present to hear the range of concerns about his behaviour being expressed, as well as the sharing of information already indicated. Since the Care Programme Approach was not used, there were a number of areas of work with Mr Sears-Prince that are open to some criticism, though we again state that even had these problems not existed, it seems likely that the tragic incident would still have occurred. There was not a full assessment of Mr Sears-Prince's health and social needs. Though there was a clear understanding of his potential for violence, there was not full information about his offending behaviour. It should be remembered that one doctor in 1993 had determined that there was nothing that could be provided in terms of the Mental Health Act 1983 for Mr Sears-Prince as the cause of his problems was his alcohol and drug abuse which placed his condition outside the Act. Further, the doctors that saw him later all concurred in thinking that there was little that could be done for him. As it happens, there were care plans of a sort for Mr Sears-Prince, even though they did not fully comply with the technicalities required. Thus there was a care or treatment plan which aimed to address the various problems with which he presented. Had there been a fuller assessment, there might have been a more clear diagnosis of his condition, though it does appear that he has a personality disorder; and some other approaches might have been considered. It is possible that, after such a meeting, a referral to a higher security hospital might have been made, although it is not possible to assess whether this would have led to an admission. It should be recalled that Mr Sears-Prince was not being assessed by the forensic psychiatry services and had no history of admissions that had been of value or that had been under the Mental Health Act 1983.

9.2 We have expressed real concerns about the way certain actions with regard to Mr Sears-Prince were taken. However, we believe that our Report should not be used, on its own, to single out any particular individual for special treatment. There were weaknesses within the system and there was practice by individuals that was not satisfactory.

References

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Jones, J., Thomas-Peter, B., Warren, S. and Leadbetter, S., "An investigation of the personality characteristics of mentally disordered offenders under the Mental Health Act" (1998) 9 *Journal of Forensic Psychiatry* 58.

World Health Organization (1992) The ICD-10 Classification of Mental and Behavioural Disorders. World Health Organization: Geneva.

Forbes J S, Edwards L J, University of Leicester, Audit of the Care Programme Approach in LMHS NHS Trust.

APPENDIX A

LEICESTERSHIRE HEALTH AUTHORITY

The Inquiry into the Care and Treatment of Bradley Sears-Prince
Remit for Inquiry

1. To examine all the circumstances surrounding the treatment and care of Mr Bradley Sears-Prince by the local mental health services, including primary care, and 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

      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 Sears-Prince'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 Sears-Prince

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

   b. the statutory agencies and Mr Sears-Prince's family

4. To prepare a report and make recommendations to Leicestershire Health Authority.

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

APPENDIX B

LIST OF PEOPLE WHO PRESENTED THE PANEL WITH INFORMATION ORALLY AND/OR IN WRITING

Name	Position
Beeston, Ms M	Nurse
Birtwisle, Mr T	Social Services Planning Officer
Bos, Mrs S M	Trust Director of Specialist Services
Boyington, Mr J	Trust Chief Executive
Brown, Ms J	Probation Officer
Bull, Mr J	Social Services Service Manager
Chakrabarti, Dr S	Registrar in Psychiatry
Clifton, Mr & Mrs	Maternal Grandparents
Davies, Mr R B	Social Services Service Manager
Davis, Ms J	Trust Manager Specialist Services
Dring, Ms T	Nurse
Earp, Dr J D	Consultant Forensic Psychiatrist
Gale, Mr S E	Health Authority Lead Manager Mental Health
Hall, Det Sgt G	Leicestershire Constabulary
Harvey, Dr I	Consultant Psychiatrist
Hewett, Dr N C	General Practitioner
Hobbs, Ms P	Housing Assistant Director
Hopley, Mr M	Clinical Director Drug and Alcohol Services
Ifurung, Mrs C	Nurse
Kaul, Dr A	Consultant Forensic Psychiatrist
Khoosal, Dr D I	Consultant Psychiatrist
King, Ms J	Nurse
Little, Mrs M	Trust Director of Nursing Services
McCargow, Ms C	Authority Chief Nursing Advisor
McCarthy, Mr T	Team Leader Community Drug Team
McFadyen, Mr J	Authority Quality Manager

APPENDIX B (Cont)

McMillan, Mr S	Social Services Service Manager
McMurran Dr M	Head of Psychology Services
Moughtin, Ms J	Social Worker
Pillai, Ms J	Nurse
Raban, Mr A	Acting Chief Probation Officer
Rospopa, Mr J	Trust CPA Manager
Sears-Prince, Mr B	
Sears-Prince, Mrs P	Mother
Stanley, Mr A	Social Services Team Manager
Starling, Mr D	Social Services Service Manager
Turner, Dr P	Trust Clinical Director Specialist Services
Walker, Dr C A	Consultant Psychiatrist
Watts, Mr T	Social Services Divisional Manager
Webbe, Ms L	Nurse

APPENDIX C

SERVICE SPECIFICATION - DISTRICT FORENSIC SERVICES

1.0 HEALTH GAIN

1.1 Aims of Service

1.1.1 This specification covers district mental health services for offenders (or people with similar needs) outside prison.

1.1.2 The government has re-affirmed its policy

"..... that mentally disordered offenders should receive care and treatment from health and social services rather than the criminal justice system" (i)

1.1.3 The aim of the district forensic service in Leicestershire is the rehabilitation and re-integration into the community of offenders (or those whose behaviour may lead them to offend) with minimal risk to either client or community by the provision of specialist, integrated, mental health treatment and care in appropriate surroundings.

1.2 Objectives of Service

1.2.1 To work effectively with other agencies, principally police and voluntary agencies, social services, probation, courts and the Crown Prosecution Service, to develop integrated local services which will facilitate the successful provision of "Care in the Community".

1.2.2 To provide psychiatric assessment and advice, when requested by the police surgeon, on people known to the District Forensic Service currently being held at local police stations.

1.2.3 To provide psychiatric assessment and advice, at the request of general psychiatrists, on people not known to the District Forensic Service currently being held at local police stations.

1.2.4 To provide assessments, when requested, on offenders referred for such a service from Leicestershire Magistrates Courts.

1.2.5 To provide or seek appropriate services and appropriate levels of security for those people diverted from Courts following the above assessments.

APPENDIX C (Cont)

1.3 Targets for Achievements

1.3.1 100% of all referrals from Leicestershire Magistrates Courts assessed.

1.3.2 To extend the assessment and diversion of mentally disordered offenders to at least one other court in Leicestershire during 1995/96.

1.3.3 Assist the Social Services Department in the implementation of fast-track Community Care assessments. It is hoped that a Joint process can be developed between probation, Social Services and Health in support of this.

2.0 EPIDEMIOLOGY

2.1 A recent enquiry revealed that, nationally, within the daily remand population, one in three people have psychiatric problems (ii).

2.2 Gunn (iii) found that around 37% of sentenced prisoners at any one time are likely to be suffering from psychiatric morbidity. 3% of these require transfer to hospital for psychiatric treatment, 5% required treatment in a therapeutic community and 10% required further psychiatric assessment or treatment within prison.

3.0 PEOPLE SERVED

3.1 Population

3.1.1 The population served is:

- The resident population of Leicestershire;
- Travellers, homeless people and other persons of no fixed abode living within Leicestershire; and
- Other persons who may be referred by Leicestershire courts and the responsibility for purchasing services for whom rests with Leicestershire Health.

AND who, because of their difficult, dangerous or offending behaviour require the special expertise of a forensic service and cannot be reasonably managed by a general psychiatric service, yet who DO NOT require to be cared for in conditions of "maximum" or "medium" security (iv).

APPENDIX C (Cont)

3.1.2 These will include some people who may be:

- Defendants on bail (with or without conditions);
- Serving community sentences (such as probation orders and/or community service orders);
- On release from custody;
- Under a guardianship order;
- On discharge from hospital (including special hospitals and/or medium secure units).
- mentally disordered offenders with chronic and enduring mental health needs.

3.2 Location Of Services

3.2.1 The District Forensic Service will operate so as to ensure that services are provided in the most appropriate setting (within the constraints of existing resources).

3.2.2 Outpatient services will be provided at Arnold Lodge, Leicester General Hospital Psychiatric Department, Towers Hospital and other locations as appropriate.

3.2.3 In addition, some elements of the local services will be provided at Leicester Magistrates Court, "Runcorn" and "Ashcroft" hostels as well as to other local authority or independent hostels as appropriate.

4.0 ELEMENTS OF SERVICE

4.1 Prevention

4.1.1 While there is a clear link between mental health problems and offending, any causal relationship is difficult to establish. The focus of preventative work will be upon secondary and tertiary prevention of mental health problems (including general health screening).

4.2 Diagnosis, Liaison, Consultation and Assessment

4.2.1 Psychiatric assessment and advice will be provided when requested by the police surgeon on people known to the District Forensic Service currently being detained at local police stations.

APPENDIX C (Cont)

4.2.2 Psychiatric assessment and advice will be provided at the request of general psychiatrists, on people not known to the District Forensic Service currently being held at local police stations.

4.2.3 A Court Diversion Scheme will support the Leicester Magistrates Court by accepting referrals of offenders or potential offenders for assessment of their mental state.

4.2.4 Advice will be offered to the courts and the Crown Prosecution service concerning the discontinuance of proceedings against or the remand of offenders.

4.2.5 The service will also provide a consultancy and advice service for the Probation Service.

4.2.6 The service will co-operate with the Social Services Department when it carries out fast-track community care assessments on offenders.

4.2.7 The service will maintain close links with other psychiatric services (including general psychiatry, rehabilitation and continuing care and with drug and alcohol services) in order that referrals, where necessary, to other parts of the service can be made.

4.3 Treatment

4.3.1 Treatment will be provided in a setting which will provide adequate levels of security (within existing resources).

4.3.2 These settings will include:

- In-patient facilities on open wards
- Out-patient clinics.

4.4 Rehabilitation and Continuing Care

4.4.1 The District Forensic Service should aim to assist and support people to regain their maximum level of functioning and independence (within existing resources).

4. 4.2. Continued support as required for people returned to the community will be provided to minimise the likelihood of the recurrence of problems and re-offending.

APPENDIX C (Cont)

4.5 Education

4. 5.1 The service will play a full part in the teaching of medical and other staff on forensic issues.

4.6 Research

4.6.1 Where possible, research into the effectiveness of services will be undertaken and the results made available to purchasers to assist in the development of strategy.

5.0 VOLUME AND CASEMIX

230 initial contacts, 300 total referrals

6.0 INDICATORS OF EFFECTIVENESS

1. Interval between referral and first contact.

APPENDIX C (Cont)

7.0 KEY CHANGES

7.1	Service Changes
	These will be dependent upon review of the service

8.0 CURRENT PROVIDERS

Leicestershire Mental Health Service N.H.S. Trust.

FOOTNOTES AND REFERENCES

(i) Home Office Circular 29/1993.

(ii) "Revolving Doors: Report of the Telethon Enquiry into Mental Health, Homelessness and the Criminal Justice System" N.A.C.R.O. 1992 (p.p.10)

(iii) Gunn J, Maden A, Swinton M (1991) - Treatment Needs of Prisoners with Psychiatric Disorders, BMJ Volume 303: 388-41.

(iv) As defined in Annex A to EL(92)24 i.e.:
"Maximum secure provision" means the special hospitals: namely Ashworth, Broadmoor and Rampton:
"Medium secure provision" means wards or units such as regional secure units, usually organised on a regional health authority or sub-regional basis.

(v) It should be noted that not all offenders, or potential offenders, who require psychiatric assessment or care are expected to be seen by the local forensic service.

STEP BY STEP PROCESS TO THE CARE PROGRAMME APPROACH

STEP	FORUM	PERSONNEL	DOCUMENTATION	PROFFESIONAL CONSIDERATIONS & ADMINISTRATION PROCESS	NOTES
1 SCREENING	FIRST FORMAL CONTACT BETWEEN CLIENT AND MENTAL HEALTH PROFESSIONAL	MENTAL HEALTH PROFESSIONAL OR QUALIFIED SOCIAL SERVICES OFFICER	FORM 1(HEALTH STAFF) OR EQUIVALENT SSD FORM(SOCIAL SERVICES STAFF)	1.IF CARE PROGRAMME APPEARS APPROPRIATE SEND SCREENING FORM 1 TO CPA MANAGER FOR AKNOWLEDGEMENT. CONVENE MDT MEETING. 2.IF CARE PROGRAMME NOT APPROPRIATE ;SIGN FORM AND FILE IN CASE NOTES. 3.IF SEC.117 APPROPRIATE.CARE PROGRAMME IS MANDATORY. 4.IDENTIFY ASSESSMENT CO-ORDINATOR	See notes 1,2 and 3
2 ASSESSMENT & PLANNING ASAP AFTER SCREENING	MDT GROUP	RMO,NURSING STAFF,SOCIAL SERVICES STAFF, P.A.M.s,PATIENT/CLIENT ADVOCATE,ETC	SCREENING FORM 1 TO BE COMPLETED:FORM 2:SRa:FORM 2PE.	1.CONSIDER CARE PROGRAMME. 2.CONSIDER SUPERVISION REGISTER. 3.CONSIDER CARE MANAGEMENT. 4.IDENTIFY CARE CO-ORDINATOR 5.DRAW UP CARE PROGRAMME.	See note 4 and 6
3 REVIEW AT AGREED FREQUENCY	MDT GROUP	RELEVENT MDT	REVIEW FORM 3 FORM 4(UNMET HEALTH NEED) SRa/SRb	1.CONVENE MDT OR GATHER REVIEW DATA VIA ALTERNATIVE ROUTES. 2.REVIEW CARE PROGRAMME/SUPERVISION REGISTER STATUS	See note 5
4 DISCHARGE FROM CPA/SR	MDT GROUP	RELEVENT MDT MEMBERS inc.RELEVENT COMMUNITY AGENCIES	FORM 3:SRb:FORM 4	1.COMPLETE FORM 3 2.RECORD IN CASE NOTES. 3.COMPLETE SRb IF APPROPRIATE	

N.B. ORIGINALS OF ALL TRUST FORMS ARE TO BE SENT TO THE CPA MANAGER:LOCAL STANDING ARRANGEMENTS ARE TO BE MAI AINED.

APPENDIX D

APPENDIX D (Cont)

INTRODUCTION

The Care Programme Approach,applies to all clients who come into contact with mental health services.Care Programmes however,at this point apply to those clients with high dependency complex needs.Therefor,the guidelines overleaf are for the initial implementation of CPA.

In the near future,a comprehensive process will be developed to "trawl" all clients,of all dependency levels into the CPA system.The comprehensive process will have comprehensive joint agency guidelines.

NOTES

DEFINITIONS

1.HIGH DEPENDENCY CLIENT:people who fall into this category will display significant mental disturbance associated with psychosis,organic illness or damage,personality or affective disorder,or phobic symptoms and/or will be debilitated by the long term effects of their mental illness.
The debilitation will be in relation to the clients biological/psychological/social/spiritual ability to function independently.
They will also be people who will require a package of multi agency support in order to function within the community.

2.MENTAL HEALTH PROFESSIONAL:Doctor;Qualified Nurse;Qualified Occupational Therapist;Psychologist;suitably qualified Social Services staff.

3.FIRST FORMAL CONTACT:The point at which client and/or mental health professional feel that specialist mental health services are required.
(Screening can also take place at any point if a mental health professional feels it is required,i.e. for a patient for whom it was originally felt a care programme was not needed,but whose circumstances have now changed)

4.CARE PROGRAMME:A comprehensive package of multi-agency service provision designed to meet the unique needs of the individual.

5.AGREED FREQUENCY:The periods of time between MDT meetings/reviews,agreed at the previous meeting.

6.CPA AND CARE MANAGEMENT:Whilst the CPA and Care Management have many similarities there are sufficient differences to prevent their full integration whilst the CPA is in its current embryonic state.It should be noted,however,that some of the groundwork for this is evident for example the initial target group is defined in terms which allow ready identification with SSDdependency levels 1 and 2.For the present time the following guidance is given to Social Services Staff.

1. Staff will act as Care Co-ordinators only where they are undertaking statutory Social Services duties (most notably Care Management duties).Where it is clear that they are the appropriate professional and with the agreement of their line manager.
2. Staff are not expected to be responsible for the completion of the Trust CPA forms.In this respect the "appropriate SSDform" overleaf will be the form which most closely meets the needs of the CPA Manager(eg.the referral 'pink' or 'initial assessment' form instead of the screening form).

If you have any difficulties/suggestions/comments/etc please feel free to contact:

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APPENDIX E

LEICESTERSHIRE MENTAL HEALTH SERVICE NHS TRUST

CARE PROGRAMME APPROACH

FORM 1

SCREENING FORM

THIS FORM TO BE COMPLETED FOR ALL PATIENTS AT FIRST FORMAL CONTACT AND AT DISCHARGE FROM INPATIENT FACILITIES IT MAY ALSO BE COMPLETED AT ANY OTHER TIME IF THE PATIENTS CIRCUMSTANCES CHANGE

CLIENT SURNAME: CLIENT FORNAME(S):

TITLE:MR/MRS/MISS/MS/OTHER(PLEASE STATE)

GENDER

CLIENT

ADDRESS

POSTCODE TEL.No.

DATE OF BIRTH

LEGAL STATUS OF CLIENT:

CLIENTS ETHNIC ORIGIN:

WHITE	PAKISTANI
BLACK CARIBBEAN	BANGLADESHI
BLACK AFRICAN	CHINESE
BLACK OTHER	OTHER ASIAN
INDIAN	OTHER

NAME OF RESPONSIBLE MEDICAL OFFICER:

DATE OF ASSESSMENT:

NAME OF ASSESSOR:

TEAM/WARD/DEPT/COMMUNITY TEAM:

SOURCE OF REFERAL: GP IF REGISTERED:

IS CLIENT APPROPRIATE FOR A CARE PROGRAMME:YES/NO

If NO,do not complete the rest of this form.Sign it and file in clients notes.

Signed.....

Designation.....

Date.....

If a care programme appears to be appropriate,sign the form and forward it to the CPA manager for aknowledgement.It will then be returned to you for completion at the MDT meeting which must be arranged as soon as possible.(nb.do not wait for the return of the form to arrange the MDT meeting)

PLEASE NOTE.

THOSE CLIENTS TO WHOM SECTION 117(MHA 1983)APPLIES MUST ALWAYS HAVE A CARE PROGRAMME(i.e those clients on Secs.3:37:47:48 MHA 1983)

APPENDIX E (Cont)

Reasons for possible CARE PROGRAMME(see guidelines):

GUIDELINES FOR INCLUSION

1 The health professional feels that a co-ordinated package of care is needed.

2 Section 117(MHA 1983)applies to the client

3 The patient is vulnerable in the community and may be hospitalised without a monitored support programme.

(see also guidelines)

The clients possible care programme should now be discussed at an MDT meeting of the appropriate care team.This should be arranged for the earliest appropriate date.

DATE OF MEETING:

IN ATTENDANCE: NAME: DISCIPLINE/ROLE:

NAME: DISCIPLINE/ROLE:

NAME: DISCIPLINE/ROLE:

NAME: DISCIPLINE/ROLE:

NAME: DISCIPLINE/ROLE:

NAME: DISCIPLINE/ROLE:

NAME: DISCIPLINE/ROLE:

NAME: DISCIPLINE/ROLE:

CARE PROGRAMME:YES DEVELOP CARE PROGRAMME:THIS FORM TO CPA MANAGER.

CARE PROGRAMME :NO END PROCESS:THIS FORM TO CPA MANAGER:COPY IN CLIENTS NOTES.

POSSIBLE SUPERVISION REGISTER:YES/NO:IF YES CONSIDER AT MDT MEETING.

CARE MANAGEMENT:REFER TO SOCIAL SERVICES.(optional for entry screening:compulsory for discharge screening)

IS THE CLIENT/ADVOCATE IN AGREEMENT TO PARTICIPATING IN THE CARE PROGRAMME APPRO.

YES/NO

CLIENT NAME ADVOCATE NAME SIGNATURE DATE	CLIENTS NOMINATED CONTACT NAME: ADDRESS TELEPHONE No	CPA ASSESSOR NAME SIGNATURE DATE

If the client is unable to or it is felt inappropriate for them to sign then the assesor may sign on behalf of the client but they must state the reason here.....

note:the client only needs to sign this form if they are moving on to the CPA process.

one copy of this form to:CPA manager;clients notes.

This form is subject to the essential safeguards of: The Access to Health Records Act(1990)
The Data Protection Act(1984)

APPENDIX F

SECTION 2

DEPENDENCY LEVELS

Not all patients will need a multi-disciplinary assessment, care plan and review. Indeed, people can be divided into three groups, depending upon the severity of the their needs, and complexity of their specific circumstances.

HIGH DEPENDENCY

Patients who fall into this category will either:-

a. Display substantial mental disturbance associated with psychosis, organic illness or damage, personality or affective disorder, or severe anxiety related disorders or

b. Will be debilitated by the long term effects of their mental illness, to the extent that they are unable to function in the community, or are able to do so only with significant intervention and a complex package of support.

Characteristics within this definition COULD include:-

1. The need for constant support of carers and/or caring agencies to maintain someone in the community.

2. There is evidence that the patient's mental disorder has put them or other persons seriously at risk - including risk of self-neglect, suicide, serious violence to others, self harm or exploitation.

3. An assessment is required under the MHA (1983) or one has recently been undertaken which indicates a high need for supportive services.

4. Admission is required to a psychiatric hospital for assessment or treatment.

5. A comprehensive assessment of needs is required to facilitate discharge from hospital or residential care and the subsequent monitoring of a care package.

6. An assessment has identified the need for permanent accommodation in a supportive environment (i.e. Hostel/residential or nursing care).

7. There is a history of difficulty in initiating or maintaining contact with specialist services associated with significant relapse.

8. There are additional needs associated with the patient's specific life circumstances (e.g. race, gender, homelessness or substance misuse).

9. There has been either a compulsory admission or aggregate hospital stays of over three months in the past 5 years.

These patients may require Care Management in addition to CPA. They will require full multi-disciplinary assessment, planning and review.

APPENDIX F (Cont)

MEDIUM DEPENDENCY

Patients who fall into this category will have significant mental health symptomatology and their needs will be complex.They will require intervention from a **SMALL** number of different providers or disciplines, who will normally be within the same multi-disciplinary Team. Patients will find normal everday social and domestic functioning difficult due to their mental health problems (e.g. psychotic symptons, disabling anxiety related disorders and affective disorders, personality disorder, the long term effects of past or current mental ill health).

Characteristics within this definition COULD include:-

1. The need for regular monitoring of medication or community placement (e.g. because of a history of non-compliance with medication regimes resulting, in higher dependency needs).

2. Patients who are placing themselves or other people at risk, (e.g. self-neglect, suicide, serious violence to others; self harm or exploitation).

3. The patient is totally isolated and has no significant carer and requires assistance to maintain themselves in the community or carers support has, or is, in danger of breaking down.

4. There is a history of challenging behaviour related to a significant mental disorder.

These patients (HIGH and MEDIUM dependency) will require assessment, planning and reviewing by several members of the team, not necessarily the full MDT. They may also require Care Management in addition to CPA.

Those patients who are HIGH dependency or MEDIUM dependency, will be allocated a Care Co-ordinator. They will have a **CARE PROGRAMME** administered by the Trust wide process.

APPENDIX F (Cont)

LOW DEPENDENCY

Patients who fall within this category will display a degree of mental health symptomatology or who are debilitated by the long term effects of their mental ill health or personality disorder but are able to function at a reasonable level within the community and whose current level of functioning does not place them at undue risk of significant breakdown/hospitalisation. Patients who do not appear to have complex needs or do not appear to require a multi-faceted package of care to maintain them in the community. However, they may require some intervention to prevent deterioration (e.g. mild depression, anxiety, phobic symptoms etc.).

Characteristics within the above definition could include:-

1. Individual needs assessment for a single service not part of a wider specialist package of care.

2. There is a need for short term advice and/or assistance with accommodation or financial issues or marital/relationship issues.

3. The need for counselling.

Those patients who are LOW dependency will only require assessment, planning and review by a named health worker with input from those disciplines relevant or involved. Patients under this level will have a named worker whch will probably be the only member of the team with any input to the patient. They will not have a CARE PROGRAMME, but will have a **CARE PLAN** which may be so short as to only include the regular intervention planned.

People who fall below the LOW dependency level may display a slight degree of mental health symptomatology or may be slightly debilitated by the long term effects of mental ill health or personality disorder but they will be able to function at a reasonable level within the community. Their current level of functioning and specific life circumstances will not place them at risk of breakdown and no formal planned/co-ordinated intervention by specialist mental health services is currently required to prevent deterioration.

Patients who fall into the LOW dependency group will be screened utilising the Trust screening form, however, the remainder of the administrative process will be as per local procedures and documentation.

(NB The above are "joint" criteria for agreeing the general level of needs and service responses, they are not intended to indicate the levels of responsibility of individual workers or agencies).