Report of the Independent Inquiry into the Treatment and Care of Richard Allott

Commissioned by
Warwickshire Health Authority

THE REPORT OF THE INDEPENDENT INQUIRY

INTO THE TREATMENT AND CARE

OF RICHARD ALLOTT

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Dr Margaret Branthwaite

Dr Nigel Fisher

Mr Ian Milne

Mrs Jane Mackay

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CONTENTS

CHAPTER 1 - INTRODUCTION

1.1 This is the report to the Warwickshire Health Authority of an independent inquiry set up in accordance with Health Service Guidelines HSG (94) 27 para 34 into the treatment and care of Richard Allott by the mental health and social services from first presentation in 1972 until May 12th 1998, the day after he killed two young men and seriously injured a third.

1.2 The inquiry was undertaken by a panel consisting of

Dr Margaret Branthwaite, Barrister and Assistant Deputy Coroner, Inner London South; formerly Consultant Physician & Anaesthetist, Royal Brompton Hospital;

Dr Nigel Fisher, Consultant Psychiatrist and Medical Director, South West London & St George's Mental Health NHS Trust;

Mr Ian Milne, former Divisional Director of Social Services, Hillingdon; currently Director of Hillingdon Action Group on Alcohol Misuse;

Mrs Jane Mackay, former Regional Nurse and General Manager, who has extensive experience of similar investigations and to whom the rest of us are indebted for her skill in co-ordinating the inquiry.

1.3 The **Terms of Reference** for the Inquiry, agreed with the Health Authority, were:

(a) To examine all the circumstances surrounding the treatment and care of Mr Richard Allott by the mental health services and social services from presentation until 12th May 1998;

(b) The extent to which Mr Allott's care complied with the statutory obligations, Mental Health Act Code of Practice, and any local operational policies and relevant guidelines from the Department of Health as pertaining at the relevant times;

(c) To consider the adequacy of the risk assessment training of all staff involved in Richard Allott's care;

(d) To examine the adequacy of the collaboration and communication of all staff between agencies in Warwickshire involved in the care of Richard Allott, or in the provision of services to him;

(e) To consider the adequacy of support given to Richard Allott's family and principal supporters and carers by the Community Health Team and other professionals, including those in Primary Care;

(f) To consider such other matters as the public interest may require;

(g) To prepare a report and make recommendations to Warwickshire Health Authority, for the future delivery, quality and range of care and treatment available to mentally ill people including the safety of mental health users, the public and staff;

(h) At the discretion of the Independent Inquiry Chairman the Terms of Reference may be more definitive with respect to important matters.

1.4 Evidence was taken both in writing and orally. Witnesses invited to give oral evidence were advised they could be accompanied, should they so wish, and several availed themselves of this opportunity. Oral evidence was given over a ten day period in early August 1999. The procedure was informal and private but witnesses were invited to acknowledge the duty to provide comprehensive and truthful answers. All did so without hesitation. The proceedings were recorded and transcripts checked for veracity by each witness before their evidence was relied upon in the report.

1.5 The following (listed in the order seen) gave oral evidence:

Dr C Campbell	Consultant Psychiatrist and Medical Director, South Warwickshire Combined Care NHS Trust.
Mrs CM Richmond	Close personal friend/partner of Mr Richard Allott.
Dr S Saluja	General Practitioner to Mr Richard Allott from late 1997.
Mr D Lawrence	Human Resource Manager, Social Services Department, Warwickshire County Council.
Mr S Mitchell	Approved Social Worker, Warwickshire Social Services
Mrs G Hill	Senior Manager, Mental Health Services, Social Services Department, Warwickshire County Council.
Mrs P Wilcox	Community Psychiatric Nurse, South Warwick Combined Care NHS Trust;

Mr L Yates	Community Psychiatric Nurse, South Warwick Combined Care NHS Trust;
Mrs D Marriott	Approved Social Worker, Warwickshire Social Services
Ms A Christina	Staff Development Commissioning Manager, Department of Social Services, Warwickshire County Council.
Dr TDE Richardson	Consultant Psychiatrist, S Warwick Combined Care NHS Trust
Dr FS Hashmi	Consultant Psychiatrist, Woodbourne Priory Hospital, Birmingham.
Dr M Graveney	Consultant in Public Health, Warwickshire Health Authority
Ms G Hampson	Deputy Director of Commissioning, Warwickshire Health Authority & Chief Executive, Primary Care Group.
Dr J Gray	Consultant Psychiatrist (retired), S Warwick Hospitals
Mr J Lambert	Leading Paramedic, Warwickshire Ambulance Service
Mr D Trott	Ambulance Technician, Warwickshire Ambulance Service
Mr N Wells	Operations Officer (South) Warwickshire Ambulance Service who attended to accompany Mr Lambert & Mr Trott but was able to add further useful evidence as a witness.
PC Beard)	
DCI Sear)	Warwickshire Constabulary
Mrs C Griffiths	Chief Executive, S Warwickshire Combined Care NHS Trust

1.6 We interviewed Richard Allott at Reaside Clinic, South Birmingham where he was attended by his solicitor, Mr P Kenny, and named Nurse, Mr P Adams. Mr Allott also provided extensive written commentary on his history, illness and its treatment. His mother, now an elderly widow, declined to give evidence and advised us that his younger brother also did not wish to communicate with the panel. This understandable reluctance inevitably diminished our insight into some aspects of Richard Allott's life, particularly the first manifestations of his illness. Commentary on the last 14 years was provided by Mrs Kate Richmond, described as his partner by Richard Allott, albeit they have never shared a common address and she still resides at her matrimonial home.

1.7 Documentary evidence included statements prepared by most of the witnesses identified in paragraph 1.5, either specifically for the Inquiry or as part of the Police investigation into the homicides of May 1998. We selected such additional statements from the police inquiry as we deemed relevant. We were also provided with copies of Richard Allott's GP, hospital and community nursing notes, employment records and details of previous convictions. Finally we were provided with extensive documentation pertaining to the provision of mental health services both in hospital and the community within South Warwickshire.

1.8 At the start of the Inquiry we were privileged to meet the parents of the two young men killed by Richard Allott - Mr and Mrs Aston and Mr and Mrs Chandler - as well as Lee Baker whose friends were killed and who was himself seriously injured. They outlined their concerns to us and, although not forming part of our formal remit, we have endeavoured to address the issues they raised with us in the substance of this report.

1.9 We wish to place on record our appreciation, not only to those directly traumatised by this incident but to all the witnesses who attended in person and gave their evidence unreservedly, notwithstanding any cost of doing so in terms of personal distress.

CHAPTER 2 - HISTORY OF MENTAL ILLNESS

2.1 Richard Austin Allott was born on February 20th 1950 in Loughborough but spent some early months away from his immediate family because of maternal ill health. Thereafter the family moved several times before settling in Kenilworth in 1956. He describes his father as autocratic, his mother as 'remote' and the family atmosphere one of frequent conflict. There was little tranquillity and not much display of affection. Expectations of high achievement were a constant source of discontent. Richard displayed some aberrant behaviour during childhood but describes his life at school as 'stable' until he was 16 years of age.

2.2 A period of 'sensation seeking' and 'risk taking' began in about 1966. Richard engaged in various political demonstrations and, over the next two or three years, took to rock climbing, drank to excess and began to use cannabis. Conflict with the family escalated but Richard chose to ignore protestations and exhortations from his father. In 1968 he secured three GCE A level passes but failed to qualify for university and enrolled instead for teacher training at Madeley College of Education.

2.3 His college career was marred by a reluctance to accept authority and by a developing indulgence, shared with others, in recreational drugs including LSD and mescaline. When challenged by a College lecturer and advised to seek medical help, he denied that drugs were an issue and did not seek help - a decision he now considers incorrect.

2.4 In 1971 Richard Allott failed his final teaching practice, attributing this to regular use of recreational drugs. He succeeded at a second attempt later that year. Faced with a career choice he opted to return to Kenilworth to seek work. He secured some temporary employment but could not agree terms on which to accept the only teaching post offered to him and by this time had lost enthusiasm for this career.

2.5 During Easter 1972 and associated with use of both cannabis and LSD, Richard Allott's behaviour became bizarre and, during the absence of his parents, neighbours called the

police. It is pertinent to note, in his own words that
"I answered the door and was so plausible in the way that I presented myself, that they went away believing there was not a problem".
On their return, his parents were unable to regain control and there is no contemporaneous reference in the GP records of any consultation at that time.

2.6 Shortly afterwards Richard Allott defied the efforts of his parents to keep him at home and, with his mind filled with delusions, ran amok in a car park adjacent to a local Police Headquarters where he damaged a variety of police and other vehicles. He was charged and subsequently convicted of causing criminal damage and put on probation.

2.7 Immediately after his arrest in 1972, Richard Allott was admitted to the Central Hospital, Warwick under the care of Consultant Psychiatrist Dr G Dickens. Despite sedative medication, both his behaviour and his mental state were variable. Three weeks and again approximately three months later when reporting for Court purposes, Dr Dickens concluded *"he was suffering a psychotic illness before he began taking drugs and certainly at this time he is psychotic..... Some of his impulsive behaviour would appear to be in response to auditory hallucinations."*

2.8 Despite this opinion, the diagnosis at the time of Richard Allott's discharge from Central Hospital in early June 1972 was recorded as 'Drug Addiction'. In July, his General Practitioner noted the dates of admission and recorded the diagnosis as 'drug addiction' but provided certification of sickness covering the relevant dates in terms of *"confusion and depression due to drug-overdose"*, subsequently renewed for *"confusional state and depression"*.

2.9 After his discharge from hospital in 1972, Richard Allott persevered with prescribed medication and attended for regular review by Dr Dickens. Early in 1973 he was advised gradually to reduce the dose of anti-psychotics but at about the same time he again resorted to cannabis (not LSD) and then discontinued his medication. His behaviour rapidly became erratic, he attempted to access parked vehicles, was

intercepted by a Probation Officer and returned to hospital but declined informal admission. However his behaviour deteriorated and he was compulsorily readmitted.

2.10 On admission in March 1973, Richard Allott was agitated, manic and deluded. He was aggressive and destructive and, although improving with treatment, became agitated and aggressive a month or so later and smashed his fist through a window. Eventually he settled and was discharged from hospital in early July. The discharge report to his GP gave "Paranoid Schizophrenia" as the diagnosis and concluded *"Unfortunately Dr Dickens thinks that this is a psychotic defect which he will have for some time"*. Follow up was arranged at weekly ward rounds and Richard Allott was advised to continue on regular anti-psychotic medication. The hospital diagnosis was noted in the GP records but the terms of the certificate (sick note) issued at the time were recorded merely as "anxiety state", the inverted commas being part of the entry.

2.11 Richard Allott made only a slow recovery after his discharge from hospital in 1973. His parents expressed concern and were advised by Dr Dickens *"Please let me emphasise once more that Richard has not had what would be thought of as a simple nervous breakdown. He has suffered, and continues to suffer, a severe psychotic illness....."*. They were advised he should aim to take on a simple job, free from stress and strain until such time as he could cope better with everyday life. Similarly in correspondence to the GP, Dr Dickens wrote in October 1973: *"The boy has now had two acute psychotic episodes, the first....somewhat more florid.... After the first episode, he made a first-rate recovery and for a time showed no evidence whatsoever of disturbance. After the second episode, however, he has not shown the recovery which he showed after the first episode ..... I think there is now permanent damage to his capacity emotionally to respond to situations."* Concerns about slow progress were expressed at the same time by the Probation Officer and evoked a similar response from the then locum consultant, Dr Beresford. Richard Allott himself persevered with his medication, despite attributing nausea to it - a side-effect disputed by his GP.

2.12 In or about April 1974, Dr J Pallett succeeded Dr Dickens as Consultant Psychiatrist responsible for Richard Allott. In a flurry of correspondence thereafter, she records his failure to progress beyond part-time gardening work, despite the absence of active psychotic symptoms, and the escalation of family conflict, particularly with Mr Allott senior. The family situation was exacerbated when Richard's brother suffered two schizophrenic breakdowns at about the same time. The brother was making a good recovery and was ready for discharge but, understandably, the parents felt they could not cope with both disturbed sons at home and so arrangements were made for Richard to reside at an after-care hostel in Nuneaton. He changed GP as a result, his diagnosis being recorded at registration merely as "anxiety state".

2.13 Mr and Mrs Allott agreed that Richard would return to the family home in Kenilworth when he obtained full-time employment. He achieved this as a clerical officer in the Social Services Department of Warwickshire County Council in 1975. Conditions of his employment and subsequent career are considered in more detail in chapter 3. He returned to Kenilworth but family conflict persisted. Hospital follow-up, albeit infrequent, had continued with Dr Pallett while Richard Allott was resident in Nuneaton and, in mid-1975, he requested permission to discontinue and/or gradually withdraw his medications. This was agreed and one drug was stopped successfully. With his return to Kenilworth and assumption of full-time employment, Dr Pallett agreed to another reduction in treatment, further liberalisation being advocated the following year when Richard was doing well at work and seeking promotion. He had by then re-registered with his former general practice, although with another partner. Writing in March 1996, Dr Pallett stated *"He shows no signs at all of psychotic illness now"*. With no more than an expression of slight concern at the possibility of the beginning of a hypomanic swing, Dr Pallett agreed a further reduction of medication in June, culminating, by September 1976, in a decision to discontinue all medication:
"...anxious to discontinue his Modecate altogether as he has been free of psychotic symptoms for something like three years now, I think this is not an unreasonable request. He understands that there is something of the nature of a gamble and is prepared to take the chance." Dr Pallett acknowledged the alleged willingness of the

GP to 'keep an eye on him from time to time' and, subject to agreement by the GP, proposed that she would not see him again unless this was considered advisable.

2.14 The respite was short-lived. In June 1977 Richard Allott's behaviour and performance at work attracted concern by his employing authority, he was advised to seek medical assistance and was re-referred to Dr Pallett by his GP. She agreed he was *"mildly hypomanic"*, recommended medication which he accepted reluctantly, and advised him to take time away from work. Dr Pallett concluded
"Insight is pretty limited here and the prospects of his taking his pills and our keeping him out of hospital are, I think, rather uncertain."

2.15 Premature attempts to return to work did not succeed and, after initial compliance, Richard Allott defaulted from both treatment and follow-up. He hitch-hiked to Wales, spent inappropriately, behaved recklessly and unlawfully at the Eisteddffod, reverted to using cannabis and threw away his prescribed medication while hallucinating after a night climb. The episode culminated in an attempt to drive away an unattended lorry which prompted his arrest and detention in custody. Further charges followed as a result of damage to police premises and property. He was convicted in August 1977, certified as suffering from mental illness and ordered to be detained in hospital. He was transferred to Central Hospital, Warwick where initially he sought discharge but subsequently co-operated with treatment and a programme of rehabilitation.

2.16 Dr Pallett deemed that Richard Allott was fit to return to work in late 1977 and so advised the Deputy Director of Social Services at Shire Hall. He resumed his duties part-time and then full-time, stable on depot injections of Modecate and oral lithium. By January 1978 Dr Pallett was pleased with his progress and aimed to see him at gradually increasing intervals, *"largely to keep a check on his lithium levels"*. This programme was successful and, during 1978, the injections of Modecate were decreased in dose and/or frequency with a lessening of general retardation. Side-effects from lithium were minimal (early morning nausea) and the level stable.

2.17 By January 1980 Dr Pallett reported *"Richard seems to have fully recovered...."* and, having checked his lithium level, extended his further follow-up to six months with an option for earlier review if necessary. Contact was maintained through a Social Worker who suggested further review to discuss employment prospects. Richard Allott had been reported as 'slowing up' and although unaware of this, he requested cessation of lithium, possibly prompted by his brother's ability to discontinue it. His request was sanctioned although Dr Pallett would have preferred to continue lithium at the expense of a reduction in Modecate. The following year he requested reduction in Modecate, again possibly prompted by knowledge of his brother's medication, and this too was sanctioned, Dr Pallet commenting *"..there are no signs whatever that he is psychotically ill now"*. Modecate injections were finally discontinued during 1981 and, in October that year, Dr Pallett noted *"He seems quite well and confident that he is better off without his Modecate"*. It was her understanding that Richard Allott was continuing to see his Social Worker occasionally and that his GP had agreed to 'keep an eye on him'. She recorded her intention not to offer further appointments and expressed the hope that he would not need the psychiatric services again.

2.18 Dr Pallett's optimism was not rewarded. Richard Allott presented again in March 1982, hyperactive, unable to concentrate and showing flights of ideas. There was intense conflict at home, his work had suffered and compulsory admission was contemplated but not required. Some months elapsed before he improved with treatment and applied for independent medical clearance to allow his return to work. Community supervision was increased by involvement of community psychiatric nurses as well as his regular social worker, and family conflict avoided by his relocation to a hostel. This necessitated a change of GP and a careful letter of transfer outlining current condition and drug therapy was sent by his GP to the new practitioner. However, the terms of his sickness certification were still quoted as "anxiety/depression". This contrasts with Dr Pallett's first letter to the new GP describing Richard Allott as having *"a history of recurrent severe psychotic illness which is usually manic in form. He is still receiving treatment with Modecate* (ie by injection) *.....because he is an unreliable taker of medication when "high"."*

2.19 An unexplained episode of nausea and vomiting prompting intermittent absence from work and further conflict with his employer occurred early in 1983 but this settled by May and, after some initial reluctance, Richard Allott agreed to the reintroduction of lithium. By late June he was 'quite well' and receiving satisfactory reports at work. Hospital appointments were extended to three monthly and blood lithium estimations carried out then. Repeat prescriptions for lithium were obtained from his GP.

2.20 A further brief admission to Central Hospital in January 1985 was necessitated by a psychotic relapse associated with voluntary discontinuing of lithium and transitory return to cannabis. He responded swiftly to the reintroduction of an increased dose of lithium. The discharge summary concludes *"We have strongly recommended to him that he continue his Lithium despite his reluctance to do so, as he does seem to relapse into his depressive illness when he stops the drug"*.

2.21 Richard Allott did continue his medication with lithium, functioned satisfactorily at work and succeeded in establishing himself in his first independent home. However an attempt to return to teaching was unsuccessful and he remained anxious about his prognosis and the need for long-term medication. Follow up with Dr Pallett continued and blood lithium levels were monitored regularly and were satisfactory.

2.22 In October 1985 Dr J Gray succeeded Dr Pallett and continued to supervise Richard Allott as before. Intermittent requests from Richard Allott to lower the dose of lithium were resisted and he continued on the drug with satisfactory blood levels. In July 1986, he requested that further follow up be with his GP and community nurse. Dr Gray acceded to this but expressed some reservations *"given his long history"*, emphasised the need for continuing treatment with lithium and requested that Richard Allott be re-referred to her should he seek to discontinue his medication. Three months later he attended his community nurse for blood lithium monitoring but visits thereafter were erratic (the next was recorded in May 1987). However, Richard Allott complied conscientiously with the prescribed regime, obtaining repeat prescriptions by telephoning his GP's surgery.

2.23 In 1987 Richard Allott applied for a driving licence, seeking and obtaining reports from both his GP and Dr Gray. The GP wrote in the following terms *"long-standing psychosis/hypomania stemming from drug addiction in 1972.....tries to reduce his tablets ..... last bad relapse following stopping his tablets was in 1984. ...turns to alcohol or drugs when he cannot cope."* Dr Gray's letter is not within the records. The 1988 Road Traffic Act gives guidance on the issue of a driving licence. In the context of acute psychotic episodes of any type or kind *"DVLA must be notified and driving should cease pending the outcome of medical enquiry. It is a requirement that a person must be well and stable for a minimum of 3 years with insight into their condition before driving can be resumed. At that time DVLA will usually require a Consultant examination. Any psychotropic medication should be of minimum effective dosage and not interfere with alertness, concentration or in any other way impair driving performance. There should be no significant likelihood of recurrence. Mania or hypomania in a driver is particularly dangerous, and may require a longer period off driving if the illness cycles rapidly."* We do not know if these requirements differed significantly from statutory requirements applying in 1987 when Richard Allott was granted a temporary licence. A year later Richard Allott applied for a full licence, once again seeking and obtaining support from Dr Gray.

2.24 The Motor Vehicles (Driving Licences) Regulations 1996 (SI 1996 No 2824) were brought into effect a decade or so later and require that *"all psychiatric conditions which are relapsing, recurrent or progressive and which may make the driver a source of danger must be notified to DVLA and medical enquiry will ensue. When well enough to drive, the licence holder is considered to have a prospective disability under the terms of s92 of the Road Traffic Act 1988. A licence is issued subject to medical review in 1, 2 or 3 years. Before a driving licence can be issued, the Licensing Authority must be reassured that the person is unlikely to relapse within a year, the shortest period for which a licence may be issued. "Severe mental disorder" is now a prescribed disability for the purposes of s92 of the Act."* Furthermore: *"A person with a history of a psychiatric illness who has been well and stable, and on an effective maintenance medication for 4 years could be considered for a 'til 70 licence'."* We

conclude from this analysis that there was full compliance with the requirement for disclosure of Richard Allott's history of mental illness and that his well-being at the time of seeking both a temporary and then a permanent licence sufficed to satisfy both his Consultant and the DVLA that he was entitled to drive. It is perhaps noteworthy that Richard Allott later worked part-time as a taxi-driver and was also recruited by the Social Services Department to their Emergency Duty Scheme which involved out-of-hours work, including driving.

2.25 Meanwhile Richard Allott pressed repeatedly for a reduction in the dose of lithium and eventually wrote to Dr Gray setting out reasons for doing so. He was by then coping well in all aspects of his life and resented what he perceived as the 'stigma' of long-term medication or involvement with the psychiatric services. In September 1987 Dr Gray agreed to a cautious, supervised attempt to lower the dose and he remained well a month later with a blood lithium level at the lower end of the therapeutic range. He then cancelled a further out-patient appointment and Dr Gray sought to pursue this through the community nurse. Six months later (May 1988) she saw Richard Allott once more when he requested support for the application for a full driving licence. She describes him as *"very well, with a much more mature approach today to his medication. He is quite happy to continue on a Lithium dose of 1000 mg daily in total and accepts that he needs this to keep him well..... I am also encouraged by the fact that he regards access to psychiatric services as important and has agreed to this through his community nurse should he require a further appointment"*.

2.26 Richard Allott told the panel that he regarded himself as discharged from follow-up in 1988 and stated his contact thereafter with the community nurse was spasmodic, initiated only by his request and that he received no regular monitoring or supervision. A new set of community nursing notes opened in March 1989 record that Richard Allott *"comes to surgery every three months for lithium levels, occasionally fails to keep appointment but will make a further appointment"*. The GP notes are largely silent apart from entries recording repeat prescriptions, apparently requested by telephone. Richard Allott is described as *"well, a very stable person now"* in September 1990.

There are no entries of any sort in the GP records for 1991. Lithium levels were measured in February 1990 and July 1992. The community nursing notes contain no entries after June 1989. "Discharged" is recorded in 1991.

2.27 Shortly after moving house and registering with a new GP in April 1994, Richard Allott requested psychiatric review, particularly of the need to continue lithium. The letter of referral was brief but cogent, mentioned that Richard Allott was well known to the Central Hospital and quoted the hospital number. A post-script recorded a patient preference for an opinion outside South Warwickshire but this could not be arranged. Richard Allott himself wrote a detailed letter to the Consultant, Dr Hashmi, whom he had not met previously and who held a locum appointment at the hospital. He set out major improvements in life style and achievement which had occurred since his last admission but admitted concern at the seasonal occurrence of past incidents and an on-going tendency for any *'behaviour which deviates from the norm'* to occur in the spring. He questioned the propriety of lithium as regular medication.

2.28 The consultation took place at Yew Tree Day Hospital, Leamington Spa and it is unclear whether the previous file of case-notes was available. However Dr Hashmi's hand-written notes and associated correspondence are now within the file. The recorded history suggests enquiry centred on events since *"discharged from Dr Gray's care in 1986 at Central Hospital"*, and states erroneously that *"blood lithium levels are checked by you (ie referring GP) and are stable"*. Despite wide-ranging enquiry, misunderstandings appear to have arisen in that Dr Hashmi considered Richard Allott held a senior managerial post pertaining directly to delivery of social services and that he lived in a stable relationship with his partner, described as a 'psychologist and counsellor at Warwick University'. Richard Allott made a favourable impression as a personable, intelligent and insightful professional person with good personal support. Dr Hashmi concluded *"There is no doubt that his diagnosis remains seasonal affective disorder..... Formerly he was called a manic depressive"*. He advised Richard Allott to continue lithium indefinitely at the same dose, suggested he might like to record and report his mood swings, and expressed his willingness to see Richard Allott again *"... if*

at any time he feels the need for a review". Dr Hasmi's current recollection of the consultation is that it was empathetic and successful; Richard Allott now describes himself as dissatisfied, his questions remaining unanswered. However he remained wholly compliant with his medication.

2.29 Thereafter Richard Allott's only other contact before May 1998 with medical services relating to his psychiatric illness was in February 1996 when he sought advice from his GP concerning stress at work. He reported warning signs of hypomania and 'speeding up'. The history of *'breaking through lithium level under stress'* was noted. His blood lithium level was checked and satisfactory and Richard Allott reported improvement after time off work. After a brief trial of a small increase in the dose of lithium, Richard Allott once again expressed concern about the drug but was advised to continue, and also prescribed a short course of medication to relieve anxiety. This was reduced and then withdrawn early in 1997 and no further concern was expressed about Richard Allott's mental state until he presented in May 1998. It is notable that when registering with a new GP as a consequence of a change of address he usually reported his past mental history as 'drug induced psychosis, 1972', or alternatively stated 'none' or 'not relevant' in response to questions about past illness. At his most recent registration in October 1997 he stated 'drug induced psychosis, 1972' on the questionnaire and no further details were sought or volunteered when he was interviewed and assessed by the Practice Nurse. However, his blood lithium level was checked and found to be within the therapeutic range, and other variables monitored to check organ function were also within the normal range. No questions were raised about the continued prescription or dose of lithium and contact with the GP only followed when the Nurse referred him for consideration of mildly elevated blood pressure (December 1997). Medication was prescribed for its control and the result accepted as satisfactory in January and April. There was no further personal contact with the general practitioner until May 1998.

2.30 This review of Richard Allott's medical history from 1972 to 1994 led us to conclude that he suffers from a severe relapsing and remitting psychotic illness. The consistent presence of affective symptoms during periods of relapse suggests the most likely

diagnosis is either bipolar affective disorder (also known as manic depressive psychosis) or schizo-affective disorder. This illness has been

(a) manifest intermittently, usually in response to some combination of undue stress, illicit drug-taking or discontinuance of medication;

(b) held in remission for long periods by Richard Allott's compliance with recommended medication which enabled him to function in a manner perceived as within the bounds of normality by both professional and lay observers;

(c) liable to rapid, and rapidly accelerating deterioration, either in response to or independent of identifiable precipitating factors,

(d) characterised during relapse by aberrant behaviour which included impulsive destruction and aggressive resistance to restraint;

(e) 'played down' during remission by Richard Allott who, by his plausible, presentable and articulate manner, succeeded in allaying anxiety in the minds of treating practitioners and thereby induced more latitude in supervision.

CHAPTER 3 - SOCIAL CIRCUMSTANCES AND EMPLOYMENT

3.1 In about 1984, Richard Allott first met Kate Richmond and their relationship soon provided a close source of support and affection to him. He described moving from a group home to a flat in Leamington Spa as *"a great leap forward"* and was soon able to invest in property of his own. Escalating interest rates and strains upon his relationship with Kate Richmond prompted a transition to rented accommodation and, during the 1990's, a series of properties, often less than satisfactory, were leased short-term. None proved suitable for joint occupation and the couple never lived together, this at times being a matter of serious contention between them. An important consequence of these relocations was that Richard Allott attended at least five different GP's between 1982 and 1998, at least three changes being within the last five years. The implications for medical supervision of chronic illness are considered in Chapter 7. Richard Allott's final move was at the beginning of May 1998 after he decided - apparently impulsively - to terminate a recently renewed lease and move to Old Milverton. Conflict with the previous landlord and with Kate Richmond about her hesitation in setting up a joint home probably contributed to the decision.

3.2 Between 1975 and 1998, Richard Allott was employed by the Social Services Department of Warwickshire County Council. An approach on his behalf in 1975 by the Warden of Manor Hostel, Nuneaton on the basis of employment of disadvantaged persons led to the offer of a clerical post, conditional upon satisfactory completion of a six month trial period and receipt of supportive medical reports from both the Area Medical Officer and his GP. His history and condition were well known to Social Services who acknowledged that his after-care *'was the responsibility of the Department'*. The risk of absence from work was recognised to be greater for him than normal, but one which it was reasonable to accept.

3.3 The recurrence of illness in 1977, conviction for criminal damage and subsequent hospitalisation prompted an offer of resignation which he then withdrew as his condition

improved. He was allowed to return to work some months later, initially part-time and only after further interview by Social Services Department staff.

3.4 Further concerns arose in 1982 when Richard Allott's attendance and performance were both in question. Consultations between staff in Social Services, his treating Consultant and domiciliary social worker led to a period of sick leave, and his attempts to return to work prematurely were resisted. Concern was expressed about his employment prospects and the dilemma posed by the twin responsibilities of employer and provider of services was clearly recognised within the Department. A decision was taken in August 1982 that the two roles must be kept separate and those directly responsible for Richard Allott as employee should treat him in like manner to any other member of staff. Meanwhile the Director of Social Services sought an opinion on his future employment prospects from the District Medical Officer who, in consultation with Richard Allott's GP and relying on consultant psychiatric opinion, deemed it reasonable to offer "one last chance".

3.5 After a shaky start, with repeated absence on sick leave in 1983, Richard Allott's work record improved considerably. He received approval from immediate supervisors, was offered more senior positions, secured advancement to a Scale 4 Administrator and achieved a qualification in Personnel Management. His absence in early 1985 when recurrent mental illness necessitated a brief re-admission to Central Hospital appears to have passed unremarked but, notwithstanding his perception of stigma attached to attending psychiatric services, Richard Allott never sought to hide from colleagues that he had an illness which required regular medication. However he did rely, particularly in later years, on 'work commitments' to justify infrequent hospital follow-up and explain missed appointments for the monitoring of drug levels.

3.6 In 1994 Richard Allott was offered an internal transfer to become the Administrator of a team providing support services to Staff Development and Training. It was suggested to us that this was a sheltered role but he found the work challenging and enjoyable, was able to make significant improvements to the service and was applauded for so doing.

He was popular with colleagues who regarded him as 'a colourful character', 'unusual' but an interesting, innovative and humorous member of staff. His own term was 'eccentric'. In addition to his regular duties, Richard Allott was recruited into the Emergency Duty Service which entailed on-call responsibilities such as the transfer or retrieval of absconding children in care. He enjoyed contact with young people and was judged to be successful with them. Departmental policy requiring checks on police records was fully implemented before Richard Allott was recruited to this service.

3.7 It was not clear how far those now directly responsible for his supervision were aware of the entirety of Richard Allott's past medical record. A senior member of the Social Services Department who gave evidence in writing stated *"...at no time in any of the direct contacts which I had with Mr Allott did I ever see behaviour or attitudes which seemed to me to be symptomatic of a severe mental disorder"*. This corroborates the impression of Richard Allott's well-being but could also be interpreted to mean some lack of awareness of the manifestations and severity of illness which had compromised his early years of employment. The fact that he suffered some illness which necessitated regular medication was accepted without question, but staff supervising his work or with managerial responsibility were concerned primarily with his performance which, although sometimes idiosyncratic, was generally acceptable. There was some conflict with colleagues, particularly with those in positions of authority, but nothing clearly identifiable as outside the normal range.

3.8 Matters deteriorated in or about 1996 when internal reorganisation at Shire Hall threatened the employment of a number of staff within Social Services, Richard Allott among them. Curtailment of scope and interest in his work, anxiety about long-term prospects and an inability to develop and advance his career were cited as particular concerns and on two occasions he took sick leave suffering from 'stress' (Chapter 2, paragraph 29). On return to work he made no secret of the fact that his absence was attributable to the difficulty and uncertainty of his employment and prospects. However in his own words *"Things were not considered bad enough for me to come to the attention of the mental health services."*

3.9 Exceptional efforts were made to assist his redeployment, initially within Social Services but subsequently exploring associated opportunities. This included not only internal counselling but also external career assessment funded by his employing authority. None of the options appeared favourable or consistent with Richard Allott's long-term ambitions and eventually it was agreed he would take voluntary redundancy. This was effected in February 1998, although his final months were spent in an unsatisfactory secondment or called from home on such emergency duties as presented. His uncertainty had been protracted and his disappointment considerable. Although judged to be reasonably content with the final outcome, he views this period with resentment - he felt devalued and that his achievements had been denigrated or destroyed. However, his twenty-two years of service were marked by a social occasion, modest at his own request. The beginning of 1998 was an important turning point for Richard Allot because he lost not only regular employment but also structure to his life, supervision and security.

3.10 Thereafter he sought employment in a variety of different spheres which combined to give him a totally unpredictable day, often over-full and requiring swift response to unexpected demands. A relatively minor accident with a van in April was followed by a more major incident in late April or early May when a large sheet of glass shattered while he was unloading it, prompting a vitriolic and near-violent argument with the van's owner and Richard Allott's immediate dismissal. These events coincided with a stressful domestic relocation (see paragraph 3.1) and, for the first time ever of his own initiative, Richard Allott increased his dose of lithium from 2.5 to 4 tablets daily. Still with some insight into his own deteriorating mental condition, he agreed with Kate Richmond that he would take a month's holiday *"to consolidate and plan"* but meanwhile invested some of his redundancy payment in the purchase of a Nissan pick-up van with the intention of setting up in business on his own.

CHAPTER 4 - THE CRITICAL PERIOD

4.1 Richard Allott dates his deterioration from April 1998, although the account of stressful personal, domestic and employment factors in the preceding three months (see chapter 3) suggest his relapse began rather earlier.

4.2 Within the first few days of May 1998 Richard Allott first increased his daily dose of lithium and then, about May 5th, decided to discontinue it entirely and flushed the entire supply down the lavatory. He also discontinued his hypotensive medication.

4.3 He discussed cessation of lithium with Kate Richmond who urged him to contact the GP's surgery to seek another prescription. He did so about mid-day on Saturday May 9th, reporting he had lost some tablets. While awaiting retrieval of his records, he became impatient and rang off. Efforts by the staff to make contact and advise where the prescription could be dispensed failed because of his recent change of address.

4.4 That afternoon he decided to leave for Wales in the newly-purchased Nissan truck but the journey was delayed while he made by a variety of impulsive purchases. He travelled during the night and the following morning made a dangerous mountain climb. By the time he reached the summit he was hallucinating and deluded. He contacted Kate Richmond by mobile phone, instructing her to report his discovery of treasure trove to the British Museum. After descending the mountain he smashed the window of a parked camper-van because he misinterpreted the sound of sheep as a child molested by paedophiles; in fact the van was empty. This episode probably occurred between 12.00 and 16.45 hours on Sunday May 10th but details thereafter are sparse. He arrived home about 08.00 hours on Monday May 11th having had virtually no sleep for two nights and was met by Kate Richmond who was concerned by his appearance and for his safety.

4.5 About three hours later she returned and found him with staring eyes, partially clothed.

He leaped down the stairs and attacked her, knocking her to the ground, tearing an ear-ring from her ear and seizing her by the throat. She managed to escape, ran from the house and drove up the lane to reverse. As she drove back past the house Richard Allott ran out and smashed her windscreen with his fist. She drove to a telephone kiosk, phoned 999, and requested assistance from ambulance and police. The call was timed as 11.14 hours, the ambulance crew were alerted at 11.16 and attended at 11.21 with the police arriving about 10 minutes later.

4.6 Kate Richmond was described as being distressed and barely able to speak coherently when first seen by the ambulance crew. She explained initially that Richard Allott suffered from manic-depression, had discontinued his medication, made an abrupt trip to Wales and had gone *"completely over the top"*. The ambulance crew observed the broken windscreen, questioned her about it and she then reported the personal assault. They deferred approaching the house until joined by the police. When reporting to us, the police officer described Kate Richmond as 'calm', if anything underplaying her concerns and , although aware of damage to the vehicle, he could not recall that she had reported any personal assault. Her chief concern was for the safety of Richard Allott.

4.7 Entry through the door was prevented by a chain but after repeated attempts to make contact orally the police entered through an insecure window pursuant to s17 of the Police and Criminal Evidence Act 1984. Eventually Richard Allott responded to their calls and engaged in conversation with both police and ambulance crew. The ambulance crew judged Richard Allott was suffering from psychiatric illness requiring immediate medical attention. In their experience, the only means of securing this were either to request a visit from the GP or attend the Accident and Emergency Department of Warwick Hospital. Richard Allott refused both, denied that he continued to attend his GP and averred his intention of seeking medical treatment only as a private patient. The ambulance crew considered current policies precluded the calling of an approved social worker, either directly or through the Ambulance Control Unit. They left Old Milverton, anticipating Richard Allott would be taken into custody on charges of either assault or criminal damage and thereafter be assessed by a police surgeon. Their

contemporaneous record concludes:

"He seemed very disturbed and erratic - his conversation was very disjointed and seemed desperate to convince us he was sane. Refused treatment. Police informed by us that he needed psychiatric treatment".

4.8 The Police remained with Richard Allott, confirming that he refused to consult his GP but was willing to see a medical practitioner privately. The Officer then spoke to Kate Richmond who confirmed her willingness and ability to make the necessary arrangements for a private consultation and, after ascertaining that Kate Richmond was able to re-enter the premises and converse safely with Richard Allott, the police left shortly afterwards. The question of criminal charges was raised but Kate Richmond did not wish to pursue this. There is conflicting evidence on whether the possibility of section under the terms of the Mental Health Act was discussed specifically with Kate Richmond, either on her initiative or with her by the police or ambulance crew.

4.9 After the emergency services personnel had left, Richard Allott agreed he would accompany Kate Richmond to his GP and obtain further supplies of lithium. She made an emergency appointment for him to do so at 16.30 hours that afternoon and conveyed at least some history of recent events to the receptionist. The couple attended the surgery with Richard Allott driving them both in his car (not the Nissan truck).

4.10 Conflicting evidence was received as to the exact content of the history relayed to the General Practitioner during the consultation that afternoon. In particular it is not clear whether he was told then of Richard Allott's trip to Wales, the assault upon Kate Richmond or the attack on her car. The contemporaneous notes record the diagnosis of manic depression, that Richard Allott had discontinued both his lithium and the hypotensive medication, and claimed the two drugs interfered with each other. At least some irrational conversation and argument took place. The practitioner appreciated Kate Richmond's serious concern and offered either hospital admission (St Michael's) or consultation with Dr Richardson, a local Consultant Psychiatrist not previously seen by Richard Allott. Both these offers were firmly rejected but Richard Allott expressed a

wish to restart lithium in a low dose (but not the hypotensive drug) and accepted a prescription in these terms. The practitioner accepted an undertaking from Kate Richmond, whom he understood to be a Psychologist, that she would ensure compliance with the prescribed medication. Again it is not clear if the possibility of compulsory admission pursuant to the Medical Health Act 1983 was discussed specifically during the consultation but when asked by us why he considered it unnecessary the practitioner replied:

"Because he had insight into his illness, he accepted that he was not taking the lithium, he wanted to start, re-dose, he wanted his serum lithium measured. He was appropriately dressed. Most of his conversation with me was reasonable. He had the good support of a partner and he was listening to her when she said calm down. He had to comply with medication and, indeed, he asked for the medication. He was in no way threatening to me or to his girlfriend and he expressed no thought that he would harm anyone. He was low down the scale of becoming manic".

4.11 The prescription for lithium was dispensed at a local chemist and one dose taken immediately before the couple returned to Old Milverton where, in the course of the evening, Richard Allott took another dose. Kate Richmond left but phoned twice more that evening, visiting after the first call when he reported he was concerned by a metallic smell attributed to some bedding. She arrived to find this being thrown into the garden but quite quickly thereafter Richard Allott regained his composure and appeared calm, rational and relaxed. He reported an intention to watch television and when she rang again about 21.30 hours he said he was tired and had locked up.

4.12 Less than two hours later Richard Allott decided impulsively to leave, perhaps to revisit Wales, and set out in the Nissan pick-up on a destructive journey through Leamington Spa which culminated in the deaths of Richard Aston and Richard Chandler and serious injury to Lee Baker. The truck was finally brought to a halt when it was cornered by police vehicles, Richard Allott was wrestled to the ground and arrested.

4.13 Community Psychiatric Nurse Ms P Wilcox was requested to attend Richard Allott at

the police station early on the morning of May 12th and, after a brief appraisal, confirmed he was grossly disturbed and in need of psychiatric assessment. The assessment was carried out that afternoon by Dr Richardson who was accompanied by an Approved Social Worker and Richard Allott's GP. Their unanimous conclusion was that Richard Allott was suffering from mental illness but was fit to plead, to instruct counsel and to be interviewed by the police. Commenting on his behaviour during the assessment, Dr Richardson described him as *"remarkably controlled"*.

4.14 Richard Allott was interviewed by the police in the presence of his solicitor and an approved social worker who attended as 'appropriate adult'. There were three sessions which lasted approximately nine and a half hours in total and occupied the evening of May 12th and parts of the subsequent day. The social worker told us Richard Allott was generally consistent, surprisingly calm and able to concentrate. He gave considered answers when questioned directly but was voluble and keen to focus on issues important to him. Twice he displayed anger but restrained himself and was described generally as 'emotionally detached'. Formal charges on two counts of murder followed.

4.15 Secure facilities for detaining Richard Allott while on remand were not available locally and he was therefore transferred to the hospital wing of HMP Blackenhurst. Initially he was unco-operative and difficult to manage but his behaviour improved with sedation. His care there was supervised by Dr JB Brockman. On September 7th 1998 she reported *"Mr Allott is now in remission, his symptoms controlled on regular Lithium"*. The daily dose was the same as he had been taking for more than ten years and resulted in a blood level within the therapeutic range. He was described as *"..appropriately remorseful and sad about the consequence of his relapse of illness.... I am still of the opinion that it is appropriate for him to be considered by the Courts to be of diminished responsibility due to relapse of hypomanic illness....."*.

4.16 On September 23rd 1998, Richard Allott was assessed by Consultant Forensic Psychiatrist Dr AR Johns on behalf of the Crown Prosecution Service. He obtained a comprehensive history from Richard Allott, comparable in all essential elements with the

medical records. There is no evidence of attempts by Richard Allott either to 'play down' or exaggerate his illness. He told Dr Johns that by January 1998 *"it was all going downhill"*, toward the end of April he felt stressed, his sleep patterns were disturbed and by the start of May *"things started going strange"*. The only inconsistency between Richard Allott's history to Dr Johns and other evidence was his account of the aftermath of the attack on Kate Richmond and her car *"...two policemen and an ambulanceman came to the door. He assured them that it was a domestic problem and they left"*.

4.17 On the totality of evidence available to him, (which included medical records, witness statements and the recorded police interview as well as his own observations), Dr Johns reached a number of conclusions, of which the following are particularly relevant:
Mr Allott has a history of severe mental illness which first appeared when he was 22yr. He was admitted to psychiatric hospital in 1972, 1973, 1977 and 1985. Each admission appears to have been preceded by a gradual deterioration in his mental state characterised by impulsive aggression or violence, delusions and overactive behaviour. These problems were aggravated by misuse of psychotropic drugs and after the first episode, by cessation of medication, particularly lithium. Difficulties in his interpersonal relationships appear to have been a further stressor at times. Although the diagnosis was not at first clear, more recently his psychiatrists have consistently diagnosed a manic-depressive illness. ***He required psychiatric care or monitoring from 1972 until the present, from either psychiatric services or his GP.***
(Emphasis added).

The acute episodes of illness were very severe but appear to have responded well to a combination of antipsychotic medication such as modecate injections, and a mood stabilising drug i.e. lithium carbonate.

At the time of my interview Mr Allott showed no symptoms of his manic-depressive illness, nor any other significant mental symptoms. He is of normal intelligence and does not show significant abnormalities in his personality. He was contrite and tearful

about the homicides. He is complying with lithium treatment.

Mr Allott faces charges of homicide and related charges, arising from incidents on 11.5.98 when he drove at speed. In my opinion, Mr Allott was at that time suffering from a relapse of his manic-depressive illness.

The onset was insidious and apparently not related to the misuse of illicit drugs. He appears to have felt unwell by at least April 1998 and very probably from the start of May (sic). *It is difficult to identify a clear precipitant, but important factors appear to have been his planned retirement, his numerous part-time jobs and possible difficulties in his relationship with his girlfriend; and in addition he moved house on 1.5.98. At some unspecified time he said that he increased his dose of lithium to 2000 mg/day as he felt unwell, but then decided on about 3/5/98 to stop taking this medication entirely.*

I do not think that it is possible at this stage, to arrive at a complete understanding of his aggressive behaviour during the night of 11/12th May. It seems to me probable that he was impulsive, his thinking was muddled and not particularly goal-directed and that he was in a state of animated arousal and angry irritability. Although he appeared to be aware of what he was doing, he was markedly dissociated from the consequences of his actions. At times he expressed delusional beliefs. His anger was partly directed at his girlfriend, but also generalised to others that he met. I note that in the previous and present episodes of manic depression, Mr Allott's behaviour was characterised by irritability and anger rather than marked euphoria. He had very limited insight into his unwell state.

It may be suggested that Mr Allott's actions may be readily understood in terms of a state of extreme anger and irritability, arising from his arguments with his girlfriend and partly from his identification with the character of Terminator from the video. In such a state he enacted out part of the Terminator role and determinated to cause as much damage to others as possible. As such, it may appear that his behaviour was markedly goal-directed. This explanation is not in my view sufficient to account for his

impulsivity, his attack on the van in Wales, the nature of his assault on his girlfriend, and other symptoms and behaviours, nor his dissociation from the consequences of his actions; all of which suggest that he was severely mentally unwell. It may also be suggested that he made a voluntary decision to stop taking lithium. It is however my view that there were signs of relapse of his mental illness some weeks before he stopped the medication. In effect, his cessation of lithium was a symptom of his illness and not the cause. His more immediate resumption of lithium use was in all probability, too late to have a material effect on his mental illness.

In my opinion at the time of the homicides, Mr Allott was suffering from a manic-depressive psychosis, a mental illness within the meaning of the Mental Health Act 1983. I suggest that at the time of the offences he was suffering from an abnormality of mind characterised by misperception of physical acts and matters, an inability to form a rational judgment as to whether an act was right or wrong, and also an inability to exercise will-power to control physical acts in accordance with that rational judgment. In my view, this abnormality of mind was induced by the disease of manic-depression and substantially impaired his responsibility for his acts within the meaning of section 2 of the Homicide Act 1957.

4.18 Essentially similar conclusions were incorporated in reports provided by Dr Brockman to Richard Allott's solicitors in November 1998 and to the Court on his behalf later the same month by Dr C Bradley, Specialist Registrar in Forensic Psychiatry. It was on the basis of Dr Johns' evidence that Richard Allott's plea of guilty to manslaughter with diminished responsibility was accepted at Stafford Crown Court in November 1998. Both Dr Johns and Dr C Bradley were heard by a different Judge at Warwick Crown Court in February 1999 who sentenced Richard Allott to detention in a medium secure unit under s37 Mental Health Act and a s 41 restriction order was made. He was banned from driving for life and the Nissan truck was impounded.

CHAPTER 5 - COMMENTARY

5.1 Introduction

We are in full agreement with the conclusions as to diagnosis and manifestation of mental illness reached by Dr AR Johns and quoted at length in chapter 4. In this chapter we comment first on the care provided to Richard Allott and consider it against the background of Mental Health Services as they evolved during the relevant period. Landmark changes in statutory provisions and recommendations are listed first:

1983 Mental Health Act 1983 replaced Mental Health Act 1959; it was followed by a decade of change with emphasis on a preference for community care.

1990 HC (90)23: Care Programme Approach: mandatory from April 1st 1991. Principles, as annexed to HC (90) 23, are included at Appendix 1.

1994 HSG (94)27: Guidance on discharge of mentally disordered people and their continuing care in the community.

1994 HSG (94)5: Introduction of Supervision Registers for mentally ill people from 1st April 1994.

1996 LAC (96)8: Guidance on Supervised Discharge and related provisions pursuant to Mental Health (Patients in the Community) Act 1995.

1999 Revised Code of Practice for implementation of Mental Health Act 1983.

5.2 Care provided to Richard Allott, 1972 - 1988

(a) Hospital services

We were impressed by the high quality of care and found no evidence to suggest it fell below the standards of the day in any regard. Communications from Consultant to General Practitioner and to designated Social Worker were good, and efforts to rehabilitate Richard Allott were compassionate, corporate and effective. At least when seen in retrospect, the degree of optimism as to prognosis may have been unwarranted.

5.3 (b) Social Services

We make no criticism of social services provided to Richard Allott as a client. The Social Service Department was also involved as an employer, this relationship having

begun as a result of a request for Richard Allott to be considered under the provisions for employment of disadvantaged persons. We considered the Social Service Department had discharged this role well and had referred and/or insisted on Richard Allott seeking medical attention when necessary. There was a proper appreciation of the differing roles of employer and service provider.

5.4 **Care provided to Richard Allott, 1988 - 98**

(a) Hospital services

In 1988 Dr Gray acceded to Richard Allott's request that further hospital follow-up was unnecessary. She did so on the basis of his declared aversion to the perceived stigma of such attendance and his current well-being. She recalls him now and said to us *"I suppose what sticks in my mind is that he was good-looking, very well dressed, very well presented, always neat and tidy which tells you a lot about psychiatric patients. He was holding down this job and he looked neater than most social council employees ..... He was a very personable man."* She considered regular contact and supervision, including supervision of lithium therapy, were still essential however and delegated this responsibility to the Community Psychiatric Nurse and Richard Allott's GP, recording the policy to the GP by letter. It is not clear now whether the Community Psychiatric Nurse received copy correspondence. Dr Gray retired less than six months later and, without a defined out-patient appointment, there was then no reason for Richard Allott to come to the attention of any hospital staff unless prompted by GP or community nurse. Statutory provisions for aftercare in 1988 (s117 Mental Health Act 1983) provided a wide discretion and did not apply to Richard Allott because they were directed only to patients discharged after compulsory detention. The panel considered the arrangements made by Dr Gray were consistent with accepted practice at the time and would have sufficed had they operated as intended.

5.5 In 1994, shortly after registering with a new GP, Richard Allott himself sought further psychiatric advice and, although expressing a preference for referral outside the locality, agreed to see Dr F Hashmi, an experienced Consultant currently holding a locum appointment. It seems likely, even probable, that consultation at the day hospital

prevented Richard Allott's medical records being available to Dr Hashmi but he had no reason not to believe the history recounted to him by his patient. Dr Hashmi's contemporaneous notes make it clear that he obtained a more reassuring picture of Richard Allott's social, domestic and employment situation than was warranted and that he was given only a very brief account of past history. Thus he diagnosed Seasonal Affective Disorder, a more benign condition than bi-polar affective disorder and which, by definition (WHO International Classification of Diseases, Version 10), specifically excludes patients who have suffered episodes of mania or hypomania. Furthermore he concluded that the lithium treatment, which was the main reason for the consultation, was under regular review by the referring GP. This was not so and could not have been so because, as stated in the referral letter, Richard Allott had only recently registered with that practice. This must be seen as a missed opportunity for restoring regular supervision and monitoring, both of Richard Allott's mental state and his lithium treatment. However, we do not feel Dr Hashmi can be greatly criticised for failing to recognise it. He was faced by a compliant patient actively seeking information on the illness and its treatment. It was accepted practice at the time for patients using lithium in the long-term to be followed up in general practice and, although there were recognised guidelines for monitoring (eg British National Formulary), there was - and still is - no locally agreed policy setting out who was responsible for ensuring the checks were made. Dr Hashmi made the not unreasonable but nevertheless erroneous assumption that proper monitoring and follow-up were in place. He gave Richard Allott wholly proper advice to continue lithium at the same dose, reported in detail to the GP, and offered a further appointment should the need arise. The Care Programme Approach had been introduced by 1994, but the panel endorsed the view that Richard Allott's condition at the time of his assessment by Dr Hashmi would not have prompted his inclusion, and might well not do so today in similar circumstances.

5.6. **(b) Follow-up in the community**

After 1988, active management of Richard Allott's mental illness in the community was minimal. There are virtually no community nursing notes relating to his progress after he was transferred to the combined care of his GP and the community psychiatric nurse

in 1988. In April 1991, the nursing notes end with the bald entry "discharged". We were unable to establish what, if any, discussions with GP or psychiatrist authorised this decision. Contemporaneous GP records are equally unsatisfactory - essentially a list of dates on which the prescription for lithium was repeated, apparently in response to a telephone request. There are no entries of any sort for 1991. Richard Allott told us he considered he had been discharged from follow-up in 1988 and that monitoring blood levels of lithium was left for him to request as he saw fit. Measurements were made in June and November 1988, June 1989, September 1992, February and October 1994, February 1995 and 1996 and December 1997, all results lying within the therapeutic range. We found no evidence to sustain Richard Allott's view that he had suffered from lithium toxicity at any time although he did experience at least some of the recognised side-effects of therapeutic levels of medication. We have insufficient evidence to determine whether he has suffered any lithium-induced impairment of organ function, in particular renal function, but if such exists it is likely to be mild - his renal chemistry was normal in December 1997.

5.7. Several factors must be cited in mitigation of this paucity of follow-up. Richard Allott moved house several times and registered with a different GP on each occasion, albeit returning at least once to a different partner in the same practice. Until May 1998 he remained fully compliant with the recommendation to remain on lithium, his mental illness was in remission and he displayed no obvious abnormalities of mental state, life-style or behaviour. In his own words *"I chose to ignore that I had an illness that was treatable but not curable"*. The summary of treatment card attached to his GP records includes references to mental illness in 1972, 1983, 1984 and 1985, but when registering with a new practice, Richard Allott described his past history merely as "drug induced psychosis, 1972" or responded to questions seeking information on past illnesses with "none" or "not relevant". He was described by several observers as well-dressed and intelligent, and describes himself, particularly when hypomanic, as *"plausible, especially relating to authority."* Sometimes more information was obtained by direct questioning, possibly by a practice nurse and once the notes record reassuringly *'feels under control on lithium'*. His past mental history was explored in more detail by his

then GP in early 1996 when he presented with work-related stress but he recovered with some sick leave and a short period on medication. Anxiety was diagnosed. Before any long-term therapeutic relationship could be established, Richard Allott moved again and registered with another practice. He was intent on doing so yet again after moving to Old Milverton in May 1998. Despite these mitigating factors, we consider it unsatisfactory for a patient being prescribed psychotropic medication to remain on it for so long without regular, probably specialist, reassessment. Not only did the lack of professional contact prevent a perceptive observer detecting the early warning signs of relapse which were almost certainly occurring in early 1998, it also meant that neither Richard Allott nor Kate Richmond had a clear idea of where, or to whom to turn when his condition deteriorated abruptly. Both denied knowledge of any resource other than the GP or the emergency services. It has to be acknowledged that the problem was exacerbated by the disinclination of Richard Allott to accept that he suffered an illness, and his hostility to the National Health Service in general and (local) psychiatric services in particular. It is also entirely possible that the rapidly accelerating progression of Richard Allott's relapse in 1998 would have proceeded to its devastating conclusion even if his mental health had been under regular supervision.

5.8 Role of Social Services

In 1994 when Richard Allott was relocated within the Department, there may have been some lack of information transfer about his medical history to those with line management responsibility for him, but he was functioning well at the time and his behaviour gave no cause for specific enquiry. When departmental reorganisation threatened the nature and security of Richard Allott's employment, there was undesirable delay in reaching a decision on his future. It was at this stage that any ignorance of his mental health history may have allowed matters to drag on too long and for unrealistic ambitions to be explored or encouraged. However, we commend the totality of effort made by the Social Service Department on his behalf and consider it well above what is offered to many in comparable situations. There was no involvement of the Department as a provider of social services to Richard Allott after about the mid 1980's until 1998, when his care by Social Workers was considered by the panel to have been exemplary.

5.9 **The Emergency Services**

There was a lost opportunity for effective intervention on Monday May 11th when ambulancemen and police attended in response to an emergency call. Two long-serving and experienced ambulancemen regarded Richard Allott as in need of urgent psychiatric assessment and treatment but felt unable to take effective action because he refused to acknowledge that NHS services remained accessible to him despite his loss of employment, denied that he had a GP whom he could contact and would not accompany the ambulancemen to Warwick hospital. They did not consider themselves able to call for assessment by an approved social worker, did not consider this could be effected by their Control Unit and were unaware of any other source of help. We regarded this as a 'system failure', not personal failure by individual staff. The police officers were less senior and experienced and may have been misled as to the seriousness of the situation by Richard Allott's relatively rapid return to apparently rational, albeit argumentative behaviour. They too were unaware of service provisions for urgent psychiatric assessment apart from reliance upon the GP or provisions under s136 of the Mental Health Act (which did not apply as Richard Allott was not in a public place). Perhaps not unreasonably in the face of a de-escalating situation, they relied upon the commitment given by Kate Richmond that she would ensure Richard Allott sought private medical advice as soon as possible. Neither the police nor Kate Richmond sought to press charges for criminal offences, so precluding another means of access to medical advice and/or psychiatric services. This too we saw as a system failure rather than individual fault. The inability of either service to secure urgent psychiatric attention must be attributed in part to reluctance bordering on hostility by Richard Allott and compliance with his wishes by Kate Richmond, though such a situation is hardly unique.

5.10 It was suggested to us that had the Police in Warwick been aware of Richard Allott's behaviour while in Wales, particularly the assault on a camper-van, they might have been forewarned and so better able to recognise his mental illness or even consider charges related to the incident. We did not pursue this but considered it unlikely that transfer of information could have helped. Richard Allott left the camp site soon after damaging the camper van which was unoccupied at the time. There was nothing to associate him

with the incident until the history of his trip to Wales began to emerge sometime after his arrest at the end of the lethal journey through Leamington Spa.

5.11 **Medical consultation on the afternoon of Monday May 11th.**

Here too there was a missed opportunity but once again the ability of Richard Allott to recover his composure and give at least some reasonable account of himself must have detracted from the ability of the GP to recognise the severity of the relapse. Similarly the willingness of Kate Richmond to be driven to the surgery by Richard Allott in a potentially fast car (a Mini-Cooper) gives some indication of the extent to which he had regained control of himself and was behaving with apparent rationality. Features of mental derangement were apparent during the consultation and prompted a recommendation for psychiatric referral or even admission, both of which were refused. This practice has excellent relations with both consultant psychiatrists and community psychiatric nurses but the general practitioner was explicit in giving reasons why he did not consider there were grounds on which to seek compulsory admission for Richard Allott under the terms of the Mental Health Act. Although this decision was shown by subsequent events to be erroneous, we cannot find significant grounds for criticism. All that can be suggested is that a clearer and perhaps more detailed history of recent past events might have been obtained had Kate Richmond been interviewed alone, and may have prompted the practitioner to adopt a more interventionist approach. The re-prescription of lithium was a correct and reasonable decision in the circumstances.

5.12 **Role of Richard Allott's carer**

At least two medical practitioners chose to regard Kate Richmond as something of a professional in terms of psychiatric care and assessment, and therefore unusually well qualified to ensure the safety and well-being of Richard Allott and/or bring him to the immediate attention of mental health services if he deteriorated. We regard such reliance as unfounded and unjust. Kate Richmond has a degree in psychology but she is neither a psychiatrist nor a clinical psychologist. Her particular expertise and experience lie in counselling. She had not known Richard Allott when his illness had been floridly

manifest. She fulfilled the role of carer and was undoubtedly his closest human contact but she has never lived with him and denied that she had ever seen him as a 'client' to whom she provided counselling. Her concerns can only have been exacerbated by an awareness that at least some of the conflict in Richard Allott's life was attributable to strains on their own relationship. The most that can be said is that she was surprisingly unaware of service provisions for the mentally ill, either through the regular channels or the voluntary organisations. This at least is all the more surprising in that she has apparently had, but only in the past, some professional association with local mental welfare services.

CHAPTER 6 - CURRENT PROVISIONS FOR MENTAL HEALTH IN SOUTH WARWICKSHIRE

6.1 We were provided with extensive documentation, in particular details of

The Care Programme Approach (CPA) revised in 1998; local guidelines setting out principles and practice for implementation are included at Appendix 2.

The Supervision Register (effective from 15.8.94)

Supervised Discharge (undated)

Risk Assessment Guidelines (undated)

A Sharing of Information Protocol, (currently being implemented).

We also received documentation relating to the provision of services, namely:

Strategic Commissioning Framework, adult mental health services (October 1998)

Programme for Moving Forward Adult Mental Health (on-going)

Service Level Agreement, St Mary's Mental Health Resource Centre (May 1999)

CPN Link Worker Role (May 1999); this document is included at Appendix 3.

CPN Out of Hours/On Call Service

Assessment and Treatment of Mentally Disordered Offenders (May 1999)

Finally we were provided with copies of

Trust policy for critical incident reporting (undated)

Report of an internal enquiry into the case of Richard Allott (July 1999)

Report of independent user-led review of community mental health services in Warwickshire, particularly application of Mental Illness Specific Grant (1997).

6.2 This documentation was supplemented with oral evidence amplifying how these policies were being implemented, the degree and efficacy of inter-agency working, the extent of multi-disciplinary staff training, and availability of out-of hours services for the mentally ill, including voluntary services over and above the CPN on-call service.

6.3 A network of mental health services is available through Mental Health Resource Centres, psychiatric in-patient and out-patient hospital facilities and staff working between primary and secondary care. An approved social worker is always available,

there is always a consultant psychiatrist 'on call', and the Community Psychiatric Nursing service has extended its working hours to 10.0 pm. Patients already registered with the service may be able to obtain urgent out-of-hours assistance if they call or present directly to St Michael's hospital, although the more usual route is by referral from a General Practitioner. Previously unknown patients are assessed first at Warwick Hospital or during a domiciliary visit from social worker or psychiatrist, usually at the request of a GP. There is some pressure on in-patient beds but we were encouraged to learn that GPs in the area consider it is 'always possible to obtain a bed if necessary' and enjoy close co-operation with both psychiatrists and community psychiatric nurses. Social workers and community nursing staff both considered they had achieved close co-operation with each other at a practical level, although there was a suggestion of some divergence of opinion at managerial level. The availability of mental health services at Resource Centres, through community psychiatric nurses and the voluntary agencies is advertised to the general public, although it was acknowledged that such information might only impinge on persons likely to need access to them.

6.4 Other aspects of inter-agency collaboration are less comprehensive. The management of mentally disordered offenders is provided for by well developed links between police custodial services and both approved social workers and community psychiatric nurses. Informal training is inevitably a part of the frequent exchanges between these personnel. Conversely junior police officers on the beat have very little contact with the mental health services and are not provided with specific training beyond those aspects which lie within their own authority. The ambulance staff are also isolated in that although they are involved in the transfer of patients suffering from mental illness, they have no specific training in the subject and no opportunity for informal leaning through contact with professional colleagues. The view was expressed that current organisational arrangements limit rather than foster their links with approved social workers (formerly mental welfare officers). We were also concerned to note that a recently agreed policy for inter-agency collaboration makes no mention of the ambulance service, although individual NHS Trusts are identified as well as the overall commitment of the Warwickshire Health Authority.

6.5 Current mental health services are based on the Care Programme Approach. South Warwickshire was among the first to introduce it and we could find no significant grounds for criticising its implementation or operation *for in-patients, new patients referred by any route or those currently being followed in the community.* The essential elements are that patients deemed to be suffering from an on-going mental illness are recruited to the plan according to an agreed index of severity. Their future management is considered by a multi-disciplinary team, a key worker is identified as the contact point with user and carer, and regular review arranged by the team. There is however no policy to go back over old records and identify patients such as Richard Allott who would now be recruited to such a plan were he to present as he did in 1972.

6.6 The only opportunities to recruit Richard Allott to a Care Programme before 1998 arose in 1994, when he sought review by Dr Hashmi, and 1996 when he consulted his GP. His well-being at the time and the circumstances of his consultation with Dr Hashmi were such that most commentators considered he would not be recruited to the CPA even now. *'Building Bridges', a guide to arrangements for inter-agency working for the care and protection and severely mentally ill people,* published by the Department of Health in 1995, stresses the need for *"the adoption of a tiered Care Programme Approach in order to focus the most resource-intensive assessment, care and treatment on the most severely mentally ill people, whilst ensuring that all patients in the care of the specialist psychiatric services receive the basic elements of the CPA"* (para 3.0.1). In para 3.0.3 the Guide reiterates the importance of the CPA as the cornerstone of the Government's mental health policy: *"It applies to* ***all*** *mentally ill patients who are accepted by the specialist mental health services".* These terms exclude patients such as Richard Allott whose chronic mental illness is maintained in remission by regular medication and have been discharged from the secondary mental health services.

6.7 Although Richard Allott presented with *symptoms* to his GP in 1996, the potential severity of his condition was inapparent and the episode resolved with only minor treatment. We considered it reasonable, *by the standards of the time,* for the GP to take no further action. However we do not consider it is acceptable today for patients

with chronic mental health maintained in remission by regular medication to be discharged to the care of their general practitioner without specific provision for continued supervision being agreed by GP, hospital staff, patient and carer. Without a clearly agreed plan, it is all too easy for patients, particularly those reluctant to attend for follow-up, to lose contact with any source of professional help. Similarly the potential significance of their illness is likely to be overlooked if recorded information on past history is degraded by the passage of time and is not specifically brought to the attention of successive practitioners with primary care responsibility. Reliable follow-up is more likely to be achieved if the patient is involved in the planning process and understands the reasons for it. Richard Allott is now subject to a hospital-based Care Plan and expresses satisfaction with it. He appreciates the provision of written information about his medication, and describes himself as *"empowered"* by his involvement in the planning of his future care and needs.

6.8 Our concerns therefore centred on the interface between primary and secondary mental health care rather than on the manner in which current statutory guidelines and recommendations had been implemented. In general we were favourably impressed by local arrangements for the delivery of health care to the mentally ill. South Warwickshire regards itself as a leader in the field and we found no reason to dispute this assertion. Despite attempts to 'bench-mark' services against provisions elsewhere in the country, we concluded this was impractical, there being no realistic markers and scant means of distinguishing the needs of urban, rural or mixed communities. The areas where we did identify deficiencies were as follows:

a) lack of any means for identifying patients with chronic illness in remission who are at risk of relapse or who, during a relapse, present significant risks to themselves or others; this problem is likely to be widespread nationally;

b) lack of sufficient inter-agency training for staff 'in the field' - eg ambulance crew and police constables on general duties;

c) inadequate means for ensuring the availability of complete and unified records when patients attend facilities which are geographically separated;

d) lack of information available to users and carers about service provisions.

6.9 We were also disappointed at the tardy response of the Trust in setting up an internal inquiry in response to homicides by Richard Allott in May 1998, while acknowledging he was no longer attending as a current patient and that the Trust was in a state of organisational flux as a result of a merger and consequent major managerial changes. The recommendations of the internal inquiry were broad but we were reassured to learn that the appointment of a new Chief Executive in August 1998 has already been followed by plans for improving the maintenance and availability of records, an extension of the out-of-hours CPN service and its better integration with other acute facilities, and a pilot exploration of 'FACE' - the proposed risk assessment guidelines. Financial pressures and short-term difficulties in recruitment have created some constraints but we found no evidence to support the contention that Richard Allott's care was compromised through lack of resources. At the critical time he was not in effective contact with the services.

CHAPTER 7 - RELAPSING MENTAL ILLNESS IN THE COMMUNITY

7.1 Problems manifest by Richard Allott

How then *did* Richard Allott's relapse of mental illness progress to such devastating consequences? We identified nine main areas of concern:

a) his effective discharge from consultant psychiatric supervision in 1988 and subsequent discharge from the community nursing services in 1991 placed full responsibility for his mental welfare on a series of General Practitioners;

b) this transfer of responsibility took place without a clear and agreed hand-over or any definition of what constituted an appropriate level of future supervision;

c) while in the care of the secondary mental health services, information as to the severity of his illness or the factors precipitating relapse had been transmitted to the current General Practitioner but there was no effective mechanism for alerting successive practitioners to its continuing potential relevance;

d) opportunities for recruiting Richard Allott to some form of regular supervision were missed in 1994 and 1996 despite, on both occasions, careful review of his *current* mental health and confirmation of an on-going need for lithium;

e) Richard Allott's plausibility and apparently successful integration at work and in a wider social sense lulled even experienced observers into under-estimating the severity of his mental illness;

f) the lack of a comprehensive and unified hospital record, readily available to all relevant personnel, may have contributed to this as well as the lack of specific hand-over from one General Practitioner to another;

g) neither Richard Allott nor his carer (Kate Richmond) were aware of potential sources of supervision or support, in part as a result of marked reluctance on the part of Richard Allott to admit the severity of his illness or accept that reliable and appropriate treatment could and would be made available to him locally;

h) as a result of frequent relocations, Richard Allott failed to establish any firm therapeutic relationship with any medical practitioner, nurse or social worker;

i) emergency duty service personnel were too inexperienced and/or unaware of mechanisms for securing urgent psychiatric assessment of patients at home.

7.2 Discussion

We turn now to consider the general problems presented by patients suffering from relapsing mental illness, in particular the threshold for hospital admission. This issue featured prominently in the report of an earlier inquiry *The Falling Shadow: Blom-Cooper et al (1995)* in which it was argued forcibly that psychotic symptoms do not need to 'ripen' before s3 of the Mental Health Act 1983 could be implemented. The authors concluded the statute allows patients who become non-compliant with treatment to be detained, purely on the basis of anticipated relapse. The decision whether or not to detain an *individual* patient in such circumstances was to be determined by clinical assessment. Commenting on these conclusions in a discussion paper dated June 1998, The Mental Health Act Commission was more cautious and observed:

"....the group accepts that early intervention following a withdrawal from treatment is often desirable. However, it also accepts that such an approach carried its own peculiar risks, in that the patient may refuse further contact with the psychiatric services once that admission is over. ..... All that can be done is to balance the competing risks as judiciously as possible in the knowledge that the decision will necessarily be based on an incomplete knowledge of all those factors which may affect the outcome.

....each case turns upon its own facts; that psychiatrists must act on evidence, not hunch or suspicion; that, in the absence of a very clear pattern of relapse, waiting to see whether psychotic symptoms emerge may be the only possible approach.

..... Although, in exceptional cases, the admission criteria may be satisfied even though the patient is virtually asymptomatic, the "unsoundness of mind" whose presence is essential to justify a compulsory order, manifestly means more than mental illness which qualifies a person to be a voluntary patient.....

In offering an opinion on whether a patient may lawfully be admitted to hospital under Part II despite the absence of any signs of mental disorder, the Commission's Legal and Ethics Special Interest Group offered (among others) the following opinions:

a) *A person who has suffered from schizophrenia, mania or depression and whose symptoms are merely controlled by medication still suffers from mental illness specifically and mental disorder generally. Furthermore, the fact that a person is in remission, and there are no longer any symptoms or signs of mental disorder, is not proof that the underlying disorder is not of a severe nature.*

b) *The nature of a person's disorder is revealed by its history and, if the historical evidence is particularly compelling, the law would permit early intervention. Nevertheless, the right to liberty is highly prized by English law.....*

c) *it is probably the case that there must be some evidence that the patient's mental health has begun to deteriorate....Only if there is evidence of the continuing existence of a disorder which has this nature, and which is developing along its natural course, could one be justified in concluding that future events will follow the previous pattern if not checked, so that deprivation of liberty is justified.*

The cogency of the first of these conclusions was reinforced in the High Court case of ***R v Mental Health Review Tribunal for South Thames Region ex parte Smith (Anthony David) QBD 4th August 1998*** in which a decision in favour of continuing detention for his own health and safety, or for the protection of others, was upheld on the grounds that the nature, albeit not the current degree, of his chronic illness sufficed.

7.3 The panel considered that Richard Allott came within the framework of statutory requirements for compulsory admission of relapsing patients, at least by the time he voluntarily discontinued his lithium therapy. In reaching this conclusion, we did not seek to imply negligence in the legal sense to any health professional for failing to arrange compulsory admission. The Mental Health Act 1983 is phrased in discretionary terms and reasons for the exercise of that discretion were provided to us, particularly in relation to Richard Allott's consultation with his General Practitioner on May 11th. We

were more concerned by the lack of any planned means for early detection of Richard Allott's deteriorating mental health and the failure of carefully considered emergency systems to operate effectively. The fact that the most critical point of the relapse (before the lethal journey) occurred during weekday working hours, only adds to the sense of frustration and disappointment.

CHAPTER 8 - CONCLUSIONS AND RECOMMENDATIONS

The ***FINDINGS*** of the panel were that

1. Richard Allott suffered from very severe relapsing/remitting mental illness, first manifest in late adolescence and first presenting to the mental health services in 1972.

2. After about a decade of turbulence, Richard Allott's illness was maintained successfully in remission, primarily by the long-term administration of the mood-stabiliser, lithium.

3. His apparent well-being was such that follow-up by any of the specialist services terminated before the advent of the Care Programme Approach.

4. The transfer of responsibility from secondary to primary care occurred without a clearly defined hand-over or agreement as to the requirements for future supervision.

5. The lack of a unified and comprehensive set of case notes, available at any secondary care location, limited opportunities for swift and accurate appraisal of past history;

6. Supervision in the community of both the illness and its treatment was compromised by frequent changes of General Practitioner which, in the absence of an agreed plan, led to inconsistencies of management and failure to establish an effective or long-term therapeutic relationship with any one health care professional.

7. Richard Allott's mental illness began to relapse in the early months of 1998 and accelerated rapidly during April. Voluntary cessation of lithium at or about this time was symptomatic of, and may have exacerbated the relapse, but did not cause it. There was nothing to suggest a causal role for either excess alcohol or illicit drugs.

8. Hostility, aggression and damage, to property if not persons, were manifest in previous episodes of illness and, although the precise nature and consequences of events could

not have been predicted, Richard Allott fulfilled the criteria for detention in accordance with the provisions of the Mental Health Act during the 5-6 days before May 11th 1988. He should have been subject to a formal Mental Health Act assessment which might, although not necessarily would, have interrupted the subsequent course of events.

9. An opportunity for effective crisis intervention on the morning of May 11th 1998, during normal working hours and on a weekday, failed through a combination of opposition by Richard Allott, rapid fluctuation in his mental state, and organisational systems which limited the availability of procedures to emergency personnel.

10. Undue reliance was placed by professional staff upon the presumed specialist knowledge of his carer, a counsellor who was unaware of all the potential implications of Richard Allott's relapsing illness or the means of securing urgent assessment.

Based upon these findings, the ***CONCLUSIONS*** of the panel are that

11. Current provisions for the management of patients with chronic severe mental illness, maintained in prolonged remission by anti-psychotic medication and under the sole care of a General Practitioner, are inadequate.

12. Local implementation of statutory provisions and health service guidelines is good overall but flawed by lack of sufficient dissemination of knowledge, especially of emergency procedures, to both professional personnel (particularly within the police and ambulance services) and to the lay public.

As a consequence of these conclusions, the panel ***RECOMMENDS*** that

13. The Health Authority should instruct General Practitioners to create a register of patients with severe and enduring mental illness such as mania and schizophrenia who are no longer in direct contact with the specialist mental health services. Such a recommendation is anticipated in the *National Service Framework for Mental Health.* Registration would promote both the well-being of patients and public safety.

Nevertheless, the system should be discreet and recognise the residual perception of 'stigma' attached to involvement with mental health services. Its purpose would be

(a) to ensure that patients had reliable access to a source of professional support,

(b) they, their carers and General Practitioners agreed a management policy and

(c) knew what to do in the event of a mental health crisis.

14. The Health Authority should liaise with Primary Care Groups and the Local Medical Committee to establish a protocol which ensures that when such a patient moves within or between health districts, the new General Practitioner receives written notification of the illness and its registration directly from his predecessor. The Health Authority should approach relevant bodies to promote this recommendation on a national basis.

15. The Trust and Health Authority should agree guidelines for ensuring ***regular*** contact is maintained with non-compliant or unco-operative patients by whatever measures are deemed appropriate in individual circumstances.

16. The Trust and Health Authority should agree guidelines for the proper monitoring of patients on long-term lithium treatment and clarify where responsibility lies for their implementation when care is transferred between primary and secondary services.

17. The Warwickshire Safer Communities Chief Officers Group should ensure inter-agency training on mental illness includes police and ambulance personnel. Social Services, Police and the Ambulance Service should co-operate to provide staff likely to come into contact with acutely disturbed and, particularly, unco-operative patients, with clear written guidelines for securing assessment by an approved social worker.

18. The Trust should ensure that all staff providing services to the mentally ill have ready access to a single, comprehensive patient record. Current developments promoting such access should be given a high priority. Documentation required for the Care Programme Approach should be accessible, without loss of confidentiality, by general practitioners and relevant staff from Social Services.