# REPORT OF
# THE INDEPENDENT INQUIRY
# INTO THE CARE AND TREATMENT OF

# GARRY LYTHGOE

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Commissioned by
The Wigan and Bolton Health Authority

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**MAY 2000**

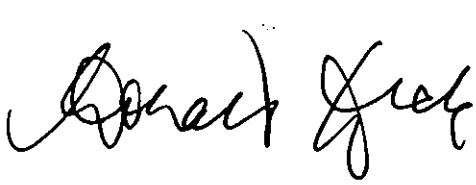
**To: The Chairman of Wigan and Bolton Health Authority**

We have now concluded our inquiry into the care and treatment provided to Garry Lythgoe by the mental health services of Wigan and Leigh NHS Trust and the Wigan Metropolitan Borough Council Social Services Department. Our conclusions and recommendations are clear and we trust helpful.

We would like to express our special thanks to the family of Garry Lythgoe who, despite their particular distress were open and co-operative in their evidence to the inquiry and through their account of Garry's life greatly assisted us in our understanding the background to these tragic events.

We have tried to answer the questions raised by Mr Nigel Lythgoe and his family and by the Terms of Reference set by the Health Authority. In doing this, we have been assisted by the willingness of the people who have come into contact with Garry Lythgoe during his relationship with various services in Wigan and we would like to express our thanks to those witnesses from health, social and non statutory organisations.

Although many of the messages from this inquiry have already been recognised and action taken to improve services and standards, we would commend our recommendations to the Health Authority and to those responsible for providing mental health services and urge that the lessons of this tragic case are a spur to constant vigilance in monitoring the quality of all services provided to those suffering from mental illness.



**Dr Donald Dick (Chairman)** **Mr Ian Cartwright**

**9 May 2000**

# INDEX

APPENDICES

## 1. THE REASON FOR THE INQUIRY

We were invited by the Wigan and Bolton Health Authority to conduct an independent Inquiry into the treatment and care of Garry Anthony Lythgoe. On 22 April 1999, at Manchester Crown Court, he had pleaded guilty to the manslaughter of his mother and to the attempted murder of his father on 10 October 1998. The Court accepted manslaughter on the basis of diminution of responsibility for his acts because of mental illness. He was made subject to a hospital order under Section 37 of the Mental Health Act 1983 with a restriction order under Section 41. Mr Lythgoe had been treated by the Mental Health and Social Services in Wigan and Leigh during 1997 and 1998 and had been an inpatient in Leigh Infirmary in the psychiatric department on two occasions. This Inquiry was therefore required under Health Circular HSG (94) 27.

## 2. MEMBERS OF THE INQUIRY

The members of the Inquiry were: Dr Donald Dick, Consultant Psychiatrist, formerly Director of the Health Advisory Service (Chairman) and Mr Ian Cartwright, formerly Director of Social Services in Doncaster. We were most ably assisted by Mrs Diane Sankey, of the Wigan and Bolton Health Authority.

## 3. METHOD OF WORKING

Having clarified and agreed our terms of reference with the Health Authority, we read through the considerable number of documents, notes, reports and policies seen to be relevant to the case, which are listed in detail at the end of the report. Following discussion with representatives from the Wigan & Bolton Health Authority, Wigan & Leigh Health Services NHS Trust and Wigan MBC Social Services Department, we drew up a list of the witnesses whom we wished to interview.

We asked for a written statement from each of these in a letter outlining our areas of interest. We also provided witnesses with a copy of the procedure to be followed by the Inquiry Panel. We explained that we would be recording the evidence and that the transcripts would be confidential to the Inquiry, but that we might find what was said to be worthy of quotation in the report. We gave witnesses the choice of being accompanied by a friend or representative. We asked witnesses of fact to read a simple form of affirmation: "I affirm that the evidence which I shall give to this Inquiry will be the truth".

We began our interviews on 7 October 1999 and sat also on 8 October, 14 October, 15 October, 17 November and 18 November 1999. In addition, the Panel also interviewed Garry Lythgoe at Ashworth Hospital on 13 October 1999. Soon after each interview a transcript was sent to each witness with the request that it should be corrected, supplemented or expressed in a different way and then signed and returned to us. All witnesses returned their corrected transcripts within good time. The Inquiry Panel met for discussion and drafting its report on 15 December 1999 and 23 February 2000.

## 4. TERMS OF REFERENCE

1. With reference to the incident which took place on the 10 October 1998, to examine the circumstances of the treatment and care of Mr Garry Anthony Lythgoe, by the mental health and social care services, in particular:

   (i) the quality and scope of his health care, social care and risk assessments and the availability of local services to meet his needs.

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

      (a) his assessed health and social care needs;

      (b) his assessed risk of potential harm to himself and others;

      (c) any previous psychiatric history, and any history of drug and alcohol abuse and any history of offending and criminal convictions;

      (d) statutory obligations, national guidance (including the Care Programme Approach), HC(90)23/LASSL(90)11, Supervision Registers, HSG(94)27 and local operational policies for the provision of Mental Health Services.

   (iii) the extent to which Mr Lythgoe's prescribed treatment and care plans were:

      (a) documented
      (b) agreed with him
      (c) communicated appropriately within and between relevant agencies and his family
      (d) carried out
      (e) complied with by Mr Lythgoe

2. to examine the appropriateness of the training and development of those involved in the care of Mr Lythgoe and the supervision and monitoring of performance.

3. to prepare a report of the Inquiry's findings and make recommendations as appropriate to Wigan & Bolton Health Authority.

## 5. SUMMARY

On 22 April 1999, at Manchester Crown Court, at the age of twenty-five years Garry Anthony Lythgoe was tried and, on pleading guilty, was convicted of the manslaughter of his mother, Mrs Irene Lythgoe and of the attempted murder of his father, Mr Nigel Lythgoe. He was made subject to a hospital order under Section 37 of the Mental Health Act 1983 with a restriction order without limit of time under Section 41 of that Act. He is detained at Ashworth Hospital.

After what appears to have been a normal childhood and upbringing in which he is described as a bright and pleasant lad, Garry Lythgoe insidiously developed paranoid schizophrenia in his early twenties, in the way that this illness often progresses. He was a regular user of cannabis and experimented with other illicit drugs from his late teens onwards. We have concluded that this drug usage may have aggravated his developing illness, but did not cause it.

He had some contact with community mental health services in 1996, when he attended Brooklea Community Mental Health Team centre in Atherton. He was interviewed by a student social worker, but not by a doctor or senior nurse. His first admission to a psychiatric hospital was in July 1997. This followed threatening behaviour towards his mother with a knife in the context of delusional thinking. Although the diagnosis of serious mental illness was not made, he responded to treatment. When he left hospital, he was discharged to his parent's address. There was no Care Programme Approach plan or community follow up. Despite care of their son, Mr & Mrs Lythgoe found his deteriorating behaviour increasingly difficult to cope with and Garry Lythgoe eventually went to live in a hostel in Leigh in January 1998. He had in effect, become homeless, with all the consequent difficulties for anyone with severe mental health problems. He did not cooperate readily with rather low key continuing care and discontinued prescribed medication. He had no insight into his illness.

His second admission, in March 1998, was an emergency admission under Section 4 of the Mental Health Act. The admission followed further psychotic disturbances and violent behaviour in which he trashed his room and was threatening in his behaviour. The hostel staff had great difficulty in making contact with mental health professionals. The process of admission was much more protracted than would have been the case, if adequate follow up and a Care Programme Approach had been in place. The emergency order was not converted to either a treatment order under Section 3 or an assessment order under Section 2. He absconded to London soon after admission but was returned later after a brief stay in a London hospital. He remained as an informal patient until his discharge.

A month after admission he was discharged on 2 April 1998 from hospital with a discharge plan which no one accepts as adequate. He was still actively psychotic; he had a history of violence, was homeless, had no GP and was refusing medication. A discharge summary was written but not sent out. He was given an out patient appointment for four months time and told to contact the drugs advisory service if he wished. No community key worker was identified to supervise his continuing care. His parents were not given a contingency plan in the event of further recurrence of the symptoms of illness and indeed seem to have been little involved in his follow up.

On 1 May 1998 he registered with a GP who had little information to go on and only later received a summary of his first admission of 1997, but not the more recent one. Contact with psychiatric services had been lost by this time. The GP responded to concern over Garry's health from neighbours but found him to be unwilling to resume psychiatric help or to take medication. Garry was living in a rented room but not in contact with community mental health services.

On 10 October 1998 Garry Lythgoe, in what was beyond doubt an acute and florid psychotic state, attacked his mother with a hammer in her bed at home and seriously assaulted his father. Mrs Lythgoe died on 13 October 1998. Mr Nigel Lythgoe recovered.

At the time of this Inquiry, Garry Lythgoe was detained at Ashworth Hospital, where we interviewed him in October 1999. He is under the care of Dr Stephen Noblett, Consultant Forensic Psychiatrist, who, with colleagues, told us of his treatment and progress from the time of his arrest and remand in prison until the present. Garry Lythgoe is improved in his health but is still being assessed.

Our examination of the events described leads us to observe that the organisation and delivery of the mental health services available to Garry Lythgoe whilst his illness was developing were not satisfactory on several counts. There were a number of lost opportunities in his management from the time when he first made contact with the services to the time of his mother's death. At the first contact, he did not have a psychiatric assessment and the seriousness of his illness was missed. The consultant psychiatrists under whose care he was admitted had no contact with him before or after either admission. There was little communication with his family at any time and only a sketchy evaluation of the social circumstances was carried out. Follow up arrangements on both admissions were very unsatisfactory. Information which would have helped community workers and his new GP was not available. The delay in securing his admission on the second occasion was excessive. The opportunity for a thorough assessment under the Mental Health Act was lost. The quality of his treatment and discharge planning was of poor standard.

Our abiding impression of the mental health services, which we have been studying, is of low standards, indifferent leadership and minimal expectations for quality.

Despite our criticism of the management of Garry Lythgoe's care, we do not believe that the attack on his parents could have been predicted. What happened was a very rare event and few general conclusions can be drawn. What we have concluded is that a more effectively organised and well-led service would have better met Garry's needs and the outcome of his illness might have been very different. It is our hope that the result of this Inquiry will be to stimulate the development of a local mental health service for the people of Wigan of high achievement which constantly checks and adjusts its performance to the highest standards of quality.

## 6. THE HISTORY OF EVENTS

### Background and Family Life

Garry Lythgoe is now aged 26 years old, being born at Leigh Infirmary on 23 January 1974, the elder of two sons, to his parents, Nigel and Irene Lythgoe. We spoke with his father, his younger brother and his mother's sister, an aunt who has known Garry all his life. From each we heard of a normal childhood and upbringing in a supportive and loving family. His aunt told us that Garry had been very close to his mother. Garry is recorded as describing his childhood as a "happy" and "superb" time. He has said that his relationship with both parents during his formative years was excellent. His father told us **"He was a very good lad. He was so polite to everybody. He did exactly what he was told to do."**. His mother, Mrs Irene Lythgoe worked in the Finance Department at Bolton Town Hall. His father Nigel Lythgoe had his own window cleaning business employing a number of men. When we spoke to Mr Nigel Lythgoe he identified a number of questions which the family had raised. We have addressed these specifically in Appendix A and the body of the report also deals with many of the issues raised.

There is no family history of psychiatric disorder, alcohol or drug abuse or of suicide or self-harm. As far as we know, no member of his family has had convictions recorded against them.

Garry had childhood asthma, which caused him to be briefly off school at times but not to be especially protected or dependent on his mother. He was close to her but not unusually so. When we asked his brother directly about this, he said that his mother did not coddle Garry nor did she favour him. There was nothing unusual about his schooling or his day to day behaviour. He was of above average ability and the promise was that he would go on to higher education. He conformed to the patterns of school and family life.

*Comment*

*We explored with all the family members the possibility that Garry might have shown abnormal traits of personality in early life, which might later progress to a personality disorder. Also, we wondered whether he had been over dependent on his mother. We could find no such evidence. He appears to have been a pleasant, likeable boy progressing well with promise until his middle teens.*

### Schooling and Adolescence

His first school, from the age of four or five was St George's C.E. Infant School in Atherton, from where he progressed to the junior school. At eleven and until he was sixteen, he attended Hesketh Fletcher C.E. High School, a comprehensive school in Atherton.

At school, he made normal progress, mixed well and took part in school life. He was above average in intelligence. He was entered for and obtained nine GCSEs, three at grade C, in English Language, English Literature and Mathematics. The results fell

short of both Garry's and his teachers' expectations. Garry himself said he had been **"expected to do better"**, but he had become less motivated and was disinterested in schoolwork. He said that he played truant on a few occasions later in his schooling, but usually because he had failed to complete an assignment. At about this time, at the end of his school days, he began to smoke cannabis. His interest and application to schoolwork began to fall away. His brother did not notice anything unusual about him at the time, just **"not as interested in going to school".**

Garry left school at sixteen and enrolled for A level courses at Wigan & Leigh College. He paid little attention to the courses and although he sat examinations, he failed each one. By this time he had begun to work part time in a cash and carry warehouse, enjoyed the money and did not return to college. His father told us that Garry had later admitted to being involved in a fraud where he would steal cigarettes from a warehouse for some shopkeepers who allegedly threatened Garry with violence if he did not comply with their demands.

At nineteen, in 1993, he left the Cash and Carry and joined his father in his window cleaning business. It appears that for his first year and more, he worked well and was a reliable employee. Then his application to work deteriorated and at the same time his relationship with both his father and mother changed.

**His Father's Accident – October 1995**

In October 1995, Garry's father Nigel Lythgoe fell from a ladder during the course of his window cleaning work. He was found unconscious with a head injury near the foot of the ladder with a wheelie bin on top of him. He was taken to the intensive care ward in Manchester Royal Infirmary, where he remained unconscious and on a life support machine for several days. Nigel Lythgoe says that since then he has had immediate memory difficulties.

Garry returned to the scene of the accident some days later to thank the woman who had called the emergency services. He told us that he realised at this very moment that what had happened was not a simple accident but was part of a conspiracy in which he and his family were the victims. He believed that someone had tried to kill his father and told the police. The police could find no evidence to take the matter further. In retrospect Garry dates the onset of his illness and his extraordinary ideas to this incident. His father thought that some time before the accident, Garry had become irritable and was not getting on as well with the family, being at times quarrelsome and getting up late.

After his father's accident, in October 1995 Garry says, **"I started playing up".** Eventually, his father asked him to leave and at the same time Garry moved out of the parental home. From the family's recollection and Garry's memory, it appears that the relationship between him and his parents changed about three years before the assault in October 1998. His brother noticed that he became "weird" after his father's accident and became paranoid, **"seeing under the bridge, red eyes and stuff like that".** Garry's views became notably right wing: **"to be honest, I really did not listen to him because he was talking rubbish".**

*Comment*

*It seems very likely that Garry's mental disorder insidiously began to affect his behaviour and thinking three years before the attack on his parents, when he was about twenty-one years old. The earliest possible impact might have been during his last year at school, when his performance at school fell away. However this was also a time when he began to use cannabis and was more interested in earning money than studying. There were no observable signs of psychiatric disorder until early 1996.*

## Early 1996

The family describes increased drug taking and disorganised argumentative behaviour from this time on. Eventually, his father told us, **"we did throw him out".** There had been an argument about the tidiness of his room and **"he was halfway to putting this wardrobe up and I cannot remember what happened, but he started arguing with us and he went upstairs and he just totally wrecked all his bedroom and he smashed his wardrobe up, smashed his hi-fi system up, kicked the bed in. He came downstairs. Then we were telling him to stop or we were going to 'phone the police and he just got hold of the telephone table and kicked that all over the house. Obviously we were shouting at him and he was shouting at us. We were telling him, "You can't stay here. You've got to get out". He was just turning round and saying, "I don't want to stay here". He was swearing at us and all sorts and just slammed the door and went off down the street.".**

## The First Contact with Psychiatric Services January 1996

The records from Brooklea Community Mental Health Team centre show that he first attended on 26 January 1996 on the advice of Dr C Higgins and was interviewed by the duty officer, who decided that he needed help with depression and confidence building. He was given an appointment for 28 February 1996 when he was seen by a student social worker on placement. We were told by Amanda Harrison, Approved Social Worker who was responsible for the student's supervision at the time, that the duty officer was a student nearing the end of her training. The notes of that meeting record biographical facts about Garry, mainly his occupational history, mention his use of cannabis but do not contain any evaluation of his mental state. There is no mention of the family's concerns or of contact with them. Garry was offered further contact with an appointment in March 1996 but did not take it up. The case was closed.

We asked Garry about this period of his life when we spoke to Garry himself at Ashworth Hospital, in October 1999. At this time, he was calm and settled without any features of a psychotic state of mind. He said that the olanzapine, which had first been prescribed in prison, suited him well, much better than the risperidone, which he had been given in hospital. He presented as a pleasant likeable young man who talked freely to us and answered all the questions that we asked him thoughtfully.

He told us of his first visits to the Brooklea community mental health centre in January 1996, on the advice of his GP. He was seen by the duty officer and after discussion given an appointment for February 28 through the allocation system. When he returned, he was interviewed by a young woman (in fact a social work student on a training placement). His father had recently had his accident. Garry said **"The accident was horrific and it was on my mind all the time"**. He was hearing voices. **"I didn't know that I was hearing voices you see. I just thought they were really there if you know what I mean. I couldn't distinguish the difference between them being in my head"**. He did not think to tell the person that interviewed him about them and she did not ask him about them anyway. He did not think that he had a mental illness, but that he was **"just very depressed and very worried"**. He was worried that he might be breaking down. He said he was told that if he wanted to get back in touch for a chat he could do so. He thinks that he went back once or twice but told us **"I don't know why I went because they can't really do anything for you. They can only listen"**. He was not offered an interview with a doctor or a nurse.

His maternal aunt kept a diary of family events and described to us how Garry became increasingly odd after his father's accident. His parents were clearly finding it difficult to cope with the changes in their son and Mrs Lythgoe in particular discussed her concerns with her sister. The family managed to persuade him to go back to the Brooklea centre in Atherton, which he attended on 17 February 1997 and again in April 1997. There does not appear to have been any improvement in his condition as a result. On this occasion he was seen and given general advice but no arrangements were made for a psychiatric assessment.

For a time, Garry lived with friends or in a rented room. He went home occasionally or visited his aunt, his mother's sister. His father told us **"He had no money and was going round for food and any money or whatever"**. He began to talk to himself and to talk rubbish about the end of the world and how everybody should take cannabis. **"Then he started going on about Martians coming down and how all the human race began with magic mushrooms".**

Other members of the family, (his mother's brother and his wife) were also involved and were upset by Garry' behaviour. His aunt said **"he was definitely mentally disturbed at the time: his actions and the way he spoke. It was just not old Garry. It just took you a few seconds to realise he had actually changed topics, because when he first started speaking, it would perhaps be normal and then he would jump to aliens and different things"**. She told us in her written statement **"Irene was very frightened at this time"**. His aunt thought steps should be made to get help for Garry and agreed that she would support his parents in trying to get Garry some suitable support. She tried to persuade Garry that he needed help and after a time, he agreed. It was soon after this in July 1997 that his parents took him to Brooklea centre in Atherton.

*Comment*

*It is clear to us from talking to the family and to Garry himself that from 1996 onwards he showed signs of increasing mental disturbance, which the family believed, were probably the result of taking drugs. In retrospect it seems to*

*us that had a mental health professional of experience interviewed him and talked to members of the family at any time during this period, the severity and nature of his developing mental illness would have been apparent. Garry's condition was seen as a social disturbance and not as mental illness. It is the general practice of the National Health Service that acceptance or not into specialist health services should follow a diagnostic interview. It is essential that a patient who is to become the responsibility of the specialist services should be seen by a doctor at an early stage for this reason. The system operated by the Community Mental Health Team at Brooklea did not appear to include a methodology, which distinguished between patients requiring social or other support and those with symptoms of serious mental illness who needed to be seen by a psychiatrist for diagnostic purposes.*

## Contact with Community Mental Health Team 1997

### February 1997

Garry referred himself to Brooklea on 17 February 1997 "complaining of stress symptoms such as a variable sleep pattern and lack of confidence in talking to people. Feels guilty re offences committed aged 17 to 18." He also talked of being followed by someone in a car and watched by another person. He claimed to have received an anonymous telephone call and letter. He said he had not used illegal drugs for some time. He was advised to discuss his past offences with his parents, to attend the job centre and to return to Brooklea if he thought that stress management was relevant. He did not have a diagnostic interview with a doctor nor was the visit to the centre reported to his GP who at that time was Dr Anjali Rawson. The case was closed on February 18, the following day.

### April 1997

He referred himself to Brooklea again on 18 April 1997. He was asking for "a short holiday", by which he seems to have meant admission to hospital, on the advice of a friend. The female duty officer who interviewed him, noted him to be "very high" and to show pressure of speech. **"He towered over me as demonstration of how he behaves when he is out with people. I felt he was trying to intimidate me as he made reference to not liking women".** He was encouraged to ventilate his feelings and to go to see his GP if he thought he needed to go to hospital. The case was not to be allocated. In the box in the notes, headed "Risk", it was noted that he should have a male worker. He was not offered a diagnostic appointment with a doctor and no report of this attendance was sent to his GP.

*Comment*

*Again, there is evidence in the notes made at the time, of good reasons to ask for a diagnostic interview either from a psychiatrist or his GP. There was a pattern of problems discernable in the three visits to Brooklea, which should have suggested that at least there was a possibility of mental disorder in addition to social problems or drug misuse. The opportunity for earlier intervention might have been missed. The GP holds the information about a*

*patient's health throughout their life and must always be informed of contact with other parts of the health service*

**July 1997**

On 11 July, Garry was seen by Dr Alastair Thompson, another GP from his own doctor's practice and on his instruction, the Practice Manager at Sevenbrooks Medical Centre, Atherton, telephoned Brooklea to ask for advice. Both Dr Anjali Rawson and Dr Alastair Thompson had known Garry previously and it was reported to Brooklea that he was showing increasingly odd behaviour and inappropriate responses to questions. He seemed to have lost touch with reality. He had threatened his mother with a kitchen knife on the previous evening. His father was talking of throwing him out of the house again. He denied taking drugs, except for cannabis. It was agreed to arrange a Mental Health Act assessment that afternoon, with Dr Thompson, a Section 12 approved doctor, who had already completed a medical recommendation under Section 2 of the Mental Health Act.

At interview Garry was described as very agitated, "high", demonstrative and intimidating. He showed odd behaviour, flight of ideas, and paranoia especially towards the family. It was decided that "Garry was borderline sectionable". However Dr Thompson recorded in his notes "..hyper, mild flight of ideas, reservation of speech, family disputes, depressed - hidden by hypo-mania, tearful". In the event, he was unwilling to go to hospital but agreed to go to stay with a friend and to accept help from the doctor. His mother was unhappy about the situation and said that Garry was "a habitual liar" and that she had heard it all before.

On 23 July 1997, his aunt made a telephone call to Brooklea requesting an urgent home visit. Following a telephone call to his home, Garry arrived at the centre five minutes later, accompanied by his parents. Dr Alastair Thompson and Amanda Harrison, ASW who attended the centre, agreed that he needed immediate admission under Section 2 if necessary. Garry was openly paranoid, believed that someone was now looking to kill him, that he was a prophet with a mission to save the world and that he was trying to recruit a team, including his GP and the Prime Minister. He was extremely antagonistic in the presence of his parents and there were fears about Garry's increasing loss of control

When confronted with the inevitability of admission, Gary agreed to go, whilst protesting that **"I am right and you are wrong"**. There was some difficulty in finding an available bed at Leigh Infirmary but eventually he was admitted to Ward 10.

*Comment*

*It is a surprise to us that the consultant who was to treat Garry when he was in hospital and responsible for the local community's psychiatry was not personally involved in assessing him before he came into hospital or in agreeing the admission. Most general psychiatrists are protective of bed usage and search for less restrictive alternatives or alternative community approaches before accepting admission. In this case, the admission was arranged apparently without the consultant's knowledge. Furthermore, Dr K*

*Yasin the Consultant Psychiatrist was on leave at the time of Garry's admission and no formal system of cover between the consultants appears to have existed.*

**The First Admission 23 July 1997 to 27 August 1997**

Garry was admitted to Leigh Infirmary at 7.30 p.m. under the care of Dr K Yasin, Consultant Psychiatrist and was examined by Dr Obinani the SHO, who wrote a very full admission note of good quality. The threat to his mother with a knife was noted and a range of delusional and grandiose ideas was described. Dr Obinani telephoned Mrs Lythgoe and obtained a history of "gradual change in his behaviour in past five years, which deteriorated in the past few weeks". He had become aggressive and threatening, particularly towards his mother. Dr Obinani recorded that Garry had "put a knife to his mother's throat yesterday" and she was very scared. The detailed description of Garry's mental state confirms that he was suffering from an acute psychotic disorder with many of the features of acute schizophrenia. The provisional diagnosis was of Psychotic Disorder (drug induced) and the differential diagnosis was: Behavioural Problems, Personality Disorder or Paranoid Psychosis. A drug screen was ordered by Dr Siddiqi, locum consultant psychiatrist at the time, but there is no record of the outcome in the notes and it is not mentioned in the discharge summary. The assessment was incomplete in that it lacked the necessary investigation of Garry's social and family circumstances by a social worker. Dr Obinani then contacted Garry's mother but the opportunity was missed to establish a working relationship by a social worker with the family, which might have been so valuable later on.

Garry was prescribed thioridazine and risperidone, which are both anti-psychotics and which have a dual action of both calming behaviour and of acting on psychotic symptoms. The medical and nursing notes describe how he remained somewhat aggressive and paranoid for a while, but by mid August, he was more settled. His mother said he had not been this well for five years. He had a number of home leaves and was referred to the Hospital Social Work Department for help in finding accommodation. When it seemed likely that he would return to his parents' home, the attempt was discontinued. During his admission, he was under the care of three different locum consultants, none of whom offered a firm diagnosis. Garry was discharged on 27 August 1997 after a thirty-five day stay in hospital.

The discharge summary was written by an SHO who does not seem to have had much contact with Garry during his admission and who repeated the diagnoses of Drug Induced Psychosis and Personality Disorder without any evidence for doing so. There was no Care Programme Approach plan on discharge. He was not assigned a community worker despite the history of threatening behaviour. He did not keep the outpatient appointment and it was left to him to find his own accommodation.

*Comment*

*The use of speculative diagnoses in the discharge summary almost certainly affected Garry's future management. The approach by staff to patients diagnosed as seriously mentally ill may be very different to those whose troubles seem to have been brought on by themselves. It is an invaluable*

*discipline to use internationally accepted diagnostic classification systems, such as the World Health Organisation's ICD-10 or the American Psychiatric Association's DSM-IV. By their use any doctor can check whether diagnostic criteria are met and what weight to place on them. We cannot infer the Responsible Medical Officer's opinion, as he did not write it down. The uncertainty about diagnosis did not help the planning of Garry's treatment. If a CPA plan had been implemented, there would have been a wide multi-disciplinary contribution plan and the family would have been included.*

**January and February 1998**

Having spent some time at his parents' home, Garry found himself a place at the Lord Street Hostel, Leigh, provided by the County Palatine Housing Association, in January 1998. The Citizen's Advice Bureau in Leigh suggested that he should make the approach. Gail Fairhurst, who is a support worker for the Association's hostels, explained to us that this hostel is for young single homeless people. They take referrals from Social Services, local Probation Officers and self-referrals. People with mental health problems are accepted, but with some caution. Gail Fairhurst interviewed Garry and introduced him to his four fellow residents. She accepted him on her own responsibility. In her statement for the Inquiry, she told us that her job **"is to see each person on a regular basis to encourage them to seek employment. Teach, (if need be) basic household skills and try budgeting their money, set aims and monitor their progress. If a person is using drugs, we would refer them to the Community Drug Team".**

The contact sheets kept by Gail Fairhurst show that she tried to make contact with Garry almost daily either in or out of hours for the first two weeks without success. Eventually she met him by appointment to discuss the arrears of rent, which he had already incurred.

On 18 February 1998, while Gail was on holiday, one of the fellow residents came to the office to report that Garry had trashed his room on the night of 17 February. Garry had been throwing crockery at his walls and damaged the smoke alarm. There was spaghetti all over the walls. The smoke alarm, curtain rail and light fitting were broken. He had been talking to himself. When he came to the office later, he said that he had heard a voice talking to him through the radio and was convinced that the room was bugged and that there was a hidden camera in there. He was sorry and promised to tidy up the mess. He refused to seek medical help.

On Monday 23 February when Gail Fairhurst returned to work, she asked Garry to come to the office, where he appeared **"very unbalanced"**, saying that he needed to speak to the Prime Minister. After a time, she persuaded him to allow her to make an appointment for him to see his doctor. Although Garry had actually been removed from Dr Rawson's list on 9 February 1998 as he had moved from the area, the surgery offered him an appointment and made one for Tuesday 24 February 1998 with Dr Rawson but Garry failed to attend. Gail Fairhurst also made a second appointment for Wednesday 25 February with Dr Rawson after trying to secure an appointment with Dr Thompson at the request of Garry's mother. Dr Thompson was unavailable until Monday 2 March 1998.

On Tuesday 24 February 1998 Garry Lythgoe left Lord Street Hostel and spent the night at his parents' home. Gail Fairhurst was therefore unable to accompany Garry to the doctors appointment she had arranged for Wednesday 25 February and despite going to the surgery in an attempt to meet him, was unable to speak to the doctor – Garry having already had his appointment when she arrived. Gail Fairhurst told us she felt Garry did not wish her to speak to the doctor about his behaviour and the GP's records do not indicate that Garry presented any evidence of his mental disturbance at this appointment.

He later spoke to Gail who found him to be very talkative, skipping from topic to topic and possibly hinting at suicide. His mood seemed very variable. Gail was still concerned about Garry and telephoned Ward 10 at Leigh Infirmary to seek advice and spoke to Dave Parry, the Ward Manager, who said that he would contact the Community Mental Health Team and report back to her. Having heard nothing, Gail Fairhurst telephoned the ward again later the same day and received a message that a Mental Health Act Assessment was being arranged for the following day. In fact, it was still a few days off.

*Comment*

*It is likely that Garry was trying to cover up his symptoms although he was experiencing a florid outburst of his illness at the time. Mrs Fairhurst tried very hard to get help for Garry as soon as she realised that he was unwell. Had a referral been made under the Care Programme Approach at the time of his discharge from hospital, she would not have had to struggle to make her way through a system with which she was not familiar.*

**Arranging the Second Admission to Hospital February and March 1998**

It took from 17 February 1998, when Garry trashed his room and showed undoubted features of a severe relapse of psychotic symptoms, until 3 March to get him into hospital. Gail Fairhurst described her attempts to get something done through the GP and approaches to the psychiatric unit at Leigh Infirmary. The thoroughly recorded details of what happened in the days leading up to admission are to be seen in the Diary Sheets kept by Rosie Stenhouse and Donna Griffiths, Community Psychiatric Nurses in the Leigh CMHT.

On 27 February 1998, having had no update that action to help Garry was in progress, Gail Fairhurst telephoned Leigh Community Mental Health Team. She had been struggling to get help for Garry Lythgoe for ten days and had no natural point of contact with health or social services. Rosie Stenhouse and Donna Griffiths subsequently made seventeen telephone calls before 2.30p.m. It was their aim to co-ordinate a Mental Health Act assessment and Rosie Stenhouse rang Garry's former GP, Dr Rawson, his mother, the ASW on duty and David Budd the CMHT manager. She kept Gail Fairhurst informed and established that a bed was reserved for Garry's probable admission to Ward 11 at Leigh Infirmary. The assessment was planned for later in the day.

As Leigh CMHT had no Approved Social Workers attached to it at that time, Dave Bradshaw, ASW from the Ashton and Golborne CMHT, was assigned to the case and

took over in the afternoon. He made a further eleven telephone calls, the last at 5.10pm. He telephoned four doctors approved under Section 12 of the Mental Health Act, none of whom would agree to attend for the assessment. They included Dr Malik who was the consultant psychiatrist responsible for psychiatric services in Leigh and under whom Garry was to be admitted. Eventually Dr Alastair Thompson, who had known Garry previously and was Section 12 approved, agreed to attend but could not do so until after his surgery finished at 6.00 p.m.

By now, out of hours, the assessment became the task of the Emergency Duty Team (EDT) and Amanda Harrison was the ASW who told us **"The concerns that I recall at that stage were about Garry and his behaviour at the flat – that he was heard to be stomping around the flat at all hours, talking and shouting to himself and had actually on one occasion caused criminal damage to some property in the flat".** She went round to Lord Street Hostel with Dr Thompson. They requested the police to attend. Amanda Harrison's notes stated, **"When we all arrived, unable to gain access to Garry's room - other residents unsure whether he was in or not".** They agreed there were no grounds to force entry which would require a Section 135 order signed by a magistrate. They decided to ask Catherine Blakely of County Palatine to monitor the situation over the weekend and to contact the EDT if necessary.

Garry had been at his parents home anyway. His mother said he had been unsettled and talking to himself but was not violent. He returned to Lord Street Hostel on 1 March (Sunday). Amanda Harrison talked with Mrs Lythgoe on the telephone and after discussion, Mrs Lythgoe requested a Mental Health Act assessment under Section 13(4) which states:

> (4) It shall be the duty of a local social services authority, if so required by the nearest relative of a patient residing in their area, to direct an approved social worker as soon as practicable to take the patient's case into consideration under subsection (1) above with a view to making an application for his admission to hospital; and if in any such case that approved social worker decides not to make an application he shall inform the nearest relative of his reasons in writing.

By Monday 2 March, although there had been no further incidents, it was decided definitely to proceed with the assessment. It took a further day to assign the case to an ASW, who was Fran Thomas from the Ashton and Golborne CMHT. On 3 March, she interviewed Garry with Dr Anjali Rawson, his former GP and in the presence of Dave Bradshaw, ASW at his parent's home in Atherton. Yet again, it had not been possible to find a Section 12 doctor. Both Dr Rawson and Fran Thomas concluded that Garry was so disturbed that emergency admission under Section 4 was justified. The medical recommendation on Form 7, completed by Dr Rawson, states that any delay might result in harm.

Dr Rawson told us **"He was psychotic. He had had a past history of having knives to peoples' throats. So in itself somebody who is psychotic and has had that past history has the potential to follow it through, so from that point of view he was dangerous. He was also behaving in a manner inappropriate to the occasion which also led me to believe that he was also putting other people in danger".**

Fran Thomas told us in her written statement that Garry was **"physically intimidating standing close to me and gesturing into my face. There was evidence of paranoia, he maintained that cameras were watching him in his room at the hostel and that was why he had smashed the room up so 'they' could no longer watch what he was doing. There was flight of ideas and pressure of speech. He was uncooperative, with no insight into his condition. He was hostile especially to his mother, but would burst out laughing incongruously"**.

In the event, Garry went to hospital by ambulance without resisting.

*Comment*

*It took fourteen days to manage a situation, which from the start required urgent action. The unacceptable delay and absence of effective management would not have happened if a contingency plan following the Care Programme Approach had been made at the time of Garry Lythgoe's discharge from hospital in August 1997.*

*Almost every link in what should have been a routine of continuing community psychiatric treatment of serious mental illness failed after that discharge. Because there was no key worker or CPA plan, there was no continuity of information or a contingency plan. Neither the family nor Gail Fairhurst knew whom to approach or what to do if Garry's behaviour gave rise to concern. There was no handover of responsibility or information between CMHTs when he moved from Atherton to Leigh nor a system for doing so.*

*Our reading of the notes from a variety of sources shows that Garry was persistently seen to suffer from drug induced psychosis and personality disorder, not schizophrenia. We have concerns that his management might have been different if the process of schizophrenia had been recognised. Follow up may have been much more assertive.*

*Too many of the telephone calls requiring urgent attention were met with "not available", "out of the office", "in a meeting", "distracted by other things yesterday and had not got round to it".*

*The difficulty in finding a Section 12 doctor who was willing to assess Garry's mental state really does seem to have affected the management of the case. The time between recognising the need for admission and bringing it about was surely sufficient to avoid an emergency order under Section 4.*

**The Second Admission 3 March 1998 to 2 April 1998**

When Garry was admitted to Ward 11 at Leigh Infirmary on March 3 1998, he was examined by the admitting doctor, Dr Mehta, duty SHO, who wrote a good account of the history and present mental state. The admission note concludes, well justified by the evidence that Garry Lythgoe suffered from a paranoid psychosis with a possible differential diagnosis of personality disorder.

The nursing notes record that he had a fairly settled night and was interviewed at 1.30 p.m. the following afternoon by Dr Malik, Consultant Psychiatrist. Dr Malik's entry in the notes was:

> 4.3.98: **Settled, pleasant and courteous.**
> **Vague in ideational process but no evidence of thought disorder, paranoid beliefs or other delusions, no hallucinations.**
> **Wishes to return to the hostel by Friday.**
> **No grounds for compulsory detention.**
> **Revoke Section 4. Discharge whenever it suits him.**

Both Garry's parents telephoned the ward on separate occasions on 6 March to protest about the possibility of early discharge. They asked for him to be detained under the Mental Health Act, as he was mentally disturbed and homeless. David Bradshaw the Social Worker, who had been present in support of Fran Thomas at the time of the assessment also telephoned and spoke to Dr Felix Nwokolo, SHO to register his concern. Fran Thomas as the ASW making the application for admission to hospital wrote immediately to Dr Malik, RMO expressing her alarm, but received no reply. She told us:

**"I was told Mr Lythgoe had been reassessed and regraded down to an informal patient which I felt was not good practice because we had assessed him as a dangerous person, extremely ill and he had never really been assessed for some period of time and felt a period of assessment would have been good for him. I was worried that he would, if he was in hospital informally discharge himself, just go. That had happened before and I was quite worried that people were just not taking on board what had happened at the admission. I spoke to the ward and I spoke to Dave Parry who was the Ward Manager and went through all these points with him. There was an awful lot of hostility being expressed by Garry to his mother whilst we were there. I knew he was not able to go back to the hostel because of the condition he had left the room in and the problems they had had with him. They told me they were going to revoke his tenancy so I knew he had nowhere to live. I also knew that he had no GP. These are not good things to let somebody go out to".**

In her letter to Dr Malik, Mrs Thomas expressed the concern of both herself and Dr Rawson about the abrupt revocation of the Section 4 order.

Dr Felix Nwokolo, Dr Malik's Senior House Officer wrote in the clinical notes **"I looked at Garry and there was no ground to section him"**. Dr. Malik was on the premises and Dr. Nwokolo told us that he advised Mr. Bradshaw, as he was the SHO, to contact the Responsible Medical Officer, who had just made the decision to revoke the Section. Dr. Nwokolo also told us that he had had lengthy discussions with Garry and his parents in coming to his conclusion about the grounds for detention.

*Comment*

*We are concerned that the medical judgement about the risk to Garry's health and safety or the safety of others was made after what seem to have been brief interviews and without consultation with relatives or other professionals,*

*especially Dr Rawson and the ASW. (See Section 2(2)(b) of the Mental Health Act 1983). The judgement seems to have taken into account only the current mental state and not the recent history of the disorder or the views of others. The decision not to proceed to assessment under Section 2, which allows 28 days of investigation, was in our view an opportunity lost. Almost certainly, full multidisciplinary assessment would have progressed to a Care Programme Approach plan. In particular, a social worker would have investigated the family situation and established working links. The community team would have made contingency plans to follow him up after discharge.*

*We are also concerned that where there are serious differences of opinion between professionals who should be working to commonly held aims, there appears to be no procedures to resolve conflict.*

Later on in the day on 6 March 1998, Garry went missing from the ward. He first went to his parents' home, asking for money. When he was refused, he kicked the furniture and left. The nursing notes record a telephone call to his parents. His father said he was going to make a complaint and was told how to do so. The police were informed.

When we saw him at Ashworth Hospital, Garry described his state of mind at the time. He said that he did not tell the doctors of his thoughts as he believed them to be reality and that there was no need to do so.

**"To prove I was very ill, I thought that there was the Mafia and the IRA trying to blow the hospital up. So I thought I had a message for the Queen. So I went down to London. I walked out of the hospital, got on the train at Atherton, went to Manchester, with no money, got on the train at Manchester with no money on my way to London. The guard, the ticket checker, at Milton Keynes says, 'You've no ticket. You will have to get off' and so I hitched lifts and things from Milton Keynes down to London and I was sat outside Buckingham Palace waiting to see the Queen, and after I had spoken to the Queen I thought I had to visit Nostradamus' house in France to unveil the secrets. Nutty."**

**"...what happened when I was in London, I started feeling very ill. So I went to hospital because I was in a state of near collapse, you see. I thought I was very ill. I thought I had like a brain tumour, a cancer, or AIDS or something and would die. I thought I was dying. So I went to hospital and told them this, and so this psychiatrist came down and he went through asking me loads of questions for an hour or two and then he sent me to a private hospital in London somewhere. I stayed at that for about a week and then they found out I was from Charles Day at Leigh and so they came down in a taxi to pick me up to take me back to Charles Day."**

After he had been to Buckingham Palace, where he was sent on his way by the sentry, Garry went to St Thomas' Hospital, was assessed and then because of bed pressure at St Thomas' was admitted to Charter Nightingale Hospital, a private facility as an extra contractual referral. The in-patient notes of that admission show that although he remained mentally ill, he accepted the need to remain in hospital. He was collected by two nurses from Leigh Infirmary in a taxi and returned to Ward 11 on 11 March. He remained on the Ward as an informal patient until his discharge on 2 April about three weeks later. We have read all the entries in his medical and nursing notes about this period and have questioned a large number of the clinical staff who looked after him. At first he seems to have been settled and compliant with treatment. Later he began to refuse medication and was difficult to get out of bed in the morning.

Many of the entries report him to be composed and mixing well with fellow patients. At times, he expressed paranoid ideas, such as on 11 March 1998 "A little worried that someone may have put something in his food/drink". 13 March "Refused to get up". 18 March "Refused medication. It is interfering with his manhood". 19 March "Very argumentative". 20 March "Loud and jovial". 21 March "Agitated, demanding to read notes. Hostile and somewhat verbally abusive". Garry also displayed illogical thinking about the manner of his admission. "Excessive noise throughout the night". "Continues to express paranoid ideation through the evening despite accepting prescribed medication". 22 March "Continued to express paranoid ideation. For discussion with medicals regarding his threatening paranoid presentation later this morning". 24 March "Overheard to be expressing several paranoid ideas".

On 26 March 1998, he had an interview for a flat. The nursing notes record the telephone conversation with the Housing Agency afterwards. "Garry's speech content was very bizarre saying he spoke to the radio and laughing bizarrely. They have declined to offer him a place. I have informed him of this. Whereupon he launched into a long speech about people being out to get him". On 27 and 28 March, he "remains bizarre while conversing".

The medical notes, which are fairly sparse, record little about his mental state. There is an opinion that he has a probable paranoid psychosis but that his main problem was accommodation. He is reported to be insistent on the virtues of cannabis. The only drug screen result in the notes is "weakly positive" for cannabis. The sample was submitted on 11 March and reported on 23 March 1998. Donna Griffiths, CPN, made an entry in the community link ward book about Garry's state of health but although he was noted to remain psychotic, there was no further action.

**Discharge Plans and Arrangements For Follow Up**

Dr Malik held a Clinical Meeting on 30 March 1998. The nursing note records the names of those present, that Garry is continuing to look for accommodation and:

**"Plan**
**1) Discharge before Friday**
**2) Medication to be discontinued**
**3) If no accommodation to be discharged to Salvation Army Hostel"**

The medical note records the plan simply as **"Plan: for discharge by Friday".**

He was in fact discharged to his parents' address on 2 April 1998. He was given no medication. He did not have a GP. The summary of the admission was dictated on 7 April and typed on 23 April. It was not sent out, as there was no GP. The diagnosis is recorded as Drug Induced Psychotic Disorder. The medication on discharge was said to be Risperidone (anti-psychotic), Zopiclone (hypnotic) although none was issued. An outpatient appointment in eight weeks was to be arranged but the actual date offered was 7 August 1998, four months ahead. Garry did not keep it when the time came and no further action was planned.

*Comment*

> *Although Garry Lythgoe remained in hospital for a month, the nature of his progressive psychiatric disorder was not revealed by multi-disciplinary investigation. He was seen as an uncooperative young man with a drug induced psychosis. There was plenty of evidence of active psychosis throughout the admission. The planning of his discharge can be acceptable to no one. The opportunity to set up a package of care which might have led to a different outcome was lost. Contact with his parents was not established and they were left without a contingency plan in the event of relapse. No referral was made to any of the community services despite there being multi-disciplinary mental health teams in Leigh and Atherton, where Garry lived during the development of his illness.*

**The Summer of 1998.**

Garry left hospital on April 2 1998, discharged to his parents' address. We asked Nigel Lythgoe about contact with the hospital and psychiatric services about his son. He said, **"To me there was no contact both times. In the hospital, no doctor had a word with us, no doctor told us what was wrong with him.... He told us himself "I'm paranoid schizophrenic". I had not a clue what it was".** No one from community services made contact either.

Garry at first stayed with friends but soon found himself a flat in Leigh and a job. He registered with a new GP, Dr D.N.Das on 1 May 1998. Dr Das and the practice nurse saw him on 1 May and recorded his past history of asthma and also his admission a month ago to Leigh Infirmary under Dr Malik for "? Paranoid psychosis". He was not taking medication and did not wish to do so. His practice notes arrived from the Health Authority on 24 May. They contained the discharge summary from the admission in 1997 but not the more recent one, which remained in his hospital notes.

In the next few months, Dr Das saw him six times in the surgery for a range of minor physical complaints. On 6 July Garry remarked that he "feels that people are laughing at him". This was the first time he had reported any kind of psychological symptom.

We managed to obtain the record of a visit which he made to the Accident and Emergency Department, Royal Bolton Hospital on 22 July 1998. He had been taken there by ambulance, noted to be "Suicidal. Paranoid psychosis. Can be violent". He had apparently taken two tablets of risperidone. Garry complained that a camera was following him but refused to speak further. He said that he preferred to discuss his problem with his GP. Dr Das' records show that Gary attended his surgery on 24 July. The visit to A & E was not reported to Dr Das. The hospital was not obliged to report a visit to the GP unless the patient was either admitted or offered an outpatient appointment. This practice has now changed and from 4 October 1998, the hospital began to send brief reports about patient visits to Accident and Emergency, whether or not admitted or offered an outpatient appointment.

On 22 September 1998, Dr Das noted that Garry's neighbours reported him to be unwell. Later in the day, Dr Das called round to see Garry at his flat and to prescribe risperidone and thioridazine (both anti-psychotics) which had been his medication on discharge when under Dr Yasin's team in 1997. Garry was not in, so Dr Das gave the prescription to one of his housemates.

Two days later, on 24 September, the neighbour came to the surgery with the torn prescription, which we have seen, saying that Garry had torn it up. Garry himself came to the surgery on the next day "worrying about a hernia for which there was no evidence". Dr Das tried to broach the subject of mental illness. Garry became **"A very angry man"** and Dr Das feared for his safety. As he left the surgery, Garry remarked that he had **"a lot in his head and he heard voices".** Dr Das was not sure of the diagnosis. He hoped that he was still being followed up by CPNs but had had no communication from them. Dr Das agreed on the need for improved communication between specialist and primary care services where patients with continuing mental illness are to be managed while living in their own homes.

*Comment*

*Garry was breaking down again during this period. However neither he nor his parents knew how to obtain specialist help. He tried to get it for himself in an oblique way. He called on his GP for minor physical complaints; he had himself taken to Accident and Emergency for a very minor overdose. Perhaps he hoped that someone would see through his story and do something.*

In his statement to the police in October 1998 Garry's brother reported that before Saturday 10th October 1998, when the assaults took place, Garry **"had been fine recently."** He last saw him on October 4th. Garry had been living in a flat in Leigh. He was in the habit of calling round to visit his parents on Saturday. His father said, **"He would fetch his washing to do and have a good meal."** Although **"he seemed friendly"**, one time **"he went upstairs and started having conversations with himself."**

Garry had found himself a flat and a job at food manufacturers in Leigh. When we saw him in October 1999, he recalled his state of mind:

**"I worked in this food factory in Leigh and I actually went up to one of the lads and I said something like 'It's not my fault'. He said, 'What's not your fault?' I said, 'How long have you known about this?' He said, 'Known about what?' I said, 'All these cameras watching me'. He said, 'What cameras watching you?' I said, 'That one over there' and he just looked at me puzzled and said, 'What are you on about, man?'**

**I thought I was being watched by the Prime Minister, Gerry Adams, Liam and Noel Gallagher, just loads of people; footballers, film stars, celebrities. I just thought they were all watching me because when I killed my mother as well, on the day, I thought there were cameras in the bedroom watching me and that's really why I went to do it, you see, because I was sort of saying to them, after I had done it, I was thinking to myself, 'Right, is that good enough for you, camera work?' you know what I mean. I thought the Prime Minister was racing me to my mother's and father's to kidnap them to take them away to torture them and so when I got there on that Saturday afternoon I was surprised to see they were still there, you see."**

**Mrs Lythgoe's Death**

On Saturday 10 October 1998, Garry called round to see his parents at about half past four. His father was watching football on TV. His mother was upstairs in bed. In his statement to the police, Nigel Lythgoe said **"She had gone for a lie down"**, as they were going out to a party later. **"Garry came in and went to the kitchen. He was reading the newspaper at the kitchen table. I then heard him go upstairs. I was not disturbed, he usually went for a shower or went to his brother's bedroom to watch telly. I put the mute button on the telly so I could listen to hear if he was making a noise. I couldn't hear anything, so I went upstairs. I saw Garry coming out of the bedroom, he had a hammer in his hand. Garry said 'this is it for all of us. It's got to end'."**

Mr Lythgoe went into the bedroom and found his wife unconscious and bleeding from a head injury. Soon after that, Garry attacked his father with the hammer. **"I got it off him and he ran down stairs. I followed him into the kitchen. He pulled out a knife. I tried to stop him stabbing me. I grabbed the blade with my right hand and he let go of it."**

Eventually, after trying to stop his father from going out to seek help, Garry ran out of the house. His father then summoned help from neighbours and went back to his wife. The police and ambulance services came promptly. Both Mr and Mrs Lythgoe were initially taken to the Royal Bolton Hospital for treatment. Mrs Lythgoe died without regaining consciousness on 13 October 1998 at the Neurosurgery Unit, Hope Hospital, Salford.

After arriving at his parent's house, the police began to search the immediate area and Garry was arrested without resistance, not far from the house.

**Events Following the Arrest**

After his arrest, Garry Lythgoe was examined in Leigh Police Station by Dr R D Choudhury, a doctor approved under Section 12 of the Mental Health Act 1983 together with Amanda Harrison, Approved Social Worker. They determined that he was fit to be charged and that in the circumstances it was necessary for him to progress through he criminal justice system, rather than the health service. Dr Choudhury told us **"I found him to be very disturbed and he was deluded. He had auditory hallucinations and the remark he made to me was that this was the proudest moment of his life, having done what he had done"**. Amanda Harrison noted at the time that it was immediately apparent that his actions were triggered by an elaborate paranoid delusional system. He believed that he was born into a plot and that his food was being poisoned. In attempting to kill his family he was saving them from their **"prolonged horrific death"**. Garry acknowledged that he was experiencing auditory hallucinations, coming from the radio and TV.

Garry was interviewed at Leigh Police Office on Sunday 11 October 1998 by two police officers in the presence of Amanda Harrison and a duty solicitor. The transcript of the interview, which we have read, shows that Garry was in a roused acute psychotic state with muddled disjointed thinking, inappropriate emotions and mood. He talked freely of delusional and hallucinatory ideas, mixed in with a factual account of recent events in his life. He described how he had attacked his mother and father with the intention of killing them and had also decided to kill his brother but he had not returned home at the time of the incident. Garry said he was proud of what he had done and felt he had saved his family.

He was charged with the murder of his mother and the attempted murder of his father and remanded to Strangeways Prison.

**Psychiatric Assessment**

At Strangeways Prison, Dr Aideen O'Halloran, Consultant Forensic Psychiatrist, examined Garry on several occasions. She made a diagnosis of paranoid schizophrenia and presented this opinion at Garry Lythgoe's trial, with a recommendation for treatment under a hospital order. It was not her view that Garry Lythgoe suffered from personality disorder or a drug induced psychosis. She confirmed this when we spoke with her. Whilst he was still in prison, Dr O'Halloran started him on treatment with the anti-psychotic drug olanzapine and began to discuss a recommendation to the court for secure hospital accommodation and made contact with colleagues at Ashworth Hospital. Garry was also examined by Dr Helen Whitworth, at that time Senior Registrar in Forensic Psychiatry to Dr P R Snowden, Consultant Forensic Psychiatrist, Mental Health Services of Salford, Adult Forensic Service, Edenfield Centre, Salford for the defence. Dr Whitworth wrote a thorough and thoughtful history and examination from all the available sources. She also made a firm diagnosis of paranoid schizophrenia and was of the view **"I did not consider that there were any realistic differential diagnoses. In particular, I was not of the opinion that Mr Lythgoe's presentation in October 1998 and in January 1999 could be accounted for by his history of substance misuse".**

## The Trial

On 22 April 1999, Garry Lythgoe appeared before His Honour Judge Rhys Davies QC at Manchester Crown Court. He pleaded guilty to the manslaughter of his mother, the plea being by reason of the diminution of his responsibility of his acts because of his illness. He also pleaded guilty of the attempted murder of his father. The Judge was satisfied that an order was necessary under Section 37 of the Mental Health Act with an order restricting release without limitation of time under Section 41. A place was available at Ashworth Hospital to which he was soon transferred.

## Progress at Ashworth Hospital until the present time

With Garry's further permission, we spoke to Dr Stephen Noblett, Consultant Forensic Psychiatrist, Sue Anson, Social Worker and Claire Cunningham, Named Nurse who are looking after Garry at Ashworth Hospital. We were told that he had improved considerably since his admission and, indeed, that the symptoms of acute psychosis had been resolved before his transfer from prison. Garry was now settled in his mental state and working well with his care programme. Dr Noblett was of the view that the prescription of olanzapine, an atypical anti-psychotic had been an important reason for this. Garry was still going through further assessment, in particular by a forensic clinical psychologist, and exploration of the causes of his actions at the time of the offence. A number of issues were being identified which would lead to the construction of a treatment programme. It was too early to make predictions about the prognosis or the outcome of treatment. Dr Noblett was satisfied that he was correctly placed in Ashworth Hospital because of its range of amenities, rather than in a Medium Secure Unit which had less amenities and was geared to a shorter length of stay than was likely in Garry Lythgoe's circumstances. There were further questions to be answered about his personal and social functioning in the years between school and the offence.

Dr Noblett and his colleagues confirmed the diagnosis of paranoid schizophrenia, which had developed insidiously from 1995 onwards and possibly earlier. Drug misuse had not been causative, but might have made the condition worse. There were aspects of his personality, which needed to be explored further. The clinicians expressed the opinion that Garry was adept at concealing his symptoms and had been throughout his illness.

## 7. FINDINGS

### Health and Social Services Policies, Procedures and Strategy

The Inquiry received copies of the policy and procedures of the Wigan Social Services Department and the Wigan & Leigh NHS Trust. The Panel was satisfied that these were comprehensive and well written documents giving effective guidance to staff involved in mental health work. Any review of these documents should take place when the recommendations from the Independent Inquiry have been considered by the appropriate authorities.

The Inquiry also received the document Improving Mental Health in Wigan & Bolton – Setting a Strategic Framework, that was adopted by the Health Authority in March 1997. The Joint Consultative Committee received progress reports on the strategic framework in June 1998, September 1998 and a service development schedule in March 1999. The Inquiry accepted these documents as evidence of a strategic approach with regular review.

### The Internal Inquiry

We have included, as an appendix, the executive summary of the Internal Review of Psychiatric Patient Care - Wigan and Leigh NHS Trust, into a number of incidents, presented to the Wigan and Bolton Health Authority in September 1999. The review covers four suicides and the case of Garry Lythgoe. As far as Garry is concerned, we agree with the broad findings. These are about unsatisfactory practice in the implementation of the Care Programme Approach, risk assessment, the implementation of agreed policies, and communication between teams, disciplines and other agencies.

We agree with the selected recommendations in the summary, but had some doubts about the practicality of the timescales suggested for follow up of patients who have been at high risk, unless met by substantial increases in staff working outside the hospital.

The detailed findings and recommendations of the report itself set out many of the same problems that we have identified in our inquiry. We have understood from those to whom we have been speaking that the major issues are already being addressed and that progress towards solution is being made. We have taken the view that the main function of an inquiry such as this is to identify major problems and to require that the solutions adopted be properly monitored to show a successful outcome. We acknowledge that the recommendations proposed by the internal review are capable of being written as actions which can be verified. We hope that an action plan can be based on the review's findings but it should also include the further issues which we have raised.

It was a disadvantage not to have a psychiatrist on the internal inquiry. One of the main failings in Garry Lythgoe's management was the missed diagnosis of serious mental illness, which led to unhelpful attitudes in the planning of his care.

## Care Programme Approach Procedures

The Inquiry received the revised guidelines for the implementation of the supervision register at Level 3 Care Programme Approach and a copy of the relevant forms. This procedure was established in 1997. The procedure as written appears to be adequate but the Care Programme Approach was not implemented for Garry Lythgoe.

Reports of the visits from the Mental Health Act Commission from 1997 to 1999 were made available to the Inquiry. It is significant that the Commission made a number of recommendations throughout this time that have a direct bearing on the management of this case. The use of Section 4 emergency admissions and the use of Section 2 and 3 are raised. The use of Section 5(2) doctors holding powers are also commented on as are leave of absence and a variety of other matters relating to the care and treatment of patients with mental ill health.

## Legibility of Notes

A range of entries in the notes that we have read is on the edge of illegibility. While the ideal of all notes being typed may not be possible, key entries should be. The opinions and treatment plans of the Responsible Medical Officer should always be typed, as should an admission formulation and a record of the pre-discharge planning meeting.

## 8. CONCLUSIONS

It is our conclusion that Garry Lythgoe was not well served between 1996 and 1998 by the mental health services which have been the subject of our inquiry. We see them to have been poorly organised, of low standards, indifferent leadership and minimal expectations for quality. However we do not believe that the assault on his parents could have been predicted. There was little to distinguish the nature of his illness from that in others in which the outcome does not lead to such violent behaviour. Killing in the course of schizophrenia is very rare and notoriously difficult to predict in any one individual.

In the following, we have identified a number of lost opportunities in the management of his illness which if taken might have led to a very different outcome.

- We are concerned about referrals to Community Mental Health Teams where there has been little or no medical or nursing contribution to assessment. Open access need not be discouraged but must be balanced against the complexities of diagnosing and treating the seriously mentally ill person. In Garry Lythgoe's case, the first contact did not lead to medical interview, multi-disciplinary discussion or involvement of the family. We see this as one of the lost opportunities in his care.

- At the time when an urgent Mental Health Act assessment was needed, no Section 12 approved doctor was available. Not enough Section 12 doctors are being recruited for the area.

- We were told of times when there were staff shortages, particularly of social workers, in a number of key areas. The arrangements to provide cover rapidly were not clear and did not work well, for example leading to the delay in achieving admission.

- There were many occasions of concern when Garry was living at home or elsewhere in the community, which might have, but failed, to bring about the help and services that he needed. These include the visits to Brooklea Centre in 1996, police interventions at the request of his parents on 27 December 1997, 9 January 1998, and 19 February 1998, and the aborted Mental Health Act assessment in March 1998.

- There was no properly informed or effective multi-disciplinary discussion of this man's needs during his contacts with the mental health services. The result was fragmented and ill-directed care, which failed to provide him and his family with support and explanation, during a developing serious mental illness.

- The circumstances of Garry Lythgoe's second admission to hospital in March 1998 illustrates the inadequacy of the system operating at the time. The Approved Social Workers experienced unwarranted or unreasonable delays in getting appropriate responses to their concerns about Garry Lythgoe's mental health needs. Messages were either not acted upon or responded to and there was no evidence of an effective communication system being in place. However, certain non professional personnel made outstanding efforts in an attempt to obtain help for Garry Lythgoe in particular, Mrs Gail Fairhurst from the non-statutory County Palatine Housing Association.

- The consultants' job plans are incomplete. What we have seen are better described as timetables and do not set out the expectations or responsibilities of the consultant's work. For example, the consultants should be obliged to take part in a duty rota for availability for Mental Health Act assessment at the request of Approved Social Workers. They should be required to contribute to the medical management of services, to monitor the outcome of the Trust's medical policies and to take part in clinical audits of quality issues.

- There were several indications of serious mental illness that should have led to more assertive treatment and support for both the patient and his family.

- The evidence for making the diagnoses of Personality Disorder and of Drug Induced Psychosis, recorded in the medical case summaries, does not accord with the description of these conditions in either of the international classifications ICD-10 (World Health Organisation) or DSM-IV (American Psychiatric Association). They appear to have been made with insufficient knowledge of the patient or his social and family circumstances. The diagnoses led to a different approach to his management, which was to his disadvantage. Too much was expected of him in seeking help for himself. Had the diagnosis of paranoid schizophrenia been made, the response of the services would almost certainly have been more assertive with a better care and treatment plan.

- The account of Garry Lythgoe's childhood, adolescence and early adulthood shows no evidence on which to base a diagnosis of personality disorder.

- The evidence was available within the family from an early stage in the illness that this young man was breaking down over a period of time, into a psychotic state. However, the family were not drawn into the diagnostic process or the formulation of future plans.

- The guidance of the Care Programme Approach, despite being introduced in 1991, was not followed.

- Garry Lythgoe was wrongly assigned to Level 1 CPA. He should have been placed in Level 3 in view of the seriousness of his history and presentation.

- Garry's request not to contact his family should not have been accepted without further action. Garry was known to have threatened his mother with a knife. An evaluation of risk could not be done without consulting her and other members of the family. In the circumstances, his objections should have been over ridden.

- The responsibilities of the social workers in the psychiatric wards at Leigh Infirmary at the time of his admissions were not clear. They appear to have been aimed at providing on-the-spot social work responses and not to develop the continuity of care required for the management of illness after discharge.

- No efforts were made to find a GP for Garry on his discharge from hospital on the second occasion. As a result, continuity of information about his serious mental illness was lost to workers in the community who came to be responsible for him. He was not given medication to take with him, despite the assertion in the discharge summary that he was. The discharge summary should not have been filed in the notes but sent to the Health Authority, for inclusion in his GP notes.

- The discharge plan for his time in hospital in March 1998 was entirely inadequate. It can be taken to reflect an assumption that Garry Lythgoe's troubles were self-induced and were for him to solve without the help of the health and social services.

- Dr Malik misunderstood the role of keyworker for the CPA in declining to take responsibility for Garry's follow up after discharge. The obligations of the Care Programme Approach were not well understood or followed in the service.

- The family were not kept informed nor supported in their efforts to cope with Garry's illness after his discharge from hospital on both occasions. Their contribution could have materially altered the approach to diagnosis and the course of his care and treatment plans.

- The concern expressed by Fran Thomas, the Approved Social Worker about the discontinuation of assessment under the Mental Health Act was justified, as Dr Malik now accepts. The subsequent discussion between doctors and social workers was conducted with acrimony. The policy documents written by both The Trust and the Social Services Department on the resolution of such differences do not cover this particular issue: that is when the ASW believes that assessment under Section 2 is necessary and the Responsible Medical Officer does not.

- The multi-disciplinary mental health working groups within the Trust and Social Services Department do not appear to monitor and evaluate the quality of services provided within the health service. We are sure that they should do so.

- We conclude that Garry Lythgoe's mental disorder was not fully evaluated until he found himself remanded in prison accused of his mother's murder and of the attempted murder of his father. Before then, there had been a fragmented approach to his assessment, which failed to involve his family properly. During his admissions as an inpatient the opportunity to report on his social circumstances or to obtain a collateral account from family members was passed by.

## 9. RECOMMENDATIONS

### I Consultant Job Plans

- The consultants' job plans should be revised yearly. They should include on call rotas for Mental Health Act assessments in the community as approved doctors. It should be exceptional for a patient to be admitted without the personal involvement of the consultant who is to be responsible for in-patient treatment. The consultant should have identified time to work within community mental health teams serving the community for which he or she has accepted responsibility. Time should be allocated to train medical and other staff, for clinical audit and to contribute to the construction and management of the Trust's policies. Time and a budget should also be allocated for the consultant's own continuing professional education on topics mutually agreed with the Trust.

- The Trust should re negotiate the contracts of the consultant psychiatrists that it employs. Responsibilities should be clearly defined to include the obligations of national and local operational policies for the provision of Mental Health Services. The contract should describe the ways in which the consultant must contribute both to the hospital and community based management of mentally ill people who have been referred to them.

### II Section 12 Doctors

- More doctors must be recruited and trained for approval under Section 12 of the Mental Health Act 1983. Incentives such as the additional payment of retainer fees and payment for secondment for training should be very seriously considered.

### III Assessment Under the Mental Health Act

- Doctors and Approved Social Workers should be required to meet and agree on protocols for assessment under the Mental Health Act. Assessments should always include an independent account where possible and involve the family or carers in making the decision about detention. It should be exceptional for the consultant who is to be the Responsible Medical Officer under the Act not to be involved before the admission. Current mental state should never be the only determinant of the need for admission.

### IV Diagnosing Mental Illness

- The Trust should ensure that response to referral to Community Mental Health Teams is multi-disciplinary and always include a diagnostic interview by medical staff if there is any possibility of mental illness. Such an interview need not be at the time of first contact but should follow soon afterwards.

- Medical staff should be very strongly encouraged to use international diagnostic classifications such as ICD-10 and DSM-IV. By doing so rigorously, future responsible clinicians will know exactly how and why the diagnosis was made.

## V Care Programme Approach

- The Trust should fully implement the Care Programme Approach and monitor it against standards of outcome and documentation. All staff should be made fully aware that implementing the Care Programme Approach is not an option but should be part of the contract of employment of all staff.

- The process whereby the CPA level is assigned should be re-examined, especially taking account of homelessness, drug misuse, the risk of violence and non-compliance with treatment.

- The Trust should arrange a programme of training and development on mental health issues, especially the Care Programme Approach. All disciplines and multi-disciplinary teams, including doctors should be obliged to attend. The content of training should include confidence building between CMHTs and inpatient teams; multi-disciplinary discussion and decision taking; risk assessment; compulsory detention (sectionablity) with an opportunity for all staff to consider the positive aspects of the Care Programme Approach.

- Completed Care Programme Approach documents should be scrutinised against agreed standards by a group of clinical managers.

## VI Risk Assessment

- Risk assessment procedures should be re-examined. They were not well done in this case. Decisions were taken with inadequate consultation with those who knew Garry's recent history, such as his family, and sometimes followed brief examination of his mental state. Risk assessment is a prolonged and sometimes tedious process. It should always be multi-disciplinary and fully recorded. There is a range of risk assessment procedures in use in other services and published in the literature. One of them should be selected, staff should be trained in its use and it should be locally adopted.

## VII Discharge Arrangements

- No patient should ever be discharged from the need for follow up if the current state of their mental health is not known.

- Where a patient has no GP at the time of discharge, every effort must be made to register him with one. If this is not possible, the discharge summary must be lodged with the Health Authority so that further action can take place.

- The Trust is recommended to examine and adopt the principle of assertive outreach for patients with severe mental illness who may not cooperate with care and treatment plans.

## VIII Communication

- Measures should be sought to improve the efficiency of communication between the component parts of the service and with other agencies.

- Information about all contacts with specialist health services, including CMHTs, must be reported to the patient's GP.

## IX Monitoring and Improving Performance

- Discharge plans should be subject to clinical audit by peer review, possibly through sampling. They should include typed contributions from each of the disciplines involved. Standards of performance should be negotiated by Trust managers.

- A number of performance targets should be determined for the work of the service, such as waiting times for first outpatient appointments, hospital appointments following discharge, the time taken to achieve urgent admissions and failed follow up of patients known to be at risk.

- Finally we recommend that a lot of attention should be given to the commitment and morale of the mental health services. We were disappointed to observe a habit of passive observation of behaviour and not much therapeutic intervention. The leadership did not seem to be dynamic. We could feel little sense of mission. The expectations of delivering a service of high quality were low. The Trust's recent initiative on raising the quality of services might choose this issue as an early task.

**APPENDIX A**

**Questions Asked by Mr Nigel Lythgoe in his Statement to the Inquiry and our replies. In some instances the Panel has provided an overall response to a number of similar questions posed by Mr Lythgoe**

1. What (*illicit*) drugs did Garry say he was on, and what did the hospital say they thought he was on?

   *Garry admitted to regular use of cannabis and of a range of other drugs in the past, but not recently. On one occasion, whilst in hospital, he tested weakly positive for cannabis but for no other illicit drugs.*

2. Was he correctly placed? Was the ward he was in appropriate for drug users or not?

   *We believe that he was correctly placed while being assessed. His drug usage was secondary to his mental illness, which could be much better assessed in a general psychiatric setting.*

3. Could Garry have been treated in a different psychiatric hospital where he could have had more appropriate care?

   *No, Leigh Infirmary psychiatric unit is the mental health facility for the district covered by the Trust. Transfer to another hospital outside the area could have been considered if he had special needs, which were not met within the district.*

4. Given the diagnosis of paranoid schizophrenia, was a proper risk assessment carried out?

   *The risk assessment was not carried out to the standards of best practice. A clinical judgement was made but it did not follow a full multidisciplinary assessment.*

5. Were all the relevant circumstances explored and discussed?

6. Was proper consideration given to our own safety?

7. Why did the hospital not seek appropriate details of Garry's clinical history and past behaviour in order to address the degree of risk and its nature?

8. Were we properly consulted as to our willingness and ability to cope with the risk?

   *We have concluded that the family were not properly consulted on Garry's social and family circumstances nor on their ability to cope with Garry's illness or with the possible risks that it presented.*

9. Were there alternative options available for managing this risk?

   *Better support for Garry and the family after he left hospital on both occasions.*

10. Why was the legal order on him of such short duration?

*The Responsible Medical Officer is obliged to use the "least restrictive alternative" in considering the need for extending an order for detention under the Mental Health Act and did not convert the order to Section 2 because he believed that Garry was willing to stay in hospital informally.*

11. What were the circumstances of the Section 4 admission that made it impossible for a second doctor to attend while he was in the community?

*A shortage of doctors approved under Section 12 of the Act in the local community who might attend Mental Health Act assessments.*

12. Were the grounds satisfied or would an application under Sections 2 or 3 have been more comprehensive and appropriate?

*Section 2 would have been appropriate, as he was not known to the doctors assessing him.*

13. On what grounds was the legal order discharged so abruptly?

14. Was the decision to seek Garry's discharge so soon after his second (compulsory) admission in keeping with the law and professional good practice?

15. Was the initial application under Section 4 and the decision to allow it to lapse at the time of his first admission sound both professionally and legally?

*It was Dr Malik's judgement at the time, that Garry could be treated as an informal patient (see also the answer to question 10 above). In retrospect, Dr Malik has told us that he recognises that it would have been better to have converted the emergency order (Section 4) to an assessment order (Section 2). He did not discharge Garry but regraded his status to informal. On his return from London, Garry remained in hospital for three weeks as an informal patient.*

16. Could the nature of his admissions in any way have influenced the later decision making, particularly surrounding his discharge?

*What seems to have most influenced decision taking at the time of discharge was the belief that that his illness was self induced through taking drugs or was due to personality problems.*

17. Why did the hospital discharge him on the second occasion without ensuring that he had a suitable place to live?

*Because the clinical team believed that he could manage for himself.*

18. Why was there not on each occasion a care programme with a designated keyworker to whom Garry or his relatives could turn, as well as with a regular system of review?

19. Why was there no way of following Garry up to ascertain whether or not the medication was being effective and working appropriately given that he did not attend outpatients?

> *There appears to have been a departure from good practice on both occasions. If Garry did not want follow up, it could not be forced on him. However no key worker was assigned to try persuasion either. There should have been contact with the family in view of the previous threatening behaviour.*

20. Was an injection administered and monitored by a community psychiatric nurse a feasible alternative?

> *Yes, but only if Garry was willing and co-operated with treatment of this kind. He would also need to have had a trial of the effectiveness and safety of such treatment whilst under observation in hospital.*

21. Was the treatment process medicalised with little regard to social factors (the impact of family living, Garry's use of drugs and his own understanding of his condition)?

> *Garry's treatment plan was incomplete and should have paid much more attention to the factors mentioned.*

22. When he did not attend his outpatient appointments, why was there a decision simply to close his case?

> *Again, this was a departure from good practice. The case should not have been closed, until his mental state was satisfactory.*

23. Was there a role for the CHMT, social services or a voluntary body, such as "Making Space"?

> *There was certainly a role for a community agency to be involved, especially if it could engage his trust.*

24. Why were the hospital staff behaving as if they did not want to know Garry, seeming to want to get rid of him as soon as possible? How were decisions about his future care made?

> *The hospital staff had concluded that Garry was unco-operative in his treatment and that his symptoms were self-induced through drug misuse.*

25. Why were his family members not told what was wrong with him, how to manage his condition, of any risks it could prevent, and of any support

available to them? Was the reason of confidentiality sufficient for the lack of meaningful communication with his family?

*We accept that his family was not involved and should have been.*

26. Has the Health Authority carried out its duty of care to Garry and his family?

*This is the central issue addressed by this Inquiry.*

27. Did the approved social worker who made the application to admit carry out his or her duties properly?

*Yes, she did. We have no criticism of her action.*

28. Did Garry have the capacity to make a treatment decision?

*He complied with what was required of him in hospital, apart from the trip to London, but not after discharge. He lacked full insight into his need for treatment.*

29. Why was help so difficult to obtain in the first place?

*Communication between the agencies involved was scrappy. No one was managing the case. A formal referral from a general practitioner to a psychiatrist at an early stage might have helped. A community key worker might have been able to co-ordinate the response of services.*

30. The police were often involved but appeared to have no system of referral for domestic disputes where there were issues of both mental illness and dangerousness.

31. Would a system of rapid referral and assessment for agencies be helpful in preventing a recurrence of these tragic events?

*An effective community service for mental health includes regular liaison between all the community agencies, which may become involved in the care of mentally ill people. These agencies certainly should include the police, probation services, health and social services and voluntary organisations. Many also include user groups and relative support groups. In October 1998, communication between agencies does not appear to have been effective.*