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Report of the Independent Inquiry Team into the Care and Treatment of NG

Presented to Ealing, Hammersmith & Hounslow Health Authority
and
the London Borough of Hounslow

April 1996

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1. INTRODUCTION

Background

1.1 On 6 September 1994 Nilesh Gadher (NG) ran over and killed SK, a complete stranger. NG was known to suffer from paranoid schizophrenia and had recently been discharged from hospital and was subject to the Care Programme Approach. Pursuant to Department of Health policy, as set out in HSG(94)27, the Local Health Authority were required to commission an Independent Inquiry to investigate the circumstances and report, and the London Borough of Hounslow agreed to participate in the process of the Inquiry and to meet part of its cost. Accordingly we were invited by the Authority and by Hounslow Social Services to form a Panel of Inquiry: this is our report.

Terms of Reference

1.2 We were given the following terms of reference :-

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

   (i) The appropriateness of his treatment, care and supervision in respect of:

      (a) his assessed health and social care needs;

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

      (c) any previous psychiatric history;

      (d) the number and nature of any previous court convictions.

   (ii) The extent to which NG's care corresponded to statutory obligations, particularly the Mental Health Act 1983; relevant guidance from the Department of Health (including the Care Programme Approach HC(90)23/LASSL(90)11, Supervision Registers HSG(94)5, and the discharge guidance HSG(94)27); and local operational policies.

(iii) The extent to which his prescribed care plans including medication were:

(a) effectively delivered;

(b) complied with by NG.

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

(i) The agencies (Hounslow and Spelthorne Community and Mental Health NHS Trust, Hounslow Social Services, the General Practitioner and the Star Centre) involved in the care of NG or in the provision of services to him, and

(ii) the statutory agencies and NG's family.

3 To consider the overall standard of care arrangements offered to NG and the relationship between these arrangements and the events of 6/9/94.

4 To prepare a report and make recommendations to Ealing, Hammersmith and Hounslow Health Authority and the London Borough of Hounslow.

Panel of Inquiry

1.3 The Panel of Inquiry comprised the following individuals:-

- His Honour J R Main QC - Chair
- Dr John Wilkins BSc MB BS MRCPsych, Medical Director, The Riverside Mental Health Trust
- Mr David Pope BA RMN DMS CQSW, Associate Member of the Association of Directors of Social Services
- Mr Steve Manikon SRN RMN DMS, Former Director of Mental Health, Mid Surrey Health Authority

1.4 We are grateful to the Authority for their administrative support and for their hospitality during the period of the Inquiry.

1.5 We are aware that there have regrettably been several Inquiries nationally into similar incidents in the recent past. We have read some of the more recent resulting reports in full and utilised the Zito Trust publication "Learning the Lessons" to review the wider picture. We have been greatly assisted by the Report produced earlier this year by the Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. Whilst we have tried to avoid duplication and repetition of points already made, as much as it appeared reasonable to so do, the Inquiry did identify a number of key problems similar to those of other Inquiries, and these are, of necessity, detailed in our report.

Method

1.6 We decided to proceed by reading the relevant papers and by inviting those most directly concerned to give oral evidence to us privately. In addition to the reports and policy documents provided by the Authority, the Trust and Social Services we were able to see copies of all relevant hospital, nursing and general practitioner notes and Social Services files. With one exception all those who were invited to give oral evidence agreed to do so. We are grateful to them for giving up their time to give evidence.

1.7 We made it plain to each witness that we would not be able to discharge the task given to us unless we were told the truth and each of them appeared to understand and accept this obligation.

1.8 A transcript of a tape recording of the evidence of each witness was supplied to the witness for correction.

1.9 We heard oral evidence from some witnesses on 29, 30 and 31 January 1996 and from others on 14 and 15 February 1996. When we began to form some provisional views as to the likely contents of our report we felt that three witnesses ought to be given the opportunity to give additional evidence.

One of them agreed to do so and we heard her evidence on 13 March 1996. We saw NG himself on 11 March 1996.

1.10 Among the papers available to us were the report dated 12 December 1994 of an internal review of the care and treatment available to NG commissioned by The Chief Executive of the Trust and the Director of Social Services, together with the record of the evidence given to the review team and supporting documents. As will be seen (see especially 3.19) we do not agree with all of the conclusions of the review team, but we agree that their recommendations based on those conclusions were valuable and we note that much has been done to implement them. Where action or progress has been initiated we have not sought to repeat these matters.

1.11 The internal review team did not interview NG himself nor did they interview any member of his family or the husband of the victim. As will be seen we found that NG and his family were able to give us considerable assistance. All of them expressed genuine regret at the tragedy which occurred and their sympathy for the family of the victim.

1.12 SK, the husband of the victim, could not give us much help on the facts because he was at work at the time of the incident. We were impressed with his dignified attitude to the cruel blow which he and his small daughter have sustained and his courage in facing the future with the support of his family. Echoing prosecuting counsel's words at the Old Bailey when NG appeared there to face trial on a charge of murder, to which he was found unfit to plead, he said " I was told at the time that my wife was in the wrong place at the wrong time. "I find that hard to accept. "You can't be in the wrong place at the wrong time on a Tuesday when you are shopping and parking your car. "So I don't accept that - she wasn't in the wrong place at the wrong time. "He was in the wrong place at the wrong time so far as I am concerned." He could not have summarised our task in more simple and moving words.

Abbreviations

1.13 We have used the following abbreviations in the course of our report :-

"the Authority" means the Ealing, Hammersmith & Hounslow Health Authority

"CPA" means the Care Programme Approach in accordance with Department of Health Circular HC(90)23/Local Authority Social Services Letter LASSL(90)11

"CPN" means Community Psychiatric Nurse

"DVLA" means the Driver and Vehicle Licensing Agency

"MRCPsych" means Member of the Royal College of Psychiatrists

"PSAW" means the Psychiatric Support and Aftercare Workshop

"SHO" means Senior House Officer

"Social Services" means London Borough of Hounslow Social Services Department

"the Trust" means the Hounslow and Spelthorne Mental Health and Community NHS Trust.

2. THE FACTS

2.1 We begin by setting out what appear to us to be the relevant facts. We take these from medical and social work records supplemented and, where appropriate, corrected by the oral evidence which we heard.

Early days

2.2 NG was born in Kenya on 2 June 1958. He came to the UK with his family at the age of 12 and continued his education here obtaining four GCSEs, three A levels and a degree. He qualified as a pharmacist and worked in this capacity for about five years, finally owning his own business and house. He was married in 1982 and has one son; the marriage ended in divorce in 1986 and he lost contact with his wife and son. He remained in contact to some extent with his father and some other members of his family.

Illness

2.3 The family noticed some changes in his behaviour in 1982 which they are inclined to attribute to the shock of an accident in which he was not injured although his car was badly damaged. He began to talk differently, complaining of hearing noises and quarrelling with a colleague at work; he began to say that songs he had written were being stolen and carried a box of records with him; if contradicted on these matters he would become aggressive. He was referred by his GP to a consultant psychiatrist in 1984 and a diagnosis of paranoid schizophrenia was ultimately made. His mother died in1985 and the family felt that this was another shock which affected his health.

2.4 He was charged with an offence of forging prescriptions in May 1985 and was placed on probation; in 1986 he was struck off the Pharmaceutical Register.

His father arranged to take over his house and to sell his business, and this action remains a source of dispute between them.

First admission to hospital

2.5 The GP notes record violent and threatening behaviour on 14 August 1985 and an urgent appointment was obtained with the consultant psychiatrist. NG was well enough, however, to travel to India for two months in September 1985.

2.6 In April 1986 he was working as a pharmacist in Wales awaiting the outcome of the disciplinary hearing by the Pharmaceutical Society of Great Britain. While living there he attacked his wife with a knife and attempted to kidnap his son. He was admitted to and detained in hospital in Wales under s.3 Mental Health Act 1983 and remained in hospital until July that year.

2.7 Thereafter he remained under medication and was seen by his GP and as an outpatient at the West Middlesex Hospital. On 7 February 1989 he assaulted his father and refused all medication when seen by his GP and a social worker. The family formed the view, which they retain, that NG was very reluctant to accept medication; as they understood it he disliked injections. He would apparently agree, while in hospital, to accept oral medication as an alternative to compulsory admission, but stopped taking it on discharge if not before. He frequently quarrelled with his father and, according to evidence given by his family, to get into fights in pubs and clubs he frequented.

Second admission to hospital

2.8 Dr CR, a consultant psychiatrist at the West Middlesex Hospital who had not been involved previously, saw NG at home on 10 February 1989; initially NG

was angry and verbally aggressive and pushed the Community Psychiatric Nurse accompanying Dr CR out of the house. Admission to hospital was recommended.'

2.9 On 15 February 1989 NG was admitted to the West Middlesex Hospital and detained under s.2 Mental Health Act 1983 until March 1989. NG then registered with Dr NR as his GP.

Songs recorded

2.10 In 1990 NG realised some investments and was able to have at least two songs, for which he had written the words, recorded on disc and on tape. His father found in his flat after his arrest a 45rpm disc which appears to have been published by NG himself trading as Ash Music. We have listened to the disc with interest.

Violence in India

2.11 In that year NG also travelled to Kenya, New York and Los Angeles and then made his way to India. In India he threatened Bank officials with a knife in the course of a dispute about some missing travellers cheques and was arrested, and the assistance of the family was obtained by the consul. This whole episode suggests that he was acutely ill at this time.

2.12 In May 1991 he was referred by Dr NR to Dr CR who saw him at an accelerated out-patient appointment. Dr CR reported that he was a difficult patient to treat because of his suspicion of doctors and his guarded way of answering questions. On 14 June 1991 Dr NR recorded that NG was displaying threatening behaviour in surgery so that the police had to be called.

Third admission to hospital

2.13 By the autumn of 1991 NG was facing a number of difficulties caused primarily by his illness. He had failed to obtain re-registration as a pharmacist and was inclined to blame Dr NR for this. He had had some employment but mostly of an unskilled nature, apart from a brief spell as an assistant in a pharmacy. He had quarrelled with his father and was living in bed and breakfast accommodation.

2.14 In November 1991 NG assaulted a police officer at Brentford Magistrates Court and when he appeared at Uxbridge Magistrates Court on 7 November 1991 in connection with this matter a Probation Officer arranged for the attendance of a psychiatrist and an Approved Social Worker and he was detained in West Middlesex Hospital under s.3 Mental Health Act 1983. The criminal charges were subsequently dropped.

2.15 He did not settle in hospital and was inclined to appeal against the order for compulsory admission. After 28 days there was a possibility that he might be discharged and he stopped his medication. His behaviour promptly deteriorated so that further compulsory detention was considered and he punched the junior doctor who was examining him for this purpose.

Move to Hounslow

2.16 He was discharged in February 1992 to the Psychiatric Day Hospital attached to the West Middlesex Hospital and he was provided by Thames Valley Housing Association with a flat at 92 Harris Close, Hounslow. This move meant that when he was discharged from the Day Hospital in January 1993 he ceased to be under the care of Dr CR and came under the care of Dr LP in whose "catchment area" he lived and that similarly social work support was

provided by the London Borough of Hounslow Mental Health Team (West) and not by the East Team.

2.17 The West Team has had a number of difficulties since its inception in 1992. Unlike the East Team, it has to deal with three hospitals and is not situated close to any of them. There has been a high turnover of staff and frequently it has not been possible to fill vacancies with qualified and experienced mental health social workers, as quickly as would have been desirable. The Team Leader at the time was ME who was promoted to the post when it was created and we were told that some former colleagues found his style of leadership unhelpful. The senior management of the mental health service within the department experienced a series of unfortunate and often rapid leadership changes during the period in question, which led to a less than effective response to junior managers on occasions.

Social work file closed

2.18 NG made good progress during 1993 and appeared to be considering opportunities for education and employment and (except to the family) to be taking his medication. In October 1993 it was decided that he should come off the s.117 register and that the social work file should be closed.

Health deteriorates

2.19 He was still attending psychiatric outpatient reviews and was seen for this purpose on 15 November 1993. Dr NR wrote to Dr LP on 2 November reporting that NG was complaining to him of psychotic symptoms and Dr HA (then SHO to Dr LP) replied on 16 November referring to a fall which NG

suffered on 14 November but otherwise indicating her opinion that NG was stable.

Overdose and fourth admission to hospital

2.20 On 5 December 1993 NG took an overdose of paracetamol (he said that he had taken 164 tablets) and was admitted to hospital. NG told us that he was overwhelmed by despair at his failure to enlist any support for his application for re-registration as a pharmacist and at the prospect of eviction from his flat, and wanted to die, but it was thought from what he said at the time that he had reacted to a quarrel with his father. He was examined on 7 December by Dr HA. He said that he had been lying to the doctors regarding his tablets - he had been non-compliant for 18 months. He had not taken medication because he felt there was nothing wrong with him and because of undesirable side effects. Dr HA considered that NG was still a suicide risk because he had no-one to turn to other than his family whom he (NG) thought saw him as mad when he was not.

2.21 In hospital NG from time to time indicated that he would not take medication on discharge and depot medication was considered but not implemented. His brother visited him and spoke to nursing staff but otherwise there was no contact between hospital and family. Dr LP felt that he would need social work support on discharge and requested that a CPA meeting be arranged which should be attended by father and brother; the nursing notes record that no decision as to discharge would be taken before they had been seen.

2.22 On 17 December 1993 a referral was made to Hounslow Social Services and the Social Worker recording the referral noted that neighbours at Harris Close were complaining of noise and that Thames Valley Housing

Association had sent a letter about it. A copy of this letter remained on the file but appears not to have been further noticed until after NG's arrest in September 1994. It was also noted that NG had been violent in the past attacking members of his family and that he could be abusive.

2.23 The case was allocated to HF, an Approved Social Worker in the West Team with considerable experience. By this time the medical and social work teams were endeavouring to follow the Care Programme Approach set out in Circular HC(90)23/LASSL(90)11 and HF was requested to convene a CPA meeting. This was originally arranged for 8 February 1994, but the appointment was cancelled by HF at a late stage although NG's father and brother were not informed of the cancellation and attended; they had not previously met Dr LP. She was annoyed by the cancellation and wrote a sharp letter to HF. She explained to us that her irritation was partly due to her perception (shared by others) that she received much less co-operation from the West Team than from the East Team. ME when asked about this by us expressed a reciprocal view and pointed out the difficulties from which the West Team suffered (see 2.17 above) which limited the capacity of the team to respond as effectively as they and their health service colleagues would wish.

Discharge to Day Hospital

2.24 The CPA meeting took place on 8 March 1994 attended only by Dr LP, HF and NG. NG's father and brother arrived at the hospital in time and reported to reception but the meeting was over before HF was aware of their presence. Dr LP had already left but they spoke to HF and NG. Father formed the view

from his son's demeanour and the appearance of his eyes that he was not well. On being told that it was proposed shortly to discharge NG father said that such an action would be the responsibility of others; if discharged as he then was he was likely to kill himself or somebody else. Father and son felt so strongly about this that they made a note of the conversation. HF noted their names on the CPA documentation as attending the meeting but made no record of father's views in either the CPA record or the SS case record, nor was this information shared with medical colleagues. We would have wished to have discussed this matter further with HF, but he declined our invitation to appear before us on a second occasion. The family had no further meeting with anybody at the hospital or with HF before NG's arrest.

2.25 The formal record of the CPA meeting was made by HF. It was noted that discharge from hospital was proposed on 11 March and would be followed by attendance at the Day Hospital. This regime would remove the need for visits by a Community Psychiatric Nurse and involvement of a CPN was noted as "on hold till discharge from Day Hospital". The CPN service was not informed of the decision and no CPN was allocated.

2.26 It was also noted that NG would in future attend the Star Centre. This is a voluntary organisation offering support to those with mental health problems on a "drop in" basis. The Centre asks for referrals to be made on a form provided by the Centre which includes provision for the patient to record consent to the disclosure of information. Such a form was completed on 14 March by Dr JH, then SHO to Dr LP. That post is filled on a rotating basis by a GP trainee who will, in the ordinary course of events, have had little psychiatric experience. She completed the form in her own handwriting but

can hardly have foreseen the difficulty to which this would lead later on (see 2.43). She also noted under the heading "History of aggression/violence" that NG had been "charged with ABH and assault 1991 but charges dropped - no other known history".

2.27 At the Day Hospital NG was once more under the care of Dr CR who, for historical reasons, looked after all patients while in the Day Hospital. Activities there were then co-ordinated by SC, a recently qualified psychiatric nurse. The clinical team felt that NG would benefit from anger management therapy. A postgraduate psychology student was attached to the Day Hospital to gain clinical experience and had set up group therapy sessions. SC was doubtful whether NG had sufficient insight to benefit from group work in this field. These doubts were borne out in practice: NG did not co-operate and his attendance at the sessions ceased.

2.28 A referral was made in May 1994 by the Day Hospital to the Heston Work Centre. This is a facility provided and funded by the London Borough of Hounslow. It was originally intended to provide work for the physically disabled and for those with learning disabilities but a number of those attending now have psychiatric illness. It is the policy of the Centre not to accept anybody with a history of aggression or violence. There is no set form of referral and no procedure for obtaining the consent of a patient to the disclosure of information. The information provided by the Day Hospital to the Centre supplemented by what they were told by NG himself gave the

staff at the Centre (who are not trained or experienced in the field of mental health) a very incomplete picture; in particular they knew nothing about the history of violence.

Discharge from Day Hospital

2.29 HF was requested to arrange a further CPA meeting and this was fixed for 28 June 1994, although NG was discharged from the Day Hospital on 10 June. It is probable that the meeting took place in Dr LP's room at the West Middlesex Hospital and that the hospital notes relating to NG were still in the Day Hospital at the time. It appears that only Dr LP, HF and NG attended. Because NG's primary needs at that time appeared to them to be social work needs HF was selected as Key Worker and there was no referral to a CPN, although it was recorded that the CPN was to be involved upon discharge from day care. HF should have completed the CPA documentation recording the decisions taken at the meeting but did not do so until after NG's arrest.

2.30 After NG's discharge from hospital in March 1994 HF visited him at home from time to time. HF had a caseload of some twenty cases, two or three of which he regarded as potentially more problematic than NG. Although NG himself at one stage expressed a wish for more frequent visits, the pattern of visiting had become monthly by the end of June.

2.31 On 11 July Dr JH saw NG at an out-patient review and reported to Dr NR that he seemed stable although occasionally experiencing symptoms. These were thoughts which seemed to run in parallel to his own. He declined an increase in his medication. Otherwise he said that he was sleeping and eating well, attending the Heston Work Centre every morning and two afternoons a week and the Star Centre two afternoons a week. He appeared to Dr JH to

be doing well. She arranged for him to be seen by her successor in two months time.

Medication

2.32 It was very important to the continued good health of NG that he should receive regular medication. In many similar cases this can be promoted by regular injections - sometimes referred to as depot injections. As noted above (see 2.7 and 2.21) NG was known not to like injections and consequently relied on oral medication. This made it difficult for anybody to be sure that he was in fact receiving the medication which he needed, although a change in his behaviour could well be an indication of failure to take medication.

2.33 While he was an in-patient or was regularly attending the Day Hospital there was a measure of supervision over his medication, but on discharge from the Day Hospital the arrangement was that NG would collect monthly prescriptions from his GP Dr NR, who would normally see him on these occasions.

2.34 HF made a routine visit to NG on 27 July 1994. HF's case notes record an apparently stable situation; NG was regularly attending Heston Work Centre on a daily basis and the Star Centre twice weekly and was in contact with his family. HF recorded "N remains well".

2.35 On 2 August NG visited Dr NR and was given a repeat prescription. He was noted to be well.

Health deteriorates

2.36 It seems that thereafter there was a marked deterioration in NG's mental health. NG informed the Inquiry Panel he ceased taking his medication in June or July. At Heston Work Centre NG was employed in the preparation of

stationery packs for aircraft passengers. The room in which he worked was under the charge of JK, a former nurse and housewife now on the point of retirement. She was concerned at NG's behaviour on Wednesday 3 August. He objected to the music being played on the radio saying that the songs were all his having been stolen from him by people who had entered his flat for the purpose. His facial expression was different and his eyes were bloodshot. He made indecent remarks to female users, some of which may well have been provoked. Some users asked to leave early, but one who lived near to NG felt that he sometimes followed her home and asked to leave later than him.

2.37 GJ, the Manager of the Heston Work Centre, very properly reported these concerns and her own observations to SC at the Day Hospital on that day. SC undertook to inform Dr LP. It appears that the message reached Dr LP on Friday 5 August in the course of a ward round at West Middlesex Hospital. The social worker in attendance noted that all were very concerned. Dr LP's response was to ask that HF be informed that NG had deteriorated and that he be requested to visit and report; unfortunately this response was ineffective because HF went on leave on Saturday 6 August and did not return until Tuesday 30 August. There was no system for a designated worker under the CPA procedures to make specific arrangements for cover during absence on holiday; in emergency a duty social worker would try to take appropriate action, possibly guided by a note left on the file.

CPN involvement

2.38 Dr LP also asked Dr JH to ask a CPN to assess NG. It is not clear precisely what transpired between Friday 5 August and Tuesday 8 August - no notes

were made at the hospital - but on the Tuesday Dr JH made a telephone call to SG, a Community Psychiatric Nurse, and asked her to visit and report. SG had not herself previously met NG; any previous CPN notes were not readily available to her and she knew no more about the case than Dr JH was able to impart over the telephone.

2.39 Meanwhile on Thursday 4 August NG was seen at the Heston Work Centre to have an injury to his nose which he ascribed to an incident in a public house on the previous evening in which he had been accused of staring at someone and then head-butted by him. He saw Dr NR on Monday 8 August with the same complaint.

2.40 NG did not attend the Work Centre on Monday, Tuesday or Wednesday but he was there on Thursday 11 August and SG, who had been searching for him, was able to see him there. She was looking for active symptoms of psychosis in a man who had made a suicide attempt, rather than for a general deterioration which she had no means of measuring, and not finding them decided that no action was required and so informed Dr JH. She enquired whether NG's next out patient review scheduled for September could be accelerated but was told that this would be difficult unless there was real urgency. She therefore requested a formal referral of NG to the CPN service so that the position could be monitored and Dr JH provided this. Dr JH felt that the case now rested with the CPN. Social Services recorded the view of the CPN that NG was not causing concern.

2.41 The Heston Work Centre noted that NG was once again complaining about the radio on Wednesday 17 August, but SG saw him there again on the following day and saw no reason to change her previous view. She was

confident that he was regularly attending the Centre and that the staff there would keep her informed of any cause for increased concern. He seemed neatly dressed and presentable and said that he was complying with medication.

Further concerns

2.42 On 23 August it was reported to the West team that further complaints about noise (see 2.22) were being made by NG's neighbour to Thames Valley Housing Association and to Social Services. ME was consulted and decided that this was a matter which could wait until HF returned from leave.

2.43 Meanwhile the staff at the Star Centre were becoming concerned. JG, the Drop-in Co-ordinator, although not professionally trained, was aware that if NG became "loud" it was probably a sign of deteriorating mental health, and he did become "loud" during August. On Wednesday 24 August DV, the Manager at the Centre, decided to contact NG's Social Worker and report the position. She had no documentation apart from the referral of 14 March 1994 (see 2.26 above). It was her usual practice to begin by trying to make contact with the person making the referral but she had difficulty in reading the handwritten name of Dr JH and the West Middlesex Hospital were not able to assist in identification. In any event Dr JH was nearing the end of her training placement and was on leave. Eventually DV was able to identify HF as the responsible social worker and learned that he was on holiday until the end of the month. She left a message for him on 31 August and he returned the call the following day.

2.44 On Thursday 25 August NG informed staff at the Heston Work Centre that he would not be attending again because he was going to work as a driver for a Mini Cab company, using a car which he had bought at auction two weeks previously. GJ and another member of her staff endeavoured to dissuade him from taking this course but were unable to do so. It was the intention of GJ to inform SG of this development, but the Bank Holiday week-end intervened and in the event she did not do so before HF telephoned her on Wednesday 31 August.

2.45 In addition to these matters HF also became aware on his return from holiday of the further complaints about noise (see 2.42) and the complaining neighbour spoke to HF on the telephone on 30 August. HF was unaware of the original complaint (see 2.22) and took the view that such a complaint might well be exaggerated.

Visit by key worker

2.46 HF called to see NG twice on 30 August but did not find him at home; he did succeed on 31 August. NG invited him in to the flat and then, as was his custom, locked the door, putting the key in his pocket. HF understood this action to be intended as a defence against intruders rather than as a threat to himself and told us that he did not feel threatened, but he was cautious and did not raise any controversial matters until he was safely on the other side of the door. NG alleged that people were breaking in, stealing his songs, damaging his clothes and tampering with a large bolt which he had put on the inside of his bedroom door; it was this tampering which required attention with a hammer. HF took the view that although NG presented as paranoid as usual and was in an agitated state, there was insufficient cause for concern about his

health and safety to suggest that he needed to be in hospital and nothing to justify the use of Mental Health Act powers. He felt that weekly visiting would be appropriate.

2.47 On 2 September HF discussed the case with ME. HF understood that he was being instructed to consider either consulting those concerned in NG's Care Programme or arranging for a medical re-assessment of NG's mental state using compulsory powers if necessary; ME told us that although he was careful not to fetter the discretion of an Approved Social Worker he was instructing HF to take one or other of the two courses outlined. We were unable to detect any clear instruction.

2.48 Later that day HF received another complaint from NG's neighbour alleging that he was following her on her journeys to school with her child and that he seemed always to know where she was in her flat, perhaps by means of a hole in the ceiling. HF noted that she sounded almost paranoid.

Second visit by key worker

2.49 On 5 September 1994 HF visited NG at home. His general impression was that he had been correct in taking no action under the Mental Health Act on 31 August, because NG appeared to have improved and was not "sectionable". NG said that he had stopped hammering, but still believed that people were entering his flat in his absence and stealing things such as his petrol receipts. He was not finding Mini Cab driving to be profitable. After NG's arrest HF discovered on attempting to arrange a CPA meeting that Dr LP had gone on leave at the end of August until 19 September.

The fatal day

2.50 On 6 September NG attended the Star Centre in the morning when it opened. JG spoke to him for nearly an hour. He repeated his view that Mini Cab driving was not profitable but did not appear to blame anybody for this. He mentioned that tapes of his singing were not playing as well as they had and thought that they might have been interfered with. After this conversation NG sat calmly at a table for some time and left at about 11.30 am. JG did not feel that NG was "sectionable". We would have liked to hear oral evidence from JG in amplification of his helpful written report but he declined an invitation to attend.

2.51 In the afternoon of that day NG was in his car in a car park in Hounslow and knocked down and fatally injured the driver of another car as she walked across the car park. We have read numerous differing accounts of this incident. NG told us that at the time he was totally engrossed in his own thoughts which concerned apparent alterations to the words of one of his own songs recorded on tape which he was playing at the time, and the fear of eviction from his flat and that he simply failed to notice either the pedestrian or the speed at which he was driving. However we feel unable to accept this account at its face value, because we are aware that NG has indicated in interviews with other key professionals that he was angry at the interference with his song and that some of that anger became directed at the pedestrian. In all the circumstances, including the fact that the relevant evidence has never been tested in court, we are unable to determine what (if anything) NG had in mind.

2.52 In the light of the medical reports obtained after the arrest of NG we are satisfied that there was at the material time a substantial exacerbation of his

paranoid schizophrenia and that he was much more unwell at the end of 1994 than at any previous time in his life. It is possible that this process began in August 1994. NG is at present detained in a secure hospital.

3. COMMENTS AND RECOMMENDATIONS

3.1 It is apparent from a recitation of the facts and without the use of hindsight that there were numerous failures and shortcomings in the care given to NG. We have left many of these to speak for themselves and have tried to select the most significant for specific comment.

Race and Ethnicity

3.2 We mention one matter which is capable of being significant but which we are able to put to one side. The 1991 census indicates that the population of Hounslow is 208,000, with an ethnic minority population of 24.4% predominantly from the Indian sub-continent. Such a population requires the development of organisations and services which are designed to address and redress the effects of racism and discrimination. Black and ethnic minority people who are mentally ill may suffer double discrimination. Numerous reports and studies (see Resource Materials) have indicated that mental health services are failing to meet the needs of ethnic minority communities nationally. The evidence of prevalent rates of mental illness in black and ethnic minority communities is inconsistent and unreliable; there is considerable debate and there are conflicting interpretations of the current data. However, there is growing agreement regarding the key issues that need to be addressed to provide relevant services to meet the needs of users and carers.

3.3 NG is a Kenyan Asian; the victim was also Asian. We scrutinised the Joint Strategy for Mental Heath Services and the Community Care Plans produced by the Authority, the Trust and Social Services. These show an understanding of the key issues and a willingness to address them. In addition, we have tried to be alert to these issues in our consideration of the voluminous documentation obtained from all sources and in our interviews with witnesses. We did not find any evidence or suggestion of racial prejudice or discrimination in the provision of services to NG.

Resources

3.4 The mental health services are provided, and professional staff are required to operate, in a resource context that is recognised nationally as under intense pressure. Overall the financial resources available for mental health services, provided by the health and social services, have been severely constrained over many years, even though there is a substantial body of evidence that indicates that demand continues to expand.

3.5 The situation facing service providers in Hounslow matched the national picture, but also had some unique and important elements.

3.6 The Joint Mental Health Strategy for Hounslow (October 1995) produced by the Authority, Trust and Social Services Department, stated:

"When Ealing, Hammersmith & Hounslow Health Agency (EHH) was formed on 1 April 1993 it inherited a mental health funding level for Hounslow residents that was low in comparison to other similar boroughs . . .

"In April 1993 EHH spent £24.6 per Hounslow resident each year on all mental health services, the figures as of April 1995 is £40.1 per Hounslow resident. EHH Health Agency's contract with the local provider, Hounslow & Spelthorne Community and Mental Health NHS Trust, has risen from £5.9 million in April 1993 to just over £10 million in April 1995."

3.7 Low funding led at that time to excessive workloads placed on consultant psychiatrists, an absence of doctors with MRCPsych qualifications to share the workloads, inadequate numbers of CPNs with heavy caseloads, and an inadequate range of services for users.

3.8 It is to the credit of the Health Authority that a review of mental health services was commissioned which, coupled with the Authority's own research on accepted indicators of mental health need, has led EHH to initiate a substantial phased investment in mental health services in Hounslow, which is being targeted systematically at improving the quality of existing services as well as commissioning new services for Hounslow residents.

3.9 With regard to the resource position of the Social Services Department, we were advised that whilst the Department's overall budget had been reduced over the last few years, a situation replicated in the majority of SSDs nationally, the Department has given priority to the mental health services budget which has been protected from budget cuts. However, it has not been possible to increase resources into the mental health service to any great extent, except by the use of specific grants. Compared with other Outer London Boroughs, Hounslow's Social Services Department's investment is better than average: the DoH key indicators for 1995/96 indicate that the budget for mental health services (age 18-64) is £20.00 per head of population.

3.10 The mental health commissioners and providers are jointly redressing historial deficiencies: much has been achieved, but all the professionals accepted that much more needs to be done and that resources will remain constrained in the future. The Inquiry Panel commend the efforts made to date and support the general approaches set out in the strategic documents presented. We were sorry to learn, however, that despite strenuous efforts, the Trust has been unable to appoint the additional consultant psychiatrist for whom funds are now available.

Closure of the social work file

3.11 In our view the events of November 1993, if they showed nothing else, showed that NG required regular social work support. We do not consider that the social work file should have been closed in October 1993 (see 2.18). Obviously, the constant and continuing demands on the social work teams need to be effectively managed by closure of appropriate cases. However, in our view, a full and proper assessment of all the circumstances would have identified NG as a priority case, requiring continuing support and supervision. We **recommend** that all persons known to suffer from severe mental disorder should continue to receive appropriate support from a multidisciplinary

Mental Health Team and should not be expected to rely on the duty social worker for assistance.

Discharge to Day Hospital

3.12 We are concerned about the way in which NG was discharged from Hospital in March 1994 (2.20 to 2.25). There appeared to have been a significant change in NG's condition resulting in symptoms not previously seen. Concern about this had been communicated by Dr NR to Dr LP in his letter of November 1993 (see 2.19). Dr HA assessed NG but did not in our view place enough weight on the concerns of Dr NR who knew him well. However we acknowledge that she was a GP trainee with limited experience. We also consider the suicide attempt leading to admission to hospital to have been a significant event which should have led to a cautious approach to discharge and its planning.

3.13 The view taken by Dr LP was that the suicide attempt was impulsive following upon a disagreement with father and was not a significant manifestation of psychosis. However NG was experiencing some psychotic symptoms and she felt that he should be on medication and told him that if he did not accept medication he would be sectioned. She began with oral medication because that made the dosage easier to adjust. She suggested depot injections but NG was unwilling to accept these and she did not pursue the matter. Dr LP did not consider compulsory detention in hospital for treatment was an option because NG was not 'sectionable' under the Mental Health Act 1983. This appears to have been based upon her assessment that he was compliant with oral medication. In all the circumstances she considered that he could safely be discharged to the controlled and supportive environment of the Day Hospital.

3.14 On the other hand it seems to us that Dr LP might have taken the view that there was evidence of psychotic illness, which could be effectively controlled by medication, and that depot injections were indicated in view of NG's lack

of insight and stated disinclination to take oral medication after discharge. On this basis, in our view, an application for compulsory admission under s.3 of the Mental Health Act 1983 for treatment by depot injection might have been successful. Dr LP repeatedly told us that NG was not 'sectionable' (see 3.36 below). By this Dr LP meant that he did not fulfil the criteria for compulsory detention for treatment. Whilst we accept that such an application might have been unsuccessful, NG certainly could have met all the criteria for compulsory treatment. He was mentally ill. It was of a nature, although perhaps not of a degree (the two are alternatives), to warrant detention in hospital for treatment in the interests of his health but perhaps not safety (these are also alternatives). As NG was manifestly not going to co-operate with oral medication out of hospital and had not done so for the previous eighteen months, compulsory treatment could certainly have been justified.

Unfortunately, misunderstanding in relation to the Mental Health Act led to an assumption that he did not meet the criteria for compulsory admission for treatment. This led to reliance upon a treatment plan that was doomed to fail. This was, at best, naive. NG might, therefore, have been detained until he had gained enough insight to accept depot injection voluntarily.

Such a course would have had the support of NG's family if, as we consider they should have been, they had been fully engaged in the decisions relating to his care.

3.15 In the end we do not feel able to say that Dr LP was wrong to take the course which she did although in the light of later developments it is unfortunate that the opportunity to institute a more satisfactory therapeutic regime was missed. We note that NG does unwillingly accept depot medication in the secure hospital in which he is now held.

CPA Meetings - February/March 1994

3.16 We do not need to comment further on the abortive CPA meeting in February 1994 (see 2.23 above). We accept that multi-disciplinary meetings have to be cancelled from time to time but inconvenience to busy people is very likely to be the result, and those whose attendance is essential should regard attendance as a very high priority. Likewise we are aware that from time to time a failure of communication will result in people who have arrived for a meeting finding that it has taken place without them (see 2.24 above). However every effort must be made by all concerned to avoid such mishaps and, if one occurs, every effort should be made to ensure that any information which is known only to those who missed the meeting is recorded and imparted to all parties attending.

3.17 Those concerns apart we do not need to comment extensively on the March CPA meeting or the record that was made of it. We bear in mind that NG was being discharged to the Day Hospital where he could be expected to receive a good deal of supervision and support. Nevertheless it would have been better if it had been a truly multidisciplinary meeting and, in particular, a CPN should have taken NG on to his or her caseload at that stage so as to assist in his ultimate discharge from the Day Hospital. The record of the meeting should have been fuller and should have been more widely circulated. We think that these obvious deficiencies would be remedied under the CPA procedures now in place.

Anger Management

3.18 We note that some work was done at the Day Hospital in the field of anger management (see 2.27 above). We consider that work in this field ought not to be left to an inexperienced person or left in the air once the need for it is recognised and we **recommend** that anger management therapy should only be undertaken by or under the close supervision of experienced qualified staff. Failure of this form of treatment should lead to a consideration of alternative

treatments including referral to a specialist centre. Furthermore it should have been registered as an unmet need in NG's CPA review in June 1994 (see 2.29 and 3.19).

Discharge from Day Hospital

3.19 As set out above (see 3.12 to 3.15) we have some doubt as to whether NG should have been discharged from hospital in March and, for similar reasons, we are doubtful whether he was ready for discharge from the Day Hospital in June. However, if Dr CR and his team were correct in their view that he was ready for discharge then very careful consideration should have been given to his needs on discharge. In the first place the CPA meeting should have preceded the date of discharge and not followed it (see 2.29). This was made all the more necessary by the change of consultant responsibility on discharge. Both consultants did not attend the CPA meeting, and the Day Hospital notes were not utilised. We note that the issue of consultant responsibility at the Day Hospital is under review, with the objective of providing continuity of this responsibility and that there is now better communication between Day Hospital and catchment area consultants. We think it important that these matters are finally resolved as soon as possible and are concerned that further delays may occur due to other internal reorganisations. Accordingly we **recommend** that the Chief Executive of the Trust ensures that the issue of consultant responsibility of the Day Hospital is resolved without delay. Secondly it should have been a multidisciplinary meeting and invitations should have been extended to agencies such as the Star Centre (see 2.26), the Heston Work Centre (see 2.28) and to the family, and a CPN should have been in attendance and might well, with advantage, have been chosen as key worker. Finally a proper record of the meeting should have been made and circulated at once. All in all we regard this meeting as a travesty of a proper CPA meeting. Dr LP and HF should have discontinued the meeting and

reconvened it as soon as possible with proper information and having secured the attendance of all those involved in NG's care plan.

3.20 From a detailed examination of the past and current documentation, we note that CPA procedures have been and are being modified and improved and we consider that all necessary amendments in procedure should be implemented as soon as possible. The challenge for management is to ensure that as far as possible procedure and practice go hand in hand. We were advised that the multidisciplinary training undertaken in 1994/95 was well received by relevant staff. The revised procedure will require additional training input, both to reinforce existing training and to address the needs of newly recruited staff. We have not thought it appropriate to examine the work of the relevant working party in detail; we would expect them to take into account the following points if they have not already done so.

3.21 It is important that the transmission of vital information is not hampered by undue concern about confidentiality. In our view the discharge of patients subject to the CPA procedure with a history of violence is an area where the public interest is dominant. This is addressed in para 6 of HSG(94)27 and we understand that the Trust has received legal advice in similar terms. As an additional safeguard the consent of the patient to necessary disclosure should be obtained and recorded. **We recommend** that all statutory, voluntary and independent agencies (and particularly including general practitioners) likely to be involved in the care of patients subject to the CPA procedure should be invited to attend CPA meetings and should receive copies of the record of the meeting whether they attend or not. It is particularly important that a copy of the record should be given to a relevant agency if it is unable to attend because pressures of work and limited resources may make it difficult for staff to attend meetings.

3.22 We note and support the amendments to the CPA documentation which provide an opportunity for user and carer(s) to make a contribution. There is

substantial evidence contained in Authority, Trust and Social Services policy and practice documentation of an understanding of the value of working in partnership with users and carers. It is regrettable that in this case the agencies individually and collectively failed to communicate with or involve NG's family in any meaningful way. We accept that such an approach can be problematic, particularly as in this case where NG was in conflict with his father (but not with his brother and other siblings). However it is essential that professionals ensure that users and carers are adequately informed about the CPA/care planning process and the resources and services that might be available to them as part of the individual care programme and give credence to their wishes and views which should be supported if necessary by independent advocacy. We **recommend** that as well as the user, all likely carers of patients subject to the CPA procedure should be invited to attend CPA meetings and should receive copies of the record of the meeting whether they attend or not.

3.23 HSG(94)27 provided detailed guidance on the importance of risk assessment in discharge decisions and a number of Inquiry Reports and other publications (many listed under Resource Materials) provide further information. We therefore do not intend to repeat all these except to reiterate that all organisations need to develop a risk management strategy aimed at promoting the safety and security of patients, staff and the public. Such a strategy would include a reporting process for informing staff of a patient's propensity to violence, environmental assessment, incident reporting system, and continuing training for staff. The Report of the Inquiry into the Care and Treatment of Christopher Clunis also reinforces the practice that an accurate record should be made of any incident of violence and the details should be included in the discharge summary, accompanied by an assessment of risk whenever the patient has acted with violence. We note that such recording

systems are now being implemented and we **recommend** that the risk assessment should be an integral part of the CPA documentation circulated.

3.24 We further **recommend** that the CPA documentation should include information as to the nature of the patient's medication (at least indicating whether it is taken orally or by depot injection). In line with the recommendations made in other Inquiry Reports, we **recommend** that all members of the team should be alerted to the signs and symptoms in the patient which may indicate that the patient is likely to relapse. These indications may be identified by the doctors, the patient or carers. Non compliance with medication should be recognised as a significant pointer to a relapse.

3.25 We further **recommend** that a deputy for the key worker should be identified and the identity recorded at the CPA meeting and that the key worker and deputy should not be on holiday together without making specific arrangements for cover. These should include arrangements for handover and for notification to all concerned.

3.26 In addition NG had the benefit of a referral to the Star Centre (see 2.26 above). This agency appears to do good work within the limits of its resources. The problems which the staff experienced when they became concerned about NG should be addressed by improved CPA practice. We **recommend** that all referrals to the Star Centre of patients subject to the CPA procedure should be accompanied by full CPA documentation.

3.27 NG also had the benefit of a referral to the Heston Work Centre (see 2.28 above). We do not consider that the Heston Work Centre, as currently staffed and managed, is a suitable environment for the placement of people with severe mental illness and with a history of violence. The Director of Social Services told us that the long term future of the Centre had been under

consideration for a number of years. It is evident that the Centre has operated over the last few years with a more "open door" policy than had originally been intended, but that this expansion of the service has not been reflected in the staffing complement or organisational location of the Centre. We consider that this change of role, if the Social Services Department intends to continue to use it for such purposes, should be formally recognised, although we appreciate that considerable investment in resources and personnel would be required to provide a wholly appropriate service. We understand that more suitable facilities (PSAW and Mental Health Day Centre) have been under consideration for some time but that for reasons largely attributable to lack of funding they have not come to fruition. We note that supported employment is to be provided through two new projects in 1996/97 (Draft Community Care Plan 1996/97). We **recommend** that all referrals to the Heston Work Centre, or to any other day care resource, of patients subject to the CPA procedure should be accompanied by full CPA documentation.

Medication

3.28 The arrangements for NG's medical care on discharge were that he should be reviewed as an out-patient and should obtain monthly prescriptions from his GP. We note that out-patient reviews were conducted by an SHO with limited experience. We appreciate that the workload of the responsible consultant may require this course to be taken, and no doubt the SHO gains valuable experience in the process. Nevertheless we **recommend** that out-patient reviews of patients subject to the CPA procedure should be under the close supervision of the responsible consultant. We further **recommend** that doctors without the qualification MRCPsych should not assess patients except under supervision. This means that if an assessment is to be conducted by an inexperienced SHO the responsible consultant should be available and ideally there should be time both before and afterwards for the SHO to discuss the

case with the consultant; it should not be left to the SHO to ask for help. We understand that present practice adopts this procedure.

3.29 In our view, in the light of his recent history, NG should have been subject to monthly out-patient reviews and Dr JH should have arranged for him to be seen again in August rather than in September (see 2.31 above) especially since she would have been replaced by her successor in September.

3.30 We note with approval that Dr NR saw NG when he requested repeat prescriptions. It appears that NG last visited Dr NR for this purpose on 2 August (see 2.35 above) and that he should have asked for a repeat prescription at the end of August or beginning of September but did not do so. Ideally, by the use of specific 'software' within a computerised patient database, a GP can arrange to be informed if a patient does not request a repeat prescription. Such an arrangement would be particularly useful in the case of a patient subject to the CPA procedure and where compliance with treatment is in doubt. We accept, however, that it may be difficult in practice to make such an arrangement or to make contact with the defaulting patient. This position reinforces the need to maintain monthly out-patient reviews in appropriate cases.

Health deteriorates

3.31 There was regrettable delay in addressing the concerns expressed by the Heston Work Centre (see 2.37 and 2.38 above). Such delays should not recur if agencies such as the Heston Work Centre are aware of the identity of the key worker through the proper implementation of the CPA and if the key worker has an identified deputy or other cover for holiday periods (see 3.25).

CPN involvement

3.32 We have already recorded our view that a CPN should have been involved at a much earlier stage (see 3.17 and 3.19). It was in our view reasonable of Dr LP to involve a CPN in August, but it was difficult for SG to appreciate the true position from the information given to her. At that time the CPN service

was in great difficulty arising from a heavy workload and lack of effective middle management, of which senior management was not fully aware. Ideally SG ought to have endeavoured to secure any notes that might have been available, although we recognise the pressures that she was under. We understand that work is in hand to improve the co-operation between the CPN service and Social Services and that both the Director of Social Services and the Chief Executive of the Trust are committed to the establishment of multi-disciplinary Community Mental Health Teams. The plan being initiated to bring into operation Community Mental Health Centres will, in our view, enhance working relationships and communication and reduce the likelihood of a repetition of the situation which developed in the case of NG in August 1994, but it is essential that the planning and implementation of these is undertaken as a joint enterprise between the SSD and Trust. **We recommend** that the Trust and Social Services Department develop a costed and timescaled strategic plan for the development and implementation of integrated multidisciplinary Community and Mental Health Teams as soon as practicable. We support the recommendations of the Brotchie report (see Resource Materials) which identifies a range of key issues that need to be addressed to improve the efficiency, effectiveness and quality of the CPN service. Professional supervision and managerial support should be readily available to Community Mental Health Centre and Team Managers. CPN caseloads should be kept under review and CPN record keeping should be subjected to an internal audit process.

Further concerns

3.33 A growing volume of information (see 2.42 to 2.44) suggesting that NG was unwell was available in August but was not reaching Social Services in the absence of HF and in the absence of an identified deputy or specific cover. It is not easy to appreciate the significance of small pieces of information in the absence of a working knowledge of the complete picture and it is not easy to

acquire such a working knowledge from a brief perusal of the file. It is understandable that ME felt (wrongly as it now appears) that no action was required on 23 August (see 2.42) and we bear in mind that he was guided by the view of SG that no action was required (see 2.40). We are satisfied that the opportunities for the occurrence of such errors will be much reduced if proper holiday arrangements are in place (see 3.25).

Visits by key worker

3.34 We are also satisfied that HF made an error of judgment in deciding that no action was required on 31 August (see 2.46). He had received a mounting body of information suggesting a marked deterioration in NG's health and he was in a good position to appreciate the significance of that information, although limited thought appears to have been given to whether NG was still compliant with his medication and the implications if he was not. The principal reason for this error appears to have been a misapprehension as to his powers under the Mental Health Act 1983.

3.35 We noted in the evidence of both ME and HF a widely held but erroneous view as to the criteria for compulsory admission to hospital under the Mental Health Act 1983. In both section 2 and section 3 of the Act the words used are "health ***or*** safety" and not "health ***and*** safety". This means that an application for admission for assessment under section 2 (or an application for admission for emergency assessment under section 4) may be made solely on the ground that the patient's health requires compulsory admission regardless of the question of safety (see also 3.14). Indeed the real criticism which we have of HF's decision to take no action is that by misapprehending his powers he did not concentrate upon the state of NG's health and in effect took it upon himself to conduct an assessment on the doorstep. We are of the opinion that

if a proper assessment had been conducted at that stage, either voluntarily or compulsorily, NG might thereafter have been admitted to hospital for treatment.

3.36 We note that similar confusion can arise from the use of the word "sectionable" (see 2.49, 2.50 and 3.14). It is desirable to distinguish the patient who has no need to be in hospital either for assessment or treatment from the patient who needs to be in hospital but does not meet the criteria for compulsory admission. HF as the potential applicant for the compulsory admission of NG should not have assumed what the medical recommendation might have been.

3.37 We are aware that these specific issues have been the subject of recommendations in earlier Inquiry Reports. Even though many practitioners are experienced, these are matters which need to be addressed in training and refresher training. We **recommend** that all personnel having to do with the operation of the Mental Health Act should be instructed on these points at the earliest possible opportunity.

3.38 We are of the opinion that a much more precise instruction should have been given by ME to HF on 2 September (see 2.47). HF should not have been permitted to gain the impression that he was being given complete discretion as to the course which he should adopt so that taking no action at all would be acceptable.

Leave arrangements for doctors

3.39 We note that at the end of August both Dr LP and Dr JH were on leave (see 2.43 and 2.49). We consider it to be wrong in principle for two members of a team such as this to be on leave together although we appreciate that it

may be difficult to organise other arrangements. We **recommend** that the Medical Director of the Trust, in consultation with the medical staff and with their agreement, should implement a policy whereby consultants and junior doctors should so arrange their leave so that no more than one medical member of a team is away at any one time. A consultant who is going on leave should ensure that the key worker for all patients subject to the CPA procedure is aware of the arrangements made for cover. Furthermore, when consultants are away clear arrangements for the supervision of junior medical staff need to be made which consist of more than help at the end of a telephone.

Driving

3.40 Finally, we are concerned that NG was able to buy and drive a car and perhaps to carry fare-paying passengers in it, although we have not received any convincing evidence that he actually worked as a Mini Cab driver. The fact of the matter is that a car is every bit as lethal a weapon in the wrong hands at the wrong time as is a firearm. It is the duty of the holder of a driving licence who is admitted to hospital with a psychosis to inform the DVLA of the fact of illness and treatment, and he should be advised by his doctor not to drive for a period of six months, or longer if symptoms persist. If a patient is advised by his doctor of the obligation to inform the DVLA, but does not do so, it may be appropriate for the doctor to communicate with the DVLA. The driving licence may be revoked if there is loss of insight or judgement.

3.41 Dr CR (who was looking after Dr LP's patients during her absence on leave at the material time) told us, not surprisingly, that he would have advised NG not to drive and certainly not to drive a Mini Cab. GJ from the Heston Work

Centre (see 2.44) tried to find out the identity of the Mini Cab firm, but NG refused to say more than that it was in the Hanworth Road. She told us that she felt like visiting all the Mini Cab firms in the Hanworth Road to alert them to the problem, but did not feel able to do so. HF asked about insurance on 31 August 1994, but did not pursue the topic after being told that it was "a private matter".

3.42 As we understand the position there is nothing to prevent any person who is so minded and is at liberty to do so from driving against advice or even illegally. We wish to draw the attention of all personnel having to do with the operation of the Mental Health Act to the risks to the safety of the patient, or of others, if a patient who should not be driving a car by reason of mental illness or medication or both insists on so doing despite advice to the contrary. We note that the internal review team (see 1.10) recommended that guidance should be produced by the Medical Director of the Trust for Medical Staff, Nurses and Social Workers on the application **locally** of the requirement by the DVLA for patients/clients to notify the DVLA of hospital admission or medication but, as we understand it, this consisted of the circulation of photocopies of relevant pages of the DVLA publication "At a glance guide to the current medical standards of fitness to drive" which, although helpful as far as it goes, does not give any guidance on the question of notification by doctors, nurses or social workers. In our view there should be as far as possible a uniform local practice in this regard and we **recommend** that the Medical Director of the Trust should formulate and circulate a clear policy statement indicating the circumstances in which it would be appropriate for professional staff to notify DVLA of the illness of a patient.

3.43 In view of the importance of this matter we further **recommend** that consideration be given to the desirability of including in the CPA documentation a note of the advice given to the patient about driving.

Final Conclusions

3.44 This tragedy probably occurred because NG was out of hospital and driving a car at a time when he was not taking the medication which he needed and was unwell. In our view he would, in all probability, have been discharged from hospital at that time in any event, but he might still have been in receipt of medication - if a failed management plan had not been relied upon and a more assertive plan, for example by imposing depot medication, had been considered and implemented. However, he should not then have been driving a car. Signs of a deterioration in his health were apparent to those who could recognise them but his possible need for further hospital treatment was not met. Although it was, we think, predictable that he would stop taking oral medication and that he might, in consequence, become unwell, and that if unwell he might exhibit some degree of violence, we do not consider that a tragedy of this magnitude was predictable. It might have been prevented if the management of this case had taken a different course and if he had been re-admitted to hospital on or soon after 31 August 1994 or if he had then been prevented from driving, but we are unable to say that any one person or any one agency is to blame for what occurred. In the end we are unable to say, positively, that NG was in the wrong place at the wrong time, but we hope that our recommendations will help to ensure that those who are ill but who are not in hospital are nevertheless seen to be in the right place.

4. SUMMARY OF RECOMMENDATIONS

4.1 We **recommend** as follows :-

1. All persons known to suffer from severe mental disorder should continue to receive appropriate support from a multidisciplinary Mental Health Team and should not be expected to rely on the duty social worker for assistance (3.11).

Action to be taken by: Trust

2. Anger management therapy should only be undertaken by or under the close supervision of experienced qualified staff. Failure of this form of treatment should lead to a consideration of alternative treatments including referral to a specialist centre (3.18).

Action to be taken by: Trust

3. The Chief Executive of the Trust ensures that the issue of consultant responsibility of the Day Hospital is resolved without delay (3.19).

Action to be taken by: Trust

4. All statutory, voluntary and independent agencies (particularly including General Practitioners) likely to be involved in the care of patients subject to the CPA procedure should be invited to attend CPA meetings and should receive copies of the record of the meeting whether they attend or not (3.21).

Action to be taken by: Trust, SSD, Voluntary Organisations

5. As well as the user, all likely carers of patients subject to the CPA procedure should be invited to attend CPA meetings and should receive copies of the record of the meeting whether they attend or not (3.22).

Action to be taken by: Trust

6. The risk assessment should be an integral part of the CPA documentation circulated (3.23).

Action to be taken by: Trust

7. The CPA documentation should include information as to the nature of the patient's medication (at least indicating whether it is taken orally or by depot injection). In line with the recommendations made in other Inquiry Reports, we recommend that all members of the team should be alerted to the signs and symptoms in the patient which may indicate that the patient is likely to relapse. These indications may be identified by the doctors, the patient or carers. Non compliance with medication should be recognised as a significant pointer to a relapse (3.24).

Action to be taken by: Trust

8. A deputy for the key worker should be identified and the identity recorded at the CPA meeting and the key worker and deputy should not be on holiday together without making specific arrangements for cover. These should include arrangements for handover and for notification to all concerned (3.25).

Action to be taken by: Trust

9. All referrals to the Star Centre of patients subject to the CPA procedure should be accompanied by full CPA documentation (3.26).

Action to be taken by: Trust, SSD, Voluntary Organisation

10. All referrals to the Heston Work Centre or to any other day care resource of patients subject to the CPA procedure should be accompanied by full CPA documentation (3.27).

Action to be taken by: Trust, SSD, Voluntary Organisation

11. Out-patient reviews of patients subject to the CPA procedure should be under the close supervision of the responsible consultant and doctors without the qualification MRCPsych should not assess patients except under supervision (3.28).

Action to be taken by: Trust

12. We recommend that the Trust and SSD develop a costed and timescaled strategic plan for the development and implementation of integrated multidisciplinary Community and Mental Health Teams as soon as is practicable (3.32).

Action to be taken by: Trust, SSD

13. Professional supervision and managerial support should be readily available to Community Mental Health Centre and Team Managers. CPN caseloads should be kept under review and CPN record keeping should be subjected to an internal audit process. (3.32).

Action to be taken by: Trust

14. All personnel having to do with the operation of the Mental Health Act should be reminded at the earliest possible opportunity that the words used in sections 2 and 3 of the Act are "health *or* safety" and not "health *and* safety" (3.37).

Action to be taken by: Trust, SSD

15. The Medical Director of the Trust in consultation with the medical staff and with their agreement should implement a policy whereby consultants and junior doctors should so arrange their leave that no more than one medical member of a team is away at any one time. A consultant who is going on leave should ensure that the key worker for all patients subject to the CPA procedure is aware of the arrangements made for cover (3.39).

Action to be taken by: Trust

16. The Medical Director of the Trust should formulate and circulate a clear policy statement indicating the circumstances in which it would be appropriate for professional staff to notify DVLA of the illness of a patient (3.42).

Action to be taken by: Trust

17. Consideration should be given to the desirability of including in the CPA documentation a note of the advice given to the patient about driving (3.43).

Action to be taken by: Trust

5. LIST OF WITNESSES

NG
VLG, father of NG
YG, brother of NG
SK, husband of victim
Chief Executive, Hounslow & Spelthorne Community and Mental Health NHS Trust
Chief Executive, Ealing, Hammersmith & Hounslow Health Authority
Director of Social Services, London Borough of Hounslow
2 Consultant Psychiatrists, Hounslow & Spelthorne Community and Mental Health NHS Trust (Drs LP and CR)
NG's GP (Dr NR)
Senior Housing Officer to Consultant Psychiatrist, Hounslow & Spelthorne Community and Mental Health NHS Trust (Dr JH)
Community Psychiatric Nurse, Hounslow & Spelthorne Community and Mental Health NHS Trust (SG)
Ex Community Services Manager, Hounslow & Spelthorne Community and Mental Health NHS Trust (AC)
Ex Co-ordinator, Lakeside Day Hospital (SC)
Social Worker (West Team), London Borough of Hounslow Social Services (HF)
Team Leader (West Team), London Borough of Hounslow Social Services (ME)
Therapeutic Manager, Star Centre (DV)
Project Co-ordinator, Star Centre
Manager, Heston Work Centre (GJ)
Officer, Heston Work Centre

6. RESOURCE MATERIALS

Blom-Cooper L, Murphy E & Hally H (1995) **The Falling Shadow - one patient's mental health care 1978-1993.** Duckworth, London

Brotchie J (1994) **Review of Community Nursing Services - Ealing, Hammersmith and Hounslow.**

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The Committee of Inquiry was also provided with information by the relevant commissioners and providers of mental health services in the form of:

Committee reports
Contract documents/audit and review procedures
Memoranda
Operational policies
Reports of Mental Health Act Commissioner's visits
Service specifications
Statistical data on resource allocation and service delivery