STRICT EMBARGO

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Report of the Independent Inquiry into the care and treatment of Shane David Bath

A report commissioned by
Dorset Health Authority and
Bournemouth Social Services and
Dorset Social Services

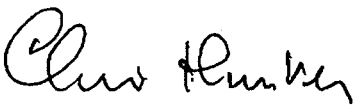
Published June 2000

Preface

We were commissioned in September 1998 by Dorset Health Authority, Dorset County Council Social Services and Bournemouth Borough Council Social Services Directorate to undertake this Inquiry into the circumstances surrounding the treatment and care of Mr Shane Bath.

We have now completed our report.

ASWINI WEERERATNE
Barrister



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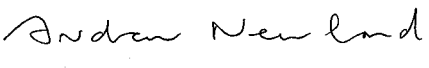

ANDREW NEWLAND
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Abbreviations

ASW	-	Approved Social Worker
CADAS	-	Community Alcohol and Drug Service (West Dorset)
CFT	-	Community Forensic Team (East Dorset)
CMHT	-	Community Mental Health Team
CPA	-	Care Programme Approach
CPN	-	Community Psychiatric Nurse
DHA	-	Dorset Health Authority
DSS	-	Dorset Social Services pre-1997
ECT	-	Electro-Convulsive Therapy
MDO	-	Mentally Disordered Offender
MenDOS	-	Mentally Disordered Offenders Scheme (West Dorset)
MHA	-	Mental Health Act 1983
MHRT	-	Mental Health Review Tribunal
MHSW	-	Mental Health Social Worker
RMO	-	Responsible Medical Officer
RSU	-	Regional Secure Unit

Chapter 1

THE INQUIRY PROCESS

- Setting up of the Inquiry
- Approach
- Documentation
- Procedure
- Family
- Administration

A. The Inquiry

1.1 This Inquiry was set up jointly by Dorset Health Authority, Dorset County Council Social Services and Bournemouth Borough Council Social Services under NHS Executive Guidance (HSG(94)27) entitled 'Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community' following Shane Bath's plea of guilty to the murder of Ayse Sullivan and his sentence to life imprisonment on 14 May 1998.

1.2 Mr Bath was in the care of Dorset Social Services and then Dorset mental health services for much of his life and until 1997. There is a chronology at Appendix A. This Inquiry's role has been to investigate the care and treatment he received from those services during this time. The Inquiry's Terms of Reference are reproduced at Appendix B.

1.3 Membership of the panel was finalised in September 1998 and comprised Ms Aswini Weereratne, Barrister (Chair), Dr Chris Hunter, Consultant Forensic Psychiatrist and Clinical Director of the Caswell Clinic, South Wales and Mr Andrew Newland, Mental Health Services Consultant and former Social Services Manager.

B. Approach

1.4 The Inquiry Panel are only too aware that this is now one of numerous other such independent inquiries and have been anxious to avoid unduly repeating findings or recommendations previously made.

1.5 We are also aware of the stress that can be experienced by individuals and agencies while an Inquiry is under way and the perception of a 'climate of blame' which is aroused.

1.6 We do not think that attaching 'blame' or finding 'scapegoats' is a positive way forward after tragedies such as these have happened, but one or two of those who gave evidence to the Inquiry felt that this has been the function of Inquiries thus far. We have found that it is difficult to adopt an approach or procedure which removes this altogether. In finalising our report, however, we have tried to be constructive in our criticisms and it has not been our mission to find individuals to blame.

1.7 In compiling this report we have, however, been guided by the question of whether Ms Sullivan's death was preventable. This is an inescapable role of an Inquiry which is set up following a homicide. Whilst this is inevitably stressful for all concerned, it is nonetheless necessary to examine the accountability of services and professionals in the delivery of services when things may have gone wrong. This is an exercise which should lead to the development of improved services.

1.8 We are also only too aware that some tragic incidents are unavoidable and we do not wish to perpetuate a culture which thinks otherwise. As a society we must learn to understand that such incidents will sometimes happen and it is not necessary or productive to find someone to blame as long as lessons are learnt along the way.

1.9 We have approached this Inquiry from the point of view that psychiatric diagnoses and risk assessments, particularly in relation to a personality disordered person are not exact sciences. There is much room for errors of judgement. It is now a truism that no human being or group of human beings can ever with full confidence predict the future behaviour of another human being.

1.10 Although mental health professionals must be accountable for good practice, they cannot ultimately be expected to carry responsibility for the actions of their patients. There is a limit to the control and influence which it is possible for them to achieve over any individual. It would be wrong to overlook the personal responsibility which a person, even one who is mentally disordered, carries for his or her actions, except in the rarest circumstances, for example, those with profound learning disability or dementia, which does not include Mr Bath.

1.11 The events relating to Mr Bath's treatment and care within the adult services span a period of 10 years and prior to that he had been in local authority care from the age of 10, a total of 20 years. We have tried hard to make judgements and form opinions without the benefit of hindsight and to consider the standards of practice that would have prevailed at the relevant time.

1.12 In providing recommendations we have been conscious that our analysis of the services in Dorset is based only on the care received by Mr Bath. However, we attempted to test through our questioning of witnesses the wider attitudes and practices prevalent over time in the services for individuals like Mr Bath, suffering from mental disorder, including personality disorder and substance misuse.

1.13 The recommendations are directed to both NHS Trusts involved in the care of Mr Bath even though he had significantly more contact with Dorset Healthcare NHS Trust in the East of the county. We felt that this was a reasonable approach, encouraging a uniformity of approach even if the criticism from which the recommendation flows relates only to one of the Trusts.

1.14 We initially attempted to focus on the last two years prior to the killing, but soon discovered that there were key events throughout his history which required investigation in order to make sense of the final picture. We concluded that it was vital to tell the whole story in some detail and having done so are reassured that this was the best way to convey an overall impression of the type of person Mr Bath is, the problems and needs he presented with over time and the responses of the services. This is a complex story and in chapter 25 we summarise those episodes which we consider to have been important when considering the final tragic outcome.

C. Remit

1.15 There are times when Mr Bath's contact with services crosses the boundary with another county. This occurs, for instance, when he was in Southampton, Devon and London. We have described those events and taken evidence where relevant, but have taken the view we were not entitled to make any formal recommendations with regard to the services offered.

1.16 Where we consider issues of national significance arise we have taken the liberty of directing a recommendation to the appropriate government department.

1.17 In addition we have specifically not taken any evidence from services involved with Ayse Sullivan, save for one social worker with the London Borough of Southwark, due to her contact with Ms Sullivan shortly before her death. In not being able to investigate this side of the story, however, we do feel that the picture we paint is incomplete. Ayse Sullivan was a vulnerable teenager who had recently left local authority care. In focusing entirely on the care of Mr Bath the precise role of those other authorities and agencies involved in the care of Ayse Sullivan, whose actions may or may not have made a difference to the tragic outcome, is omitted.

D. Documentation

1.18 Mr Bath consented to our having the use of his medical, social services and other records. Much of this had been gathered with little difficulty by the time that the Inquiry panel first met in September 1998. The process of gathering information, however, remained an ongoing one throughout the period leading up to and including the hearings themselves.

1.19 The documents which we did not have immediately available to us included those social services records which related to his time in local authority care, prison records and information held by the police. As a non-statutory inquiry with no power to summons witnesses or to order the production of documents, we had to rely on the combined persuasiveness of members of the panel and the administrative team, to obtain some very necessary material. This added to the time taken to prepare and complete this Inquiry.

1.20 As for the child care records we were given access to Mr Bath's file on micro-fiche and obtained copies of records which were deemed relevant by Mr Newland after he had painstakingly reviewed them. We did also get some social services court reports for this time, but not any psychiatric evaluations or child guidance notes.

1.21 We encountered little difficulty in obtaining the information we requested from Dorset Police.

1.22 The prison records, including health records, proved much more difficult to obtain for reasons of both bureaucracy and poor filing practices. We were told that in this context Mr Bath's consent covered access to his prison health records only.

1.23 There is a greater difficulty with the prison inmates' records. These are the property of the Home Office and subject to public interest immunity and Mr Bath's consent was invalid for the purposes of obtaining them. They were relevant to our deliberations because we wanted to know how Mr Bath behaved when he was in a more structured prison setting as opposed to in hospital or the community.

1.24 Once a request had been made for the records and it had been made clear that no documentation relating to security arrangements was being sought, we were told that a decision would be made as to how much of the remaining material would be disclosed to us based on legal advice.

1.25 However, obtaining any documentation was far from straightforward as each time a prisoner enters prison he is given a fresh prison number and there is no centrally held record of all prison numbers issued.

1.26 We are grateful for the assistance of Mr A H Chapman from the Dispersals Unit of the Prison Service who tackled the problem of locating the records for us.

1.27 In the end we were provided with documents relating only to two terms of imprisonment and no periods on remand: 12 months for burglary in May 1995 and 12 weeks in September 1997 for assault on a police constable.

1.28 It is important that an Inquiry has access to all relevant documents to make it a meaningful process. That prison records may become necessary is only to be expected and we would like to see quicker access to this material and to that end a procedure should be established by the Home Office and Prison Service for the use of inquiries.

1.29 We would like to acknowledge the assistance which we received in this regard from the Governor of HMP Belmarsh and Mr Glyn Jones at the Home Office.

E. Procedure

1.30 The procedure adopted is set out at Appendix C. We were guided by principles of fairness and equality of treatment for all witnesses. We borrowed heavily from the published procedures of previous independent inquiries and acknowledge our indebtedness to them.

1.31 Following the preparation of a detailed chronology, over 100 witnesses of fact were written to initially and asked for a written account of their contact with Mr Bath. Where possible, comment on issues which were thought to be particularly relevant to any witness was specifically sought. Of these, 34 were invited to give oral evidence to the Inquiry Panel. Some of those from whom the Panel would have liked to hear evidence proved to be uncontactable and in those circumstances we have had to rely on the written records only. We have indicated when this approach was adopted at the relevant point in the text of the report.

1.32 We also obtained the written input of 11 experts in various fields. We called three of them to provide oral evidence. Finally, evidence was taken from various managers of the sponsoring authorities, seven of whom attended hearings.

1.33 A list of all witnesses who gave oral evidence or provided written statements is at Appendix D. We would like to thank all those who responded for their patience and co-operation and we appreciate that they have been under some strain pending the publication of this report. We would like to reassure all those concerned that despite the volume of material and the breadth of issues arising, we have produced our report as quickly as possible.

1.34 Hearings were held on various dates between January and March 1999 at the Trouville Hotel in Bournemouth. We tried to keep these as informal as possible and witnesses were given every opportunity to tell us all that they wanted to. A daily transcript of the hearings was produced by Harry Counsel Ltd and our thanks go out to them for their hard work. We would also like to thank the staff and management of that hotel for their considerate handling of our needs.

F. Family

1.35 Members of the Sullivan family were seen less formally by the Chair and Inquiry Co-ordinator. They were eager to be involved and were very helpful. Family representatives were also invited to give evidence to the Inquiry more formally if they wished. This did not prove to be possible.

1.36 The only member of the Bath family to speak to the Inquiry was Mrs Bath and she provided us with invaluable background information.

G. Shane Bath

1.37 The Inquiry Panel interviewed Mr Bath at Belmarsh Prison in November 1998.

H. Administration

1.38 The Inquiry Panel is very grateful to Miss Jean Harvey, who having recently retired from Dorset Health Authority, gave up her valuable and busy time to administer this Inquiry as its Co-ordinator. We would also like to thank Giselle Thornton who was seconded from the Authority to offer secretarial assistance to Miss Harvey. They were both tireless in the performance of their tasks and having been assured that this was a part-time undertaking were generous with their time when it turned out to be the complete opposite.

1.39 We cannot emphasise how much intensive work is required in managing and co-ordinating an inquiry, particularly in the early days when documents have to be gathered and witnesses located and written to. It is a job which ideally benefits from a dedicated manager who can offer a complete and independent service. This is also likely to mean a speedier and more cost-effective inquiry process.

1.40 We should like to thank Karen Walton, a junior barrister, for all her energetic efforts in assisting the Inquiry. In particular, she acted as a ready point of contact for witnesses and liaised with the Prison Service and Home Office over the production of the prison records.

1.41 Additionally, our thanks go to Genevra Richardson who was initially appointed to chair this Inquiry and who had laid the groundwork for it prior to being appointed to chair the expert committee appointed to review the Mental Health Act by the Department of Health.

Chapter 2

THE SERVICES

A. Introduction

2.1 This chapter is intended to provide a brief review of the services in Dorset with which Mr Bath had contact and subsequent changes in the services are noted where possible. It is not exhaustive of all services available in Dorset. The map at Appendix E shows the main locations referred to.

2.2 Mr Bath was mainly in contact with services in Dorset although he also presented himself to agencies in Wiltshire, Hampshire, Devon, Sussex and London. He used services frequently and intensively. As well as mental health services he came into contact with, or made demands upon, general hospital services, general practitioners, social services departments, voluntary organisations, local authority housing services, probation services, police forces, the courts and prisons.

2.3 Mr Bath was admitted to four psychiatric hospitals, two in Dorset, one in Wiltshire and one in Hampshire. He was admitted to these hospitals about 32 times over a 10-year period. He was also admitted to general hospitals covering this region. There was extensive contact with an alcohol and drug advisory agency in West Dorset and two services for mentally disordered offenders.

2.4 Approximately 80 per cent of Mr Bath's admissions to psychiatric hospitals were to hospitals in Dorset. Of these, 85 per cent were to St Ann's Hospital, Poole and the other 15 per cent to Forston Clinic, Dorchester.

2.5 Mr Bath had frequent admissions to general hospitals for treatment arising from self-harm episodes. He also sought assistance from general hospitals for occasional physical health problems. He often used (and changed) general practitioners.

B. The Health Services

Dorset Health Authority

2.6 Dorset Health Authority (DHA) covers the whole county of Dorset, from Lyme Regis in the west to Christchurch in the east to Sherborne and Shaftesbury in the north. The county has a population of approximately 690,000 people.

2.7 The DHA is responsible for commissioning mental health and other health services from NHS Trusts throughout Dorset. The total mental health services budget in 1997/98 was £30,500,000 which was approximately 10 per cent of the total health budget for that year. We have been told that this represents average expenditure nationally. There are two NHS Trusts responsible for providing mental health services: Dorset Healthcare NHS Trust and Dorset Community NHS Trust.

2.8 Prior to 1994 there were two health authorities in Dorset: East and West. They merged to form the Dorset Health Commission which then became the DHA in 1997.

Dorset HealthCare NHS Trust (East Dorset)

2.9 The Dorset HealthCare NHS Trust provides mental health services to the mainly urban population of east Dorset. The area covered includes Bournemouth, Poole, Wimborne, Ferndown and the Isle of Purbeck.

• St Ann's Hospital

2.10 St Ann's Hospital in Poole has 94 general acute beds for adults below the age of 65. In addition the hospital has a low secure facility known as Studland Ward.

2.11 Mr Bath was admitted to St Ann's most often and was mainly under the care of consultant psychiatrist, Dr Martyn Rowton-Lee who had responsibility for Merley and Studland Wards. Dr Hashim Mohammed, associate specialist covering these wards, also saw him frequently while he was an in-patient there. At other times he was the responsibility of consultant psychiatrist Dr Nas Choudry, addictions specialist, who covered Branksome and Flaghead Wards.

2.12 Studland Ward was opened as an intensive care facility in 1993 with six beds. It has had 12 beds since early 1998.

• Community Mental Health Teams (CMHTs) in East Dorset

2.13 There are now nine multidisciplinary and joint agency community mental health teams covering Wimborne, Christchurch, Bournemouth, Poole, Purbeck and Ferndown. Eight teams were introduced by April 1995 and include consultant psychiatrists, junior medical staff, community psychiatric nurses (CPNs), community occupational therapists and social workers. In addition there is input into each team from psychology services. Each team operates within agreed geographical boundaries and relates to specific general practices. There are intended to be links with wards at St Ann's.

2.14 Wimborne CMHT was managed by a single manager jointly appointed by the Trust and Social Services. Since December 1999, a joint manager has been appointed for health and social care staff within the Christchurch, Wimborne and Purbeck CMHTs.

• The Community Forensic Team (CFT)

2.15 The plan for a multidisciplinary Community Forensic Team was conceived in 1991 and was up and running by 1993. Dorset Social Services became involved with it in 1996. It provides assessment and treatment for mentally disordered offenders (MDOs) and aims to minimise the risk of re-offending.

2.16 The team is based at St Ann's. At the relevant time it was led by Dr Grace Leung, consultant clinical psychologist, and currently has 10 members of staff. The team comprises assistant psychologists, nurses, social workers and probation officers. The team has no dedicated medical staff time although Dr Rowton-Lee acts as an advisory consultant to the project.

2.17 There is no formal link with any particular ward at St Ann's although we are advised that such an arrangement is being planned with Studland Ward. There is a link with Dorset Lodge and Creek House, probation hostels provided by the Bournemouth Churches Housing Association and with Home Office and Social Services funding. (See chapter 29 for more on the CFT).

Dorset Community NHS Trust (West Dorset)

2.18 The Dorset Community NHS Trust provides mental health services in the rural west of Dorset going east as far as the Blandford and Shaftesbury areas. There are six consultant psychiatrists covering the area across two hospital sites, two sub-acute units and six CMHTs. There is no equivalent to Studland Ward of St Ann's Hospital and the MDO service is less well developed.

- **Forston Clinic**

2.19 The central admission unit is at Forston Clinic in Dorchester which had 34 acute beds for adults. Forston Clinic had 12 beds within the 34 acute beds (now increasing to 16) which can be used for intensive care purposes depending on demand. Mr Bath was seen here by Dr Graham Gallimore and Dr Duncan Veasey, consultant psychiatrists.

- **Blackdown Hospital**

2.20 There were another 11 acute beds at Blackdown Hospital in Weymouth which also has a day hospital facility. This has been replaced by the Linden Unit.

- **Community Mental Health Teams in West Dorset**

2.21 There are five CMHTs (covering Dorchester/Sherborne, Bridport, Blandford, Gillingham/Shaftesbury, Weymouth and Portland). Dorset Social Services has told us that the teams have been jointly managed by Nurse Team Leaders and Social Services Team Leaders from the outset. Dorset Community NHS Trust has told us that all of these teams are co-ordinated by a single manager on a day to day basis, however, the locality team leader is appointed by health services and is not jointly appointed. Social Services has its own management structure above the social workers working within the teams, however, the approach to delivery of care is said to be fully integrated and jointly provided. These were set up in 1988.

- **Mentally Disordered Offenders Scheme (MenDOS)**

2.22 This offers an assessment and short-term treatment service for mentally disordered offenders. It was staffed by one full-time community psychiatric nurse and since May 1997 also by a full-time social worker (senior practioner). The service also has a part-time clinical psychologist.

- **Community Alcohol and Drugs Advisory Service (CADAS)**

2.23 This is based in Dorchester. It provides a comprehensive assessment, counselling and treatment service for people with alcohol or drugs problems across the west of Dorset. In 1999 it had seven CPNs, 2.5 social worker posts and a probation officer. There is no medical attachment to the team.

2.24 In addition to the Dorchester office there are units based in Weymouth and Bridport. Use is made of Dorset Drugs and Alcohol Advisory Service (DDAAS) premises in Blandford and of the 'bungalow' at the Social Services office in Gillingham. It started in 1986.

2.25 There is also the DDAAS, which is now a separate organisation staffed by volunteers which is funded partly by the health authority and partly by Social Services.

General Practitioners

2.26 Mr Bath changed his GP often. It has not been possible to give an estimate of how many GPs he was registered with over the period from 1987 to 1997, often he was not registered with any. At various times it is known that he had contact with GPs in Bournemouth, Weymouth, Blandford, Shaftesbury, Southampton and Exeter. We have not been able to find out whether he had any contact with a GP while resident in London.

General hospital services

2.27 He presented on at least 17 occasions to Accident and Emergency units in Bournemouth, Poole, Weymouth, Salisbury, Southampton and London with self-harm episodes. He also used general hospital services for assistance with physical health problems such as psoriasis and bronchial difficulties.

Regional Secure Unit (RSU)

2.28 Regional secure services are provided at Ravenswood House, Knowle Hospital, Fareham, Hampshire. Mr Bath was assessed by a consultant psychiatrist from this unit on one occasion in 1993.

C. The Social Services

Dorset Social Services

2.29 Until 1 April 1997, Dorset County Council provided social services to the whole of Dorset (i.e. an area co-terminous with the Health Authority). As a consequence of the local government review two years earlier Dorset was split into three local authorities-Bournemouth, Poole and Dorset County Council, which covers the rest of Dorset and is mainly rural with about half its previous population, the largest town being Weymouth.

2.30 Mr Bath's contact with Social Services across Dorset was almost entirely pre-April 1997 therefore it is the 'old' Dorset Social Services with which we are concerned in this report. All references to Dorset Social Services (DSS) are to Dorset County Council.

Contact with Dorset Social Services

2.31 Dorset social workers have been visiting the Bath family since before Mrs Bath first had children. Shane Bath was in care from 1979 until 1986. During this time he had three social workers. This was his first prolonged period of contact with Social Services.

2.32 After leaving care his contact with Dorset Social Services was sporadic although there were two periods of sustained contact-from February to April 1995 and for six weeks from late February to the beginning of April 1997. Otherwise Mr Bath made frequent one-off demands on social workers for help with social security benefits, housing benefits, requests for accommodation and attendance of an appropriate adult at police stations.

Social Services expenditure

2.33 The three Social Services departments in Dorset together plan to spend just over £7,600,000 in 1999/2000 on adult mental health services. Average expenditure as a percentage of total budget is about 6.5 per cent across the three departments. We understand that this is within the average range of expenditure nationally.

Devon Social Services

2.34 In March 1997 St Petroc's Day Centre in Exeter referred Mr Bath to the local CMHT where he was seen by a duty worker. He was referred to a social worker in the CMHT who worked with him over the next four months. Ms Ayse Sullivan was in the care of Devon County Council before moving to London.

Southwark Social Services

2.35 Devon Social Services referred Ms Sullivan to Southwark Social Services in September 1997 as a care-leaver entitled to services under the Children Act 1989 so that an assessment could be carried out of her needs. At that time she was living with Mr Bath. A social worker was allocated to the case in October. She visited

Ms Sullivan at the end of October and in November. She met Mr Bath on two occasions but did not have any responsibility for his care.

D. Criminal Justice Agencies

The police

2.36 Mr Bath frequently brought himself to the attention of the police and the police frequently had cause to interview him about offences, including offences (of which he was later convicted) of theft, robbery, assault, arson, failing to surrender to custody, burglary, forgery, obtaining property by deception, criminal damage, breaches of probation or community service orders and carrying a loaded air weapon in a public place.

2.37 He was detained under section 136 of the Mental Health Act 1983 twice as far as we are aware. At other times he would attack the police or behave in a very reckless and aggressive manner when interviewed by the police and give them cause to arrest him.

2.38 Most of his contact was with the police in Dorset although he was arrested by Sussex Police in Eastbourne in August 1997.

The courts

2.39 Mr Bath appeared before juvenile courts in Bournemouth, Totton and Hythe and magistrates' courts in Bournemouth, Poole, Weymouth, Dorchester, Gillingham and Southampton. He also went before Crown Courts in Bournemouth and Dorchester. Finally, he appeared at the Central Criminal Court in 1997 charged with Ms Sullivan's murder. All together between 1979 and 1997 he appeared 20 times for sentence and was convicted of 53 offences.

Prisons

2.40 Mr Bath served sentences of imprisonment in youth custody centres or prisons in Dorchester, Channing's Wood near Newton Abbot, Devon, Dartmoor and Guy's Marsh near Shaftesbury and finally at Belmarsh Prison, London. He also had periods of remand in Dorchester, Exeter and Winchester Prisons.

2.41 While in prison he was frequently referred to, their health services. These services were (and are) provided by the prison rather than by the National Health Service.

Probation Service

2.42 Mr Bath was often subject to statutory or voluntary supervision by probation officers. He was supervised by at least 12 probation officers over the period 1988 to 1997. Dorset had by far the most contact but Hampshire Probation Service had involvement with him too.

2.43 He was accommodated at Dorset Probation Service hostels: Weston Hostel, Creek House, part of Dorset Lodge, and Dorset Lodge. The latter two are also linked to the CFT.

E. Voluntary Organisations

2.44 While in care as a child, Mr Bath spent periods in two homes provided by the Church of England Children's Society: Hawkslease and St Katherine's.

2.45 Michael's Night Shelter is an independent non-denominational charity which was set up by members of local churches and caring organisations to provide for the needs of single homeless men and women in South East Dorset. Since 1999 it has had its own Board, and a management arrangement with East Dorset Housing Association.

2.46 Mr. Bath presented himself to WAVES in February 1997, a voluntary organisation in Weymouth run by The Children's Society which advises young people who have 'no fixed abode'. WAVES assessed him as an emergency and linked with Social Services (CMHT) locally over his problems with accommodation and benefits.

2.47 In March 1997, Mr Bath went to Exeter where he made contact with a day centre for homeless people at St Petroc's, a registered charity run under the auspices of the Exeter Community Umbrella Ltd. From here he was referred on to Palace Gate Hostel, a 35-bedded direct access hostel for men managed by the Exeter Shilhay Community. He stayed here for periods of three days, five weeks and two days before moving to London.

F. Housing

2.48 Between 1988 and 1997 Mr Bath at various times lived with his half-brothers or sister or lived in bed-sits and flats which he found himself. At other times he was homeless and slept rough or he stayed at hostels for homeless people. He often stayed with his mother, sometimes while she was in sheltered accommodation. He was occasionally placed in hostels by the probation service and once by Social Services in private sheltered accommodation (sympathetic landlady) for people with mental disorder.

2.49 On several occasions he brought himself to the notice of a local housing authority, North Dorset District Council and then Signpost Housing Association, although he did not apply for housing or present himself formally as vulnerable and homeless to that or any other housing authority.

Chapter 3

THE SULLIVAN FAMILY: AYSE

A. Introduction

3.1 In putting together some background information about Ayse Sullivan and the events leading up to her death, we have been greatly assisted by the co-operation of members of her family, and in particular, Mrs Eileen Sullivan, her mother and her brother, Erjan, and sisters Suzanne Martin and Rebecca Townsend, who have been eager to participate in the inquiry process. This is not intended to be an exhaustive history of Ms Sullivan's life or of the Sullivan family.

3.2 We appreciate and acknowledge that this must have been and still is a difficult time for the family in coming to terms with the death of a daughter and a sister. We are also aware that there are other members of the family who have been too affected by her death to be able to speak to us directly and, in the circumstances, this is completely understandable. We feel that their views have been represented to us by those members of the family whom we have seen.

B. Ayse Sullivan

3.3 Ayse Sullivan was born on 8 November 1979 and was killed by Shane Bath on 23 November 1997. She had recently turned 18 and both of them had attended a party for her birthday in Devon where her mother lives. She was his girlfriend and they had met in Exeter earlier that year. We have been unable to ascertain precisely when they met and have heard various dates ranging from late February to the end of April 1997. At the time of her death they were living together in a flat in Marden Square, London SE 16, which had been arranged for her by Southwark Social Services.

3.4 We do not have any information about her schooling. Photographs show her to be slight in build and we were told that she was of strong character, spirited and quick, much like her sisters. We have the impression that she was a likeable young woman with a supportive family network.

3.5 Ms Sullivan's parents were divorced and she had little contact with her father until she was about 14 and her mother moved down to Devon from Southwark in London. We have no further detail of this contact. She was the youngest of six children. In 1994, at the age of 15 she was fostered out by Devon Social Services to her older sister Mrs Townsend who remained in London, and Ms Sullivan went to live with her in Rotherhithe, Southwark. Mrs Townsend demonstrated a conscientious and caring attitude towards her sister.

3.6 In 1996 Ms Sullivan moved back to Devon and although she stayed with her sister Michelle at times, she was accommodated in the early part of 1997 by social services in a hostel in Exeter for those preparing to leave care. It was planned that she would move back to London. We were told that Mr Bath was then and at the time that they met, living at another hostel in Exeter.

3.7 In about May 1997 Ms Sullivan made a trip to London to sort out her housing. She left Mr Bath in Exeter looking after her pet rat, Cain. She was due to move into her flat in London on about 24 June. Mrs Sullivan recalls meeting Mr Bath in the London flat in about July. There was no furniture in it and he said that he was waiting for a delivery the next day and that the social workers were arranging it. Other accounts state that she moved into the flat in August.

3.8 Ms Sullivan was seen by the Southwark Social Services Leaving Care Team after she moved to London and was last seen by them on 19 November 1997. We deal with this episode later (chapter 23).

C. Shane Bath and the Sullivan Family

3.9 Mrs Sullivan told us that when first introduced to Mr Bath he told her that his mother lived in Australia and had recently died of cancer. We know this to be untrue, but she had no reason to disbelieve him at the time. On occasion she said that he would contradict himself, for example, he said initially that he had no children, but later said that he had a daughter called Dawn aged 9. Again, we know that he has a daughter called Charmaine who we believe is about 9 years old but with whom he has had no contact since she was a baby.

3.10 Mr Bath was generally disliked by the Sullivan family and particularly by Ms Sullivan's brothers and sisters who advised her to leave him. They considered that he was too old to be having a relationship with their sister. He seemed shifty and made no eye contact. When Suzanne Martin first met him he said to her 'I know you don't like me but I love your sister'.

D. The Relationship Between Shane Bath and Ayse Sullivan

3.11 Mr Bath and Ms Sullivan are known to have had heated arguments. It is also known that he hit her on more than one occasion prior to 23 November. There are also accounts of their genuine fondness for each other. At her birthday party he publicly proposed marriage to her. Her nickname for him was 'cornflake' a reference to his psoriasis. The family relate that Ms Sullivan did on occasion appear to be frightened of Mr Bath, but she was 'drawn to him like a magnet'. Her brother Darren had 'thumped' Mr Bath once because he had given her a black eye. It is not clear precisely when this took place.

3.12 On 15 August 1997 Ms Sullivan was reported to the Metropolitan Police as a missing person by Darren Sullivan. Most of the family had recently been in Ireland at the funeral of Mrs Sullivan's mother and on their return found that she had disappeared. She was eventually found in Eastbourne later that month. This was following an incident at a hotel in Eastbourne on 20 August to which the police were called after Mr Bath had assaulted Ms Sullivan causing bruising to her face. Ms Sullivan was collected by Mrs Townsend and her brother Darren from the police station and taken back to London.

3.13 Ms Sullivan declined to support a prosecution against him and Mr Bath was arrested and transferred to Poole on an outstanding warrant relating to charges arising in September 1996. He was sentenced to 12 weeks imprisonment on 15 September 1997 in relation to these matters and released on about 26 September, once his time in custody on remand had been taken into account (chapters 21 and 22).

3.14 Concern was expressed by Ms Sulllivan's family that Mr Bath's return to Marden Square was supported by the probation service and heralded by a letter from them to Ms Sullivan. Due to the length of the sentence there was no probation involvement with Mr Bath on his release and we have been unable to trace a copy of any letter from that service to Ms Sullivan. We believe that Mr Bath's solicitor may have written to Ms Sullivan, on Mr Bath's instruction, informing her of the date of his release. There can be no criticism of him for doing so.

3.15 The family tried to persuade Ms Sullivan not to resume her relationship with Mr Bath after this assault.

3.16 In early November 1997 when Ms Sullivan went to Devon for her birthday she had no marks on her face. She seemed happy otherwise.

E. Contact with Social Services

3.17 It will be apparent from the above that Ms Sullivan was in the care of Devon Social Services and then transferred to Southwark Social Services when she lived with her sister Mrs Townsend. When she was leaving care and had moved to London in June 1997 she was referred back to Southwark Social Services Leaving Care Team by Devon Social Services in September 1997.

3.18 The evidence which we have heard is that none of the agencies involved with Mr Bath in Devon became involved with Ms Sullivan (chapter 20). We did not seek any evidence from Devon Social Services regarding Ms Sullivan as we considered that to be outside our terms of reference. We did take evidence from her appointed social worker in Southwark who saw her in the weeks and days before she was killed and this was primarily because that contact was contiguous with her death.

3.19 Ms Sullivan was still in the care of the local authority when Mr Bath came into her life. As we have been unable to do so, we think that Devon and Southwark Social Services should review their practices in relation to keeping in contact with young people leaving care.

Chapter 4

THE EARLY YEARS

- Deprived and dysfunctional background
- Developmental difficulties
- Sexual abuse
- Early offending
- Remand into care aged 11
- Severe challenging behaviour in care
- Arrangements for leaving care
- Early signs of personality disorder

A. Introduction

4.1 This chapter is intended to offer an insight into Shane Bath's childhood history without, in any way, blaming or finding fault with individual family members. This is an important period in his life and we felt that it was necessary to set it out in some detail. It shows a dysfunctional family dynamic against a backdrop of poverty and hardship. He was taken into local authority care during which time the extent and the depth of his difficulties, many of which were to echo across his adult life, were revealed: his criminality, self-harming behaviours, aggression and violence, lack of remorse about personal harm or damage caused, the intractable management problems he presented to staff and lack of reliability. This set the pattern for more dramatic behaviour over the course of his adult life.

4.2 These were among the early signs of Shane Bath's potential for developing an anti-social personality disorder. There is also information which would have been invaluable to the psychiatric assessments which he underwent as an adult, but which was never accessed by the adult mental health services.

4.3 The information in this chapter was mainly obtained from his family's social services files including social workers' running records and case summaries, six-monthly child care reviews and social workers' reports to juvenile courts. The information available to us was incomplete. No running records were obtainable for the period from his birth until late 1978.

B. The Family: Relationships and Hardship

4.4 Shane David Bath was born in Boscombe Hospital, Bournemouth on 21 March 1968 into the family of Mr and Mrs Ronald Bath. He never knew his real father and discovered that Ronald Bath was not his father when he was a young child. Mrs Bath is his natural mother and also has an older daughter from an earlier relationship who is seven years older than Shane Bath. There were two boys of the Bath marriage (born on 13 August 1966 and 9 May 1969).

4.5 Mr Bath senior was discharged from the army in 1943 as medically unfit and later became partially sighted. He was not able to work for many years and received invalidity benefit. He died in November 1992. Mrs Bath has also suffered from health problems. The records indicate that she always showed her family affection but frequently found it difficult to manage the family finances, control her children or to challenge her husband's aggressive behaviour.

4.6 Shane has described to us and to various psychiatrists how important his mother is to him. She has been the only source of unconditional love for him and he has showed an almost constant affection for her over the years.

4.7 In response to a question about his happiest childhood memory, Shane Bath told us:

'Being close to my mum really. If anything happened to my mum. I cannot cope anyway. I have got a very strong bond because I have got a different dad. My good years I spent with my mum really'.

4.8 In contrast, his relationship with his stepfather was difficult and often characterised by hostility. He felt that not being his father was a difficulty for Ronald Bath and that this led to many disagreements between them. In his evidence he said that his stepfather did not harm him physically although he was violent to his half-brothers. However, Mrs Bath told us that her husband did hit Shane but far less than he hit the other boys and Shane alleged at different times to different professionals that his stepfather hit him.

4.9 There is some evidence that Shane Bath was taunted by his stepfather and his half-brothers about the fact that he was not his real son. This led to strong feelings of rejection for Shane Bath which he would often mention on admission to hospital as an adult. The lack of any proper relationship with his natural father also emerges as a presenting feature of his admissions to hospital. He also alleged that his stepfather had sexually abused him.

4.10 Shane claimed to us that he had been sexually abused by a neighbour from the age of 5 to 11. He also told us that he was sexually abused by his stepfather from the age of 5 to 11. In 1982 (aged 14) while in care he alleged that another boy had tried to have anal sex with him. He later withdrew the allegation.

4.11 It is known that Dorset Social Services (and before that, Bournemouth Children's Department) had been involved with Mrs Bath at least since shortly after the birth of her daughter in 1961 and probably before. Records indicate that the baby was received into care when three years old. There were also concerns about the other two boys, the older of whom was received into care on two occasions early on in his life, later being made subject to a care order. The younger one was made subject to a care order at the same time as Shane.

4.12 The family have always found it difficult to make ends meet. At the time of Shane's birth in March 1968 they were 'homeless' and living in temporary accommodation provided by the local authority. In January 1969 the family moved to permanent local authority accommodation in Bournemouth. Social Services were in very frequent contact with the family throughout the period of his childhood and adolescence.

4.13 A description in the Social Services records for 1980 would seem to represent fairly the general home background over time:

'Home circumstances are poor and deprived of much comfort. The rooms are sparsely furnished with goods provided by various agencies. However, the rooms are kept tidy and reasonably clean, clothes are washed and children turned out tidily for school. The family live on invalidity benefit and children's allowances. They have never been able to budget sufficiently to live on this amount, regularly falling behind with payments and taking on loans which they find expensive and difficult to repay. Little appreciation is shown of the need to use money for necessities of food etc as a priority and a great dependency is built up over the years that agencies and authorities will supply deficiencies'.

COMMENTS

- **Parenting**

4.14 Expert evidence we received concluded that Shane Bath received a destructive mixture of parenting styles. Ronald Bath presented as anti-authority and at times anti-social in his personality. Social Services reports indicate that he was either always aggressive or inconsistently aggressive. Mrs Bath had a limited understanding of what Social Services were attempting to achieve when social workers tried to bring about changes in the family.

- **Sexual abuse**

4.15 We have seen records relating to a police investigation into sexual abuse by a neighbour of the Bath boys and while it must be borne in mind that Shane Bath is an unreliable historian, given his evidence to us and the outcome of that investigation it seems probable that he was sexually abused by this man.

4.16 There is no evidence of any reference to sexual abuse by his stepfather until 1992 (during an interview with a junior doctor at St Ann's) when he claimed that abuse took place between the ages of 2 and 13 years. At other times he has claimed that it took place during a different time frame. Whilst it is always possible that he was sexually abused by his stepfather, we are aware that it could also be the case that this allegation is one of his many attention-seeking confabulations. On balance we conclude he probably was not sexually abused by Ronald Bath.

- **Dysfunctional family**

4.17 Shane Bath was clearly not a 'problem child' within an otherwise functioning family. His difficulties during childhood were arguably not much more severe than those of his siblings.

C. Birth to Age 11

4.18 In April 1968, one month after his birth, Social Services records note that there were concerns about his physical development and that his mother had declined to attend the health clinic.

4.19 In January 1972 (aged 3) there were indications that he had possibly suffered a non-accidental injury (NAI). While 'no evidence of bruising was found' it is also recorded that the Probation Service said that consideration should be given to reception into care. Unfortunately, this statement is not expanded upon.

4.20 No further information is available until April 1975 (aged 7) when the beginning of a period of difficulties with school attendance was noted. Shane also went missing on his way to and from school.

4.21 During May 1975 he was found in a 'dustbin' in a garden near to his home. He also laid in the road 'waiting for a car to run over him'. After these incidents a period of care (on a voluntary basis) was offered to his parents and at first agreed by them. However, while waiting for a place in care his parents withdrew their consent and refused reception into care.

4.22 In September 1975 he was admitted to Poole General Hospital after being injured while lying under a stationary lorry. It is reported that Ronald Bath told him during this time that he was not his real father.

4.23 The next month Social Services convened a case conference in which it was decided that there was not enough evidence to remove Shane from home, that is, to obtain a care order from a court to enable Social Services to take him into care without the parents' consent. During a Social Services-run summer camp it was noted that there was a marked improvement in his health and appearance.

4.24 In August 1976 Shane (aged 8) was reported to have stolen a watch and been involved in an 'attempted arson'. No further details are given. Early next year he was admitted to Poole General Hospital having been knocked down by a car. In February he was questioned by police about damage to a building site. In October 1977 he (aged 9) was the subject of several police referrals regarding thefts and self-reporting when 'lost'.

4.25 He was seen by a child psychiatrist in February 1978. She formed the view that it was best to keep him at home in view of his close relationship with his mother although she was very pessimistic about the outcome.

4.26 In November 1978 he (aged 10) was investigated by the police for allegedly breaking into a lorry. A social worker, Mrs Mildred Cross, made her first (introductory) visit to the home.

4.27 He was cautioned by the police on 18 March 1979 for theft from a lorry.

4.28 Mrs Cross noted in her records that during the summer camp in early August Shane (aged 11) presented as a 'very deprived child' and 'clung to every scrap of care he was shown even to the extent of inventing a "birthday" and the cooks making him a cake etc'. The police questioned him about a fire-raising incident in August 1979.

4.29 He told us that he had set fire to some blankets in his bedroom because it was claustrophobic and so he could move in with his brothers. He claims that smoke caused more damage than fire. He was cautioned for the arson offence on 23 September 1979.

4.30 At the end of August he was found collapsed in a doorway saying he had no food. He claimed he had not eaten for several days.

4.31 In early December 1979 Mrs Cross outlined her work with the Baths and what she was trying to achieve. She thought that the potential for delinquency in Shane was now more apparent and that he was subject to insufficient control by his parents. Her objectives for his care at this stage were to try and avoid future court appearances, to explore whether his school and local organisations could help him and consider providing a family aide to assist the Baths in coping with their children at home.

4.32 She also noted that in December he was to appear before the juvenile court as a result of an alleged theft of bicycles. Mrs Cross noted that he showed no remorse about this: 'Shane came over as quite disturbed-he feels everything and everyone is against him'. Mrs Bath admitted she could not control her son.

4.33 Records of the time note that he had difficulty associating with his own peer group and tended to choose younger children as companions, but was largely considered to be a loner.

COMMENTS

- **Development**

4.34 Notwithstanding the case conference decision in 1975, by the age of 7 it was apparent that there were significant problems with Shane. Even at this early age it was plain that he was physically and emotionally deprived at home.

4.35 By the age of 11 there is additional evidence of his level of disturbance; the beginning of a long criminal career from the age of 8 with two attempted arsons and numerous thefts; more examples of extreme attention-seeking behaviour; further

evidence of a failure to thrive at home and of physical deprivation; a referral to a child psychiatrist and Mrs Bath's acknowledgment that she cannot control him.

4.36 We were unable to interview her but Mrs Cross's care objectives in early December 1979 may seem optimistic given the history so far. She did, however, recognise the potential for delinquency and the need for intervention and assistance for Shane Bath and the family.

D. Care Proceedings

4.37 On 19 December 1979 Shane (aged 11) appeared before the juvenile court in Bournemouth, alongside his younger brother charged with the theft of two bicycles. His father became very abusive in the court and Shane refused to stand as required by the magistrates. The local authority advised the court that they were seeking an interim remand into care under the Children and Young Persons' Act 1969 for purposes of assessment. The care order was granted. He was taken to Southwinds, a local authority children's home in Weymouth. He was returned home briefly for the Christmas period.

4.38 On 30 January during the hearing for the full care order Mrs Bath told the chairman of the bench that she agreed with the reports presented by the social worker. This prompted Ronald Bath to become very aggressive to her and the court. Shane's response to this was to lift up a large table in front of the bench and topple it over. Mrs Cross's records indicate that he may have been copying the behaviour of his stepfather in court. He was not allowed back to school while at Southwinds because he was said to be too disruptive. The plan was to admit him to the Observation and Assesment Centre (O and A centre) in Dorchester once a vacancy became available.

Serious incident

4.39 While awaiting a vacancy at the O and A centre an incident occurred at Southwinds in which Shane was found to have tied up a 3 and a half-year-old girl with raffia string tight enough to cause her legs to turn 'bluish' and to have stripped her, apart from her pants.

Case conference

4.40 At a case conference held on 22 January 1980 at the O and A centre (he was still at Southwinds at the time) reports were received from a psychiatrist in connection with his general mental health state and a psychologist regarding his educational needs. The psychiatrist reported that Shane was 'not very demonstrative and seemed like a little boy lost who lives in a world of his own and does not seem to know what is going on around him'. The educational psychologist, advised the meeting that he was a boy with low IQ who would benefit from a 'maladjusted' school. Both the psychiatrist and the psychologist expressed the firm view that he was likely to re-offend again if he was not removed from his family.

4.41 The manager of the O and A centre pointed out that Shane was inclined to bully younger children and was 'very unco-operative' with female staff.

4.42 The case conference agreed that a full care order should be pursued and Shane (and his brother) admitted to a children's home.

Hawkslease

4.43 In February 1980 he was moved to the O and A centre. While at the O and A centre it was decided that a Church of England Children's Society home in Lyndhurst, Hampshire called Hawkslease was likely to be the most suitable available longer term home for him. He had a trial weekend there on his 12th birthday. While at Hawkslease he attended the Oak Lodge ESN (educationally sub-normal) school at Applemore, Dibden Purlieu, near Hythe.

4.44 Shortly after his move to Hawkslease Mrs Cross handed over as the social worker in the case to Mr David Pearce. We have not interviewed Mr Pearce.

4.45 At his 'six-monthly review' on 30 October 1981(the regular review of a child's progress in care required then under the Children and Young Persons' Act 1969) it was noted that Shane (aged 13) was at the top of the ESN needs range, and that he needed 'firm control' and 'clearly defined boundaries'. On 10 November he appeared before the Hythe juvenile court charged with theft of monies for which he was sentenced to a 12 month Conditional Discharge Order.

4.46 At the six-monthly review on 30 April 1982 he (aged 14) was reported to have shown improvements in his behaviour. It was speculated that this might be because of a behaviour modification programme which the manager of the home had put in place. This progress did not continue however, in June mention was made of his 'fibbing and manipulation' and he was reported as behaving strangely in Hythe so as to draw attention to himself.

4.47 There were reports of aggression at school towards younger children. Teaching staff complained of 'tremendous problems' at school. They had reported Shane as having stabbed a lighted cigarette out on a girl's arm. Further concerns were noted about disruption and agitation. His attention-seeking behaviour became more marked, for example, claiming to have eaten dangerous wild mushrooms in the New Forest, threatening to jump out of a minibus etc.

4.48 The record of the six-monthly review held on 1 November 1982 states that by this time he had attacked three female members of staff at Hawkslease. It was decided to involve a psychiatrist and Shane was seen by a consultant child psychiatrist in the latter part of this year. His opinion was that his problems stemmed from his strong relationship with his mother and he offered her and Shane counselling on a joint basis. However, at the six-monthly review on 25 April 1983 he said he had decided against trying to work with Mrs Bath because of her 'inadequacy'.

He prescribed medication to be used as a last resort. Shortly after this Shane (aged 15) was prescribed largactil syrup three times a day.

4.49 Mr Steve Witheyman took over as his social worker from Mr David Pearce in November 1983. Shane appeared in Hythe juvenile court on 8 November charged with burglary and was sentenced to a 12 hours' attendance centre order. His continuing temper tantrums were noted at the six-monthly review held on 9 November 1983.

O and A centre

4.50 On 16 January 1984 he was moved from Hawkslease to the O and A centre in Bournemouth (it is not apparent why from the records). On his sixteenth birthday on 21 March he appeared before Totton juvenile magistrates' court charged with an assault on a female member of staff at Hawkslease and received a Conditional Discharge of 12 months' duration. At the six-monthly review on the same day an incident had been noted where he had put his hand through a window and required stitches. The recorded goals at this stage of his care were to reduce offending, effect a smooth transition from the O and A centre to home and to establish him in work when he left school.

St Katherine's

4.51 Shane moved to St Katherine's, a Church of England Children's Society resource centre for adolescents, in Bournemouth in July 1984. On 5 September he appeared before the Bournemouth juvenile court, this time charged with possession of a weapon in a public place (an air pistol) for which he was fined £20.

4.52 On 23 October 1984 mention is made at his six-monthly review of three admissions to hospital for overdoses (unspecified).

COMMENTS

- **Diagnosis**

4.53 No formal diagnosis is apparent. Our expert advice is that on the basis of the behaviour shown at that time his diagnosis today would be that of a mixed disorder of conduct and emotion. There would also be a query about his cognitive ability.

4.54 He was seen by two psychiatrists (and a psychologist) during his childhood and adolescence. One was involved in the context of his educational needs assessment on only one occasion and the other following his assaults on three female members of staff at his children's home in 1982.

4.55 It would have been very useful to have had a full psychiatric formulation of his mental health needs at key points of his childhood. Such a formulation may have been undertaken but we have not seen it. It may also have been helpful if the psychologist had advised on the management of his behaviour.

4.56 It is now acknowledged that children who demonstrate similar conduct disorders in early life may present in adult life with anti-social personality disorders (R Loeber, 'Development and Risk Factors of Juvenile Anti-social Behaviour and Delinquency' (1990) 10 Clinical Psychology 1-4).

4.57 A psychiatric formulation would have highlighted features of his presentation which would have been material to assessments of Shane Bath in adulthood and enabled an assessment of likely future needs to have been undertaken.
These features include:

- emotional abuse as a result of inconsistent parenting styles and the aggressiveness of his stepfather;
- sexual abuse;
- poverty and material deprivation;
- violence and aggression;
- criminality;
- self-harming behaviours;
- lack of remorse;
- intractable management problems.

4.58 Largactil is the proprietary name for chlorpromazine hydrochloride, an anti-psychotic drug. We presume that it was administered for its sedative effect rather than as a treatment for any psychosis. Its prescription in this way to children and young persons is highly questionable.

E. Leaving Care

4.59 At the six-monthly review on 4 April 1985 the goals with Shane (aged 17) were to: explore his overdosing behaviour with him (there had been another one since the three reported at the last review), ensure he became more independent within his last six months of care and help Mr and Mrs Bath to come to terms with this independence. In May he moved to another address in Bournemouth and in August he went back to St Katherine's.

4.60 On 4 October 1985 he found himself at Bournemouth Magistrates' Court charged with two offences of assault - an assault on another resident at St Katherine's and one on his girlfriend of the time. He was fined £50 for each offence.

4.61 At his last six-monthly review the goals were for him to remain at St Katherine's, stay out of trouble with the police, to remain drug-free (this is the first reference to drug misuse) and in work, to have a successful re-integration into society on reaching 18 and to persuade Ronald Bath and Mrs Bath that it would not be desirable to have him back living with them. An overdose was noted as was the comment that 'his prospects of successful rehabilitation are extremely low'. He worked for very brief periods as an assistant with autistic children, a commis chef, a bakery worker and at 'numerous' other jobs according to his social worker at the time, Mr Witheyman. He moved to another address in Bournemouth.

4.62 In his evidence to us Mr Witheyman advised that it was his expectation that St Katherine's would 'pick up the baton' of his care and encourage him to stay with them until such time as they thought he was ready to leave. In effect it seems that they, rather than the social worker, would be expected to have taken on the primary role for planning his care.

4.63 It is noted that Shane moved to his mother and stepfather's home in Bournemouth on 3 February 1986. This is the latest date referred to in the child care records. The next recorded contact is in the Dorset Health Care NHS Trust records and refers to an appointment with Dr Rowton-Lee, consultant psychiatrist, at St Ann's Hospital on 5 August 1986 who says that 'Shane came to the clinic on 5 August, snooped around and "pushed off". I am afraid he will continue to misbehave. When he wants to do better, we will try to get to grips with him. Until then, I do not propose to run out and chase him'. His next contact was in January 1987 when he was first admitted, aged 18, to St Ann's under Dr Sedman (chapter 5).

COMMENTS

- **Leaving care arrangements**

4.64 If rehabilitation was to be measured by compliance with the goals outlined above (especially the goal of a successful re-integration into society on reaching 18) then it is understandable why the chances of success were considered to be extremely low.

4.65 There is no sense at this point of a realistic plan for his post-care life. It rather looks as though very unrealistic objectives were set because those charged with his care believed that the chances of him adhering to any after-care arrangements were so slight that it did not matter what was put down on paper. As our expert adviser put it 'the impression is that Shane just fell out of care'.

4.66 Dr Rowton-Lee's note indicates that he had some prior knowledge of Shane Bath at this time. There is no record that he did ever assess him and because of his persisting difficult behaviour we think that there should have been a more formalised referral between the child and adult psychiatric services at this time so that information was not lost to those who were likely to become involved with his future care and also to provide some continuity of care.

F. RECOMMENDATIONS

1. The Health Authority and Social Services should review:
   (a) how its children and adolescent mental health services can most effectively be accessed by Social Services and other agencies, for example, schools, for children in need of assessment and treatment;
   (b) the level of its investment in mental health services for families, children and adolescents.

2. Social Services should:
   (a) review the effectiveness of its arrangements for young persons leaving care including arrangements for assessment, follow-up and service engagement;
   (b) develop a joint policy, procedures and liaison arrangements with the NHS Trusts for assessment and follow-up, where appropriate, by the adult mental health services for those young persons leaving care who may have significant mental health needs.

3. The NHS Trusts should produce evidence-based advice for clinicians on the prescription and administration of neuroleptic drugs to those under the age of 18 years.

4. The Department of Health should identify research-based interventions into families with histories of dysfunction and deprivation with a view to offering assistance at the earliest stage aimed at preventing and managing the development of early childhood conduct disorders and possible associated personality disorders.

Chapter 5

FIRST ADMISSIONS TO ST ANN'S HOSPITAL, EAST DORSET: 1987

- First admission to St Ann's Hospital, 21-24 January 1987
- Situational crises
- Use of MHA
- Involvement of Social Services
- Information-gathering and sharing
- Second admission to St Ann's Hospital, 2-8 July 1987
- Personality disorder
- Fire at family home
- 5 Carlton Road North
- Out-patient appointments
- Old Manor Hospital

A. Introduction

5.1 This chapter covers Shane Bath's first two adult admissions into psychiatric care at St Ann's Hospital, Poole. They were brief: three and six days respectively, and the impressions gained by the treating doctors at this time were to influence his treatment at St Ann's in the following years. He complained of psychotic phenomena, in the form of visual and auditory hallucinations, and claimed suicidal and homicidal ideation. There was no proper or full assessment of any mental disorder at this time.

5.2 Mr Bath was having difficulties at home where he had returned to live. He was not getting on with his brothers or stepfather. This led to accommodation problems for him, not least because he set fire to the family home, although no charges were brought against him on this occasion. He ended up at 5 Carlton Road North, a social services mental health hostel in Weymouth, where he was difficult to manage. He was then admitted to Old Manor Hospital, Salisbury, Wiltshire having cut his wrists. This was a particularly disturbed and unsettled period for Mr Bath.

B. First Admission to St Ann's Hospital, 21-24 January 1987

5.3 Shane Bath was first admitted to the Adult Psychiatric Services, aged 18, on 21 January 1987. On that date he was admitted to St Ann's Hospital under the care of Dr Garrioch Sedman, consultant psychiatrist, having been referred by a child and adolescent psychiatrist who was concerned by Mr Bath's mental state apparently after the death of his natural father 'two days' previously. On the day he was admitted to St Ann's Mr Bath had cut his wrists.

5.4 On admission Mr Bath reported having felt 'depressed' for two years. He said he had been in contact with his natural father between the ages of 6 and 16 years since when he had not seen him. He said he had been informed by a friend of his father's death from cancer. He told the admitting doctor of a poor relationship with his stepfather and his two brothers in the family home who he felt picked on him.

He reported having been unemployed since December 1985 before which he said he had worked as a care assistant in a home for the mentally handicapped for 11 months, but 'could not cope'. He said he had been under the care of child psychiatrists since the age of 6 years as a result of truancy and running away from home and said he had lived in a children's home from 11 to 18 years of age.

5.5 Mr Bath reported feelings of tension over the previous year causing him to feel 'suicidal and homicidal'. He additionally reported the experience of both visual and auditory hallucinations.

5.6 The admitting doctor's diagnosis was of a 'reactive depression and grief in an inadequate personality'. The doctor advised 'observation' and the prescription of hypnotic medication at night. The only other medical note of this brief admission to hospital was to the effect that on 23 January 1987 Mr Bath 'appears relaxed today'.

5.7 The nursing records show that on admission Mr Bath had reported having tried to strangle one of his brothers as a result of 'provocation and a feeling that he was being got at for everything'.

5.8 On 23 January 1987, a note of a multi-disciplinary team meeting recorded Mr Bath's 'very unhappy home situation' and indicated a plan that the following week 'long-term social care away from the family' would be considered. However, the following day, 24 January, Mr Bath was recorded to have become 'verbally abusive' when reminded by a nurse that he should not take cups of tea into a corridor. Mr Bath reacted aggressively, slamming a door and is said to have 'stormed into the dining room and kicked over two ladies' cups of tea'. He refused to discuss the situation and the nursing record stated that he 'packed his belongings and left'.

5.9 On 28 January 1987, Dr Sedman's registrar wrote to Mr Bath's GP. He referred to Mr Bath's report of being ill-treated at home by his stepfather and his two brothers and went on to say 'he feels unable to resist them and this leads to him feeling both suicidal and homicidal at times'. The Registrar concluded that 'we were dealing with a transient situational disturbance but the possibility of a depressive illness or even a psychotic illness could not be ruled out'.

5.10 He said that the plan to observe Mr Bath's mental state had been frustrated when Mr Bath 'started acting out in a most aggressive manner and he kicked cups and coffee around the ... room which led to some of the elderly patients being scalded. He was asked to either moderate his behaviour or to leave. His behaviour continued and he was then asked to leave the premises. He did leave the hospital on Saturday, albeit reluctantly. I believe it is necessary to keep a close eye on him over the next few months. He will be followed up at the Out Patient Department'. Mr Bath subsequently failed to attend the Out Patient Department on 23 March and 6 May.

5.11 Dr Sedman in evidence to us, noting that he was understandably reliant upon records rather than memory, said that he did not believe he had personally seen or examined Mr Bath during that brief admission to St Ann's Hospital.

5.12 Mr Bath was next admitted to St Ann's under Dr Sedman between 2 and 8 July 1987. This admission took place via the Accident and Emergency Department of Southampton General Hospital where he had been admitted having inflicted lacerations to his wrist with a razor blade.

5.13 After contact was made with St Ann's it was noted that 'mainly personality disorder with some psychotic features, does not comply with Out Patient treatment: they are refusing to accept him unless he will comply with further treatment'. There is no copy of the initial referral in January 1987 in the records. Dr Sedman then agreed to see him. On arrival he was noted to be saying that he wanted to die and was unable to cope with life. He said that he was unwanted by his family. There is mention of his feeling 'anxious and depressed' and also possible suggestions of a psychotic illness in the form of paranoid ideas and hallucinations. His ideas of harming members of his family is again recorded and said to be distressing him.

5.14 The doctor concluded that the diagnosis was one of either 'personality disorder with paranoid features' or 'mild psychotic illness with affective change'. Mr Bath was admitted voluntarily and given a 'test' dose of major tranquillising medication for its calming effect. A later record states 'not psychotic'.

5.15 The nursing staff noted that Mr Bath was a suicide risk and he had said that his main problem was that he had nowhere to live. At a multi-disciplinary meeting on 3 July it was noted that a social worker would see him 'about looking for his father's grave plus any other problems Shane feels need discussing'.

5.16 He then absconded from hospital and was noted the next day (5 July) as being at his brother's house where he was creating a difficulty and had taken some of his father's tablets. His stomach was washed out at Poole General Hospital and he was returned to St Ann's.

5.17 On 21 August 1987, Dr Sedman's registrar wrote to Mr Bath's GP. He said Mr Bath's admission on 2 July had been precipitated primarily by his having been asked to leave the family home. He said 'no evidence of mental illness per se' had been found. Mr Bath had been 'told he could stay on the ward to sort out these difficulties with our Social Worker if his behaviour on the ward was tolerable. However, this did not prove to be the case and he was discharged back to the family home on 8th July 1987 on no medication. He will be sent a follow-up appointment at the Out-Patient Clinic in due course'.

COMMENTS

- **Information-gathering**

5.18 Whilst reference is made in the records to his long involvement with child psychiatric services no attempt was made to obtain the relevant records, which

would have given a fuller picture of the extent and seriousness of his previous aggressive and offending as well as self-harming behaviour. This omission at the time of his first contact with adult services set a pattern for the future, whereby those concerned with Mr Bath never had nor sought a full picture of his background. This is a theme which recurs throughout Mr Bath's contact with the services.

5.19 Had records been obtained his long-standing behavioural problems associated with the dynamics within his family, attention-seeking and violence are likely to have formed a clearer part of any assessment at that time and also been available for the future. Incidents such as an alleged attempt to strangle one of his brothers are noted but not verified. As a result, whatever assessment was performed at this stage was incomplete.

- **Mental Health Act 1983 (MHA)**

5.20 There is no evidence that consideration was given to formally admitting Mr Bath under a section of the MHA. We think that the criteria for an admission under section 2 for assessment were fulfilled on both occasions. Mr Bath was suffering from a mental disorder which was not properly assessed for its form. He was claiming suicidal and homicidal thoughts, the latter of which were directed at his half-brothers and stepfather. At the time he was asked to leave St Ann's Hospital following aggressive behaviour which had caused harm to other vulnerable patients, his diagnostic condition was uncertain. He had reported depression and hallucinations as well.

5.21 We acknowledge that this was early in Mr Bath's history of contact with the mental health services as an adult. There is likely to have been a proper reluctance to 'stigmatise' him with a compulsory order at this time. Although Mr Bath was only 18/19 years old we feel that in circumstances like these, the balance is in favour of such an admission. He was still very much an unknown quantity.

5.22 We are aware that a section 2 admission was considered in November 1987 at Old Manor Hospital, Salisbury, but was turned down by the Wiltshire social worker. It is possible that a social worker may have reacted similarly on this occasion also but we feel that given Mr Bath's presentation at this time he would have benefited from a more prolonged in-patient assessment.

- **Personality disorder**

5.23 It is not possible to make such a diagnosis without much more information than was available during these admissions. Apart from the lack of childhood information, there should have been interviews with family and more prolonged observation and evaluation than was possible at this time and this diagnosis was, therefore, necessarily a preliminary diagnosis requiring further assessment.

5.24 A full assessment and/or the use of the MHA is likely to have resulted in the conclusion that Mr Bath was suffering from a personality disorder. It may also have been concluded that he was untreatable and there was nothing he could achieve in hospital, but such conclusions would have been reached on a proper basis and would have been instructive for future assessments.

- **Social Services and information-sharing**

5.25 Despite the 'multi-disciplinary meeting' on 23 January we are surprised that no liaison appears to have taken place with Social Services. This is an early example of failure of multi-disciplinary and multi-agency working which was to be repeated with regularity throughout Mr Bath's contact with services. The failure to involve Social Services or for them to become involved once Mr Bath was in hospital is a recurring theme in this case.

5.26 The involvement of a social worker during the second admission was minimal. There was no continuity between one admission and the next.

5.27 We also think that in spite of the lack of child care information on these records, the assessment that he required long-term social care away from his family was accurate. Unfortunately, as a result of a combination of his own lack of co-operation and the failure of Health and Social Services really to take hold of his problems and deal with them, this assessment was never followed through. This should have been possible through proper multi-disciplinary working which was not a novel concept in 1987.

- **Discharge letter**

5.28 The discharge letters to Mr Bath's GP following these two admissions were seriously lacking in important information, not least concerning the nature of his behaviour in hospital which led to his being discharged, the risk he might pose in the future to himself and to others and indeed no prognosis of any sort was offered. The poor standard of discharge letters and summaries from St Ann's and also Forston Clinic is another recurring theme in Mr Bath's contact with the Health Service.

- **Situational crisis/crisis management**

5.29 As with the majority of Mr Bath's future admissions, this second admission was precipitated by a crisis when he was thrown out of home. Family and accommodation problems are repeated features of his presentation to services.

C. Fire at the Family Home

5.30 On 10 July 1987 an entry in Mr Bath's medical notes records the receipt at St Ann's Hospital of a telephone call from a GP to say that 'patient has attacked his father and burnt the house down. Police and a large crowd of angry neighbours attending at the scene, police demanding admission to St. Ann's under a Section of the Mental Health Act despite the fact that patient is asking for admission. Police

refused to take him to a cell saying that he is mentally ill. Parents refuse to prefer charges. Patient says that the fire was caused because he had a cigarette and became drowsy due to an injection he had recently'. Under this typewritten record of the telephone call is an unsigned note in manuscript: 'Dr. [...] adamant that patient MUST NOT be re-admitted'.

COMMENTS

- **Mental disorder**

5.31 Given the diagnostic uncertainties during Mr Bath's two brief admissions to St Ann's Hospital earlier that year, we find difficulty in understanding the confidence in refusing to accede to the request of the police that Mr Bath be re-admitted to St Ann's for further assessment of his mental state. Although we have been unable to clarify the precise details of this incident, and the recollection of it by Mr Bath and his mother are hazy, this was clear evidence of further escalation of his dangerous and disturbed behaviour which in the light of Mr Bath's history required further psychiatric evaluation.

5.32 This approach seems to us to have been based on the earlier finding of a personality disorder. Whilst we could not argue with this evaluation today, we cannot find any proper basis for a formal diagnosis at that time and, therefore, are of the view that the way in which Mr Bath's management was determined then and in the future was guided by a poor assessment of his presenting condition.

5.33 A full assessment would have had the advantage of enabling other mental illnesses to be properly discounted. We find the phrase 'no mental illness per se' to be uninformative. This was a diagnosis by default which was not justified at the time on the available information. Even though ultimately the diagnosis was correct it should not have been arrived at in such an uninformed manner and without further planning for its future management.

- **Facilities at St Ann's**

5.34 Secure facilities at this time were limited to two or three beds at the end of Branksome Ward which were usually not locked and used only for the purposes of temporary seclusion for psychotic patients. Dr Rowton-Lee told us that even then there was no pressure on beds.

D. 5 Carlton Road North

5.35 In September 1987, Mr Bath was living in a mental health hostel at 5 Carlton Road North in Weymouth. It was noted that on 10 September 1987 he had cut his arm and on 22 September 1987 he attended an out-patient appointment with a consultant psychiatrist at Blackdown Hospital. This psychiatrist, in a subsequent letter to the officer in charge at Mr Bath's hostel, reported that he 'could not detect any evidence of current active psychiatric illness and assume that his wrist cutting comes within the category of disordered behaviour. I plan to keep an eye on him while he is in the Weymouth area'.

5.36 In response, the warden at the hostel wrote on 5 October 1987 that 'like yourself I have seen no evidence of any psychiatric illness as such, but unfortunately he has gravitated our way by default I suspect and from time to time does resort to wrist cutting. He has also been in trouble in the past on account of what I understand to be a very violent temper'. He noted Mr Bath's claim to be depressed and wondered whether major tranquillising medication by depot injection might help him.

5.37 The psychiatrist replied the following day to tell the warden that Mr Bath had failed to attend his appointment at the Out Patient Department. He went on to say:

'I have now received some rather sketchy notes from St. Ann's Hospital where he was under the care of Dr. Gary Sedman. My reading of the notes is that he has had various forms of behavioural disturbance since childhood, but no formal psychiatric illness. On at least one admission when he became aggressive and started to break things they asked him to leave the hospital forthwith. The view of the psychiatrists who have observed him is that he does not show evidence of formal psychiatric illness, but does show a disturbed personality'. In respect of major tranquillising medication, he observed 'it will be to give him a little more control over his impulses but not because it will in any way alter his way of thinking'.

5.38 He concluded that 'it looks to me as if you have been landed with an unknown quantity as a means of "disposal". I would have thought that a move to Carlton Road North ought usually to be part of a carefully planned rehabilitation programme and if I were you I would insist on the psychiatric services (including myself of course) making out a case of need with objectives in mind rather than passing on difficult problems'.

5.39 That evening Mr Bath climbed on the roof of the hostel at 5 Carlton Road North and threatened to leap off. He was dissuaded from doing so by hostel staff. The following day he was urgently referred back to Blackdown Hospital and was seen in the Out Patient Department by a psychiatric registrar, who noted that Mr Bath 'appeared to be quite rational, showing no evidence of a depressive illness or any psychotic phenomena and he seemed to be enjoying the attention he has received at the moment'. He recommended that Mr Bath be prescribed injections of major tranquillising medication as he reported feeling tense and said he had been previously helped by such medication at St Ann's Hospital.

5.40 Eleven days later, on 19 October 1987, Mr Bath again climbed on the roof of the hostel and threatened to commit suicide. The fire brigade were summoned and he threw coffee mugs at firemen. The police were called and he was taken to cells at Weymouth Police Station. The following day he was allowed to leave and was told to report back to the police on 15 November 1987. Mr Bath then left the area and was formally discharged from the hostel on 28 October.

5.41 It appears that he then found his own accommodation in Boscombe where he remained until 7 November when he left, taking with him all his possessions. Subsequently he was found lying in a gutter in Ringwood with a cut to his head

and was taken to Royal Victoria Hospital in Boscombe where he told staff that he had been living at the hostel in Weymouth.

5.42 Social Services were contacted and discovered that Mr Bath was in rent arrears with his landlady in Boscombe. In early November 1987, Mr Bath failed to attend an out-patient appointment with the psychiatric registrar and on 12 November inflicted serious wounds to his wrist. He was admitted to Poole General Hospital and the following day transferred to a specialised plastic surgery facility at Odstock where, however, he refused treatment. From Odstock he was transferred to Old Manor Hospital at Salisbury.

COMMENTS

- **5 Carlton Road North**

5.43 This is a Dorset Social Services rehabilitation hostel for people with mental health problems. We have been unable to discover how Mr Bath arrived there and like the Blackdown consultant feel that the hostel was somehow passed a difficult client without any rehabilitation package, or plan for the future, being thought out. This was, in our view, the result of the poor assessments and multi-disciplinary work thus far.

- **Out-patient appointments**

5.44 By this time Mr Bath was already showing a consistent failure to comply with out-patient arrangements.

E. Old Manor Hospital, 12 November

5.45 The admitting doctor at Old Manor Hospital elicited a history from Mr Bath of repeated acts of self-harm since the age of 16 years: 'says he cannot cope with stress and things build up'. Mr Bath reported the experience of auditory hallucinations: 'hears voices saying that he is wasting his life and he ought to kill himself, he then either takes overdose or slashes wrists. On this occasion the precipitating factors were being thrown out of home on a Court Order and having to live rough'.

5.46 The admitting doctor found no significant disturbance of Mr Bath's mental state and diagnosed '? personality disorder'.

5.47 The following day, an entry in Mr Bath's medical notes indicates that 'with some persuasion' Mr Bath had given the name of a social worker of Bournemouth Social Services as a person whom he felt had helped him in the past. When told that she would be contacted with a view to him being discharged back to the Bournemouth area Mr Bath ran to the bathroom, 'from which after some minutes he had to be forcibly extracted and restrained from cutting himself with a razor blade. When told that in view of his behaviour he would be discharged he ran out and has ascended the roof of Linford Ward'.

5.48 The next note states 'has come down and made an assault on property and persons with a length of telephone cable'. Mr Bath was then restrained with the assistance of police and was placed in a seclusion room where he remained for about 35 minutes 'to prevent further damage'.

5.49 The following day he was noted to be behaving 'normally at present', but that evening he became 'agitated' and was allowed into the garden of the ward. From there 'he escaped over the wall but then returned and started smashing furniture and threatening staff'. As a result Mr Bath required to be restrained and once again he was placed in seclusion where he refused to say why he was behaving in that manner.

5.50 Mr Bath continued to behave violently in the seclusion room, banging upon the door which was noted to be 'in danger of breaking'. Consideration was then given to placing Mr Bath under section 2 MHA 'for uncontrolled behaviour secondary to psychopathic personality disorder'. The following day, however, it was noted that the social worker was not agreeable to Mr Bath being placed under the section and Mr Bath agreed to accept sedative medication. A doctor at St Ann's Hospital was contacted and he agreed to accept Mr Bath on transfer 'if he has not taken his discharge first'.

5.51 On 18 November, Mr Bath was transferred from Old Manor Hospital to St Ann's Hospital escorted by three male nurses. On admission to St Ann's Hospital nurses noted that he appeared to be low in mood and he told them that he had been hearing voices 'telling him to attack people'. Nursing staff recorded that 'admission is for assessment only and is to be discharged immediately he causes any problems'. The following day Mr Bath was discharged from St Ann's Hospital.

5.52 On 24 December 1987, Dr Sedman's registrar wrote to Mr Bath's GP. He said that 'following his admission Mr. Bath showed no evidence of any active psychiatric illness, but instead showed considerable behavioural disturbance in the setting of a severe personality disorder. It is Dr Sedman's feeling that Mr. Bath has little to gain from in-patient hospital treatment but has suggested that he might benefit from placement in a therapeutic community ... our Social Worker ... will be looking into the possibility'. He said that he would attempt to follow Mr Bath up at Out Patients but noted that he had been irregular in his attendance in the past.

5.53 On 17 February 1988, Mr Bath attended the psychiatric Out Patient Department where it was noted that he felt 'quite settled....main problem at present is accommodation....due to leave his present B & B tomorrow....parents won't have him'. A note was made that the doctor who examined Mr Bath on that occasion would discuss with the social worker the possibility of Mr Bath's admission to a therapeutic community. Two days later it was noted that Mr Bath had been ejected from the parental home and an injunction had been taken out against him.

COMMENTS

- **Diagnosis and assessment**

5.54 Had a proper assessment taken place the diagnosis of anti-social personality disorder is likely to have been confirmed. Mr Bath was still only 19 years old and we feel that the clinicians having pinned the label of 'personality disorder' on him failed thereafter to formally assess its treatability. If untreatable, then even a decision that the Health Service had nothing to offer with the result that he be excluded from the hospital in-patient services could have been justified as long as it could be demonstrated that a proper assesment had been performed.

- **Social Services**

5.55 This was the first, somewhat half-hearted, attempt to engage with the personality disorder therapeutically, but it did not come to fruition and we have found no record of any actual contact between Mr Bath and a social worker. There was no proper consideration given to resolving Mr Bath's homelessness. This is an enduring theme in his history.

F. RECOMMENDATION

5. The NHS Trusts and Social Services should reinforce the key principles of information gathering, inter-agency communication and multi-disciplinary working and their application to MHA, CPA and care management through training, guidance and supervision (see also chapters 28 and 29).

Chapter 6

OFFENCES AND ARSON IN 1988

- Court report
- Information-gathering
- Proper charge and sentence
- Increase in dangerousness, Hospital and Restriction Order

A. Introduction

6.1 Mr Bath was prosecuted for offences committed while he was at 5 Carlton Road North in 1987. He then committed an offence of arson while on bail at a resettlement hostel in Southampton for which he was given a sentence of six months' youth custody. This represented a significant increase in his dangerousness and is a key event in his history. A court report was provided by Dr Sedman.

B. Offences

6.2 In March 1988, Mr Bath, then aged 20, was arrested for nuisance telephone calls to the emergency services, criminal damage to a fire engine and taking a conveyance without consent, offences committed between June and December 1987 while resident at 5 Carlton Road North, Weymouth, to which he pleaded guilty.

6.3 There is a court report from Dr Sedman on 22 March in connection with these charges. In it he stated that Mr Bath was well known to him. He outlined his early behaviour and care since January 1987 and included the diagnosis of intractable behaviour disorder at the age of 6 which continued into adolescence. He referred to the fire at the parental home in July and stated his opinion that an admission to hospital under the Mental Health Act was quite rightly refused at that time. He stressed that on admission in November 1987 no signs of mental illness were found. It was his view that the break up of Mr Bath's parents' marriage and the unhappy relationships in the family were of relevance and mentioned that although 'above average intellectually Mr. Bath had problems at school, difficulties in employment and had to cope with partial deafness'.

6.4 Dr Sedman's opinion and recommendation to the court were written from his previous knowledge as Mr Bath had not kept the appointments made for him for assessment, and were as follows:

'Mr. Bath suffers from severe personality disorder, he has little self-control, he is aggressive, self destructive, immature and attention seeking. Psychiatric treatment had achieved nothing so far and I am reluctantly of the view that further treatment is not likely to change him. Time and maturity hopefully will moderate his anti-social antics. All the experts who have seen him have reached the same conclusion that he is not mentally ill and he is in Law responsible for his actions. I cannot therefore make a recommendation of medical treatment to the Court. If granted his liberty we will still try and place him in a therapeutic community'.

6.5 Dr Sedman told us that he has always taken the view that crime, and particularly serious crime, is better dealt with by the police and the courts once it has been established that 'there is no mental illness proper (by this I mean a psychotic illness)', hence his recommendation to the court. In spite of this he did offer to try to place him in a therapeutic community and as he put it his 'therapeutic nihilism was never entire'. He acknowledged, however, that his real expectation of a positive outcome for Mr Bath at, for example, the Pilsdon Community was very slight.

6.6 He told us that the Pilsdon Community was run by a priest and offered a highly structured environment. He had known it to have some success with difficult offenders.

COMMENTS

- **Court report and information-gathering**

6.7 This court report is informative in relation to the early difficulties and diagnosis of Mr Bath and also of the unhappy family relationships. However, it is interesting to note that even at this relatively early stage in his contact with the adult services, there are factual errors which could have been avoided through simple checking.

6.8 These are that there is no evidence that his parents marriage had broken up at this or any other time and this also contradicts his initial story that his father had recently died. Secondly, it is difficult to identify how the assessment of his above average intellectual ability could have come about, particularly when stated in the context of his problems at school where he was assessed as educationally sub-normal.

6.9 While we acknowledge that it may be possible to disagree with any earlier evaluation, there is no evidence that Dr Sedman's view was based on any more recent assessment of Mr Bath's intellectual functioning. We also have no confirmation of his partial deafness.

6.10 Dr Sedman confirmed in evidence that he did not have any information available to him from the child psychiatrists or any social services background, largely by reason of the fact that Mr Bath's admissions to St Ann's had been for short periods of time.

6.11 It is our view that a practice whereby a search for past information, from as many sources as are reasonable, is initiated as a matter of course has much to recommend it. In this case valuable information was available from the child care services and in view of it being recent history at that time, one would anticipate little difficulty in locating the relevant information.

6.12 Our views in this regard, which are expressed in the previous chapter, are underlined by the need to provide a court report, which if based on unverified information runs the risk of misleading the court as well as any future assessments. It also impacts on the ability to provide a confident diagnostic formulation to the

court. A court must be able to rely on the information which underpins a recommendation or opinion as being thoroughly researched.

6.13 It is correct to state that this was not the only opportunity which arose to verify historical data and this is a failure which also dogged Mr Bath's later contact with the services, but it is our experience that unqualified statements of fact in such reports, and indeed written into records, do come to be regarded as authoritative in later years. It should be said, however, that the factual errors mentioned above did not materially influence any later assessments.

D. Arson

6.14 Before the above offences reached Bournemouth Magistrates' Court for sentencing, however, Mr Bath was arrested on 23 April 1988 for setting fire to a magazine under the mattress of another hostel inmate while he was resident at the Millbrook Resettlement Centre, Southampton. Later in his medical notes this incident was mistakenly referred to as Mr Bath pouring petrol over the legs of another person and setting fire to him.

6.15 We heard evidence from Mr Bath that he had tried to hang himself and to cut his wrists on arrest. He was seen at Southampton Central Police Station by a doctor from Royal South Hants Hospital whose clinical note does not support that account and records that Mr Bath 'became disturbed whilst in police custody-banging head on wall, struggling with officers etc'. His opinion was that Mr Bath had had a disturbed upbringing and had associated personality problems. He was prone to self-harm when stressed, but was not showing signs of formal psychiatric illness and admission to hospital was not an appropriate response. He was remanded to HMP Winchester where he says he was initially on the hospital wing, a fact which we have been unable to confirm directly but seems plausible.

6.16 The accommodation in Southampton had been found for him by the Probation Service pending his appearance at court on the earlier charges. Mr Bath initially denied setting the fire. Later in admitting it he said that he disliked having to share a dormitory with older men. Two of the men were in their 60s and B, whose mattress he had set fire to, was 34. B was taking speed, drinking and a 'real slob'. Mr Bath said that he was often hit or beaten by him.

6.17 He said that he set fire to B's bed to 'teach him a lesson', he wanted him out of the dormitory. He also complained that others were stealing from his locker and stated that as far as he was concerned it was a dreadful place. He emphasised his psychiatric history and attempts at self-harm to his solicitor and said that he thought that he should be sectioned again (although he had never been detained under a section of the MHA by this time) and needed help from Dr Sedman.

6.18 He said that the fire at his parents' home had been accidental. He had recently come out of St Ann's and had received a depot injection which made him drowsy.

The bedroom went up in flames when he dropped a cigarette in his bed. We have been unable to obtain any independent verification of the facts of this fire.

6.19 The advance disclosure summary from the Crown Prosecution Service, though incomplete, is in the notes of both Dorset NHS Trusts relating to Mr Bath, together with the court reports of Dr Sedman and various letters from Mr Bath's solicitors. It indicates that the fire was detected at about 2.30 p.m. on Saturday 23 April when the alarm was raised by Mr Bath and otherwise the facts of the offence accord with those set out in his own statement. When we saw him at HMP Belmarsh Mr Bath told us that that the fire had happened early in the evening when B was out drinking. The fire was set on the first floor of the building and there were other people downstairs. There was damage to the value of £100.

6.20 He was charged with arson (section 1(1) and (3) of the Criminal Damage Act 1971) and sentenced on 9 September 1988 to a total of six months youth custody at Bournemouth Crown Court with a three months sentence to run consecutively for taking a conveyance without authority and concurrent sentences for the other offences, making a total of nine months youth custody.

6.21 Dr Sedman provided an updated report to the court dated 23 June 1988. We do not have a copy of the social enquiry report provided to the court. Dr Sedman stated that the reasoning and actions on this occasion are 'only too typical of Mr Bath's immature judgment, he did not think the matter through, there was no thought that a fire might get out of hand and endanger life or that he would be the obvious choice of culprit'.

6.22 He noted that once back on normal location at HMP Winchester he appeared well and had been no cause of concern and that although requesting psychiatric treatment this was probably seen by Mr Bath as preferable to custody.

6.23 He maintained his opinion that any medical recommendation for treatment in an open psychiatric hospital was inappropriate and considered that within a prison setting the therapeutic facilities at Grendon Underwood would make it suitable or that if allowed his freedom a therapeutic community which can provide time and support might be of benefit. In fact the length of the sentence passed precluded Grendon. He stated:

'For most of his life he has been receiving some form of care and as I concluded earlier there is little evidence that psychological help achieved anything. Attempts to manage him in open psychiatric hospital, after care hostels have been a complete failure and have put others at risk'.

6.24 Dr Sedman told us that the secure facility at St Ann's at this time was limited to a small unit of two to three beds at the end of Branksome Ward which could be locked internally. He referred to these as secure or 'semi-secure' beds which

were rarely locked and then usually only to seclude disturbed psychotic patients temporarily. The main ward was open.

6.25 Dr Sedman, who retired in August 1988, was asked during his oral evidence about the admission of personality disordered patients to his ward at St Ann's and what consideration had been given to obtaining a forensic assessment from the Regional Secure Unit (RSU) at Ravenswood House, Knowle Hospital, Fareham. He said that, in general, admission to his ward would occur when there was an immediate crisis usually in the community and the facilities offered were then of containment on a short term basis rather than treatment.

6.26 The forensic service for the Wessex region at that time was Lyndhurst Ward, interim secure unit at Knowle Hospital. He said that he considered that a specialised RSU would have been a more suitable environment but his experience was that it was 'nigh impossible to ever get anyone admitted to it'. In all his years he never managed to get anyone admitted to Lyndhurst Ward and that this was a difficulty with psychotic as well as personality disordered patients. It was possible to obtain forensic assessments, but beds were more difficult.

6.27 He told us that he would not have considered referring Mr Bath to Lyndhurst Ward because he did not think that they would have taken him, nor that they had anything in particular to offer over the prison service and neither did medical management have much to offer him. In retrospect he did consider that a forensic opinion would have been useful after the charge of arson had been laid, given his own view that the prognosis for Mr Bath was likely to get worse and the escalation in seriousness of his behaviour.

6.28 It is notable that at this time, whilst Mr Bath is likely to have been taking illegal drugs there is no evidence that he was abusing them regularly, or that this was considered to be a problem.

COMMENTS

- **Proper charge**

6.29 We were initially concerned by the fact that the charge of simple arson was too minor given the potential risk of harm to others. We have received advice from a senior prosecutor at the Dorset Crown Prosecution Service, that the charge proffered was appropriate on the facts of this case.

6.30 On the evidence that there was no one in the bed or in the dormitory when the fire was set and that Mr Bath sounded the alarm soon after setting the fire thereby reducing the risk to any others present in the building, it seems unlikely that an aggravated offence of arson (section 1(2) and (3) of the Criminal Damage Act 1971) could have been maintained by the prosecution.

6.31 Simple and aggravated arson offences carry maximum sentences of life imprisonment (section 4 of the Criminal Damage Act). Arson is always a 'violent

offence' and one which is viewed seriously, whether simple or aggravated. In this case we think that the choice of charge does not in fact diminish the seriousness of the offence.

- **Increase in dangerousness and use of MHA**

6.32 We think that this was a significant episode in Mr Bath's history. We are not satisfied that the apparently sudden increase in the dangerousness of his behaviour was properly addressed. The offence charged enabled the court, at the very least, to consider a much stronger statutory framework in relation to disposal and follow up under the MHA, for example, either a hospital or guardianship order under section 37. This option was effectively removed from the court by the report of Dr Sedman.

6.33 We understand the frustration that Dr Sedman expressed at the difficulty in obtaining a bed at Knowle Hospital and we also consider his view that the long term needs of people with personality disorder cannot be managed on an ordinary psychiatric ward to be reasonable. We do think, however, that this was an excellent opportunity to seek or advise that a specialist forensic opinion be sought, even if only as a precautionary measure to support his own view.

6.34 Dr Sedman's approach demonstrates a surprisingly high level of confidence in his own judgement in this case, but his reasoning is open to criticism. He relies on his analysis that attempts to manage Mr Bath on open psychiatric wards and after-care hostels had failed in the past. By his own admission those periods in hospital were very brief, and their value in predicting his likely responsiveness to a more secure setting is questionable. In addition he had no details of any psychological interventions used with Mr Bath in childhood.

6.35 In this worrying episode, Dr Sedman's reports are an important assessment of the risk posed to others. This is not 'risk' in the formalised sense in which it is now used, but the assessment of future behaviour which every psychiatric assessment must address, particularly in the context of offending and arson. In performing this assessment, more detail of Mr Bath's early childhood history is likely to have been influential. There were after all two other incidents of fire setting in his childhood apart from the one in 1987 and a number of convictions for actual bodily harm.

6.36 In an individual with a psychiatric history such as Mr Bath's at this juncture, the lack of any signs of mental illness should not have precluded an assessment of his personality disorder under the MHA.

6.37 We accept that the issue of treatability will have influenced any recommendation for an admission under the MHA for treatment and that any final disposal under the MHA would ultimately have been for the court to make. However, a remand to hospital (section 35) or an interim Hospital Order on conviction (section 38) would have offered the court more flexibility on sentencing and clinicians more time to consider his treatability, especially as Mr Bath was still only 20 years old.

6.38 For the same reasons this was also an occasion on which a Restriction Order (section 41) may have accompanied a Hospital Order. Given the gravity of the offence, Mr Bath's background of violence and the likelihood of further violence, we think that had a Hospital Order been considered appropriate, a Restriction Order could have followed, although at this early stage in his life it is unlikely to have done so (see chapter 13 for more on Restriction Orders).

- **Sentence**

6.39 It is not our view that a life sentence would have been appropriate in this case, although the sentence of six months' youth custody may have been lenient (Foulger (1983) 5 CAR (S) 246). The importance of the custodial sentence, however, was that it only allowed a brief period of statutory follow up by the probation service and no real framework within which to ensure his compliance with the conditions of the youth custody licence (see chapter 7).

6.40 We have no probation report for this offence. A clear alternative to a MHA disposal would have been a probation order with a requirement of treatment. This does require the consent of the offender, but at this early stage and where he was relying on his psychiatric history in the preparation of his case for court, it seems likely that Mr Bath would have complied with the making of such an order.

6.41 This would have been a reasonable attempt to set some boundaries for Mr Bath at an early stage, to bring about his compliance and which would have brought him back to court upon breach of the conditions imposed.

C. RECOMMENDATION

6. The NHS Trusts and Social Services should offer training and guidance on the provision of court reports, emphasising the need for accurate information, a consideration of risk factors (including the need for section 41 MHA where appropriate) and an outline of the range of possible sentencing options available to the court.

Chapter 7

1988 ARSON: YOUTH CUSTODY LICENCE AND PROBATION SERVICE

- Accommodation
- High risk status
- Information-sharing
- Breach of youth custody licence
- No Health or Social Services involvement
- First record of drug abuse

A. Introduction

7.1 Following his conviction for arson and other offences, Mr Bath was sentenced to a total of nine months' youth custody. This was his first custodial sentence and thereafter, his first contact with the Probation Service, which supervised his release on licence and carried out a good analysis of the risk which he posed to others and this was assessed as 'very high'. During this period he was not treated as a mentally disordered offender and there was no Health or Social Services involvement on his release.

B. Probation and After-care

7.2 Having spent time on remand in custody since 23 April, Mr Bath, now aged 20, was released from prison on 9 September 1988 on a youth custody licence to be supervised by the Probation Service. We have no records relating to his progress in prison on this occasion for the reasons set out in chapter 2. The Probation Service and after-care service case record summary information sheet indicates that his youth custody licence ran from 9 September 1988 to 22 January 1989 and that his entitlement to voluntary after-care ran to 21 January 1990. His case was terminated on about 30 June 1989 owing to his lapsed contact. This was Mr Bath's first contact with the Probation Service.

7.3 The youth custody licence was supervised by Sue Garnett at the Blandford Probation Office in Dorset. On release, Mr Bath lived initially with his brother (also referred to as both brothers) and his girlfriend; then with his sister in Gillingham (North Dorset) from 21 September; Weston Hostel (Weymouth) between 30 December and 23 January 1989; Buxton Road, Weymouth and then again at the Weston Hostel from 16 to 23 February.

7.4 The analysis of the risk which he was considered to pose to himself and to others at this time was recorded as 'very high'. His violent acts are recorded as acts of arson and destruction, three convictions for ABH and one for carrying a loaded weapon. The build-up was assessed as 'frustration and use of drink and drugs' and the trigger was 'lack of accommodation, rejection. Arguments with authority'.

7.5 Due to the speed of his release he left prison with no fixed abode and with instructions to report to probation, which he failed to do as he went straight to

Bournemouth to the house in which his brother(s) were living. It was not possible to place him through the probation accommodation officer due to the nature of his offence. The difficulties over accommodation are clearly noted and it is stated that all avenues were explored at the social enquiry report stage by the social worker.

7.6 On 14 September 1988, there was a probation service high risk offender (HRO) conference (known today as a potentially dangerous offender (PDO) conference). This was attended by Pat Rance, Assistant Chief Probation Officer, E P Lee, senior probation officer and Sue Garnett. Mr Bath's acute housing problem was discussed and the possibility of placing the brothers (all three) together was to be pursued. It was agreed that Mr Bath was 'HIGH RISK or VERY HIGH RISK'. It was also agreed that the Director of Social Services should be made aware of Mr Bath's conviction as he stated that he had previously worked as a care assistant. We have not seen a copy of any such letter, but there is a note that it was drafted on 15 September.

7.7 By October 1988, the probation records note that Mr Bath had a job interview in Gillingham and his potential employer, who contacted the probation office, was fully briefed as to his background by letter and allowed to peruse his file on a visit to the office. He still decided to give Mr Bath a job operating machinery in his bacon factory. Mr Bath was described as co-operating exceptionally well apart from his initial lapse of going off to his brother and very afraid of going back to prison. He was able to find the work for himself.

7.8 Unfortunately, by 8 November 1988 Mr Bath appeared to be unemployed again. By the time that his youth custody licence expired on 22 January, Mr Bath had made direct contact with the Community Alcohol and Drugs Advisory Service (CADAS) and had been convicted of theft from an electricity meter and ordered to pay £26.00 compensation and £20.00 costs on 15 December 1988. The fact of the youth custody licence was brought to the attention of the court dealing with the theft offence in the probation court report.

7.9 His after-care supervision was taken over by Stephen Fremantle on 8 February 1989. On 15 February, Mr Fremantle had been called to accommodation where Mr Bath had apparently taken an overdose and slashed his wrists. He was taken to Weymouth and District Hospital and assessed as having a 'marked personality disorder exacerbated by drug abuse, but was not in any way certifiably ill and did not require any in-patient treatment'. CADAS was involved further and he was allowed to return to the Weston Hostel on an emergency placement.

7.10 There was another high risk offender conference on 20 February. It was decided that in view of his needs and risk of further serious offending and of drug involvement that a treatment resolution should be sought. CADAS was to be explored for help with his drug problem although his desire for treatment for drug addiction was questioned as possibly being attention-seeking. His high risk status was confirmed, but because he was subject to voluntary after-care only, probation responsibility was to be limited unless there was no response from other agencies

when voluntary support would be re-imposed. He was told that he could stay at Weston Hostel until 27 February, but was to find his own accommodation thereafter. Mr Fremantle would remain his key worker to co-ordinate and achieve a multi-disciplinary solution. He apparently moved to an address in Weymouth on 23 February.

7.11 Enquiries for treatment for his drug abuse were made and a possible placement was found at Alpha House. However, having announced to staff at Weston that he had found independent accommodation elsewhere in Weymouth he then turned up at the Bournemouth Probation Office claiming to be homeless and in need of assistance. At a case conference held that same day (27 February) it was confirmed that probation involvement would be restricted to that of voluntary after-care. It was noted that this information was passed on to him, that the independent accommodation was a lie and that 'our next contact with Shane will be to cope with the next emergency that happens to him but our role will be reactive, rather than proactive'. Elsewhere his continuing vulnerability was noted and further unsuccessful efforts were made to find him a hostel placement. Later he moved into his parents' accommodation.

7.12 By June 1989 it was noted that he was 'still on a downward spiral' and his after-care was terminated in July due to a lapse in contact. He was admitted to Forston Clinic between 6 and 25 April 1989 following a crisis at his parents' home (chapter 8). He was removed from the high risk register although it was noted that if he should be subject to a probation order in the future, then a further high risk conference would be necessary to assess the level of risk. He was adjudged to be a risk to himself and since the arson conviction, also to other residents in any house in which he might live.

COMMENTS

- **Accommodation**

7.13 This was an enduring issue for Mr Bath. It is clear that real efforts were made to grapple with it by the Probation Service at this time. The nature of his offending, not only the conviction for arson, but the previous fire-setting incidents which were known and convictions for violence, made it very difficult to place him in anything other than fully supported accommodation. It is fortunate that Weston Hostel was willing to take him and offered him his longest period of stability at this time.

7.14 Unfortunately, his early good response to the boundaries set by the youth custody licence did not last long. He lost his job within one month. He abused his accommodation at various private lodgings, even stealing from the electricity meter and eventually also at Weston Hostel. He received much attention and input from the Probation Service, but it came to nought. Mr Bath received intensive follow-up from the Probation Service following his conviction for arson. Our expert evidence is that extending supervision after licence (albeit for a short time) was then an exceptional practice.

7.15 Supervising Mr Bath in the community assertively was obviously difficult and it is hard to see what more the Probation Service could have done at this time which was ultimately anything more than reactive. This is, however, another recurring theme in Mr Bath's care and again one which we think should have been tackled on a multi-agency basis. Mr Fremantle was to pursue a multi-disciplinary solution, but in doing so apparently failed to invite the Social Services and housing authority.

• High risk status

7.16 We were told that all Dorset probation officers have been required to follow County High Risk Procedures since 1988/89 and that in doing so were ahead of most other probation areas in the country. We were provided with copies of the procedures which were amended in 1992 and 1995. Even at this time there was a mine of information in the probation records relating to Mr Bath's risk not only to himself but to others and the likely pressure points. This is far better than anything that we have seen on Health or Social Services files. We believe that probation assessments could be of value to other services in that they are able to take into account more of the detailed forensic background of an individual.

7.17 We were also told that the high risk conference in Dorset has now evolved to the state where every such conference is attended by a police officer and a professional from any agency concerned with the individual, or which is likely to become so involved. The conference should decide which agencies are to receive automatic notification of and advice relating to high risk status and this would have been so after 1992. It was acknowledged that Mr Bath remained a high risk from September 1988 through to at least January 1996, but we have no evidence that the Probation Service did in fact alert other agencies to his high risk status during this period. All high risk conferences are overseen by an assistant chief probation officer.

• Information-sharing

7.18 We are impressed by the way in which there was relevant and proper disclosure of information at this time, first, to the Director of Social Services and then to Mr Bath's potential employer at the bacon factory. There was also appropriate liaison with Weymouth and District Hospital and CADAS when a crisis arose. We were told by Pat Rance that there should have been a 'continual communication going on between whichever agencies were handling him at the time'. This would have included St Ann's, however, we have not seen nor heard any evidence that this happened either at this stage or later. This is unfortunate and a failure of the probation procedures at the time which was acknowledged by Ms Rance.

7.19 One reason for this may be that Mr Bath was not being managed as a mentally disordered offender requiring any Health Service input at this time. If his history had been considered, however, at least the possibility of his contact with that service would have been clear. He was referred to CADAS for his drug problems and although we are not clear what became of his self-referral in November, he was seen in February 1989.

- **Breach of licence**

7.20 Although opportunities to take Mr Bath back to court for the breach of his youth custody licence offered themselves on numerous occasions, for example, his not staying in one place and the theft conviction, we were told that there would have been little point in doing so and that it was difficult to see what the court could do which would result in a healthy outcome for him. He was not in and out of prison at this stage and it is likely that a magistrate would simply have imposed a fine on him which would bring probation involvement to an end. We accept this as a reasonable analysis although it did not send the right message to Mr Bath about the consequences of his actions.

C. RECOMMENDATION

7. The Dorset Probation Service should review its multi-agency working procedures with a view to:

(a) ensuring that all other agencies involved, or likely to be involved, in the care of an individual, are alerted to an evaluation of high risk and that information pertaining to that evaluation is shared with the agencies identified;

(b) combining with other agencies to develop and provide assertive community supervision particularly to those individuals with a poor history of co-operation with services. (See also chapter 18, recommendation 17(a) and chapter 27).

Chapter 8

FIRST ADMISSION TO FORSTON CLINIC, WEST DORSET: 1989

- Services working in isolation
- CADAS
- Drug rehabilitation
- No Social Services involvement
- Housing assessment

A. Introduction

8.1 This chapter deals with Mr Bath's first admission to Forston Clinic, Dorchester (Dorset Community NHS Trust) where he was treated by Dr Graham Gallimore for his escalating drug abuse.

8.2 He had left Weston Hostel (chapter 7) and accommodation continued to be a problem for Mr Bath. He moved into his mother and stepfather's local authority warden-controlled accommodation in Stourpaine, near Blandford Forum on 28 March 1989. According to the Social Services records of his parents, a crisis developed which ended with his admission to Forston Clinic.

8.3 He had earlier been referred to CADAS from Blackdown Hospital, Weymouth but only kept one appointment with Ms Nicky Brown on 11 April. He was seen again during his admission to Forston Clinic and was to be offered their support in the community while he was awaiting a place for drug rehabilitation. Unfortunately Mr Bath failed to co-operate with these arrangements.

B. Forston Clinic.

8.4 On 6 April 1989, Dr G R Gallimore, consultant psychiatrist, admitted Mr Bath to Forston Clinic in Dorchester from Blandford Police Station after a 'serious incident' at his mother and stepfather's accommodation in Stourpaine. This incident seems to have been Mr Bath threatening his stepfather with violence.

8.5 In a letter to the referring GP following admission on 10 April, Dr Gallimore described how Mr Bath had left prison five weeks previously. On his release he had spent two weeks in a hostel in Weymouth and then three weeks with his half-sister in Gillingham. He had to move on from there because there were 'threats to evict her and her boyfriend'.

8.6 Dr Gallimore asked a social worker to assess him to see if any accommodation could be provided (there is nothing noted in the Social Services files relating to this request). This was apparently not possible and as Dr Gallimore had concerns about him returning to his mother's, he reluctantly admitted Mr Bath to Ashmore Ward at Forston Clinic to await assessment by CADAS.

8.7 In a later letter to the GP, dated 12 May, Dr Gallimore mentioned that the police at Blandford had voiced the concern that Mr Bath might kill someone if released, possibly his stepfather. However, it was not possible to charge him as he had committed no offence at the time.

8.8 The information about Mr Bath having left prison five weeks earlier is not true. He was released from prison in September 1988.

Diagnosis

8.9 Dr Gallimore advised the GP on 10 April that Mr Bath had a 'psychopathic personality disorder and associated drug abuse problems'. He was confident about this diagnosis throughout his contact with him. He went on to say that at his interview with Mr Bath in the police station it was clear that he was 'a tense and explosive individual' but there was no evidence of psychiatric illness. He was asking for help in general and in particular for help with his drug misusing problem.

8.10 In a letter to Dr Philip Fleming of the Wessex Regional Drug Unit, Portsmouth, dated 17 April (see below), Dr Gallimore stated that Mr Bath had expressed physical complaints and had threatened to harm himself unless he was given some antidepressants 'because he was so suicidally depressed'. However, there was no consistent evidence of depressive mood. He concluded:

'I suspect this young man's drug abuse reflects his very damaged personality deriving from his very adverse childhood experiences. I think he is going to be a very difficult young man to help in the long term'.

8.11 In his evidence Dr Gallimore told us there was no in-patient facility specifically for those with personality disorders at Forston Clinic and that his own experience of such patients was limited. Both wards at Forston were unlocked and anyone with very disturbed behaviour would require one-to-one nursing care:

'We would deal, in effect, with personality disordered patients a lot, who had other mental illness problems, in an in-patient setting. Inevitably, people with schizophrenia and manic depression would also have personality problems and we would deal with them that way. But there was no body of expertise in terms of in-patient care of people with personality disorder'.

8.12 Dr Gallimore advised us that there are very few specific treatment programmes available at Forston Clinic for those with personality disorder. The treatments that were provided to such patients were for co-existing mental illnesses. In addition, according to Dr Gallimore, there was, and is, no dedicated hospital psychology service at Forston Clinic:

'It really was a situation where we would make assessments of those people rather than offer a specific treatment facility for their personality disorder, as such. We attempted to focus on what we felt were treatable elements of their problem.

If they had co-morbid depression, often these people get into very difficult situations and they get very depressed and miserable about the situation they are in. Often they use illicit drugs or alcohol and we would focus on those areas in working with them rather than attempt specifically to tackle their personality disorder'.

CADAS

8.13 On 11 April, five days after he was admitted to Forston Clinic, Mr Bath was interviewed by Ms Brown from CADAS. The purpose of the interview was to assess his suitability and motivation for residential drug rehabilitation. She asked him to complete a drug usage self-assessment form which he did. Ms Brown's observation on this, however, was that the information he supplied cast doubt on the accuracy of the drug history provided, for example, he referred to 'come down' and overdose effects of cannabis (neither is characteristic of cannabis use) and did not identify the negative effects of amphetamine use which are generally well recognised by users.

8.14 Ms Brown asked Mr Bath about violence. He mentioned to her two convictions for violence including the arson incident at the resettlement centre in Southampton. She questioned him further about his tendency to violence and he told her about how he bottled up his frustrations and irritations.

8.15 Her conclusion was that he should be referred to Alpha House, a residential drug rehabilitation centre in Droxford, Hampshire (later referred to one called Face to Face, also in Hampshire), either directly, or via Highclere, the in-patient part of the Wessex Regional Drug Dependency Unit in Portsmouth. However, in view of his:

'criminal and psychiatric records and the possibility that his drug related symptoms may be masking an underlying, psychological condition, I would like to suggest that Dr Philip Fleming, who is more familiar with the regimes of Alpha and Highclere, further assess the case, with a view to a possible admission to the Regional Drug Unit, Portsmouth'.

8.16 Prior to the above Mr Bath had referred himself to CADAS by telephone on 20 December 1988. This would appear to be his first contact with the agency. On 6 January 1989 a CPN at CADAS wrote to Mr Bath thanking him for contacting the agency about his problems with alcohol and offering him the opportunity to contact them again.

8.17 CADAS received a referral from his GP on 17 February after he had deliberately harmed himself two days previously and been admitted to Weymouth and District General Hospital. Mr Bath's primary substance use according to this referral was of cocaine although he was also described as being a poly-drug user. It was recorded that he was using drugs intravenously.

8.18 On 22 February, Dr Bonello from Blackdown Hospital wrote to CADAS asking if they could see Mr Bath. He was offered an appointment for 28 February which he did not keep.

The Wessex Regional Drug Dependency Unit

8.19 On 17 April, Dr Gallimore wrote to Dr Fleming at the Regional Drug Dependency Unit, Portsmouth, sending him copies of the notes together with notes, reports and other information from St Ann's Hospital and Old Manor Hospital.

8.20 On 19 April, Dr Fleming saw Mr Bath in Portsmouth. The next day he wrote to Dr Gallimore saying that Mr Bath wanted to go into residential drug rehabilitation and that while this would be a reasonable goal most providers of these services would not consider him while he was on psychotropic medication. He therefore suggested to Dr Gallimore that he should consider gradually reducing this and seeing if he could manage without medication.

8.21 Dr Fleming agreed to put Mr Bath on the waiting list (between 8 and 10 weeks) for the regional in-patient unit. In the meantime he suggested that he could receive support from CADAS and be encouraged to find stable accommodation and perhaps a job. He found Mr Bath to be a 'very immature young man who can't cope easily with stress and who tends to react impulsively in difficult situations'.

Discharge to Face to Face

8.22 On 25 April, Mr Bath was discharged from Forston Clinic to 'Face to Face', a residential drug rehabilitation community in Lymington, Hampshire, but he was 'to be admitted to the Regional Drug Unit in due course'. The very brief (handwritten) 'final discharge summary' refers to his diagnosis of 'situational crisis (with) psychopathic personality disorder'. This mentioned his past history of self-harm attempts.

8.23 Mr Bath was taken to 'Face to Face' by Ms Brown that day. She commented that he appeared very agitated but said he wanted to become drug-free. She was concerned that his 'attention seeking immaturity' might cause him to leave before he had given it a chance. We have been informed by a current member of Face to Face staff that he never stayed.

8.24 On 31 May, Ms Brown wrote to Mr Bath at his mother's address to advise him that a place at Highclere was now available. She offered him a chance to call in at the CADAS office in Dorchester to see her. He did not take this up. The next contact he had with CADAS was in January 1990.

COMMENTS

- **Housing assessment**

8.25 Mr Bath returned to his mother's accommodation a number of times and on three occasions (March 1989, January 1992 and early 1995) North Dorset District Council (the Council) notified Mrs Bath of the possibility of legal action against her to ensure that he left. There was never any assessment of Mr Bath's own accommodation needs by Social Services. He never made any application for

housing directly to any of the housing authorities in Dorset. See chapter 30 for more on housing.

• Diagnosis and assessment

8.26 Dr Gallimore's assessment on this and other occasions was astute. The diagnosis of personality disorder was again not based on a full assessment of his history and nor was treatability assessed due to a lack of facilities at Forston Clinic to do so. However, he got the measure of Mr Bath quickly and in the absence of proper facilities to assess or treat his personality disorder made arrangements for help with his drug problems and subsequently decided that he should not be admitted to hospital at all.

8.27 Details of his offences and episodes of violence appear to have been incomplete or erroneous at this time. There was no systematic attempt to ascertain all the relevant background information from previous hospital admissions including information about levels of risk Consequently, there was no full appraisal of Mr Bath's risk or dangerousness.

• Assessment of drug abuse

8.28 It seems likely that Mr Bath was exaggerating the extent and variety of his drug misuse at this time so as to gain either 'street' status or professional attention. He is known to have used attention-seeking behaviour from childhood.

8.29 Nicky Brown's assessment was a good one. Her questioning of Mr Bath about his convictions for violence was not general practice at the time and was to be welcomed. Although the account Mr Bath gave her was not entirely accurate it did not minimise his violent behaviour. However, she clearly thought that a further assessment was warranted.

• Discharge summary

8.30 The discharge summary in April 1989 from Forston Clinic is inadequate. It failed to clarify what the care plan in the community was for Mr Bath. It was not clear whether he was expected to go to Highclere after leaving Face to Face (where he did not stay anyway) or vice versa. There were no monitoring arrangements agreed post-hospital and CADAS follow-up was unclear. The inadequacy of discharge summaries is a recurring feature of Mr Bath's contact with the Health Service. Their importance in promoting the good communication of accurate information cannot be over emphasised and we have reproduced a template for a model discharge summary provided to us by Dr K Rix of High Royds Hospital, Leeds at Appendix H.

Chapter 9

OFFENDING AND PROBATION CONTACT: 1989-1992

- Probation Order and supervision
- Southampton Probation Service
- Probation Service across county border and high risk procedures
- Multi-agency working and child protection
- Probation Service and information-sharing
- Community Service Order
- Eighteen month prison sentence
- No role for MHA
- CADAS

A. Introduction

9.1 During this period Mr Bath was primarily dealt with by the criminal justice system and Probation Service with some assistance from CADAS. There were offences of assault, predominantly against police officers who were arresting him or otherwise trying to deal with him. He was moving between Southampton and Dorset.

9.2 He got married in Southampton and became a father and there is some evidence of him being violent towards his wife giving rise to fears in relation to the well-being of his daughter. There was minimal Health Service involvement and the only Social Services involvement was in Southampton and concerned child protection.

9.3 The backdrop to his offending behaviour was drugs, but there were no incidents involving overdoses. Equally there was no other self-harming behaviour until he was sent to prison in 1991.

B. ABH, Assault on Police, and Burglary, 1989

9.4 On 6 June 1989 at Gillingham Magistrates' Court, Mr Bath pleaded guilty to offences of actual bodily harm, burglary of a Methodist Church and assault on police when arrested. He was at this time still subject to voluntary after-care by the Probation Service following the sentence of youth custody for the arson and being supervised by Mr Fremantle (chapter 7). The records show that voluntary after-care following that sentence was terminated on around 30 June because of Mr Bath's lapsed contact with the service. It was clearly stated that should he be subject to a future order to the Probation Service a high risk conference would be needed to assess the level of risk.

9.5 On 8 June 1989, solicitors acting for Mr Bath wrote to Ms Brown at CADAS stating that he had asked them to approach her concerning the prospect of a drug rehabilitation place being made available to him at his forthcoming court appearance on charges of burglary and assault:

'He told me that if he did (take up an offer of rehabilitation) then he would like the Court to make it a condition of his Probation that he attend the course because otherwise he felt they would not "hack it"'.

9.6 The solicitor asked Ms Brown to liaise with the probation officer about this. Ms Brown wrote back to him confirming that in her view he would benefit from a period in rehabilitation and that he had made an application to the Coke Hole Trust in Andover. It is not clear from the notes whether she did or did not contact the probation officer.

9.7 On 21 June, Ms Brown wrote to a drug rehabilitation centre in Bradford with a report on his current circumstances. Much of this reprised her report to Dr Gallimore of 12 April (chapter 8) but she also said that she would be meeting Mr Bath's probation officer the following week to ask for a full record of his offences. She added that:

'My own feeling was that his alleged history of violence and arson amounted to no more that isolated incidents of drug related psychosis. I therefore took him to see Dr Phillip Fleming ... who examined him briefly and endorsed my view'.

9.8 She reported that he had been misusing drugs, including alcohol, for five/six years and that his preferred drug was cocaine although he frequently used other stimulants, benzodiazepines, and hallucinogens.

9.9 There is a probation court report in relation to these offences dated 4 July and based on two interviews with Mr Bath. It was signed by Sue Garnett, who had supervised the youth custody licence earlier in the year, in the absence of the writer. It contains some incorrect factual information about the family and background, but is otherwise quite detailed. It refers to his working as an assembly worker since 12 June and his self-referral to CADAS as positive signs. It concluded that neither the probation nor medical services had any effective resources to offer the court and attempts to treat and accommodate him in the past had failed. Reliance was placed on the rehabilitative work being done by CADAS and the recommendation was that sentence be deferred for a maximum of three months for this to be pursued and to explore the possibility of a combined probation and treatment order.

9.10 On 8 July, Mr Bath was charged with burglary of an unoccupied building from which two bottles of wine were stolen and drunk with two other people and ABH of a police officer who he kicked when he is said to have become abusive and violent whilst in custody at Gillingham Magistrates' Court. He was remanded to HMP Dorchester to appear at Southampton Magistrates' Court on 31 July from where he was bailed to Highclere Regional Drug Detoxification Unit, Portsmouth, as a result of Nicky Brown's efforts, but arriving too late he was turned away and presented himself for arrest for breach of bail at Cosham Police Station.

9.11 Ms Brown wrote to Mr Bath at a Hythe address (near Southampton) on 9 August to say that Highclere had taken him off their waiting list although the offer of an interview in Bradford still stood. She advised him to contact the drug advisory service in Southampton and gave him details on how to contact them.

9.12 On 2 October, a firm of solicitors asked CADAS whether he had gone to 'rehab' or not. They were advised that a place had been arranged for him but he had not taken it up. After this there was no contact until his court appearance on 7 November.

C. Probation Order

9.13 He was sentenced on the above charges at Gillingham to 12 months' probation on 7 November 1989 and ordered to pay compensation of £139 in total. No treatment order was made. The Probation Order was to be supervised by the Probation Service in Southampton probably because this is where Mr Bath had been found accommodation with a landlady. There were three probation case workers from the Hythe office involved in supervising this order to 6 November 1990, when the Probation Order expired. It would appear that the burglary charge on 8 July was not proceeded with.

9.14 On 20 November, Ms Brown wrote to Mr Bath at Hythe to say that she had discussed his situation with a member of the Southampton drug advisory team and that they were prepared to offer him help with his problems of anxiety and aggression.

9.15 In December 1989 the probation file notes that Mr Bath was rated as high risk. He was also noted to be having a relationship with the daughter of his landlady who was now pregnant by him. His daughter Charmaine was born in June 1990. A more cryptic entry headed 'transfer summary' states 'having had recent experience of his temper and attitude, I can only emphasise that he is unpredictable and totally without reason when in one of those moods. Plainly he thinks the world exists for him and he offers little in return'. There is no detail of any incident nor any reason for this comment offered.

9.16 In January 1990, Mr Bath and his girlfriend were at his sister's in Gillingham, Dorset having had a row with her parents in Southampton. He had been in contact with Sue Garnett. He moved back to the Southampton/Hythe area in March. At this stage he was also seen by a probation officer from the Blandford office, Dorset, acting as a locum. He expressed his concern that Mr Bath would be returning to Southampton without accommodation to go to because he had been identified as high risk in the past and one of the trigger factors mentioned was lack of accommodation.

9.17 He was seen by Nicky Brown of CADAS on 30 January and 6 February 1990 in Gillingham and on 20 February she referred him to the local CPN service. The reference mentioned problems with drug dependency, anger and tension. Mr Bath

moved away before he could be seen. On being told that he was to move to a bedsit in Southampton she arranged counselling for him there. It was another seven months before he next had any further contact with CADAS.

9.18 Mr Bath married his girlfriend in May 1990. Later there is a note that information had been received that he had been violent to his wife and that he was abusing drugs again. Although the view after the baby arrived was that she seemed loved and well-cared for it was decided that a child protection conference should be held in liaison with Social Services due to his history of violence, unpredictability and temper problems. Such a conference was not held at this time and the probation officer noted that she would monitor the situation closely and organise one again if it was necessary.

9.19 A child protection conference was organised by the Southampton Social Services in November 1990. Probation did not attend nor provide a report to the conference although they were notified of the date and invited to attend. A summary of the minutes was sent to the Probation Service and is on their files. The baby was not placed on the Child Protection Register.

9.20 Mr Bath and his family were housed in a council maisonette in Southampton and it was noted that despite his problems he took his family responsibilities seriously. Up to August 1990 he had maintained good contact with the Probation Service. There was a failed attempt to engage him in an anger management course but only because he was the only person to attend.

9.21 In mid-September he suddenly disappeared back to Dorset taking his wife and baby with him and turned up at his sister's address in Shaftesbury. When we saw him in HMP Belmarsh he told us that he had sold all the furniture provided by the Council in the maisonette in Southampton before returning to Dorset.

COMMENTS

- **The Probation Order**

9.22 We think that 12 months was too short a period for this Probation Order to have any real impact on Mr Bath. There is a probation report on 29 September 1989 outlining the difficulties experienced in getting Mr Bath to co-operate, for example, his failure to arrive at Highclere in time, and stating that at that time he was out of contact. We do not have a copy of the final report to the court.

9.23 This was an early opportunity arising shortly after the arson conviction to offer some firm boundaries to Mr Bath. This could have been acknowledged by the imposition of a longer period of probation at the least which could easily have been justified given his history.

9.24 The involvement of the psychiatric services was not sought even after it became apparent that the drug rehabilitation option was not going to work and the

Probation Service made its view of the suitability of medical treatment in this instance clear. His primary problem was seen as being drug and alcohol abuse. Apart from reference to his 'temper and attitude' there is little evidence of any mental disorder at this time.

- **Hampshire Probation Service**

9.25 The approach to Mr Bath seems to us to have been on the whole passive and consistency of follow-up must have been affected by the fact that there were about six probation officers involved in this period. This clearly was not assisted by the fact that he moved back and forth between Southampton and Dorset.

9.26 The expert advice which we have received makes no criticism of the handling of this Probation Order in terms of contact with Mr Bath, but we are critical of the lack of involvement in the Social Services child protection conference (see below).

- **Probation across Dorset/Hants county border and high risk procedures**

9.27 No conference was held in this period. This is clearly in contravention of the Dorset high risk procedures which were said to be in place at that time. The main involvement here, though, was that of Hampshire Probation Service and we do not know whether they had similar procedures in place. The file which would have followed him across the county border flags up the need for such a conference should Mr Bath be subject to a further order and two probation officers (one Hampshire, the other Dorset acting as locum) referred to his previous high risk status but nothing was done about it. We can only assume that if he had been in Dorset's care such a conference would have been held.

9.28 This is particularly so where there were problems in housing again, but more because he had embarked on a relationship with a young woman towards whom he had exhibited violence and who had borne his child. He had also admitted that the baby 'wound him up' and there was evidence that he was drinking. There was also mention of a machete in connection with a dispute he was having with another man, we think that this should have rung alarm bells in relation to his young family as well. His mother-in-law had said that he had threatened the baby when he was 'stoned'. These factors are likely to have confirmed his high risk status.

9.29 We have been told that in having high risk procedures at that time Dorset were operating in the vanguard of probation services in the country and that it took some time for other areas to follow suit.

- **Multi-agency working and child protection**

9.30 Whether or not high risk procedures were in place in Hampshire, here was an opportunity to share the information above with another agency which was not taken. We are critical of the failure to attend or report to the eventual child protection conference especially in view of the highly pertinent information which was available to the Probation Service regarding his violence in a domestic setting.

D. ABH, Community Service Order and Breach of Probation, December 1990

9.31 On 20 October 1990, Mr Bath was arrested with his sister for offences under the Public Order Act and ABH when they smashed the windows of her ex-cohabitant's home. When police arrived Mr Bath is recorded as becoming violent, punching an officer in the face and head-butting him. He was also verbally abusive and threatening.

9.32 A Shaftesbury GP wrote to a consultant psychiatrist at Forston Clinic on 17 October 1990, thanking him for having seen Mr Bath and noting that apart from his excessive drinking he had taken an overdose of temazapam and been offered but declined admission to Salisbury Infirmary. The same day the GP referred Mr Bath to CADAS saying that he admitted to excessive drinking and had recurring depression.

9.33 On 26 October, Ms Brown wrote to the same psychiatrist and the GP to advise them that CADAS would not allocate a worker to Mr Bath at present in view of the fact that 'his motivation to change was limited and that his accounts of his misuse of drugs and alcohol were unreliable' but they would invite him to take part in a group at Gillingham on Tuesdays. The psychiatrist wrote to the GP with a copy to CADAS stating that Mr Bath had a long history of extremely disturbed behaviour and was known to be violent. He wrote 'Nearly all the psychiatrists who have assessed him, including myself, feel psychiatry has nothing to offer him'.

9.34 Mr Bath seems to have dropped out of the Tuesday group at Gillingham because on 19 November Ms Brown wrote to him inviting him to call in. On 10 December, Mr Nick Wilson, the project manager of CADAS at the time, wrote to the Clerk of the Court at Gillingham Magistrates' Court to say that Mr Bath had been attending the CADAS day centre at Gillingham and that they had 'started to explore the extent of his problem'. Mr Wilson went on to say in his letter that although he anticipated that this work would continue it will be entirely up to Mr Bath 'as any involvement we have will be on a voluntary basis'.

9.35 Mr Bath was sentenced on 18 December to 90 hours' community service for the ABH at Gillingham Magistrates' Court in July. No order was made in relation to the breach of probation.

9.36 There were probation reports from the Dorchester and Hythe offices. The former contains information about the previous conviction attracting a probation order, but nothing about the arson conviction. Otherwise it is quite detailed as to Mr Bath's past and mentions that he was working as a turkey plucker and had an action plan prepared by Employment Training which indicated that he would be starting a training course in January in the catering trade. It concludes: 'little can be achieved effectively in respect of this young man's extremely disturbed behaviour. He is aware of the various agencies where he can seek assistance and has shown that he can make constructive, though limited, use of them. To make another Probation Order at this stage would only duplicate the work already being done by other

agencies. I have, therefore, discussed with him the possibility of a Community Service Order'.

9.37 Hythe provided a positive report dealing with his willingness to address his drug-taking and anger management. It counselled against a custodial sentence.

9.38 Over this Christmas his relationship with his wife floundered. She went away for two weeks in which time he is said to have had a relationship with another woman. He also got involved in numerous burglaries and thefts with his sister, so that by the time his wife returned he was in custody.

COMMENTS

- **Community Service Order**

9.39 The leniency of this sentence demonstrates the effort and will which accompanied the attempts of those involved to find a community disposal allied to drug treatment.

9.40 The option of recommending another Probation Order was refused on the grounds of work being undertaken by other agencies. We cannot see what work was being carried out. Although he is said to have been attending a CADAS day centre this did not last long and there is no record of what work was undertaken when and if he did attend. He was seen at most on three occasions at CADAS. These probation reports failed to understand or convey the nature of Mr Bath or of his history and were too reliant on the limited work being carried out by CADAS which may have been overstated by Mr Wilson.

9.41 The failure by the Probation Service to take action in relation to the breach of the Probation Order would not have sent Mr Bath the correct message in terms of the need to comply with such an order. There had previously been a failure to act when he was in breach of the youth custody licence in 1989 (chapter 7).

9.42 It is worth noting that Mr Bath did not have any contact with hospitals or doctors between April 1989 and October 1990 when he was referred to Forston Clinic by a GP following an apparent overdose of temazepam. However, he did not attend and there was no admission at this time. His next contact with the Health Service was not until early 1992 (chapter 10).

E. Eight Charges of Burglary and Theft and Breach of CSO, April 1991

9.43 In January 1991, Mr Bath was arrested on multiple counts of burglaries of dwellings and thefts. The arrest summons records that over a four-month period he committed 16 house burglaries and 10 other offences of theft to supply a drug habit. He was remanded in custody.

9.44 Five days later he requested a visit and was seen on 30 January by an unknown CADAS worker. The CADAS record noted that he was likely to go to a bail hostel in Bournemouth soon, was requesting to attend a drinkers' group in prison and asking to be referred to rehabilitation. The CADAS worker advised him that this would have to await the outcome of the court case. However, 'he feels that if he is actively looking for rehabilitation the court will be lenient'.

9.45 On 19 April 1991, Mr Bath received an 18-month custodial sentence for the above from Dorchester Crown Court. The CSO was revoked. The summary information sheet states that the case was put into the court list at the last minute because his daughter had died. There was no full social enquiry report and a short probation report was put forward. The judge refused an adjournment for further reports. Mr Bath was said to be happy with the sentence as he had expected it to be much longer.

9.46 The information about his daughter is untrue. We have not seen a copy of any social enquiry report. The probation report simply puts forward an explanation for the lack of a probation report. This was due to the delay in allocating an officer to the case because they had initially written to the wrong legal representative seeking information on pleas to be offered by Mr Bath. The judge was unimpressed. Mr Bath served his sentence at HMPs Channings Wood and Dartmoor. His parole eligibility date was 19 October 1991 and his earliest date of release was 12 January 1992. His through-care was the responsibility of Sheila Newall.

9.47 He was visited at Channings Wood in July 1991 and it is noted that he was still immature and untruthful. He had said that he would probably go to his sister's on release. He had attempted suicide while in prison. Mrs Newall was left 'feeling very uneasy and felt that if he was given parole he would need very close supervision'.

9.48 At Dartmoor in July he had cut his wrists again. In September Mrs Newall expressed the view that she was not happy for him to be on parole licence as she did not feel he would keep to its terms. When she was notified that he had been granted parole to commence in November she complained on the basis of his accommodation difficulties and also that he had recently cut his wrists. His parole was suspended.

9.49 On 26 November she visited his parents at 31 Hod View, Stourpaine. Mrs Bath had gone to meet her son at the station. She had not been informed that the parole had been suspended. She had apparently been given permission by the Council for him to stay for two weeks at her address.

9.50 There was a flurry of activity regarding accommodation for Mr Bath on his release. Weston Hostel refused to take him. His sister was in bed and breakfast accommodation. In December he gave the address of his girlfriend Karen, but on a home visit she said that she was not offering him an address.

9.51 His wife (now referred to as 'ex') was planning to take out an injunction against him. Mrs Newall wrote to the Hythe Social Services informing them of Mr Bath's impending release.

9.52 No accommodation had been found for Mr Bath by January 1992 due to his past behaviour and the arson conviction. The latter is misdescribed for a second time as him setting light to an old man's bed while he was still in it.

9.53 He was released from prison on 12 January 1992 and went to CADAS requesting help with binge drinking, temazapam consumption (15 at night), regular alcohol consumption of two and a half bottles of sherry per day, amphetamine use, his divorce and suicidal feelings. He did not go back to CADAS and on 12 March his case was closed.

9.54 On 20 February, Mrs Newall sent a memorandum to Pat Rance, Acting Chief Probation Officer, saying that this case has been terminated and she believed he must be taken off the high risk register. She ends 'I have no doubt that he will "pop up" again'.

9.55 Mr Bath visited the Gillingham CADAS drop-in on 23 April to ask for help in getting a council house and custody of his two-year-old 'son' (he in fact had a 22-month-old daughter). He did not keep his appointment on 28 April and in view of the child care aspects of the case CADAS contacted Social Services to inform them of their concerns about his ability to care for the child.

COMMENTS

- **Probation supervision**

9.56 Prior to October 1992 offenders sentenced to over 12 months' custody were assessed for release on a parole licence and if this was not granted they were released unconditionally but had a right of access to a probation officer on a voluntary basis only. This was the position here.

9.57 We think that Mrs Newall's actions in alerting the parole board to the unsuitability of his release on licence and the communication with Hythe Social Services was appropriate. The effect of not getting parole, however, was that he was released with no effective follow-up. She told us that voluntary care was for Mr Bath to take up and that the Probation Service does not pursue people under voluntary care and so her contact seems to have fallen away at about the time he was released.

9.58 Her work with Mr Bath had been primarily aimed at finding him accommodation on release which clearly proved to be difficult due to his arson conviction.

- **High risk conference**

9.59 Once again there was no conference and this was Dorset where a high risk conference procedure was in place. The only mention of his registration as a high risk offender was in the memorandum of 20 February to which there was no response.

9.60 We feel that given the difficulties in placing this vulnerable and unpredictable person, a high risk conference may have served to focus the minds, particularly of more senior practitioners, to any potential risk at this stage. Although we are told that in 1992 it would have been unusual for probation services generally to require active engagement in risk terms, the process of high risk conferences was in place in Dorset. We can see no reason for failing to do so purely because he was only subject to voluntary after-care.

9.61 A conference may also have resulted in the relevant other agencies being informed of Mr Bath's unsupervised release. We think that where the person involved is an offender with a high risk status and the Probation Service is terminating its supervisory role, or only has a voluntary role, there should be a formal process of notifying other agencies in the area, such as Social Services and housing, which are likely to become involved and to share any relevant information and particularly information relating to risk, with them. There is likely to have been contact with the health side as well in view of the self-harm.

- **CADAS**

9.62 We are generally impressed by the commitment and standard of work carried out. At this time CADAS was working with little support from other agencies.

F. Theft and Criminal Damage, 1992

9.63 There were two convictions in 1992. In March, Mr Bath was fined £75 at Bournemouth Magistrates' Court for shop-lifting and in June he was conditionally discharged for 12 months for criminal damage by Weymouth Magistrates. The latter was for punching his fist through a pane of glass in the front door of his parent's home at 31 Hod View, Stourpaine. In April 1992, Mr Bath was admitted to St Ann's under the care of Dr Nas Choudry (chapter 10).

9.64 There was no further Probation Service involvement with Mr Bath until he was charged with robbery in April 1993.

COMMENTS

- **Psychiatric assessment**

9.65 No psychiatric reports were ever commissioned during this period by the court. There was no requirement to obtain a medical report for an offender who appeared to be mentally disordered prior to the imposition of a sentence of imprisonment

before 1992 and even then it is permissible not to obtain a report where there are reasonable grounds not to do so (section 4(1) of the Criminal Justice Act 1991).

9.66 Even if Mr Bath had undergone a psychiatric assessment at this time, it is unlikely that a hospital disposal or a period of in-patient assessment would have followed given the views previously expressed about Mr Bath by psychiatrists, but also

because apart from two episodes of self-harm while in prison, he did not show signs of mental disorder.

G. RECOMMENDATION

7. The Dorset Probation Service should review its multi-agency working procedures with a view to:

(a) ensuring that all other agencies involved, or likely to be involved, in the care of an individual, are alerted to an evaluation of high risk and that information pertaining to that evaluation is shared with the agencies identified;

(b) combining with other agencies to develop and provide assertive community supervision particularly to those individuals with a poor history of co-operation with services. (See also chapter 18, recommendation 17(a) and chapter 27).

Chapter 10

1992

- Four hospital admissions
- Housing liaison meeting
- Past history: prison and hospital
- Section 5(2) MHA
- Discharge summaries
- First use of CPA forms
- Social Services
- CMHT criteria in West Dorset
- Dual diagnosis

A. Introduction

10.1 Having recently been released from a sentence of 18 months' imprisonment for burglary (chapter 9), Mr Bath, aged 23, had presented himself to CADAS in early 1992. However, they had closed their file on him by 12 March due to a lack of contact.

10.2 The main events of this period are his first admission to St Ann's under Dr Nas Choudry for six days in April and then the first admission under Dr Martyn Rowton-Lee at St Ann's in July also for six days. In the intervening period he was admitted to Forston Clinic under Dr Gallimore once again, who assessed him to be 'highly dangerous' and 'grossly manipulative' and to suffer from an untreatable psychopathic disorder. He remained there for 21 days. There was a multi-disciplinary housing liaison meeting organised by the North Dorset District Council who were concerned about Mrs Bath's situation and incidents caused by Shane Bath at her accommodation.

10.3 CPA had been introduced in April 1991 (Joint Health/Social Services Circular LASSL(90)11) and there was an abortive attempt to use it for the first time by Dr Choudry.

10.4 There was no Social Services involvement with Mr Bath and in West Dorset CMHT involvement was noted to be inappropriate because he was not suffering from a mental illness.

B. Hospital Contact

10.5 On his presentation to Poole General Hospital on 21 April, Mr Bath was noted to be very depressed. There were serious lacerations to his forearms which were 'almost circumferential'. Later there is a note that they were caused when he put his hands through a window. He was transferred to Flaghead Ward at St Ann's under the care of Dr Nas Choudry.

10.6 Dr Choudry came to St Ann's in 1982 and has since developed the addictions service in East Dorset. At the time in question, apart from his workload in the community, he had responsibility for two wards at St Ann's Hospital: Flaghead and Branksome Wards. The former has now moved to Fairmile Hospital, Christchurch and comprises ten detoxification or stabilisation beds. The latter remains at St Ann's and is an eight-bedded acute psychiatric ward.

10.7 A long and detailed note was made by the duty SHO on admission. Mr Bath was once again telling lies about the death of his daughter and being HIV positive. He also said that he had recently been released from Winchester prison which was also incorrect as he had in fact been released from Dartmoor prison. He mentioned that he had been sexually abused by his stepfather between the ages of 2 and 13. Mixed with the lies were half-truths and some facts, for example, that he had been in care 'aged 13-20' and had seen a child guidance counsellor from age 6 for behavioural problems. The need to find old medical notes is recorded.

10.8 By 23 April the prisons in which Mr Bath had served his recent sentence had been clarified as Channings Wood and Dartmoor by a nurse who contacted first Winchester and then Dartmoor. The nurse had spoken to the medical unit manager who had been unable to provide much information but was able to confirm that Mr Bath had not undergone ECT and 'to the best of their knowledge was not HIV positive'. Mr Bath had said that he had received ECT in prison and been told that he was HIV positive.

10.9 The medical unit manager had said that he would ring back having consulted the prison records and with information of his treatment plan and plan on release. There is nothing on the files to indicate that this ever happened.

10.10 The nursing note for that day also shows that efforts were made to clarify Mr Bath's HIV status with his GP practice, but they were unable to help. Mr Bath had been registered at that particular surgery since April.

10.11 On 24 April a nursing note of a multi-disciplinary team meeting records: 'Ask social worker to obtain background information from family and ascertain what is true and what is not'. This is the only mention of a social worker in this admission and a rare note of a multi-disciplinary meeting. There is nothing to indicate that these investigations were ever made. Equally, there is nothing on the Social Services files in this regard. This meeting is not recorded in the clinical notes save for a side scribble which states that a check had been carried out at 'Gloucester Road' which is a genito-urinary clinic where there was no record of Mr Bath.

10.12 Mr Bath was treated with antibiotics for his lacerations and a mixture of chloral hydrate, melleril and chlorpromazine for his 'agitation'.

10.13 On the evening of 26 April Mr Bath was made the subject of a section 5(2) order under the MHA. He had become angry and abusive and had said that he wanted to

leave the ward and kill himself. He had to be restrained by nursing staff and is recorded as being 'extremely agitated'. He was sedated and moved to a secure room.

10.14 There is a brief ward round note by Dr Choudry the next day. It reads:

'I note above events
- not prepared to stay within confines of Flaghead Ward
- Personality disorder with psychopathic tendencies no evidence of mental illness.
He wishes to discharge himself. Agreed:
- sect 5(2) to come off
Full assessment necessary definitely ag[ainst] readmission'.

10.15 Later Mr Bath changed his mind and asked to stay in hospital. Dr Choudry confirmed to us in evidence that this was the only occasion on which he would have seen Mr Bath himself during this admission. The next day he took his own discharge against medical advice. Dr Choudry said he was pleased that he had been able to persuade Mr Bath to remain in hospital for a further 24 hours of his own motivation.

10.16 A CPA form was initiated on admission but never completed. Dr Choudry told us that in the circumstances where Mr Bath had taken his own discharge against medical advice on 28 April, thus demonstrating no motivation to co-operate with follow-up, he did not think that any follow-up was necessary.

10.17 He was visited by his younger brother and sister and brother's girlfriend during this admission. On 27 April, Mr Bath signed a behavioural contract with the ward. A discussion with his sister and brother's girlfriend is noted in the nursing files and states that Mr Bath 'told a lot of lies'.

10.18 The discharge summary is brief, persists in referring to his release from Winchester prison and refers to a long history of personality disorder with psychopathic features. It notes the aggressive episode leading to the section 5(2) order and states that his depression was due to drug withdrawal and was not a true clinical depression. The note concludes that 'as there was no evidence of mental illness it would not be appropriate for him to be readmitted to St Ann's without first completing a full psychiatric assessment'.

10.19 Dr Choudry told us that he viewed Mr Bath's main problem as being severe personality disorder complicated by his behaviour and a history of substance abuse. He was dealing with a crisis situation which had presented shortly before admission and again on the ward. At that time he did not consider that Mr Bath's problem was one of addiction but of the abuse of substances. However, later and in relation to a subsequent admission under his care, he said that he did regard Mr Bath as having a problem with addiction, thereby taking him outside the criteria for CPA then current (chapter 11).

10.20 Mr Bath was admitted to Forston Clinic under Dr Gallimore on 5 June at the request of his GP, Dr Percival. This GP had first met him on 29 May when he joined his list. He admitted to a history of depression and multiple overdose, self-mutilation and suicide threats. He was tense and agitated during this consultation. He was living with his parents at 31 Hod View, Stourpaine. The referral letter was written to an associate psychiatrist at Forston Clinic with whom Dr Percival had discussed Mr Bath on the telephone. He had requested in-patient help to detoxify from his temazepam habit.

10.21 During this admission, which lasted until 24 June, he was still talking about the death of his daughter. On this occasion the lie was discovered quickly. On 12 June Dr Gallimore's note reads: 'Explosive psychopath who tends to provide misleading information'. He stopped all medication and no withdrawal symptoms were observed. The medical staff were, therefore, not convinced that Mr Bath had a physical drug dependence.

10.22 Another brief discharge summary documents one aggressive episode. The diagnosis is recorded as an untreatable sociopathic disorder with childhood sexual abuse, living in a children's home and a violent forensic history said to be contributory factors. There is no detail provided of the forensic history. CADAS were unsuccessful at placing him in a rehabilitation hostel due to his history of arson and aggression. Dr Gallimore was not willing to re-admit him in the future. There were no specific psychiatric after-care plans but CADAS are recorded as being willing to support him.

10.23 A CADAS assessment on 9 June concluded:

'He feels he will need a lot of support to get through next week and doesn't feel he will be able to cope if discharged earlier unless he goes straight into a suitable rehab. He is certain he will resort to drugs if discharged ... I felt a major problem to be his unresolved grief concerning his daughter ... and he (Dr Gallimore) agreed to delay his discharge until Monday 15 June pending arrangements for Shane's aftercare and further discussion'.

10.24 On 14 July, Dr Gallimore wrote to Mr Bath's then GP, Dr Percival, stating:

'His history cannot be relied on particularly in regard to his drug taking, and though ostensibly admitted at your request to be withdrawn from temazapam, showed no withdrawal symptoms without the use of covering medication. CADAS workers were so often taken with his "story" that they tried to arrange a drug rehabilitation hostel place but, quite understandably with his history of arson and assault, he was not acceptable to any of these hostels'.

10.25 We have been advised by Ms Lorraine Tritton from CADAS that Mr Bath did not attend for the appointment arranged to discuss rehabilitation further. He relocated to east Dorset on 8 July and CADAS closed the case on 10 July 1992.

10.26 The Dorset Community NHS Trust files contain much information about Mr Bath's forensic history including the court report of Dr Sedman following the arson charge in April 1988.

10.27 On 25 June following his discharge, Mr Bath appeared in the GP's surgery threatening self-harm and demanding to be re-admitted to Forston Clinic. He smelt strongly of alcohol and became agitated. He started throwing equipment around and then attacked Dr Percival causing him a bloody nose. He was refused admission by Dr Gallimore and was taken by the police to the Casualty Department of Weymouth and District Hospital and eventually to his parents' home where he damaged property over the following days.

10.28 This behaviour led to North Dorset District Council convening a multi-disciplinary meeting on 2 July (see 10.59).

10.29 Dr Gallimore wrote to Dr Percival explaining his decision not to re-admit Mr Bath under his care on 14 July. In the letter he describes his knowledge of Mr Bath, his manipulative behaviour and use of psychiatric units. He quotes extensively from Dr Sedman's court reports of 1988 and mentions the admission to St Ann's earlier in the year. He had clearly seen that discharge summary.

10.30 Dr Gallimore concluded that:

'I consider him highly dangerous. He is a liar and grossly manipulative with threats to self-harm or attack and may carry out serious assaults on people who thwart him. He has a psychopathic disorder which is not treatable. There is no mental illness and, as I have indicated, I would not be willing to admit him again under my care. I would strongly advise that he is not prescribed psychotropic medication, which he would abuse. Like Dr Sedman, I am a pessimist about this man's prognosis. I find it difficult to see anything other than a further prison sentence or special hospital placement after a further serious incident if his current pattern of behaviour continues'.

10.31 On 17 July, Mr Bath was once again admitted to St Ann's having cut his wrists. This time he was under the care of Dr Rowton-Lee for the first time. This admission followed a period of six days when he had been admitted to Poole General Hospital having taken an overdose and then having slashed his wrists and tried to jump off a bridge.

10.32 The Poole discharge summary which was sent to the GP only shows that Mr Bath spent five days as an in-patient before being discharged on 13 July. It says that he overdosed on phenytoin, amphetamines, and benzodiazepines. It goes on 'he stated several times on the ward that he would try and kill himself again if he left the hospital however following discussion with his consultant psychiatrist it was felt that his problems were secondary to a psychopathic personality and that psychiatric admission to hospital was unwarranted'.

10.33 Contact was made with Forston Clinic by a nurse who was told that attempts had been made to get Mr Bath into a rehabilitation unit. This failed and he had been discharged back to his mother's home. Further brief background details were obtained of his history over the previous six months.

10.34 There is a long admission note. This refers to much early childhood information including the fact of the children's homes and that he had seen a psychologist aged 6. It is not clear where it came from although the most likely source on admission was Mr Bath himself. Again he said that he had been sexually abused by his stepfather who had served a five and a half year prison sentence as a result.

10.35 Mr Bath was started on a chlordiazepoxide withdrawal regime.

10.36 It is doubtful whether Dr Rowton-Lee did ever see him during this admission. A ward round note on 22 July says that Mr Bath was not on the ward, but to 'try reg[ular] CPZ [chlorpromazine]'.

10.37 This discharge summary notes a diagnosis of personality disorder and says that Mr Bath said he had been drinking and taking drugs since April. He described himself as HIV positive but this was discovered to be untrue and he had admitted as much. He was persisting in his story that his daughter had died at the age of 18 months. He had been living in a squat. He disappeared after a few days on the ward and was discharged on 23 July. There were no arrangements made for follow-up and no drugs prescribed on discharge.

COMMENTS

- **Presentation, unreliability and assessment**

10.38 Mr Bath's presentations at hospital during this year were characterised by crisis in the form of self-harm and supposed drug and alcohol abuse, unreliable information giving and generally attention-seeking behaviour, including aggression towards to others. As before he received no formal assessment of his personality disorder or its treatability and in the main appears to have been simply managed on the sedative effects of psychotropic medication. A drug withdrawal regime was started in July but not completed. There was no formal assessment of his depressive state.

10.39 His lack of reliability as a historian and undoubtedly manipulative behaviour clearly made a proper assessment of his presentation or any underlying condition difficult. He was admitted to Forston Clinic for help with his drug-taking, but Dr Gallimore was able to establish quite quickly that there were no withdrawal symptoms apparent, thus making it likely that Mr Bath was either confabulating or exaggerating his story. This was similar to his first admission to Forston Clinic in 1989 (see chapter 8) .

10.40 We cannot criticise Dr Gallimore's pessimistic view of Mr Bath's future or his recorded decision not to admit him into his care again. It was a reasonable view to

hold and one which would have been reasonable through much of Mr Bath's history. On this occasion he was left to CADAS, but there was no referral to the Social Services.

10.41 During the admission under Dr Choudry it was appreciated that Mr Bath's information needed verification. Yet the discharge summary shows that it was concluded during this short admission that his depression was due to drug withdrawal even though we have been told that steps, by way of blood or hair analysis were usually not taken to confirm what drugs, if any, he had been taking, the latter in particular being too costly. Dr Choudry told us that an experienced clinician can 'isolate behaviour of drug use'.

10.42 We have not been able to find any urine analysis results in the notes and in the light of the assessments by Dr Gallimore and CADAS regarding the likely veracity of Mr Bath's drug-taking history find Dr Choudry's view open to question in retrospect.

10.43 The GP notes do show a possible increase in the use of temazepam at this time. Mr Bath had seen his GP on three occasions between 26 February and 17 March and been prescribed temazepam. This information does not appear to have been available to Dr Choudry.

10.44 The admission under Dr Rowton-Lee followed an intense period when he had caused himself harm on about three occasions in quick succession. He was probably not seen by Dr Rowton-Lee at all and again no full assessment of his depressive state was undertaken. It is also not known which psychiatrist was contacted by Poole General Hospital for advice.

- **Checking past history: prison and hospital**

10.45 Good efforts were made to check Mr Bath's prison history during the April admission to St Ann's even though no actual records were received. They were able to throw doubt on the HIV story and this was checked further and revealed that he was lying about having been tested in prison and at the genito-urinary clinic at Gloucester Road. We do not know what these prison medical records would have shown as they are untraceable, however, we think that as soon as contact was made with the prison service a treatment plan and discharge summary should have been provided to St Ann's.

- **Section 5(2) MHA**

10.46 Apart from in August 1993 when Mr Bath was made the subject of a section 48 MHA transfer from prison to hospital and subsequently of a section 37 MHA Hospital Order, this is the only occasion on which a section of the MHA was used to hold him in hospital in Dorset. Other than that we can only say with certainty that he was detained in a police station in Dorset under section 136 MHA once.

10.47 We have seen no section papers submitted to the hospital managers for the use of section 5(2). This section authorises the detention for a period of 72 hours of a

patient already in hospital. The clinical note indicates that this section was used because Mr Bath stated a clear intention to kill himself and was going to leave the hospital. It was imposed at 8.15 p.m. on the evening of 26 April and removed by Dr Choudry at 2.55 p.m. the following day.

10.48 The purpose of section 5(2) is to prevent an informally admitted patient from discharging himself from hospital before there is time to arrange for an application for compulsory detention for assessment or treatment under sections 2 or 3 to be made. Its proper use is when the doctor in charge or his nominated deputy has concluded that an application for admission under one of these sections is appropriate (MHA Code of Practice (1990), ch. 8 para. 2). Arrangements should be made for assessing the patient as soon as this power is invoked.

10.49 There is no record of any direct input by Dr Choudry into the decision to use section 5(2). He was the registered medical practitioner in charge of treatment and there is also no record of any other doctor being nominated to fulfil his statutory functions under section 5(2) in his absence (section 5(3)).

10.50 In evidence, Dr Choudry said:

'We would have considered him at the ward rounds and other meetings and we would have felt that since there is no evidence of mental illness that the behaviour was fired by other aspects of his character and personality and there was no reason or indication to convert a 5(2) to a section 2 or section 3. A further period of assessment was not necessary because section 2 was not appropriate. He had been assessed and treatment was not possible so a section 3 was not appropriate'.

10.51 We think that this illustrates a common misunderstanding of the purpose of section 5(2). Mr Bath had been in hospital for a little under a week and had only just been seen by the consultant in charge of his care. There had been little time for a proper assessment to be undertaken.

10.52 No approved social worker was ever contacted and it is our view that this section was used as an expedient way to detain Mr Bath compulsorily and with no intention recorded of having him assessed for a section 2 or 3 admission. We consider this to be an improper use of this power.

10.53 In our view the criteria for a section 2 admission were probably fulfilled at this time and was justified in view of the assessment of the doctor imposing the section 5(2). We are unconvinced by Dr Choudry's explanation above which seems to us to be a justification with hindsight of the actions that were taken in April 1992 and do not accord with the contemporaneous notes made. It is not clear why a clinical depression was discounted or why it was considered that treatment had nothing to offer Mr Bath. It seems unlikely that an assessment had been carried out and his own note of 27 April, the day before Mr Bath was allowed to take his own discharge, states that a full assessment is necessary.

- **CPA**

10.54 The is the first attempt (April 1992) to use CPA for Mr Bath and was rather half-baked. The notion that motivation to co-operate was required in order to implement CPA is clearly wrong. Formal CPA had just been introduced, but pre-1995 there was some confusion as to those who were eligible for its application. Brian Goodrum, the principal officer for mental health for Dorset Social Services before 1997, told us that it clearly applied to those for whom section 117 after-care was appropriate and to those who had been in hospital for longer than six months. Other than that it applied to 'vulnerable' people and the eligibility was less clear. He said that post-1995 there was better implementation because it applied to everyone who had been within the specialist mental health services.

10.55 A joint evaluation of compliance with CPA undertaken by the Dorset Health Commission and Social Services pointed to only 25 per cent of patients discharged from St Ann's and 5 per cent from Forston Clinic in 1992/93 as being subject to CPA. Since that time audits have shown better compliance with CPA but the returns have been inconsistent.

10.56 The approach to CPA at this time in this case shows a clear lack of understanding of its purpose. This is demonstrated not by a failure to use it, but its misuse. Later on Mr Bath's failure to co-operate was again influential in the use of CPA and we have found that throughout his contact with the services the implementation of CPA was non-existent or very poor (see chapter 18).

10.57 It is correct to say that the Dorset Health Commission and Social Services were aware of the poor implementation of CPA through the process of audit and review. The materials which we have seen relating to this are thorough and impressive and although policies were re-written as a result, we have not seen any practical effect of this filtering through to the care of Mr Bath. The review documentation acknowledges that there was no 'ownership' of CPA and also some clinical resistance to its implementation.

- **Discharge against medical advice forms**

10.58 Again our expert advice is critical of the use of these forms. They are of limited use and can make patients reluctant to return for further help. If they are to be used they must be specific about the advice which is given and the capacity of the patient to understand the advice. There should be a witness to the advice given. Too often the forms are used to make it appear that the patient is responsible for an outcome which the hospital ought to have anticipated or prevented particularly in the cases of patients who lack the capacity to understand the risks which they are taking.

C. Housing Liaison Meeting

10.59 This meeting was convened and chaired by Helen Jenkins, senior housing officer with North Dorset District Council on 2 July 1992 at 31 Hod View, Stourpaine.

There was a wide attendance with the exception of the Probation Service who tendered their apologies for not attending but were sent the minutes of the meeting.

10.60 In her statement to us Ms Jenkins set out the occasions on which Mr Bath had created difficulties at his parents' and later, his mother's sheltered accommodation provided first by NDDC and then by Signpost Housing Association. He first came to their attention in April 1989, then again in September 1989 and October 1990. In January 1992 he returned on being released from prison and then again in June 1992. On each occasion it was made clear to his parents that their tenancy was at risk if their son remained with them.

10.61 In June Dr Percival, GP, had warned that Mr Bath was dangerous and should not be approached by individuals. Ms Jenkins and her staff took the view that Mr Bath was a disturbed individual and in view of what was perceived by her as a lack of response from other agencies, she felt that it was important that all interested parties met to discuss the situation.

10.62 Those present at the meeting included: Clare Tavernor, Sheltered Housing Supervisor and Brian Miller, Head of Housing Management, both from NDDC, Dr Percival, Dr Gallimore, a sergeant from Blandford Police Station and Valerie Hall, social worker and CMHT member. Other disciplines represented included the legal department and the warden of 31 Hod View, Stourpaine.

10.63 The minutes of the meeting refer to 'various serious incidents' which had occurred at 31 Hod View and were of concern. The background information provided by the sergeant and Dr Percival is not set out in any detail. The former is said to have provided information about 'behavioural problems' encountered when dealing with him in the community. Dr Percival was at that time also the GP for Mr Bath senior and Mrs Bath.

10.64 Dr Gallimore is recorded as having provided background medical information and advised there was no mental illness, but a severe personality disorder with psychopathic tendencies. Some forensic background was provided and the note refers to him having 'poured petrol over someone and is known to be an arsonist and has been convicted for GBH'.

10.65 Valerie Hall is said to have confirmed the information provided by Dr Gallimore and indicated the problems of finding accommodation for Mr Bath. We have not been able to hear directly from Valerie Hall as she has now moved away from the area and we were unable to make contact with her.

10.66 The feeling at the meeting was that Mr Bath fell between agencies because of his personality disorder. It was concluded that 'the exchange of information had been a useful exercise, but no solution could be found. It was agreed to monitor the situation, and to liaise as appropriate'.

10.67 A Social Services note on 1 July records a discussion between Ms Hall and her supervisor. It was 'emphasised that social work input was inappropriate as client is not suffering from a mental illness'. This was confirmed to the meeting by Ms Hall who said that as a result involvement by the Community Mental Health Team was inappropriate. There is no copy of the referral form to the Social Services available although one is referred to as being at the Sturminster Newton office. In preparation for the meeting Ms Hall also collected the Bath family file, but Mr Bath's child care file was not available because it had 'gone to be microfilmed'.

10.68 It is recorded that Ms Jenkins expressed concern for Mr Bath's care as well as for his parents and felt that some provision should be made for him. Other housing department workers had expressed concern for their own safety and that of the other residents.

10.69 Ms Hall's record of the plans was that Mr and Mrs Bath would be advised that 'their son should leave their home. If this did not happen within a reasonable time, they could be deemed to have made themselves intentionally homeless and would be evicted'. There are no plans recorded for Mr Bath. Following further discussion with her supervisor, the case was closed by the Social Services department on 3 July 1992.

COMMENTS

- **Assessment of housing needs**

10.70 We are concerned that throughout this period and following the liaison meeting, there was no assessment carried out of Mr Bath's accommodation needs by Social Services.

10.71 Our expert advice is that had Mr Bath presented to the housing authority as homeless or in need of housing he probably would have been deemed 'vulnerable' under Part III of the Housing Act 1985 and later Parts VI and VII of the Housing Act 1996. Mr Morgan, the present Head of Housing and Community Services with NDDC, agreed.

10.72 There was no direct obligation on the Council to assess Mr Bath in the absence of an application for housing. Once one was made it would have come under an obligation to assess Mr Bath's own housing needs as a vulnerable homeless person under the provisions of the Housing Act 1985.

10.73 It is difficult to consider the situation which presented itself in terms of the response of an unitary agency. The response should have been formulated on a multi-agency basis with all agencies considering the needs of Mr and Mrs Bath senior with appropriate support for Mr Bath.

10.74 To that end the response of Ms Jenkins in convening this meeting was the proper one, but the opportunity for all agencies to consider a management strategy for

Mr Bath or to acknowledge the need for a further meeting under the auspices of Health or Social Services with a more long-term plan in mind was not taken. It was not difficult to predict that there would be more problems with him in the future.

10.75 Care management under the provisions of the Community Care Act 1990 had not come into being at this date and so there was no statutory duty on the Social Services to conduct an assessment of Mr Bath's social care needs under section 47 (see also LAC(93)10).

10.76 The NDDC have no record of any application made to them for housing by Mr Bath at this time which was prior to the transfer of housing stock to Signpost Housing Association in 1994.

10.77 This meeting was an opportunity set up by the NDDC for Mr Bath's housing needs to be addressed and assessed. All that happened was that Social Services said that there were problems finding him accommodation because of his history and then the file was closed.

• Social Services and CMHTs

10.78 Mr Bath was not considered to be an appropriate client for the CMHT or Social Services because of his diagnosis of personality disorder. In closing its file, the Social Services effectively left Mr Bath homeless and wandering unsupported and unmonitored in the community. The police were left to deal with him.

10.79 West Dorset was quicker in setting up CMHTs than East Dorset so that by 1988 they were in place in the west of the county. The Review of Services for the Mentally Ill in Dorset carried out in 1995 by the Dorset Health Commission in conjunction with the Dorset Social Services, lists seven CMHTs in the West. They targeted people with 'severe and enduring mental illness and those with episodes of severe, acute, mental illness'. There is no definition of 'severe mental illness' in that document which is a review of services up to 1994.

10.80 Today there are six CMHTs whose priority is those with 'serious mental illness'. The definition of that group in the current joint Community NHS Trust and Dorset Social Services Mental Health Policy Manual does not include nor make reference to personality disorder or to dual or multiple diagnosis.

10.81 In the circumstances, the reasons for the comments of Valerie Hall become clear. Personality disorders did not and do not fall within the remit of CMHTs in West Dorset.

10.82 The way in which the decision to close the file is recorded does not convey the impression of a decision by the CMHT, but by the Social Services alone. This is not assisted by the fact that there are no unified CMHT notes for Mr Bath at any time during his contact with services in Dorset in the East or West. In many

instances we have had to assume or be told that a CMHT was in fact involved when social work input was offered (see paragraphs 18.83 and 19.43).

- **Dual diagnosis**

10.83 The joint Mental Health Policy Manual referred to above offers local guidelines for the treatment and care of people with dual diagnosis. It focuses on 'mentally ill adults' and 'serious mental illness' causing lasting disability together with misuse of drugs and/or alcohol. It also includes those with serious mental illness as a consequence of substance misuse.

10.84 While there is no mention of personality disorder, Dr Gallimore made it clear that his approach was to address those problems for which he could offer some treatment e.g. drug abuse and this is borne out by Mr Bath's admissions to Forston Clinic. Once discharged from hospital and in the community, however, he was outside the services offered and relied on agencies such as CADAS.

D. RECOMMENDATIONS

8. The NHS Trusts should review their methods of independently testing and verifying the variety and extent of drug misuse by individuals and to incorporate best testing practices into its assessment and monitoring protocols.

9. The NHS Trusts and Social Services should strengthen existing policy on the treatment, assessment and management of patients with a dual or multiple diagnosis or other complex needs including personality disorder with a view to ensuring that they are not excluded from services/CPA. (See also chapter 18, recommendation 17; chapter 26, recommendation 20 and chapter 27, recommendation 22)

10. The NHS Trusts should:
(a) include a section in every patient's file which contains a summary of the background history, corroborative evidence and indicators of risk;
(b) ensure that copies of MHA section papers are kept on a patient's file for easy access (see chapter 13);
(c) seek advice on the redesign of the discharged against medical advice forms and scrutinise their use.

11. The NHS Trusts should review the use of section 5(2) MHA.

Chapter 11

ADMISSION TO ST ANN'S; ADDICTIONS SERVICE: JANUARY-APRIL 1993

- Increased risk
- Information-checking
- Addiction viewed in isolation
- No CPA
- Discharge against medical advice
- Discharge summary
- Referral to drug rehabilitation

A. Introduction

11.1 We do not know what Mr Bath was doing between June 1992 and January 1993. There were no hospital admissions and no criminal charges. He saw his GP on a couple of occasions. In January he was admitted into the care of Dr Choudry and the addiction service. Mr Bath also demonstrated an increase in aggressive and violent behaviour and described some psychotic symptoms.

11.2 On 9 January, Mr Bath (aged 24) was detained at Bournemouth Police Station under section 136 MHA. This followed a disturbance at his brother's home where, in a fight, he is said to have attacked his brother with scissors and was ejected by his mother. He then cut his own throat and wrists and was treated in hospital before being taken to the police station.

11.3 When interviewed by the duty consultant psychiatrist from St Ann's Hospital and a social worker at the police station the following day, Mr Bath gave an account indicative of serious misuse of illicit drugs and worsening aggression. He said that two days previously he had gone to Southampton with the intention of killing his ex-wife's partner. He then became paranoid and had gone to a police station where he (falsely) claimed he had killed someone. He said the subsequent fight with his brother had occurred when he had been 'desperate' to find 'a fix'. Mr Bath reported that for the previous 10 months he had been taking large amounts of heroin on a daily basis, temazepam prescribed by his GP and additionally amphetamines and LSD.

11.4 Mr Bath reported that since his 'father's' death in November 1992 he had been hearing voices and believed people to be 'looking at him, laughing at him, talking about him'. Mr Bath 'expressed a wish to be freed of his addiction to heroin and temazepam'. He agreed to be admitted informally to St Ann's Hospital under the care of Dr Choudry. There were no criminal charges laid against him.

B. Admission to St Ann's Hospital, 10 January-11 March 1993

11.5 The admitting doctor at St Ann's Hospital noted a previous diagnosis of 'personality disorder' and Mr Bath's account of his drug abuse. He/she (the record is unsigned) suggested that Mr Bath's feeling that his family had been trying to harm him might be 'paranoid', but the doctor did not perform or record an examination of Mr Bath's mental state. A record of a physical examination was made, however, and it was recorded that Mr Bath was 'actively withdrawing'. As a result he was prescribed methadone and chlordiazepoxide.

11.6 That same day there was recorded in the medical notes an 'informal chat' with a medical student who recorded symptoms of withdrawal as 'chills, agitation, sweats, nausea, vomiting, hallucinations and depression'. 'Alcohol abuse' was also noted. In addition the record mentions 'rectal stitches-due to stepfather's sexual abuse'. This appears to be a record of Mr Bath's own self report, as no physical examination of relevance was performed or recorded. Under the heading 'Social History' is recorded 'Shane's step-father (died this past fall) began sexual and physical abuse age 6-12. Shane reported this to Mom, she denied his report so Shane reported it to a teacher at school. She called Social Worker and Shane removed from home and step-father sent to prison (two years). Beat Shane badly on return from prison. Shane home on week-ends and abused again by father'.

11.7 Dr Choudry in his evidence to us made plain that he considered Mr Bath's admission to hospital on that occasion to be solely in order that he be detoxified with a view to rehabilitation. Dr Choudry did not consider any exploration of past traumas or abuse to have been indicated at that time; indeed he felt such to have been contra-indicated: 'Here we had a chap who was a chemical mess from illicit drugs, he was in a toxic mess from a medical condition'.

11.8 Indeed two days after admission on 12 January 1993, Mr Bath was found to be 'collapsed' from 'probable septicaemia'. He was immediately transferred to Poole General Hospital where he received treatment for bronchopneumonia, returning to Dr Choudry's care at St Ann's on 18 January 1993.

11.9 On his return to St Ann's it was noted that Mr Bath was 'again saying he is HIV positive-again no evidence'. However on 26 January, Mr Bath had an HIV test. On 10 February he informed nursing staff at St Ann's that he had been told by the Genitourinary Medicine Clinic that the test had proved positive for HIV. He was described as increasingly agitated and he made superficial cuts to his wrist. Mr Bath's physical condition again showed signs of deterioration, with further chest infection and on 14 February arrangements were made for his transfer back to a medical ward at Poole General Hospital. This, however, he refused 'stating it will be his last admission. States he will be dead soon'.

11.10 A note was made in the medical record that section 5(2) MHA should be invoked if he tried to leave St Ann's that night. The following day medical staff at St Ann's

discovered that Mr Bath had lied about his HIV test result. When Mr Bath was confronted by this he showed 'little reaction'. He subsequently told nursing staff that he had been seeking attention and sympathy. Later that day he was transferred to Poole General Hospital for treatment again of bronchopneumonia, returning to St Ann's on 19 February 1993.

11.11 Within 24 hours of his return from Poole General Hospital Mr Bath inflicted a laceration to his arm which required suturing. He was reported to be distressed at having to acknowledge that he was not HIV positive and also that he felt he was getting little attention as a 'leaving party' for another patient was taking place on the ward. Subsequently it was noted during the following week that Mr Bath 'has realised he needs rehab' and had himself applied in writing to two drug rehabilitation units in the independent sector.

11.12 Mr Bath continued his methadone reduction regime. After a further episode of self-mutilation on 4 March 1993 it was recorded that his continuing stay on the ward, whilst awaiting a place at Phoenix House rehabilitation unit in London, was dependent upon no further self-mutilation. Mr Bath was being assisted in his application for a place at Phoenix House by a social worker.

11.13 On 11 March 1993, Mr Bath signed a note to the effect that he was taking his own discharge from St Ann's Hospital 'against medical advice'. There is no record in the medical notes as to what advice he received. Indeed this event is not even recorded in the medical notes.

11.14 Mr Bath was treated as a patient suffering from drug addiction alone. As a consequence Dr Choudry explained that it was not considered appropriate to use any section of the MHA to prolong his admission and treatment. He told us that a section 2 admission for assessment may have been appropriate initially on the grounds of his 'mental state was disturbed enough and he was a danger to himself or to others'.

11.15 Dr Choudry told us that 'we do not have CPA for addictions. This was considered an addiction problem. He would have had a key worker from the ward. He would have had access to the voluntary bodies for further counselling and support. He would have had access back to the Community Drug Services, but no CPA'. It is not clear to us how he would have had such access.

11.16 Dr Choudry was asked whether there was a lack of clarity in the eligibility for CPA of a patient with a dual diagnosis and he said:

'No, there is no blurring. In terms of dual diagnosis, we are thinking in terms of the Mental Illness and Chemical Addiction (MICA) patients, the mentally ill chemical abusers. If they are mentally ill and have a chemical abuse problem or an addiction problem, their CPA is with the CMHT. The addiction services are complementing the treatment that they are getting'.

11.17 If a patient has a personality disorder and a chemical abuse problem, then 'I do not consider that as a MICA patient ... There are patients with personality disorders and with chemical abuse who may have a CPA through the Mental Health Team because of aspects of their character problems or personality problems or depressive problems, borderline problems that will require the services of a Mental Health Team'. He agreed that if such a patient had presented to Dr Rowton-Lee for psychiatric as opposed to addiction services then he would have been eligible for CPA, but did not consider this to be anomalous.

C. 12 March-25 March 1993

11.18 On 12 March 1993, Mr Bath was re-admitted to St Ann's from Poole General Hospital where he had been taken following an over-dose of heroin and temazepam. This overdose he had taken the previous day having left St Ann's. In the Accident and Emergency Department at Poole General Hospital he was noted to be expressing serious suicidal intent. There he was assessed by the duty consultant psychiatrist, Dr Rowton-Lee, who arranged his return to St Ann's under the care of Dr Choudry.

11.19 On return to St Ann's Mr Bath expressed regret for his behaviour, which typically he attributed to causes outside his control, i.e. pressures being put upon him by a female patient at St Ann's with whom he had started 'a relationship'. He said that he realised that he had lost 'ten weeks therapy' by taking illicit drugs the previous day.

11.20 Mr Bath remained at St Ann's on a reducing regime of methadone until 24 March 1993. Arrangements had been made on that day that he attend Phoenix House in London for an interview to see whether he would be accepted there for further rehabilitation. A social worker had arranged for a travel warrant to be provided by the Probation Service and a probation officer with the Community Drugs Team at St Ann's liaised with a colleague at National Assoication for the Care and Resettlement of Offenders (NACRO) in London, informing her of the plans.

11.21 Mr Bath never attended at Phoenix House. On 25 March 1993 he was discharged from St Ann's in his absence.

11.22 On 6 April 1993, Dr Choudry's registrar, wrote a letter to Mr Bath's GP. This letter stated that Mr Bath had been admitted on 12 March 1993 and discharged 'in his absence' on 25 March 1993. Only passing reference is made to Mr Bath's admission to St Ann's on 10 January 1993. No reference is made to any risk which Mr Bath might pose to himself or others and there is no indication in the letter of what the Clinical Team felt was Mr Bath's prognosis. Dr Choudry, in his evidence to us, conceded that this letter fell far short of an adequate medical discharge summary. The letter was not copied to any other hospital or service to which Mr Bath might present. In particular it was not copied to Phoenix House, which was Mr Bath's next intended placement for rehabilitation.

11.23 Dr Choudry in his evidence indicated that he would be concerned at such a medical discharge summary being sent to other than a named medical practitioner for reasons of medical confidentiality. He had assumed that Phoenix House would have been provided with all necessary information about Mr Bath which they needed by the social worker. However, he acceded that he could not be certain that this had been the case.

COMMENTS

11.24 It should have been clear by now that providing Mr Bath with a travel warrant and expecting him to take himself to the rehabilitation unit arranged for him was exceedingly optimistic. Nothing short of taking him there would have worked, although making sure he stayed would have been more difficult.

Chapter 12

SECTION 48 MHA TRANSFER DIRECTION TO ST ANN'S: 12 APRIL 1993-21 JANUARY 1994

- Robbery
- Section 48/49 MHA transfer from prison to hospital
- Admission to St Ann's Hospital, 14 August 1993
- ECT
- RMO workload

A. Introduction

12.1 This is an important episode in Mr Bath's life and is described in this and the next two chapters. He was remanded in custody after admitting to a robbery at knife point in April 1993. He was transferred to hospital from prison under section 48 of the MHA with a diagnosis of a depressive illness due to his self-harming behaviour and this was later turned into a section 37 MHA Hospital Order (HO) by the court in November.

12.2 During this period the newly formed Community Forensic Team became involved with its first in-patient and he was seen for several sessions by a psychologist. A forensic opinion was also sought from Ravenswood House RSU, Knowle Hospital. This was an occasion to consider a section 41 MHA Restriction Order but this possibility was never addressed (chapter 13).

12.3 He was aggressive and difficult to manage on the wards and even though he was assessed as not showing any signs of a depressive illness on admission, he underwent a course of ECT. He was discharged from the Hospital Order in December 1993 (see chapter 14).

B. Robbery

12.4 At about mid-day on Monday, 12 April 1993, Mr Bath committed an offence of robbery at a newsagents' shop at Palmerston Road, Boscombe, Bournemouth. He 'burst' into the shop which was occupied by two adult women, brandishing in front of him a kitchen knife with a blade of approximately 12 ins with which he threatened the women. One described him as pulling faces and snarling at them. Both women retreated to the rear of the premises, locking a door between themselves and the shop. Mr Bath then used the knife in an unsuccessful attempt to open the till before taking a large bottle of lager and five packets of cigarettes and leaving the premises.

12.5 Mr Bath's mother, in a subsequent statement to the police, said that he returned to her home that day carrying a bottle of lager and a kitchen knife and told her of his commission of the offence, stating of the knife 'I've put this up to a woman's neck so they ran to the back of the shop and locked the door'.

12.6 Ten days later, on 22 April 1993, Mr Bath attended Bournemouth Central Police Station and admitted the offence, stating that his motivation had been to steal money to fund his heroin habit. Following arrest he was remanded in custody.

C. Psychiatric Assessment at Police Station

12.7 On 23 April 1993, Mr Bath was assessed at Bournemouth Central Police Station by Dr Choudry at the request of Mr Bath's GP, who was also the police surgeon.

12.8 Dr Choudry, in a letter to the GP dated 26 April 1993, noted that Mr Bath had been charged with robbery and 'carrying a knife'. He referred to the early admissions to St Ann's under his care between 18 January 1993 and 25 March 1993, when 'assessment at that time revealed a personality disorder with a number of psychopathic traits and a vulnerability towards the abuse of illicit drugs'. Dr Choudry noted the hope that Mr Bath could have been admitted to a rehabilitation unit 'but this was not to be for a number of reasons'. Mr Bath told Dr Choudry that he was 'back into drugs' and that 'the crime was committed because of shortage of funds'.

12.9 Dr Choudry reported:

'My assessment of him revealed a tense individual, but there is no evidence that he suffers from a treatable psychiatric disorder. It is important that the law should take its course and I am sure we will hear about him in the not too distant future. I understand that he has threatened deliberate self-harm if he is not admitted to St. Ann's and also that he has been telling the authorities that he is HIV positive when our records show that during his last admission no such evidence existed. This clearly highlights the manipulative aspects of his disturbed personality and it is only right that he be held fully responsible for his actions'.

12.10 Given that prior to Mr Bath's admission to St Ann's in January 1993 there had been an escalation of his dangerous behaviour towards others and that within three weeks of his discharge he had committed a robbery armed with a knife, we asked Dr Choudry whether it had been remiss of him not to have sought to follow-up or maintain contact with Mr Bath after his discharge or to alert others to his presence in the community. Dr Choudry maintained that he had not been responsible for Mr Bath who in early 1993 had been a voluntary patient: 'I was not taking responsibility for him. I was helping him to make decisions about his treatment'.

12.11 We suggested to Dr Choudry that there had been a lack of appreciation of the risk posed to others when Mr Bath had been allowed to walk out of St Ann's Hospital on 25 March 1993. Dr. Choudry replied 'Well I accept what you say. Steps should be put in place to alert people but I am not absolutely convinced that that will actually prevent an individual of this character getting into a chaotic mess again and creating a situation for himself. He is the one who puts substances in his mouth, nobody else does'.

12.12 Mr Bath later told Dr Rowton-Lee that in the weeks following his discharge from St Ann's prior to the robbery he had been living rough, 'sleeping on park benches, in public toilets, in squats and dossing down in lodging houses with his drug taking friends'.

12.13 Mr Bath was remanded in custody to Exeter Prison.

D. Remand Period, Exeter Prison

12.14 On 1 July 1993, Mr Bath was committed from Bournemouth Magistrates' Court to Bournemouth Crown Court for trial charged with robbery, burglary (of a dwelling house) and theft (from his mother). On 8 July 1993 at the request of the medical officer at Exeter Prison, he was again assessed by Dr Choudry.

12.15 Dr Choudry responded in a letter dated 12 July 1993 that 'there has never been any firm indication that he suffers from a formal mental illness. He is prone to behavioural problems and at times features of a reactive depression which are more related to his emotional liability as a result of his substance abuse'.

12.16 Dr Choudry noted that Mr Bath's mother had recently died-this was factually incorrect-and that Mr Bath was showing 'bereavement phenomena' and also that Mr Bath was receiving major tranquillising medication by depot injection 'which may be holding some of his tension levels and also some of his depressive symptoms' and anti-depressants.

12.17 In his clinical assessment Mr Bath 'did not reveal an endogenous depressive state and there were no psychotic features'. Dr Choudry did 'not feel that any active psychiatric intervention is necessary at the present time and the law should take its course'.

12.18 On 5 August 1993, Dr Choudry wrote to Dr Rowton-Lee reporting that the prison medical officer and a senior registrar in forensic psychiatry at the Butler Clinic Regional Secure Unit in Devon, 'are expressing concern over his desperate state and deliberate self harm attempts. He is needing a stripped cell presently. They are requesting a Section 48 transfer which is reasonable. I think he should be on Studland'.

12.19 Studland Ward at that time was a six-bedded locked ward, the only such facility at St Ann's Hospital. Dr Rowton-Lee was the consultant psychiatrist responsible for that ward. Dr Rowton-Lee in his evidence to us described his workload at that time. He told us that additionally he had responsibility as a consultant general psychiatrist for a catchment area with special responsibility for the elderly mentally ill. He was also expected to provide consultant psychiatric input to the Community Forensic Team. He undertook one session a week at Portland Young Offender Institute and was also Acting Medical Director for the Trust. Dr Rowton-Lee told us that his workload was considerably in excess of that of his other consultant colleagues and this was recognised by the Trust.

12.20 Dr Choudry told us that his own disinclination to accept Mr Bath as a patient at St Ann's resulted not from his questioning of the opinions of the other two doctors that Mr Bath was mentally ill, which were markedly at variance with his own consistently expressed opinion of Mr Bath's mental state, but rather because he only had open beds at St Ann's and, therefore, he could not 'guarantee security'. In so saying Dr Choudry reiterated to us his opinion that Mr Bath's crime 'was not fired by mental illness or depression' and that Mr Bath 'had said he committed crimes to get drugs'.

12.21 In the event Mr Bath was transferred from Exeter Prison to St Ann's Hospital under the care of Dr Rowton-Lee as Responsible Medical Officer on 14 August 1993. The medical reports of Drs Keith and James for the purpose of the transfer under section 48 stated that Mr Bath was suffering from mental illness 'of a nature or degree making it appropriate for him to be detained in a hospital for medical treatment and that he is in urgent need of such treatment'. Both doctors noted Mr Bath to be depressed in mood, referring to his recent bereavement (false), that his condition had deteriorated and that he was actively suicidal (having made two attempts to hang himself in addition to self-mutilation).

COMMENTS

- **Section 48 MHA**

12.22 This gives the Secretary of State the power, on the recommendations of at least two registered medical practitioners, to direct the transfer of a person remanded in custody to a hospital if that person is suffering from mental illness or severe mental impairment of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and that he is in urgent need of such treatment. It does not enable such a transfer where a person is suffering from a personality disorder alone. There is no 'treatability' test to satisfy (section 27 and appendix I).

12.23 This provision gives the Secretary of State the same power of making a 'Transfer Direction' as if a person were serving a sentence of imprisonment (section 47 MHA). Such an order must be accompanied by 'a Restriction Direction' (section 49 MHA) when a person is detained in a prison or remand centre or has been remanded in custody by a magistrates' court (sections 49(1) and 48(2)(a) and (b)). A Restriction Direction has the same effect as a Restriction Order under section 41 MHA, i.e. amongst other things, denying the Responsible Medical Officer the power to discharge, or to grant leave of absence or transfer the patient to another hospital without the sanction of the Secretary of State.

12.24 We do not criticise the use of section 48 here. Two doctors had diagnosed a depressive illness. Mr Bath had been self-harming in prison and there is mention of 'bereavement phenomena'. He was being held in a strip cell and was receiving psychotropic medication. It was obviously better that he should be in hospital than prison in those circumstances.

12.25 It is worth noting that a Hospital Order can be made even where there is no causal connection between an offender's mental disorder and the offence in respect of which the order is made.

E. Admission to St Ann's Hospital, 14 August 1993

12.26 Mr Bath was admitted to Studland Ward in the mid-afternoon of 14 August. An assessment of him was undertaken by nursing staff who noted that he had settled quickly into the ward, appeared to have no problems with concentration and appeared 'animated and relaxed'. The duty doctor did not attend the ward until nearly midnight by which time Mr Bath was asleep and it was decided to leave examination of Mr Bath until the morning.

12.27 On examination the following day no objective evidence of a depressive illness was found, but Mr Bath's claim to be low in mood and suicidal was noted. Indeed throughout Mr Bath's stay at St Ann's from August to December 1993 there were never noted in the records any features typical of a major depressive illness; rather Dr Rowton-Lee's appraisal of Mr Bath was that underlying his severe behavioural disturbance was a chronic depression of mood. There was no evidence of physical illness.

12.28 During the early weeks of Mr Bath's admission to hospital his behaviour was severely challenging on an almost daily basis. He would be suddenly and unpredictably aggressive, mainly towards others but also towards himself and was obstructive in refusing to co-operate with the efforts of medical and nursing staff to interview him and to assess his mental state.

12.29 He perpetrated frequent, unprovoked physical assaults upon other patients and upon nursing staff of both sexes by punching, head-butting, attempting to strangle and throwing hot drinks into their faces. On such occasions he invariably required physical restraint by nurses trained in control and restraint techniques and he would be removed to his room and given sedative medication.

12.30 Sometimes furniture had to be removed from his room after he damaged fixtures and fittings in anger. Mr Bath would occasionally claim amnesia for his actions.

12.31 We heard evidence from Mr John Cunningham, Community Forensic Mental Health Nurse. At this time he was one of few nurses in the hospital trained to use approved control and restraint techniques in the management of patients, although he did not work on Studland Ward. Consequently, Mr Cunningham told us that he had been urgently summoned to Studland Ward to engage in the restraint of Mr Bath a number of times and that these had been his only contacts with Mr Bath prior to his discharge from hospital in December 1993. He was asked to become involved in the discharge arrangements in January 1994 (see chapter 14).

12.32 On the fourth day after his admission Mr Bath lacerated his arm with a razor and refused to say how he came by it. Subsequently he removed dressings from the wound and smeared blood over walls and over himself. He was, at the time, screaming and required physical restraint at which time he was noted to be 'smiling inappropriately'.

12.33 The following day, 19 August, he head-butted a ward sister without warning, Dr Rowton-Lee noted subsequently after interviewing Mr Bath 'he is clearly a disturbed young man. His main presenting problem at present is his personality disorder. It is impossible to assess any underlying depression while he is as menacing and aggressive as he is now. Re-assess evidence of underlying depression (bereavement problems) as soon as he is prepared to be co-operative at interview. There is reason to suppose that he has invented previous family deaths to solicit attention'.

12.34 Mr Bath continued his pattern of assaultative behaviour and as a result his management by nursing staff necessarily was largely reactive, consisting of a regime of 'close' or 'total' observations and the administration of prescribed anti-depressant and tranquillising medication, both regularly and on an 'as required' basis. On 22 August, Dr Rowton-Lee noted that Mr Bath remained 'reluctant to engage in history taking'. Three days later Mr Bath commenced a course of ECT.

12.35 In late August Mr Bath was refusing to see Ms Rachel Newman, probation officer, who had been charged with the preparation of a pre-sentence report. Dorset Probation Service had requested a report from the Community Forensic Team led by Dr Grace Leung, Consultant Psychologist, particularly to assist in the assessment of Mr Bath's risk. At the time of this referral Dr Leung was not aware that Mr Bath was in the hospital. Although the Community Forensic Team had offices at St Ann's Hospital they were not part of any hospital-based clinical team.

12.36 By 6 September 1993, Mr Bath had received four ECT treatments. On occasions he had refused such treatment and on others he had threatened to refuse, only attending for treatment after considerable persuasion by nursing staff. He remained however assaultative towards others, although with markedly decreased frequency of assaults, throughout the first three weeks of September.

COMMENTS

- **Medical management**

12.37 Mr Bath was transferred to St Ann's Hospital from prison with a diagnosis of mental illness. However, during the course of this admission to St Ann's Hospital he never displayed clear signs and symptoms of a major depressive illness.

12.38 The use of ECT in his medical treatment regime was, in our view, open to question and our expert advice concurs. We do not think that his condition was such that ECT was indicated. It is usually reserved for the treatment of very severe, generally psychotic depression which is life-threatening if left untreated. Such people may

refuse or be unable to eat and drink with a consequent high mortality and a very high risk of suicide. We acknowledge that behaviourally he was extremely difficult at this time, but we do not think that this was indicative of ECT.

12.39 We also think that given the degree of persuasion that Mr Bath is recorded as needing to undergo ECT, that we must question whether he had in fact properly given his consent to the treatment. We can find no evidence of any second opinion to support its administration and think that one should have been obtained (section 58 MHA).

12.40 Mr Bath's medical management during the course of this admission was for the most part reactive to the behavioural disturbance he displayed and poorly formulated. No attempts were made to formulate the nature and extent of Mr Bath's mental health problems and this failure was seriously compounded by the absence of any attempt to research his background by reference to records which would have been available had they been sought or the interview with Mrs Bath on 7 September 1993 (chapter 13).

- **RMO workload**

12.41 At this time Dr Rowton-Lee was undertaking an unduly heavy workload. We have been told that a new consultant has been appointed so that Dr Rowton-Lee can now concentrate on his forensic work.

- **Nursing management**

12.42 In our opinion the failure of the multi-disciplinary team as a whole properly to formulate Mr Bath's case resulted in his nursing management being once again reactive to his behavioural disturbances. Clear efforts were made by nursing staff to provide care plans for Mr Bath. It was the nursing staff who bore the brunt of Mr Bath's almost daily aggression and abusiveness and of the clinical disciplines involved in Mr Bath's care during this admission only the nursing staff in our opinion emerge with any credit.

F. RECOMMENDATION

12. The NHS Trusts should review the use of ECT to ensure compliance with the MHA and the Code of Practice.

Chapter 13

SECTION 37 MHA HOSPITAL ORDER: 12 APRIL 1993-21 JANUARY 1994

- Role of RSU
- Court reports
- Hospital/Restriction Orders (sections 37/41 MHA)
- Risk assessment
- Community Forensic Team

A. Introduction

13.1 On 22 November 1993 and following his transfer from prison to hospital under section 48 MHA (chapter 12), Mr Bath was made the subject of a section 37 MHA Hospital Order (HO) by the court.

13.2 During this period the newly-formed Community Forensic Team became involved with its first in-patient and he was seen for several sessions by a psychologist. A forensic opinion was also sought from Ravenswood House RSU, Knowle Hospital. This was an occasion to consider a section 41 MHA Restriction Order but this possibility was never addressed.

B. Court Reports and Hospital Order

13.3 On 6 September 1993, Dr Rowton-Lee provided the court with a short report indicating that his assessment of Mr Bath was not yet complete. On 7 September 1993 Mr Bath's mother attended the ward and was interviewed by nursing staff in Mr Bath's presence, providing useful background information which was then recorded in the ward-based nursing notes.

13.4 During the course of September Dr Grace Leung, Consultant Psychologist head of the Community Forensic Team (CFT), attempted to assess Mr Bath having been requested to do so by the Probation Service. On first approaching Mr Bath, however, he indicated that he did not wish to be interviewed by her. Dr Leung was accompanied on that occasion by Ms June Copeland, a clinically unqualified psychology assistant whom Mr Bath did, however, agree to see. Consequently Dr Leung allowed Ms Copeland to undertake the assessment of Mr Bath under her supervision. Dr Leung told us that this was probably the first time the CFT had undertaken an assessment of an in-patient and that her function had been to evaluate the likelihood of an offender benefiting from psychological treatment in the community if subject to probation supervision.

13.5 Dr Leung told us that she wrote to Ms Newman on 6 September indicating that 'this man I cannot treat in the community'. This, it seems, she based upon the findings of Ms Copeland, who had administered three psychometric tests which she interpreted as showing Mr Bath to have very high levels of depression of mood, anxiety and anger. Ms Copeland saw Mr Bath on a total of seven occasions,

focusing upon grief counselling which Dr Leung told us related to the death of his mother. This was despite the fact his mother's visit to the ward on 7 September 1993 when she had been interviewed by nursing staff had been recorded in the ward nursing notes and Dr Rowton-Lee's suspicion that he invented deaths in the family to solicit attention.

13.6 On 20 September 1993, Mr Bath was warned that if he continued to behave aggressively then it was likely he would be returned to prison. Thereafter the records show that his behaviour pattern changed in that there was no longer any physical violence (though difficult, threatening, unco-operative behaviour continued).

13.7 By 3 October 1993, Dr Rowton-Lee was able to write to the court indicating that Mr Bath had accepted that he needed treatment and Dr Rowton-Lee recommended that the assessment of his needs and his treatment be allowed to continue under the terms of his present detention under section 48. Dr Rowton-Lee noted that in the past Mr Bath had never accepted that he needed treatment.

13.8 In that report to the court Dr Rowton-Lee did not proffer a diagnosis. As far as Mr Bath's history was concerned he included reference to his childhood difficulties and some of his forensic history, in particular the fire-raising incidents at his parents' home and in the hostel in Southampton. He referred to his behavioural problems on the ward and emphasised the risk he posed to himself by referring to the numerous episodes of self-harm, but there was no real assessment of risk or dangerousness.

13.9 The following day Mr Bath was arraigned at Bournemouth Crown Court when he entered guilty pleas. His case was adjourned for further reports and he was further remanded in custody, to remain at St Ann's.

13.10 In early October Mr Bath assisted another patient to abscond from Studland Ward by distracting nursing staff whilst the other patient damaged a window and left the ward. Despite this, nursing staff subsequently noted that there had been 'overall good improvement in behaviour'. Consideration then began to be given to a move from the locked ward (Studland) to an open ward (Merley).

13.11 On 11 October 1993, Dr Rowton-Lee wrote to Dr Huw Stone, consultant forensic psychiatrist at Ravenswood House, Regional Secure Unit, Knowle Hospital, Fareham, which is the tertiary forensic psychiatric facility serving the Wessex region. In a remarkably brief referral letter Dr Rowton-Lee asked Dr Stone to assess Mr Bath and one other patient on Studland Ward, stating that 'both are detained on Studland Ward under Section 48 and will probably need medium to longish term treatment and I would welcome your assessment and advice'.

13.12 No specific request was made by Dr Rowton-Lee of Dr Stone for a risk assessment or for consideration of Mr Bath's security needs. Dr Rowton-Lee told us that such would be implicit in his asking for the opinion of a consultant from the tertiary

forensic psychiatry service. Dr Stone in his evidence to us firmly rejected this, stating that Dr Rowton-Lee's habit in making referrals to him hitherto had been explicitly to state what he required and indeed to follow-up with a further request if his questions were not answered.

13.13 In mid-October (the precise date is not recorded) Mr Bath transferred from Studland to the open Merley Ward. Almost immediately he absconded. Dr Rowton-Lee then gave instructions that if he returned he 'should be taken to police cells as he had broken his Restriction Order (sic) and the position reviewed tomorrow'. Mr Bath was then found inebriated in the car park of the hospital and returned to Merley Ward of his own volition. The police were, however, called and he was taken into police custody, being returned by them to the hospital the following morning.

13.14 Two days later, on 19 October 1993, Dr Stone examined Mr Bath at St Ann's Hospital. Dr Stone told us that he had no recollection whatever of Mr Bath and was reliant entirely upon the records. Not unlike other witnesses Dr Stone had been surprised prior to attending our inquiry by the background information relating to Mr Bath which we had provided for him, all gleaned from records, which had not been made available to him when he had examined Mr Bath in October 1993. Indeed the only records which Dr Stone had available to him when he examined Mr Bath were the ward medical and nursing files.

13.15 Having examined Mr Bath, Dr Stone wrote to Dr Rowton-Lee a report in the form of a letter dated 21 October 1993. In this letter Dr Stone stated 'I will not go over the details of Mr Bath's history since this is covered fully in your reports to court dated 3.10.93'. As noted above Dr Stone accepted when he attended our inquiry that he had not been fully aware of all the details of Mr Bath's history, in particular his offending history. In his letter to Dr Rowton-Lee of 21 October 1993, Dr Stone does not explore Mr Bath's offending history nor does he address himself in any way to the issue of the risk which Mr Bath might pose towards others.

13.16 Dr Stone accepted the diagnosis of a depressive illness 'possibly related to withdrawal from heroin and/or alcohol'. He noted an apparent response to ECT and anti-depressants, but said that there was clearly some way to go in his treatment the outcome of which is influenced by his personality disorder. He suggested that active treatment of the depressive illness should be continued and that a community placement should be considered when his mood lifted.

13.17 He went on to suggest that 'the best way to achieve such treatment might be through the use of a Probation Order with condition of psychiatric treatment initially with residence in hospital which could later be changed to residence in an appropriate hostel'. He concluded that he would be happy to review Mr Bath if Dr Rowton-Lee so wished.

13.18 When we asked Dr Stone about the manifest lack of a risk assessment of Mr Bath at the time of his examination of him he told us that in 1993 'I think that issues to do with risk assessment were not as much to the fore as they are perhaps today'.

13.19 When we asked Dr Stone if he had considered part of his remit at the time in examining Mr Bath to be to undertake an assessment of dangerousness rather than a risk assessment he told us 'I did not see it directly as part of my role ... if I had been asked-as you say it would have been an assessment of dangerousness, I would have expected that to be made explicit. I would have then wished more information than was available to me at the time, but I certainly can say that I did not go there on that day to see him directly to provide a risk assessment'.

13.20 We asked Dr Stone if, as a result of his examination of Mr Bath, he had considered him to be a significant risk to others. Dr Stone replied 'No, if I had felt that he was a significant risk to others then I would have recommended a Hospital Order and a Restriction Order because a Restriction Order is the only way, perhaps is a better way, of managing that level of significant risk'.

13.21 Thereafter, throughout the rest of October and early November, Mr Bath was considered to be making steady but gradual and improving progress. There is no record of any subsequent assaults upon others, though on 23 October Mr Bath lacerated his left wrist with a razor blade. Subsequently it was noted that he was receiving help with management of his anger and medical staff were able gradually to reduce the amount of major tranquillising medication he was prescribed.

13.22 His mood in early November 1993 was noted to be 'brighter and more spontaneous' and he was reported to be 'adhering to boundaries'. He was attending occupational therapy. However, nursing staff did have concerns that on occasions he might be using cannabis.

13.23 A date for the hearing of Mr Bath's court case had been fixed for 22 November 1993. On 18 November 1993, Dr Rowton-Lee wrote a report for the court. In this Dr Rowton-Lee referred to his earlier report of 3 October and said that since that time:

'He has co-operated with treatment, he is attending the Occupational Therapy department, he is having regular sessions with our Forensic Psychologists, he is accepting medication, he has accepted a course of electric-convulsive therapy with benefit, he is attending anger management sessions and he has been making as good progress as could reasonably be expected bearing in mind the very long-standing nature of his problems. We have had one incident of leaving the hospital and returning drunk on 20th October 1993 and one incident of cutting his left wrist on 23rd October 1993. On his many previous admissions to this hospital his co-operation has been poor. On this extended admission he has tried very hard to co-operate and we have noticed a marked difference in his motivation. He remains a very vulnerable personality, but we believe that there are some signs of

change and there is more reason to suppose that this is enabling a different attitude to life and increased motivation to help himself and if this progress is sustained there is some reason to expect maturation of his personality and better coping mechanisms. Nursing staff have, on occasions, found him very helpful on the ward and this is a new feature of Mr Bath's personality which we have not seen before ... our recommendation is that he should continue treatment at this hospital for as long as needs be under Section 37 of the Mental Health Act 1983 if the Court is mindful to support this'.

13.24 Dr Rowton-Lee did not in this court report make any reference to diagnosis nor indeed to any classification under the MHA. No assessment of his risk was made. No reference was made to the possibility of attaching to the Hospital Order under section 37 a Restriction Order under section 41.

13.25 When we asked Dr Rowton-Lee about the reasoning behind his decision to recommend to the court an unrestricted Hospital Order at that time he told us that previously he had encountered difficulties with restricted patients in their treatment and management by reason of bureaucratic delays in the Home Office to such requests as for leave and discharge: 'I found on previous occasions that 37/41 actually obstructed our treatment programme. I have changed my mind about this now and I have found the 41's contribute more to the treatment programme than impede it'.

13.26 Also available to the Crown Court on 22 November 1993 when the Hospital Order was made was a pre-sentence report prepared by Ms Rachel Newman. In this report Ms Newman refers to her sources of information, amongst others, as including a list of Mr Bath's previous convictions, Dr Rowton-Lee's report and a forensic psychologist's report.

13.27 In her pre-sentence report of 18 November 1993, Ms Newman notes the seriousness of the current offence of robbery and that 'in view of Mr Bath's previous convictions and current offence' the protection of the public is 'paramount'.

13.28 She refers to an earlier report of a probation officer in July 1989 which assessed Mr Bath as 'clearly a risk to other people at times and frequently to himself'. She expressed reservations that were Mr Bath to be sentenced to imprisonment then he would be 'very much at risk of committing suicide' and that if this did not occur then 'upon release from prison he would, in my opinion, still be very much at risk of offending putting himself and the public at risk'. Ms Newman went on to note the recommendation of Dr Rowton-Lee that a Hospital Order under section 37 MHA be made and concluded that 'such treatment appears to provide the only hope of Mr Bath changing his behaviour to comply with society and to reduce the long term risks of him re-offending'.

13.29 When we saw Ms Newman she told us that she did not feel at the time it was appropriate or necessary for her to argue with Dr Rowton-Lee that a Restriction Order in Mr Bath's case would be appropriate.

13.30 Ms Newman in her report referred to a forensic psychologist's report. This would appear to be a report dated 19 November 1993 prepared by Dr Grace Leung which Dr Leung told us she had sent to the Probation Service. It consists of an earlier report of 'interview data' followed by an addendum headed 'continuous assessment and treatment'.

13.31 The earlier report of 'interview data' appears to have been prepared by Ms June Copeland, assistant psychologist. The interview data reported clearly show that Mr Bath was not being truthful in his self report. The addendum 'continuous assessment and treatment' signed by Dr Leung notes that whilst at St Ann's Hospital he had been seen 'seven times by the Psychologists'. This report makes no reference whatever to any risk which Mr Bath might pose towards others, but says:

'he has been very compliant in attending the sessions. At present the work is mainly focusing on grief counselling which appears to be the priority in his life at the moment. His aggressive behaviour and anxiety have been reduced considerably compared to the time of transfer from prison due to psychotropic medication prescribed by Dr Rowton-Lee ... Mr Bath can progress over a period of treatment and rehabilitation. Overall he is still low in mood, low self esteem and a risk in taking his life. He will require a lot of input from multi-disciplinary staff in helping him to reintegrate into society. He is a damaged character emotionally'.

13.32 This report would appear to suggest that Dr Leung at that stage considered Mr Bath to be treatable, in contrast to her earlier expressed opinion.

13.33 The second medical recommendation for the Hospital Order was pro forma and provided by Dr Hanna, an associate specialist from Hahnemann House, a rehabilitation and continuing care unit in Bournemouth, and is dated 19 November. It was located for us with apparent difficulty by the Trust solicitor as there was no copy kept with Mr Bath's medical record and states as the reason for recommending hospital treatment that 'the clinical depression element of his condition is under vigorous treatment. He continues to receive bereavement counselling. He has shown clinical improvement and continued treatment is necessary. He would be vulnerable to recurrence of behavioural disorder in a less structured "therapeutic environment" at the present time'.

13.34 The transcript of the brief hearing of 22 November 1993 when Mr Bath was sentenced shows that the court took into account his criminal record from the arson conviction of 1988. The court was referred to four reports, two from Dr Rowton-Lee, one each from June Copeland and Rachel Newman. It was asked simply to convert the section 48 into a section 37 Hospital Order on the recommendation of Dr Rowton-Lee. There was no reference to the statutory criteria

required for such an order and no comment on the lack of a diagnosis in Dr Rowton-Lee's reports. There was no reference to section 41 nor to any further requirements in terms of risk and restriction.

COMMENTS

• Sentencing

13.35 In sentencing Mr Bath on 22 November 1993 the court gave bare consideration to whether the statutory criteria for the making of a Hospital Order under section 37(2) were fulfilled based on the medical recommendation forms only. The other reports furnished to the court were wholly inadequate for that purpose.

13.36 The section 37(2) criteria are that:

'(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental illness, psychopathic disorder, severe mental impairment, or mental impairment and that either -

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition; ... and

(b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section'.

13.37 There was no diagnosis in Dr Rowton-Lee's reports and the pro forma forms refer only to a broad category of mental illness. There was no oral evidence from either medical practitioner and no discussion of the form which that illness took nor of any risk factors associated with it.

13.38 The judge, having heard about his previous convictions dating from the arson conviction, simply followed the medical recommendations as he was asked to do by Mr Bath's Counsel. No details of the arson conviction were provided. This is not an unusual mode of sentencing.

• Risk assessment and Restriction Orders

13.39 There was no assessment of the risk which Mr Bath posed to others during the course of this admission to St Ann's Hospital. Mr Bath was perceived by all from whom we heard evidence as posing a greater risk to himself than to others.

13.40 We think that he did pose a greater risk to others at this time than was appreciated on this admission. This is based not only on his forensic and medical history but also on more recent events in January 1993 when he had been carrying a knife supposedly intent on harming his ex-wife and her partner.

13.41 Dr Stone's role here is unclear. We are still unsure as to why he did not consider his role to include an assessment of Mr Bath's risk. It would appear, however, that his was not intended to be a report for the court. We do accept that in performing a risk assessment it would not have been his duty to search out information, but to act on that provided to him. The current Protocol for Referral and Transfer to Regional Forensic Psychiatric Services sets out the requirement for written referrals which includes the reasons for a referral.

13.42 It is for the court to make a Restriction Order where:

'having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section...' (section 41 MHA).

13.43 The special restrictions relate to the duration, renewal and expiration of the authority to detain, applications to a MHRT and the powers of the RMO to grant leave of absence, discharge or transfer a patient being exercised by the Secretary of State (section 41(3)).

13.44 The court's decision must be based on whether or not there was a risk of Mr Bath causing serious harm rather than just repeated minor offences, but the gravity of the offences in respect of which the order is being made is not conclusive of this question. Thus a minor offence by a man who proves to be mentally disordered and dangerous may leave him subject to a Restriction Order (R v. Beulah Birch (1989) Cr. App. R (S) 202-216; Khan (1987) 9 Cr.App. R (S) 455).

13.45 The offence itself in this instance involved a 12 inch kitchen knife and was potentially serious. Mitigating circumstances are that the facts of the offence do not reveal any intention to use the knife and he gave himself up to the police a few days later.

13.46 His antecedent history included several offences of actual bodily harm, and arson. Factors contributing to the risk of further offences include his drug and alcohol misuse and lack of co-operation with services in the community. While there was clearly a risk of re-offending and a risk of causing some harm to himself and to others, whether it was likely to be 'serious' harm is more difficult to gauge.

13.47 Our expert evidence is that this 'is not a case where it is glaringly obvious that the opportunity to make a Restriction Order was overlooked' and Dr Rowton-Lee cannot be criticised for not mentioning the possibility of one.

13.48 We think that there were grounds for a Restriction Order to be recommended to the court because we consider the background of arson and knife carrying to be

capable of predicting serious harm, but we cannot say that not to recommend one was outside the bounds of an acceptable clinical decision.

13.49 However, a Restriction Order is ultimately a decision for the judge and it is correct that the court did have information as to Mr Bath's antecedent history, the background contained in Dr Rowton-Lee's report of 3 October 1993 and Ms Newman's assessment of his risk and still chose not to exercise its power under section 41.

13.50 We think that on every occasion that a medical report is prepared in order to assist the court in sentencing an offender under the MHA, the question of risk and the protection of the public in the terms of section 41 MHA should be specifically addressed. To that end standard recommendation forms used should also include explicit reference to section 41.

- **Location of MHA forms**

13.51 It is also our view that standard recommendations and other material in support of an order under the MHA should be kept on the main medical record of a patient so that it is easily accessible and the foundation of any order is clear and ascertainable.

- **CFT**

13.52 Concerning the involvement of the CFT in Mr Bath's risk assessment and management whilst an in-patient, our independent expert evidence cast grave doubt upon the appropriateness of Dr Leung allowing a clinically unqualified psychology assistant to undertake the work, albeit under her supervision, of so difficult a patient as Mr Bath. Indeed, the risk assessment undertaken was described as woefully inadequate. (See chapter 27 for more on the CFT and a recommendation).

- **Use of police station**

13.53 In mid-October, Dr Rowton-Lee directed that Mr Bath should be taken to the police cells if he should return having absconded from hospital because he had 'broken his Restriction Order'. Apart from the fact that Mr Bath was not on a Restriction Order, although he was subject to section 49 restrictions, there is no legal authority for his detention by the police. The order transferring him to hospital from prison empowered his detention at St Ann's only. Additionally, Dr Rowton-Lee in using the police cells to punish Mr Bath for absconding was displaying clinical practice, the ethics of which must be open to doubt.

C. RECOMMENDATIONS

13. The Department of Health should consider amending the standard forms of medical recommendation used for section 37 MHA to ensure that section 41 MHA is addressed in the same form.

See also chapter 6, recommendation 6 and chapter 10, recommendation 10(a).

Chapter 14

HOSPITAL ORDER, DISCHARGE AND AFTER-CARE

- Discharge and after-care arrangements (section 117 MHA)
- Multi-disciplinary team working

A. Introduction

14.1 The court disposed of the robbery charge with a Hospital Order on 22 November 1993. His behaviour deteriorated markedly thereafter, but Mr Bath was discharged from the order in his absence by his responsible medical officer, Dr Rowton-Lee on 22 December 1993. This appeared to come about quite suddenly. He had already been discharged from the CFT due to non co-operation. There was no proper discharge planning and the existence of the duty under section 117 MHA to provide after-care services was ignored.

14.2 Once again this showed a very poor understanding and implementation of the MHA and a failure to grapple with Mr Bath's future. There was no multi-disciplinary working and no Social Services involvement. In the end he was to be followed up by a CPN from the CFT although this was only in a 'helping out capacity' because it was not possible for anyone in Dr Rowton-Lee's team to do so. There was in fact no effective follow-up and no reference back to the events of this admission on subsequent admissions to hospital. He was next admitted to St Ann's in April 1994.

B. Hospital Order, Discharge and Follow-Up

14.3 In the event on 22 November 1993, a Hospital Order under section 37 MHA was made at Bournemouth Crown Court, when Mr Bath was also dealt with for breach of a 12 month Conditional Discharge at Weymouth Magistrates' Court in June 1992. Subsequently, Mr Bath expressed himself pleased with this outcome.

14.4 Subsequently, after his return to St Ann's Hospital now subject to a Hospital Order, Mr Bath's behaviour deteriorated markedly. When we interviewed him in Belmarsh Prison in November 1998 he gave us to understand that his relatively good behaviour prior to the making of the Hospital Order had been motivated by a desire to avoid a term of imprisonment.

14.5 Dr Rowton-Lee told us that in retrospect he considers it quite possible that this had been the case, though at the time he had felt that Mr Bath was making a positive response to the treatment at St Ann's.

14.6 On 23 November 1993 he was recorded by nurses as displaying inappropriate behaviour and breaking ward rules. On 25 November 1993 he left the hospital and that evening telephoned to say that he would not return until the following day. Nursing staff then contacted Dr Rowton-Lee 'who said to treat it as over-night leave'.

14.7 The following day Mr Bath did not return to the hospital as expected and Dr Rowton-Lee advised that the police be called. However, Mr Bath was then returned to the hospital by the police and reported that the previous evening he had smoked 10 joints of cannabis. Mr Bath told nursing staff that he felt 'fed up on the ward at not being able to go out'. Subsequently, in the ensuing days he told nursing staff of his feeling of being trapped and being in 'what feels like prison'. Thereafter, Mr Bath continued to complain that he felt like a prisoner and made clear by his behaviour that he was not prepared to co-operate with the efforts of nursing and medical staff to offer him treatment.

14.8 He avoided occupational therapy and spoke repeatedly of his wish to leave the hospital. On 6 December 1993 he was reported to be inebriated in the games room at the hospital, stating subsequently that he had drunk alcohol as he was 'pissed off with being in the hospital'. His attitude towards nursing staff was described as 'surly and dismissive' and on 16 December 1993 he was again smoking cannabis on the ward, having previously repeatedly been warned that this was not allowed. Staff noted that he repeatedly ignored requests not to smoke or to abuse alcohol and Dr Mohammed, associate psychiatrist to Dr Rowton-Lee who had responsibility for the day to day medical management of the ward, was recorded to have advised Mr Bath that 'we will therefore arrange alternative accommodation in Dorset Lodge' (a probation hostel).

14.9 The following day Mr Bath again absconded from the hospital and Dr Rowton-Lee was recorded as not wishing the police to be involved.

14.10 At this time a probation officer, on being contacted by nursing staff, was noted to deny 'any knowledge of what is going on or being informed. Ms Holt has also advised me that Shane is no longer their problem as he is on a treatment order'.

14.11 On 19 December 1993, Mr Bath was noted to be absent without leave from the hospital that evening and the following day he was returned by the police in the company of his brother. On return he was verbally aggressive and Dr Rowton-Lee considered that he should be returned to the greater security of Studland Ward. This however did not occur, probably we were told as a result of lack of a bed on Studland Ward and the following day, 21 December, Mr Bath again appeared angry and annoyed. He again absconded from the hospital at about mid-day, being returned by the police from his brother's home in the late afternoon apparently under the influence of illicit drugs. He absconded again for a short period during the course of the evening and subsequently avoided any interaction with nursing staff.

14.12 Having absconded yet again the following day, 22 December 1993, Mr Bath was noted in the record of Dr Rowton-Lee's ward round to be 'unco-operative with treatment, smoking cannabis, mocking nursing staff, partially co-operative with June Copeland, refusing to be seen on ward round, wishing to leave the hospital, declining CPN follow-up, Dorset Lodge unwilling to consider him'.

14.13 The record went on to state 'Plan-Discharge from Section 37, to be discharged when returns to ward'. There is also an indication that he was not to be prescribed any further medication. Dr Mohammed then made a note 'discharged from Section 37, regraded informally'.

14.14 Mr Bath did not return to St Ann's Hospital. The following day the ward sister accompanied by Mr John Cunningham, community psychiatric nurse with the Community Forensic Team, visited Mr Bath's brother's address where they left letters for him from Dr Mohammed informing him that he had been discharged from section 37 and that community follow-up would be arranged with a point of contact for Mr Cunningham and instructions as to how he could recover his property which he had left at the hospital.

14.15 On 30 December 1993, an updated psychological report from June Copeland noted that Mr Bath had been discharged since her last report on 19 November. Ms Copeland noted the difficulties encountered in engaging Mr Bath and that he had no intention of adhering to any contract of therapy. In view of this it was felt that very little could be offered.

14.16 On 21 January 1994, Dr Rowton-Lee's senior house officer wrote to Mr Bath's GP. She referred to 'a long history of substance abuse and a long forensic history, there had also been repeated episodes of self harm'. No details were given. She also referred to Mr Bath on admission to hospital as claiming to be feeling depressed and wishing to kill himself and also to his describing hearing voices telling him to kill himself. Concerning his past psychiatric history, she observes 'the rest of his history is as previous correspondence'.

14.17 A short note in this discharge summary relating to Mr Bath's progress in hospital fails to make any reference to the violent assaults he had perpetrated upon other people. The medication which Mr Bath had been prescribed prior to discharge was listed, but there was no indication whether or not this should be continued by his GP. It concluded that 'we are arranging for a CPN to monitor his progress'.

14.18 When we asked Dr Rowton-Lee about this somewhat precipitate discharge from a Hospital Order, which had been made only a few weeks previously upon conviction for a serious violent offence, Dr Rowton-Lee told us that he had been 'incensed' by Mr Bath's attitude towards nursing staff at the hospital. There was some suggestion, from evidence which we heard, that nursing staff may have put pressure on Dr Rowton-Lee to discharge Mr Bath. Dr Rowton-Lee in his evidence refuted this.

14.19 Dr Rowton-Lee acknowledged that the discharge was unaccompanied by any section 117 planning and no arrangements were made for Mr Bath's follow-up and after-care under the terms of the care programme approach.

14.20 It was not clear to us, from Dr Rowton-Lee's account, why a CPN from the Community Forensic Team rather than a CPN from his own clinical team was charged with attempting to follow-up Mr Bath. Mr Cunningham was not, however, appointed to this task as a member of the CFT as Mr Bath had by that time been discharged by that team, but as a general CPN.

14.21 In taking evidence from Mr John Cunningham, the CPN charged with Mr Bath's follow-up we expressed concern to him that he had been nominated to undertake this role in view of the fact that his only prior contact with Mr Bath had been when engaging in control and restraint of him at times of physical confrontation.

14.22 Mr Cunningham told us that he had not in any way been involved in the planning, such as it had been, for Mr Bath's discharge from hospital. He told us that on being asked to undertake his follow-up role he was possessed of little information relating to Mr Bath. He very candidly, told us that at that time he felt apprehensive about undertaking the follow-up in the light of the nature of his previous contacts with Mr Bath, but additionally, having taken up his post as Community Forensic Mental Health Nurse with the Community Forensic Team only three months previously he was 'very keen to actually make an impression, very keen to be seen to be capable of actually doing my job and dealing with difficult to manage characters'.

14.23 Mr Cunningham told us that he was satisfied that Mr Bath had received the letters offering follow-up when he heard that Mr Bath had attended the hospital to collect his belongings. Mr Cunningham made one attempt only in delivering the letters to Mr Bath's brother's address to contact Mr Bath and thereafter adopted an approach of waiting for Mr Bath to make further contact, which in the event he did not do.

14.24 On 3 February, Mr Cunningham wrote to Mr Bath's then GP saying that he was discharging Mr Bath from his caseload, but would be happy for him to be re-referred. On 24 February he was asked to visit Mr Bath by Dr Rowton-Lee at an address in Boscombe and offer him an out-patient appointment. Mr Bath failed to meet as arranged and a letter was left offering him an appointment. As he did not keep this appointment Mr Cunningham took no further action.

14.25 We assume that Dr Rowton-Lee's request came about as a result of a letter from Dorset Magistrates' Court first on 5 January and again on 23 February stating that Mr Bath was due in court for non-payment of fines and asking for an up-to-date assessment of the likelihood of his attending at court in the near future. There is nothing in the notes by way of a written response to these letters.

COMMENTS

14.26 Numerous aspects of Mr Bath's management during this period are open to severe criticism.

- **Multi-disciplinary working**

14.27 Proper multi-disciplinary assessment and management of all aspects of Mr Bath's case during this admission was noticeable by its absence. We heard that his case was reviewed on a weekly basis at multi-disciplinary ward rounds. We have found little, if any, evidence in support of this. Certainly sharing of relevant information regarding Mr Bath between disciplines also did not happen. It is not clear which disciplines were involved in the ward rounds and at a fundamental level communication between Health and Social Services was missing.

14.28 For example, we find incredible the fact that he was receiving 'grief counselling' from the CFT relating to the death of his mother when she had visited the ward and had been interviewed by nursing staff and that this indeed had been recorded in the ward-based nursing notes (chapter 13). Indeed in our view the involvement of the CFT in Mr Bath's case during the course of this admission was totally unproductive.

14.29 The multi-disciplinary team caring for Mr Bath, such as it was, was conspicuously lacking in the leadership that should have been provided by the RMO, Dr Rowton-Lee. There was no collaborative work to assess Mr Bath's complex needs during his admission and on discharge. Social Services failed to become involved, nor were they asked to become involved despite having a base in the hospital.

- **Circumstances of discharge**

14.30 We are very critical of the fact that within weeks of being made the subject of a Hospital Order following the commission of a serious violent offence, Mr Bath was allowed to walk out of St Ann's Hospital and to be discharged in his absence without any proper assessment of his needs nor of the safety of others and without any acknowledgement whatsoever of the duty to provide after-care pursuant to section 117.

14.31 Subsequently, there was no effective attempt to follow him up in the community. CPA should also have applied at this time but was not used.

14.32 We have found it difficult to unravel the thought process in the decision to discharge. It is clear, however, that his difficult behaviour was an important factor, although the discharge summary also notes that despite this there was general improvement in his condition, his 'condition' being depression. This may be an attempt to rationalise the decision after the event. Shortly before discharge Dr Rowton-Lee considered returning him to Studland Ward as needing more security and had previously told Dr Stone that medium to long term treatment was probably needed (chapter 13).

14.33 There was also no consideration given to reclassifying Mr Bath as suffering from a personality disorder to prolong his admission to hospital and the opportunity to bring about a change in his behaviour (section 16 MHA). This would have required the issue of 'treatability' to be addressed.

14.34 Such a poorly thought out discharge is not only irresponsible, but also subverts the court process. We would have no criticism if it could be demonstrated that on proper consideration discharge was a reasonable option. We cannot find any evidence that this was the case.

14.35 Even in the absence of a Restriction Order here was a clear opportunity to address Mr Bath's future needs and to grapple with the question of affording protection to those at risk from him. Even if no practical difference in the outcome was achievable, and he would have evaded supervision in any event, it was important to note that all the issues had been discussed and thought out.

14.36 The position would have been completely different had there been a Restriction Order in place. First of all he could only have been discharged by the Secretary of State (sections 41(3) and 42(2)) or a Mental Health Review Tribunal (section 73) and then he would most probably have been subject to a Conditional Discharge (sections 42(2) and 73(2)), whereupon he would remain liable to be recalled by the Secretary of State to hospital for further treatment (section 42(3)).

14.37 The likely conditions include a requirement to reside in a specified place and supervision by a social supervisor and a psychiatrist. It is within the Secretary of State's discretion to recall a patient at any time during the continuance of the Restriction Order. The exercise of this discretion can only be challenged if the decision to recall is so unreasonable that it is one which no minister properly addressing him/herself to the issues could have reached or that s/he did or did not take into account relevant material, or it fails to promote the objects and policy of the MHA.

14.38 The discretion is wide and need not only be triggered by a failure to comply with the stipulated conditions of discharge. In exercising it, the Secretary of State can have regard to the safety of the public, whether or not contact with the patient is lost or s/he is not co-operating with supervision, in addition to whether further in-patient treatment is indicated or the patient has been charged with another offence.

14.39 The result is that Mr Bath would have been subject to a strong framework in the community which he would have found difficult to avoid. This is of course a speculative exercise conducted with the benefit of hindsight. The imponderables in judging the likely sequence of events here include whether or not suitable accommodation could have been found for him and at what point he may have been discharged absolutely from the Restriction Order and not been liable to recall.

14.40 It was another four years before Mr Bath killed Ayse Sullivan and it is not possible to conclude that even if a Restriction Order had been made at this time it would have prevented her death.

- **Statutory duty to provide after-care**

14.41 This was a clear breach of the statutory duty of the health authority and the local Social Services authority under section 117 MHA to provide after-care services for any person detained under section 37. There can be no reasonable excuse for failing to comply with this duty which exists whether or not a person is 'regraded' to informal status prior to leaving the hospital. Section 117 (2) provides:

'It shall be the duty of the [health authority] and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the [health authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services'.

15.42 Further, there is a continuing obligation under this section until both the health and Social Services authorities are satisfied that the person no longer needs such services. The events here cannot be further from what is envisaged by the statute. Social Services were never involved, consequently there was no joint planning, nor any subsequent decision that such after-care was no longer required.

- **Discharge summary**

15.43 This was inadequate and the failure to produce a proper discharge summary compounds the failures discussed above. The GP was left poorly informed as to what happened during the admission. We are particularly critical of the reference to the 'rest of his history' as being 'as previous correspondence'.

- **RMO responsibility**

15.44 Ultimately, the responsibility for what happened and, more importantly, what did not happen during the course of this admission to hospital must rest with Mr Bath's Responsible Medical Officer, Dr Rowton-Lee. Consequently, whilst we accept that Dr Rowton-Lee was grossly over-worked at the time, his handling of this situation must attract strong criticism.

C. RECOMMENDATION

14. The NHS Trusts and Social Services should jointly review and audit arrangements for CPA and section 117 MHA joint after-care (see further chapter 28).

Chapter 15

1994

- St Ann's: depression and ECT
- Southampton
- Wessex Project
- CFT
- Forston Clinic: detoxification
- Crisis management
- Ineffective Social Services follow-up
- Prescription of drugs

A. Introduction

15.1 This chapter is intended to summarise what is known about Mr Bath in 1994. In many respects it is one which can be characterised as 'normal for Shane'. He presented to services following various crises usually in the form of self-harm, was very unstable and difficult to manage in hospital. He took three or four overdoses and had difficulties with his accommodation. He was admitted to hospital a number of times, these included two admissions to St Ann's, one to Forston Clinic and one to Royal South Hants Hospital. Several of the themes which recur in his history occur at this time also, for example, there was no CPA, no Social Services involvement, no multi-disciplinary working, poor discharge summaries and the inappropriate use of ECT.

15.2 Despite his rapid re-admission to St Ann's in April following his discharge from the Hospital Order in December 1993, there is no mention of it during the later admission and as an important episode in his life it became lost hereafter.

B. St Ann's, 7 April 1994

15.3 Mr Bath was admitted into the care of Dr Rowton-Lee from the police station. He had been living in his brother's bedsit and was 'feeling unable to cope'. He claimed he had tried to hang himself in the bathroom, was expressing suicidal ideas, saw no future for himself and seemed low in mood. He said he had been smoking cannabis and heroin. The admitting doctor diagnosed personality disorder with some depressive features, complicated by drug misuse. The plan was for him to continue/recommence his medication and to be seen by Mr Cunningham the CPN. Mr Bath was warned that if he misbehaved he would be discharged.

15.4 He was discharged on 27 April to accommodation of his own choosing. In the interim period he had been disruptive on the ward, throwing things at other patients and being verbally abusive to a nursing assistant. He was once again providing false information about his own circumstances and said that he had a five-week-old baby son.

15.5 Although he was assessed as not appearing to be 'overly depressed' a course of ECT was planned and initially agreed to by Mr Bath. He then sabotaged its administration by drinking tea prior to the anaesthetic. Dr Mohammed said that because he had presented as depressed with suicidal intent and had complained that his sleep was disturbed, his appetite impaired and had marked weight loss he concluded that he was clinically depressed and required ECT. He eventually did not have ECT at all during this admission.

15.6 A referral to a social worker was to be made regarding his need for accommodation. By 18 April he had cut his wrists several times and then re-opened his bandaged wounds. A ward doctor noted that he was depressed and wrote that consideration should be given to the use of section 3 MHA and a transfer to the secure environment of Studland Ward if the self-harm was repeated. He was considered to be a high suicide risk.

15.7 During this admission he was also noted to be dealing in drugs on the ward. Dr Rowton-Lee transferred his care to Dr Choudry whose registrar noted that Mr Bath was to be discharged if Dr Choudry's 'long-standing and frequently confirmed opinion of personality disorder plus untreatability is again confirmed'.

15.8 Dr Choudry's impression was one of personality disorder with affective symptoms. He proposed to allow him to go to his mother or brother. This was countered by Mr Bath himself who said that he could not return to his brother's because he had caused self-harm there and his mother was in an OAP home. He was to find a flat 'by Wednesday' and be discharged (or sooner if his behaviour was 'unacceptable').

15.9 On 27 April, Mr Bath was duly discharged to accommodation of his own choosing. In his discharge summary to the GP, Dr Choudry summarised his diagnosis as follows:

'Further concerted efforts were made to detect any sign of mental illness and to monitor breaking of contract after he had been re-informed of the boundaries. Within four days it was clear that again no sign of mental illness was detectable and he acted more or less as he pleased, with the frequent threat that he felt suicidal and wanted to be dead'.

COMMENTS

- **Assessment**

15.10 The approach taken was somewhat confusing. Initially he was deemed to be showing signs of depression pursuant to which ECT was planned. Later he was not deemed to be suffering from any mental illness but a personality disorder with affective symptoms. To be fair to Dr Choudry, he does not seem to have allowed his previous judgement on diagnosis to have influenced him here and instead took the opportunity to reassess Mr Bath.

- **Social Services**

15.11 Despite the need for a referral to be made for accommodation being noted there is no evidence that this ever happened. The Social Services files have no record of any referral. Mr Bath had to provide the information as to why he could not go to his mother's or brother's home himself. He was then to find his own flat. This is a recurring theme. The poor communication between Health and Social Services is once again highlighted.

C. RECOMMENDATION

15. NHS Trusts and Social Services should review the system for the referral of clients between them (see chapter 27, recommendation 24).

D. Southampton, June 1994

15.12 Mr Bath was admitted to Royal South Hants Hospital on 2 June 1994 following an overdose of injected temazepam. He was again confabulating stories about his parents having died in a road accident and behaving badly on the ward.

15.13 He threw a table at the chaplain and when he was asked to leave threatened a nurse with a broken bottle. He then climbed onto the roof and started to cut his arms with a bottle. He was taken by the police to the Casualty Department of Southampton General Hospital. Later he was taken to the police cells where he was assessed by a doctor and a social worker. We do not know the outcome of these events.

15.14 By August Mr Bath had been charged with theft and forgery and remanded in custody by Southampton Magistrates' Court to Winchester Prison where he came into contact with the Wessex Project. He gave them his authority to obtain his prison and other medical records.

15.15 The Wessex Project is described by Barbara Swyer, its current forensic service manager, as a multi-agency partnership between Hampshire Probation and Social Services, the prison service, Wessex Regional Health Authority and the Mental Health Foundation. Its aim is to identify prisoners with mental disorder in Winchester Prison and to improve and increase access to appropriate services on release through the introduction of the CPA into Winchester Prison.

15.16 We were told that it tried to ensure links with and between agencies in the community and to ensure that care planning took place prior to discharge. It does not carry its own caseload.

15.17 In attempting to carry out its function the Wessex Project contacted Dr Rowton-Lee, as well as a GP in Southampton who had had contact with Mr Bath and the doctor who assessed him at Royal South Hants Hospital.

Dr Rowton-Lee had also seen Mr Bath in prison at the request of the prison visiting psychiatrist. His response was that he was not prepared to admit him to hospital, but that assistance would be offered through the CFT in Bournemouth.

15.18 On 20 September Mr Bath was conditionally discharged by the court. A referral was made to the Dorset Social Services by a social worker with the mentally disordered offenders scheme in Hampshire.

15.19 On 3 October Mr Bath overdosed again, this time on chlorpromazine and was admitted to Royal Bournemouth Hospital A & E from where he discharged himself the following day. He was noted to be of no fixed abode.

E. Forston Clinic and St Ann's, December 1994

15.20 Mr Bath was informally admitted to Forston Clinic under Dr Duncan Veasey on 8 December following what is described as a 'massive' overdose of 20 temazepam and 20 oxazepam tablets plus half a bottle of whisky. He underwent a two week detoxification programme on librium and was discharged to the home of another patient, Susan (not her real name), on 22 December.

15.21 He was referred for the first time to Caroline Kinsella, CPN and co-ordinator of MenDOS, the West Dorset mentally disordered offenders scheme in order that more information could be obtained about him.

15.22 Ms Kinsella was ultimately unable to complete her work on this occasion because Mr Bath had been discharged by the time she returned from her Christmas holiday although she had been reassured that he was likely to remain a patient for sometime.

15.23 Mr Bath described himself as depressed and said that he had been looking after his sister's youngest child, aged 6. He had been living with his sister at this time. The older three had been taken into care after his sister had been sent to prison. His niece had screamed constantly and he could not take it any more. She was now with his mother. This is elaborated on in the patient profile form: *'over past 2 weeks had been looking after niece-Louise 6 years old-unbeknown to social services. He had been using drugs-LSD, cannabis and ecstasy, also drinking +++- when Louise had been in bed. He maintains he cared for her well'.*

15.24 The Forston Clinic records by this time did contain some details of his forensic history, including the arson conviction in 1988 and the Hospital Order in 1993. There is also reference to his early childhood. Dr Rowton-Lee's court report of 3 October 1993 is on the file together with June Copeland's psychology report and Rachel Newman's probation report. Apart from Dr Sedman's 1988 court report there are no further St Ann's records.

15.25 Mr Bath's behaviour was stable and compliant on this occasion and he was referred to CADAS although this came to nothing due to his failure to attend. He participated in occupational therapy on two occasions.

15.26 The discharge summary is brief and refers to his condition on discharge as being 'Normal for Shane'. His prognosis was 'terrible' and he had already started drinking on his day of discharge.

15.27 Mr Bath was referred back to Dr Choudry at St Ann's on 30 December 1994 by a GP, who indicated that Susan was also his patient. He said that this arrangement had been a 'disaster'. Mr Bath had been taking chloral hydrate (a hypnotic) at night. He had met him for the first time the previous day and given him a prescription of Welldorm (chloral hydrate). Mr Bath took 20 tablets. His detoxification at Forston Clinic was referred to in the letter.

15.28 The admission note also refers to him drinking up to one bottle of whisky a day and taking £95 of heroin daily for the last six months. He was in fact admitted under Dr Rowton-Lee.

15.29 He was noted to be complying well with staff. He had thoughts of self-harm and the possibility of detention under a section of the MHA if he attempted to leave the ward was noted. He was referred to the DSS by the charge nurse about his accommodation needs (see below). He was discharged on 11 January after being absent for 48 hours.

15.30 The brief discharge summary is scant with regard to past psychiatric history and refers to previous summaries for background history. There was no diagnosis save for a mention of a long history of depression and self-harm. Although he was admitted for assessment only he was discharged with thioridazine (anti-psychotic) and paroxetine (anti-depressant).

15.31 There is a discharge checklist which refers to personality disorder and notes that the community key worker was to be informed of the discharge. There is a CPN named, but he does not feature anywhere else in Mr Bath's history and there is no record of them ever having met.

15.32 On 17 January 1995, Mr Bath was seen at the Royal Bournemouth Hospital (RBH) following an overdose of amitryptiline. He failed to attend two out-patient appointments with Dr Rowton-Lee.

COMMENTS

- **CPA**

15.33 There is little doubt that although his presentations at Forston Clinic and St Ann's were precipitated by drug abuse that he was not considered to be outside the care programme approach, albeit the procedures which were being followed at that time

were flawed. We have already noted that pre-1995 there was confusion over the eligibility for CPA (chapter 10).

15.34 We do not consider that this is a matter of following a formal CPA policy to the letter, but of common sense. Dr Veasey told us that even if he had applied the CPA he would not have adopted a different plan. That may be so, but his care plan could have been better thought out. We also understand that he felt that he was operating under increasingly more straitened circumstances. His view and that of other contemporary medical staff was that 'psychiatry in West Dorset had been asset stripped by Dorset Health Commission following the closure of Herrison Hospital' in the move to community work and he was under-resourced, although this view is disputed by the DHA. The DHA has advised us that more funds were made available at this time and there was no reduction in the allocation of resources to the these services. In relation to Mr Bath, however, we have found that the response from Forston Clinic on this and other occasions was by far the most considered and consistent.

15.35 There was no Social Services involvement during the Forston Clinic admission. Dr Veasey did say that the social work in-put was 'non-existent' although we have been advised by the Social Services that at that time social workers were based in CMHTs rather than at Forston Clinic and should have been accessed via those teams. There had of course been a referral to Dorset Social Services by Hampshire MenDOS on 20 September which came to nothing. We feel that as a result of this his discharge arrangements were far from satisfactory and somewhat hasty, even though the female patient, to whose home he was discharged, was given 'warnings'.

15.36 We are particularly concerned at the lack of Social Services involvement in the light of Mr Bath's revelations that he had been acting as a babysitter for his sister's daughter. We think that this information could quite properly have been communicated with the relevant Social Services department and is likely to have been had there been a social worker involved.

- **Ineffective Social Services follow-up in East Dorset**

15.37 The follow-up to the referral from Hampshire was slow and ineffective: a few polite letters and then the file was closed. No real attempt to make contact with Mr Bath was made. To be fair, the referral did also say that he was being followed up by Dr Rowton-Lee and so one might seek to excuse the lack of urgency with which it was handled. In the absence of any response to the letters, however, there does not appear to have been any contact made with Dr Rowton-Lee to check that he was indeed seeing Mr Bath or in an effort to co-ordinate follow-up.

Chapter 16

THE PAVILIONS, FORSTON CLINIC AND THE CPA: FEBRUARY 1995

- Housing contact
- Only documented CPA meeting
- Information-gathering and sharing
- Second prolonged Social Services contact (eight weeks) and care management

A. Introduction

16.1 This is a key episode during which a multi-disciplinary meeting aimed at considering Mr Bath's needs was convened by Dr Veasey. It contains one of his most prolonged periods of contact with Social Services who tried hard to resolve his accommodation problems, again without much success due largely to Mr Bath's own behaviour. The other long periods of Social Services contact were during his childhood and later in February/March 1997.

B. The Pavilions

16.2 On 2 February 1995, Mr Bath was at his mother's one-bedroom flat at 19 The Pavilions, Shaftesbury, Dorset. This was warden-controlled sheltered housing managed by Signpost Housing Association. We are told that he had been there in January also. On this occasion he overdosed on her medication (voltarol and oxazepam) mixed with vodka and was taken to A & E at Salisbury and District General Hospital, Wiltshire. His presence at the accommodation put her in breach of her tenancy agreement and potentially at risk of eviction.

16.3 On 9 February he was admitted to Old Manor Hospital, Wiltshire, on a referral from a GP, as he was suicidal. The letter said that his mother could not cope and that he was demanding amitryptiline, thioridazine and temazepam. There is a long and detailed admission note. There was no evidence of mental illness and he was observed overnight. Surprisingly he was discharged back to his mother's accommodation on 10 February.

16.4 On 11 February he was back at Old Manor Hospital which had been persuaded to have him by the GP. He was taken there reluctantly by ambulance and seen by Dr West who diagnosed personality disorder, but there were no beds when he arrived. There were none at either Forston Clinic or St Ann's and a bed was arranged at a night shelter. He turned up at his mother's again banging on the door and making a lot of noise. The situation was described as 'tense'.

16.5 On 12 February 1995, there was another incident when he was supposed to have taken an overdose and an ambulance was called once again. He was apparently unconscious and came to life suddenly making a miraculous recovery and frightening everybody as he did so and being abusive to the ambulance crew.

16.6 The problems caused by Mr Bath at 19 The Pavilions are documented by Jane Christopher, the warden, in a series of reports. Mrs Christopher is now a Senior Scheme Manager in sheltered housing for the elderly employed by Signpost Housing Association.

16.7 The fact that problems were anticipated is clear from a memorandum to Clare Tavernor, Sheltered Housing Supervisor for Signpost Housing Association at the Pavilions, recording the concern at Mrs Bath moving in given the difficulties caused by her relatives while at Hod View, Stourpaine in 1992. Mrs Bath was not held to be responsible for the actions of her family but the intention seems to have been to make the management of Signpost Housing aware of the concerns so that they could take full responsibility should anything happen in the future. The notes indicate a clear concern as to Mr Bath's dangerousness.

16.8 On 13 February his sister Sharon referred him to the DSS citing his behaviour at their mother's flat as the presenting problem. She said that her mother was a diabetic and that he was spending her money. The possibility of legal action, by which it is assumed was meant an injunction against Mr Bath, to remove the responsibility from Mrs Bath is recorded. Also that the situation was discussed with Helen Jenkins of the housing authority who wanted a meeting with all involved attending and with Social Services input. She had been present at a similar housing liaison meeting in July 1992 (see chapter 10). The referral was allocated to Gary Hawker.

COMMENTS

- **Housing contact**

16.9 This was about the sixth occasion on which Mr Bath caused trouble at his parents' or his mother's home and came to the attention of either the local housing authority (NDDC) or after 1994, Signpost Housing Association. The other occasions were between April 1989 and July 1992.

16.10 By this time, the North Dorset District Council had sold off its housing stock to Signpost Housing Association which was managing the housing needs register on its behalf as agent.

C. Forston Clinic and the CPA

16.11 On 14 February 1995, Mr Bath was admitted to Forston Clinic under Dr Veasey. He had been drinking heavily and taking his mother's oxazepam and was also reported to be threatening to kill his mother, claiming that he was hearing voices telling him to do so. He settled on the ward with no evidence of psychosis. There was no direct evidence of his threats against his mother.

16.12 The admission note refers to his long history of violence, theft, drug and alcohol abuse and states that he was taken into care as a result of being sexually abused

by his stepfather. He was disorientated, incoherent and smelling strongly of alcohol and so was left to sleep. No further detoxification was planned and there was to be a CPA meeting to discuss future care. He was referred for occupational therapy and to CADAS.

16.13 He was never seen by CADAS on this occasion as he was discharged from hospital before the appointed date. This appears to have been the last contact with CADAS.

16.14 On 16 February a nurse at Forston Clinic made contact with the DSS informing them that a CPA meeting was to be convened urgently due to Mr Bath's critical accommodation problem on discharge from the Clinic. A further allocation was made to Gary Hawker. The same nurse also made contact with Caroline Kinsella at MenDOS who arranged for the police to be present at the CPA meeting on 1 March.

16.15 The nursing notes do not indicate any undue difficulties with Mr Bath. On 20 February he reported terrible nightmares including one about killing a fellow patient and there is a typed note about his dreams. The fellow patient moved rooms. On 22 February 1995 it was noted that he was waiting to have leave to his mother's. She had, however, rung to say that she did not want him anywhere near the flat or she would be evicted. This was conveyed to Mr Bath.

16.16 Later that day he returned to the ward and was suspected of having been drinking. This was confirmed by an alcometer test. He was warned about this behaviour and then requested that Dr Veasey's permission be sought for him to go for a drink occasionally on the understanding that he would not return drunk.

16.17 On 24 February he was requesting a social worker. He was offered the telephone to enquire about lodgings but is noted not to have taken up the offer. He had still not seen a social worker by 27 February.

16.18 A CPA meeting took place on 1 March 1995. Those present were Dr Veasey, Dr Ball (SHO), Caroline Kinsella, G Drake (nurse), Dorset police officer Andy Minto and Gary Hawker, social worker. The GP was invited but did not attend. It is recorded that there had been repeated hospital admissions in the past due to behaviour problems and involvement with the police and that the diagnosis was of personality disorder. Mr Bath was to be responsible for his actions. The plan was for there to be a MenDOS assessment both nursing and psychological to assist with future management. Gary Hawker was to refer him to 5 Carlton Road North. Admissions to Forston Clinic in future were to be offered when his mental state indicated that this was appropriate. No key worker was identified and the date of the next meeting was to be decided nearer to discharge.

16.19 The clinical note records Dr Veasey as saying that he 'feels hospital admission more appropriate than prison'. A full note of the meeting was made by Caroline Kinsella. This stated that Mr Bath's major problem was a lack of

accommodation. She contacted the police liaison officer to MenDOS, on 2 March to request a list of previous convictions and arranged an assessment with Mr Bath for 9 March. She also discussed the psychological assessment with the MenDOS psychologist and he agreed to offer Mr Bath an assessment. She then received a message from Forston Clinic to say that he had been arrested by the police and discharged from hospital.

16.20 Of those who became involved in Mr Bath's case, Ms Kinsella was someone who had one of the strongest backgrounds in forensic work, having worked for two and half years at the Cane Hill Special Assistance and Supervision Service (SASS) Unit, Coulsdon, Surrey, one of four satellite units around the Denis Hill Unit at Bethlem Royal Hospital, Beckenham, Kent, and part of the South East Thames Regional Secure Provision. She then returned to work in West Dorset. At Cane Hill she worked as a staff nurse and in the Community Forensic Nursing Team. A large percentage of the patients for whom she was responsible were subject to conditional discharge being restricted patients under section 41 MHA. She was no stranger to high risk patients.

16.21 In her evidence to us Ms Kinsella said that she thought that Mr Bath was 'quite a high risk patient ... More so to himself, although there was evidence that he was also a risk to others in his previous convictions'. This was predominantly a paper assessment as she only ever met him once and she had received no risk assessment training at that time. It is clear to us that at this stage in the chronology she had not seen any list of previous convictions and as she acknowledged, she had no detailed information about Mr Bath. It seems very unlikely that she had been given or seen the documents from St Ann's relating to his admission under section 48 and then 37 MHA in 1993 and contained in the Forston Clinic medical record or that she was even aware of the background to his admission on this occasion: the threats to kill his mother and his dreams about killing another patient.

16.22 In her assessment his presentation was not uncommon in that he was quite normal for the type of person seen by MenDOS, but 'extremely difficult to manage'. She did not think that much could have been done for him at that time. Dr Veasey had tried to set some limits to his behaviour which he initially agreed to but then flouted within the week.

16.23 Although Gary Hawker had been an approved social worker since 1991, he had only in January 1995 transferred to a CMHT and was covering Ferndown and Wimborne and Shaftesbury until May 1995 and thereafter Ferndown only. He had little or no experience of clients like Mr Bath with a serious forensic history and had received little formal training in CPA by then. He said that the meeting on 1 March was probably one of the first CPA meetings that he ever attended.

16.24 Mr Hawker also said that he may have been aware, although he was unsure, of some history of arson and ABH, but not of any detail. This seems unlikely to us given the importance of such information to his attempts to find accommodation

for Mr Bath. For this reason also we think it likely that he too had not been given access to the information from St Ann's relating to the 1993 admission. He also confirmed that he was primarily considered to be a danger to himself and this too would not be supported by his history of violence including arson and the alleged threats to kill his mother and his nightmares on admission.

16.25 Ms Kinsella said that this meeting was more about setting boundaries than about multi-agency planning and management. Dr Veasey too said that he was not so much seeking information from the police as impressing upon them that Mr Bath was to be dealt with through the criminal justice system if he offended again. Mr Hawker also did not consider that his role was in monitoring and supervising Mr Bath in the community, but instead was confined to resolving his accommodation problems. Key working was not discussed and he did not feel experienced nor confident enough, at that time, to question any aspect of the way in which the meeting was handled, although he would probably do so now.

16.26 Mr Bath was discharged from Forston Clinic on 7 March, when he was detained by police at Dorchester after he was caught using a stolen credit card. There is an underlined note that 'readmission to Forston Clinic is not appropriate'. At this time the proposed contact with CADAS came to an abrupt end, as did the contact with MenDOS. Caroline Kinsella had arranged an assessment meeting with Mr Bath for 9 March and was informed by Dr Veasey that he was not to be readmitted.

16.27 The attempts to place Mr Bath at 5 Carlton Road also faded at this point. He went to stay with his brother. He was discussed by Mr Hawker in a session with his supervisor on 13 March when it was decided that his vulnerability needed to be assessed in discussion with Dr Veasey, Caroline Kinsella and that the ability of his brother to cope needed to be assessed. A letter was written to him at an address in Boscombe. It stated that Mr Hawker would visit on 30 March. The letter in the records is marked 'returned address unknown'.

16.28 On 14 March 1995, Mr Hawker discussed Mr Bath's vulnerability with Dr Ball, registrar to Dr Veasey. He noted that he was 'vulnerable to an extent but had also a history of surviving in the community and a history of non-compliance. Therefore, vulnerability is acknowledged but is qualified by his non-compliance'.

16.29 Once again there is an extremely brief discharge summary dated 15 March which offers little overall information, but outlines the immediate presentation on this admission.

16.30 On 16 March, Mr Bath rang Social Services saying that his brother had been admitted to St Ann's and that he was once again homeless, as his brother would not let him be alone in the flat. Mr Hawker was on holiday and he was told to try Michael's Night Shelter and that a duty worker would contact him there the next day. St Ann's had no record of a male by the name of Bath being admitted. He was seen by the duty worker at Bournemouth Central and was asked to stay while

accommodation was checked. The notes show the considerable efforts made to find him accommodation. Eventually the YMCA offered him an interview, but turned him down also. There is no note of why he was turned down. He was asked to spend the weekend at the night shelter and to come back first thing on Monday 20 March.

16.31 On 23 March, Dr Veasey wrote to the CPA information officer at Forston Clinic and informed him that Mr Bath had been removed from the CPA because he had been in trouble with the law again. He asked that a letter be put out to this effect to all parties except Mr Bath and inviting anyone who wished to do so to call a further meeting. He, however, thought that this would be a waste of time. Dr Veasey also wrote to Dr Percival, GP, saying that he was not prepared to have him back at Forston Clinic. Unfortunately, Mr Bath was no longer registered with Dr Percival.

16.32 A placement appears to have been found at Dorset Lodge for Mr Bath towards the end of March, but was lost as a result of his behaviour to residents and staff. He also cut his wrists and went to Poole General Hospital and discharged himself after two hours. He then went to live with his brother for one day and then with another service user the following day.

16.33 In early April he said he wanted to resolve his accommodation and drug problems and Gary Hawker completed a needs assessment. He confirmed to us that this was under section 47 of the NHS and Community Care Act 1990 and that at that time Social Services were using community care assessment forms that were separate to the CPA form. This was noted to be the response to the referral made on 13 February by his sister.

16.34 The assessment states that Mr Bath had fallen out with his family and had been thrown out of home. An injunction had been obtained. His needs were identified as accommodation and support and the risk factor named was a history of self-harm only. The action to be taken was that Mr Hawker was to try Dorset Lodge again and contact CADAS. He was also to provide food until Mr Bath got his social security giro-cheque. Mr Bath was to remain in contact.

16.35 The CPA information officer sent out a letter on 4 April 1995 to all those who had been present at the initial CPA meeting as requested by Dr Veasey. On this day also a letter dated 31 March written by a Dr Surridge to the Family Health Services Authority was sent by them to all GPs in East Dorset and copied to Poole General Hospital A & E, Royal Bournemouth Hospital A & E and Bournemouth Police. It stated that Mr Bath had registered with a GP at his practice and had been noted to request repeat prescriptions of drugs with which he subsequently took an overdose. Dr Surridge expressed his personal feeling that no further drugs should be prescribed. Mr Bath was noted to be from Dorset Lodge and under the care of Dr Rowton-Lee.

16.36 On 6 April, Mr Bath was noted to be living in Dorchester and there is a MenDOS note following a conversation with Gary Hawker that since leaving Forston Clinic, Mr Bath had been moving from address to address. He was abusing drugs again. Caroline Kinsella explained that she had never been able to assess Mr Bath. She referred Mr Hawker back to the ward at Forston Clinic and the CFT at St Ann's for more information. She concluded from 'the information [she] had gathered it appeared that Shane is able to look after himself and that there appeared to be a pattern similar to his present behaviour'.

16.37 By 18 April he was no longer living in Dorchester and had stolen £150 from his landlord. Contact was then lost and on 24 April the case was 'dormanted' with the agreement of Mr Hawker's supervisor. In the 'dormanting summary' Mr Hawker concludes: 'The vulnerability is focused on his drug abuse and criminal activity and intermittent homelessness. However, Shane's refusal to any assistance renders intervention futile'. He told us that he would probably not put it in such strong language today, but that 'intervention was problematic'.

16.38 The distinction between 'dormanting' and 'closing' a file is that the former means that the care plan was at an end, but that any future contact was to be with Mr Hawker. The latter was more final and usually signified a move out of the area.

16.39 On 30 April 1995, Mr Bath was arrested for burglary of a video recorder and jewellery worth £1,000 from a friend and was in custody. There was an emergency duty service referral to Gary Hawker by a police officer from Shaftesbury Police. On 1 May, Mr Bath made direct contact from the court cells asking for help. Contact was also made by the Probation Service seeking information for the purposes of bail. Mr Bath was remanded in custody at HMP Dorchester.

16.40 A pre-sentence report was written by Sheila Newall and on 5 June 1995 he was sentenced to 12 months' imprisonment and transferred to HMP Guy's Marsh (chapter 17).

COMMENTS

- **Implementation of CPA and information-gathering**

16.41 Dr Veasey must be applauded for being the only person to convene a multi-agency meeting to consider Mr Bath's care. The only other such meeting in July 1992 was convened by the housing authority to consider Mrs Bath's needs. This was an excellent opportunity to take stock of this troublesome client and to attempt a plan for the future.

16.42 Our criticisms here relate to the lack of understanding of the CPA procedure resulting in a poor implementation of it. There was no key worker identified and it was discontinued when Mr Bath transgressed the law once again and was arrested. Also key information relating to the alleged threats against his mother and

another patient, as well as the information from St Ann's and the history of violence, was lost from the assessment undertaken.

16.43 To discontinue the CPA in these circumstances without further consideration of a plan for the future was inappropriate given the likelihood of his re-presenting himself to the mental health services.

16.44 Once it became apparent to Ms Kinsella and Mr Hawker on about 6 April that neither of them had been able to perform a full assessment, then they too could have convened another meeting.

16.45 If all the available information was provided to those present his risk profile would have been raised and it is more likely that those responsible for him would have monitored him more closely and been more motivated to plan for his next admission.

16.46 This omission seriously hampered Mr Hawker's efforts to assess Mr Bath's vulnerability. He and others at that meeting considered him to be predominantly a risk to himself. There is no indication that his risk to others was considered at all. We find that there was evidence of a risk to others during this admission which together with his recent history and violent past would have warranted a more cautious approach.

16.47 This episode does, however, show that informal boundary setting was not a solution for Mr Bath. We think that this means that even if a formal CPA had been taken, as it was lacking in powers of coercion, it is unlikely to have held him for long. It is difficult to determine what extra powers might have been proper in these circumstances.

16.48 We do not believe that this was a situation in which he should have been detained in the absence of any good reason to do so, such as an offence of violence having been committed. If the risk factors had been properly noted and assessed, then assertive management and planning by all agencies and a plan for the future would in our view have been sufficient to control the situation adequately.

Chapter 17

PROBATION SERVICE: APRIL-NOVEMBER 1995

- Probation Service and high risk procedures
- Twelve months' imprisonment
- Behaviour in prison
- CPA in prison. Arrangements on release

A. Introduction

17.1 Mr Bath was charged and convicted of offences some of which were committed during his time at Forston Clinic earlier in the year and resulted in his being removed from the CPA procedure. He received a 12 month prison sentence.

17.2 This chapter outlines the efforts which were made by the Probation Service to obtain follow-up for Mr Bath on his release from prison. The prison records for this period are available.

B. Charges and Sentence

17.3 On 30 April 1995, Mr Bath (aged 27) was arrested for the burglary of a video and jewellery worth £1,000 from a friend. He was remanded in custody and tried to contact the DSS from the cells at Weymouth Court asking for help.

17.4 He appeared at Dorchester Magistrates' Court on 1 May and pleaded guilty. On 5 June he was sentenced to 12 months' imprisonment. There is a probation pre-sentence report from Sheila Newall dated 26 May. She had last been involved with Mr Bath when he was serving a sentence of 18 months' imprisonment for burglary in 1991 and released in January 1992 (chapter 9).

17.5 Her report indicates that the charges related to four offences: two burglaries from bed-sits, an attempt to obtain £50 from a bank on 7 March and receiving a stolen credit card. The latter two were the reason for Mr Bath's being discharged from the Forston Clinic on 7 March and being removed from the CPA by Dr Veasey on 23 March (chapter 16).

17.6 She had available the psychiatric report of Dr Rowton-Lee dated 3 October 1993 and a previous pre-sentence report which from the records looks likely to have been that of Rachel Newman in November 1993, although this is not expressly stated. She included extracts from the psychiatric report which refer to Mr Bath's childhood, diagnosis of severe personality disorder and the fire at the parental home. She mentioned the allegations of sexual abuse and that he had been admitted to prison or hospital on a great many occasions.

17.7 As for sentence, she said that he feared a further section under the MHA following his experiences in 1993. He had made it clear that he wanted a sentence of imprisonment so that his heroin addiction could be dealt with. She concluded that he was not suitable for community sentences and would refuse to co-operate. She ended 'Regretfully probation, social services and medical services have attempted to help him, but he has become increasingly difficult to place or to contain in a structured setting'.

C. Prison

17.8 On 14 June, Mr Bath was transferred to HMP Guy's Marsh from Dorchester Prison and allocated to Sue Staddon, probation officer, who would supervise the arrangements for his release from prison. The automatic conditional release date was 27 October and his probation licence was due to expire on 29 January 1996. His sentence expired on 29 April 1996.

17.9 An offender sentenced to a term of 12 months or more but not greater than four years is eligible for automatic conditional release after serving half of the sentence (section 33 of the Criminal Justice Act 1991). He is then released on licence under the supervision of a probation officer for the next 25 per cent of the sentence. The last 25 per cent is unsupervised but places an offender at risk of having to serve that part of the sentence still outstanding at the date of any new offence (section 40 of the Criminal Justice Act 1991).

17.10 Ms Staddon first visited him on 18 July. He was on the hospital wing having self-harmed that morning. She recorded that the medical officer thought that he was clinically depressed but that the psychiatrist had refused to see him.

17.11 At the request of the medical officer at Guy's Marsh, Mr Bath had been assessed on 23 June on the hospital wing by a locum consultant psychiatrist, who was standing in for Dr Gallimore from Forston Clinic. His opinion was that Mr Bath was not at that time suffering from a depressive illness, nor was there any evidence of a psychotic illness. He set out a plan for management which included further review if necessary.

17.12 There were subsequent transfers to HMP Exeter on 26 July to the hospital wing and then to Channings Wood on 16 August where an automatic conditional release sentence plan was commenced. Under 'custodial behaviour' it is recorded that Mr Bath 'could use self harm ploys to achieve his own goals'. He was considered to be a suicide risk and located on the hospital wing. The officer's comments were 'After a very difficult start in this establishment he has settled into living in the prison hospital. He finds being incarcerated or having his movements logged difficult to cope with and has come into conflict with staff over this'.

17.13 On 9 August there was a probation high risk conference. It was attended by Nick Heape, Assistant Chief Probation Officer (ACPO), Dee Harris, Senior Chief Probation

Officer (SPO) and Sue Staddon. His high risk category was confirmed by reference to the arson conviction, heroin addiction, the long history of self-harm and personality disorder. The trigger factors were stated to be alcohol, drugs and mental health.

17.14 Mr Bath's potential homelessness was acknowledged and Sue Staddon was to check whether the prison hospital intended to refer him on to community psychiatric services. She was to refer him to MenDOS or CFT dependent upon which part of the county he was released.

17.15 In the August summary, Sue Staddon noted in relation to risk that those at risk were 'self, others who get in his way when upset'. The level of risk was 'High. Is currently depressed and likely to return to alcohol and drugs on release'. The comments of the SPO were 'A most worrying case which will require close supervision'. Ms Staddon was to 're-conference' him on 18 October. This was agreed by the ACPO.

17.16 Contact was made with Caroline Kinsella at MenDOS on 23 August enclosing a copy of Dr Rowton-Lee's report of 3 October 1993 and asking if it was possible to assess Mr Bath while in prison so that a support network could be set up for him on release.

17.17 In her response, Ms Kinsella said that she had discussed the referral with Dr Veasey, who was of the opinion that neither MenDOS nor the mental health services could offer anything to Mr Bath. She explained the brief previous contact that MenDOS had had with him and said that it was the view of the MenDOS team that on Dr Veasey's advice there was nothing that they could offer Mr Bath. She was apologetic. She told us that she could have gone to the prison to assess him herself had this been deemed appropriate and that in her view Dr Veasey's stance was taken on the basis that he considered Mr Bath to suffer from an untreatable personality disorder.

17.18 Ms Staddon contacted Dr Veasey again a week later on 18 September when he confirmed his earlier opinion. In evidence to us he said that it was clear to him by then that a community-based treatment was not the best option for Mr Bath.

17.19 In October Dr Rowton-Lee was asked by the visiting psychiatrist at Channings Wood, who had been looking after Mr Bath for the previous two months, if he would undertake follow-up on his release. He asked that he be seen soon after discharge as his mental state was unstable and he was likely to come to his attention acutely anyway. Dr Rowton-Lee's brief and reassuring response is dated 11 October. He said that he would be followed up by the CFT, 'which is a multi-disciplinary team, and this will place him under the CPA'.

17.20 No accommodation was found due to the history of arson and firearms convictions.

17.21 His own suggestions that he would go to his mother's accommodation were put paid to by her social worker. There are entries in the records which show that her social workers were assiduous in their attempts to prevent Mr Bath from returning to the Pavilions.

17.22 On 18 October it was noted that he had agreed to go to Creek House who were notified accordingly. This course of action was agreed at the high risk review, although there is no full note of this meeting. Creek House is a specialist hostel run by the Bournemouth Churches Housing Association and with specific links with the CFT.

17.23 There is a self-harm report in Channings Wood on 18 October which states that Mr Bath cut himself after an officer had strong words with him in order to 'show' him (the officers). He had also cut himself on 18 July. On that occasion he asked to see an officer in private and revealed a four-inch laceration to his left forearm. Later the same morning a cleaner brought in a note which stated 'Bath is looking depressed and I am worried about him'. After checking it was decided that he had written the note himself. The other notes of the time do not indicate that he was depressed. This, in our view, tends to support the note in the sentence plan that Mr Bath would self-harm to achieve his own goals, such as be taken to the hospital wing and this was most likely to be manipulative behaviour rather than indicative of a true depression at this time. He cut himself on two other occasions while in prison this time.

COMMENTS

- **Arrangements on release from prison and CPA**

17.24 This episode demonstrates a perennial dilemma. Dr Veasey was firmly of the view that the criminal justice agencies should deal with Mr Bath because of his untreatable personality disorder. Ms Staddon wanted the mental health services to become involved and to offer some assistance. In the end it was the ever-optimistic Dr Rowton-Lee who offered assistance albeit in a rather undefined form and one which, as we shall see below, did not come to fruition in the end.

17.25 Ms Staddon made real efforts to put together a resettlement package for Mr Bath and to act on her view that he required psychiatric supervision in the community. It is unfortunate that it is difficult to obtain an assessment prior to release, although perhaps in this case where he was well-known to both Dr Veasey and Dr Rowton-Lee, it is understandable.

17.26 This episode illustrates the way in which a multi-disciplinary approach is not followed once a MDO enters prison, so that prior to discharge a full assessment is performed and on discharge a meeting is convened with all agencies present and with the offenders sentence plan available so that behaviour while in prison can be taken into account.

17.27 NHS Executive Guidelines published in 1994 (HSG(94)27) provide guidance on mentally disordered people in the community and the CPA. It calls for effective links between local agencies and prisons 'so that agencies know for which patients they will eventually have to accept responsibility and can work jointly with the discharging unit to develop effective arrangements for continuing care' (para.15).

17.28 The more recent Joint Prison Service and National Health Service Executive Working Group Report, The Future Organisation of Prison Health Care (March 1999) identifies the need for 'satisfactory functioning of CPA within prisons and [the development of] mental health outreach work on prison wings' (para.62).

17.29 We would endorse the latter and find that the links demonstrated in this case between prison and local agencies were not 'effective' (see Grey Report (1995) East London and City Health Authority).

D. RECOMMENDATION

16. The Department of Health and the Home Office should jointly issue guidance on:
(a) the need for information sharing between the Prison Health Service and the NHS for MDOs returning to the community from prison;
(b) extending the CPA process to include the Prison Health Service as a specialist mental health service thereby ensuring that after-care arrangements are in place on release from prison.

E. Supervision on Release

17.30 On 27 October, Ms Staddon left a memorandum for the duty officer marked in bold 'to be seen by duty officer not duty assistant'. This note said that Mr Bath was a high risk to himself more than to others and that he was anxious about going to Creek House. Elsewhere it is stated that he had cut himself while still in prison due to his anxiety in going to the hostel. He was to be encouraged to go straight to Creek House and to see her on 1 November. It is also not clear from the CPA criteria in use in Dorset whether Mr Bath would have been subjected to the CPA if referred to the CFT (chapter 27).

17.31 Mr Bath was discussed by the CFT panel on 31 October 1995. Ms Staddon 'expressed concern that he would now do something to get a further conviction to prison. Has been violent in past. At present turning in on self but if this turns outward may involve risk to someone else'. Mr Bath had disappeared from Creek House by this stage and they said that they would be willing to keep him if the CFT were prepared to take him on for treatment. He was due to see Ms Staddon on 1 November and it was decided that if he should keep that appointment she would advise CFT so that an appointment could be made with them.

17.32 The record of contact shows that Mr Bath did attend at the probation office on 1 November saying that he wanted to live with his brother who had accompanied him. On 6 November he attended and told the duty officer that he was of no fixed abode. It was noted that now that he had given up Creek House, there was nothing that could be done for him in this regard. He was written to and offered an appointment for 13 November.

17.33 He failed to attend on 13 November and again on 27 November. Mr Bath was admitted to Royal Bournemouth Hospital on 17 November following an overdose of amitriptyline, transferred to St Ann's and discharged on 21 November. He was re-admitted to St Ann's from Royal Bournemouth Hospital on 28 November and discharged on 26 December (these admissions to hospital and the discharge arrangements are discussed further in chapter 18).

17.34 Mr Bath was never assessed by the CFT. Following his discharge from St Ann's on 21 November, he was written to by Ian Oxborrow, CPN with the CFT and offered an appointment on 7 December, by which time he was back in hospital. It was confirmed to us in evidence that this was in fact a referral made by Dr Rowton-Lee and not a follow-up to that made by Sue Staddon.

17.35 In the December probation summary it was noted that Mr Bath spent only one night at Creek House having spent all his money on drugs. He went to live with his brother and ended up in hospital having overdosed. At the time that summary was written Mr Bath was in St Ann's and Ms Staddon wrote 'His Licence expires at the end of January and I am keeping a low profile so that Shane remains to be seen as the Mental Health problem that he is'. On this occasion he was described as being a risk to himself only, but the level of risk was still noted as 'High. Depressed, still using illegal substances and alcohol'.

17.36 A readjusted risk assessment was communicated to the duty officer on 23 November as well.

17.37 The SPO's comments in December were 'a most worrying case-Shane is likely to be in trouble again but it is difficult to see how probation intervention/support is likely to positively impact on his destructive behaviour'. It was planned that he be removed from the active register following the expiry of the licence in January.

17.38 Ms Staddon told us that the way in which she recorded Mr Bath's risk reflected his presentation at that moment in time. Regardless of his earlier history, the offences for which he was sentenced on this occasion were not high risk. In her view, the probation file as a whole would give a reader the whole picture. She felt that in-depth risk profiles would be too wordy and not be read.

17.39 Ms Staddon wrote to Mr Bath in December in hospital reassuring him that she would not 'breach' him while in hospital, but that if he was to leave the hospital before 29 January for whatever reason he was to report to the probation office

leaving an address. There was no further contact with the Probation Service prior to the licence expiring. Ms Staddon appears to have assumed that he was still in hospital and said that the case was closed on 29 January.

17.40 There is a gap in the notes between 26 December and 9 February 1996 when we have been unable to track down Mr Bath's activities.

COMMENTS

- **Discharge**

17.41 More forceful measures should have been taken to ensure that further contact was made once he left hospital. Mr Bath was still under statutory supervision. For example, there is no evidence that the hospital was ever contacted for information of when and to where he was discharged.

17.42 We do sympathise, however, with Ms Staddon and the frustration which she must have felt having striven so hard to find him accommodation and to get an assessment for him with the CFT. None of these things were capable of holding him. We understand why she did not want to breach him while he was in hospital supposedly under treatment. We do think that again an opportunity for a multi-disciplinary conference with the benefit of the information that the Probation Service could offer should have been convened on his discharge from hospital or better still on his admission to hospital given his propensity to take his own discharge.

- **Risk**

17.43 During this time there was an acknowledgement of the risk which Mr Bath posed to others, but any risk was seen to be predominantly to himself. At this time this was probably not an unreasonable assessment (chapter 29).

Chapter 18

NOVEMBER 1995 TO SEPTEMBER 1996

- Twelve hospital admissions
- Challenging behaviours and crisis management
- CPA (eligibility and levels) and non-compliance
- Risk
- MHA admission criteria
- Supervised discharge
- Social Services involvement
- CMHTs

A. Introduction

18.1 From 20 November 1995 to 13 September 1996 Mr Bath was admitted or transferred to St Ann's nine times, admitted twice to Old Manor Hospital and once to the Department of Psychiatry at Royal South Hants Hospital in Southampton. This period of less than one year accounted for over a third of all of his admissions to psychiatric hospitals. Even by the standards of Mr Bath's way of life this was a very chaotic period. His longest stay in a psychiatric hospital during this time was at St Ann's for 29 days and his shortest was for one day at St Ann's and one day at Old Manor Hospital. The longest gap between discharge and admission/re-admission was 58 days and the shortest less than one day.

18.2 He was offered psychology assessment and treatment, numerous out-patients' appointments and one with the community drugs team. He did not take advantage of any of these offers of help. He received one visit from a CPN.

18.3 Mr Bath also had some contact with Social Services although it was never sustained. He requested, or nursing staff requested on his behalf, assistance with accommodation and benefits while at St Ann's. There was also contact via his mother's social worker in Shaftesbury because of concerns about Mrs Bath during the times he stayed in her flat. The police requested social workers to attend as appropriate adults after he had been charged with offences during this period.

18.4 He had some contact with the Probation Service until January 1996 because he was on a probation after-care licence from Channing's Wood Prison, having been released from there in October 1995 (chapter 17).

18.5 However, this was overwhelmingly a time of hospital admissions, re-admissions, transfers and discharges. It is difficult to be confident of the precise dates of admissions and discharges in this period because the notes are confusing and difficult to analyse. What follows is an attempt to describe the sequence of events at this time.

B. First Admission, Royal Bournemouth Hospital/St Ann's (17-22 November 1995)

18.6 On 17 November 1995, Mr Bath, aged 27, was admitted to Royal Bournemouth Hospital following an overdose. He was assessed by Dr Mohammed who noted that he was threatening to kill himself, and claimed to have been abusing amphetamines. It is noted that he was well known to St Ann's and had a long history of depression and personality disorder. His mental state examination noted 'depressed ++. Low self esteem. Suicidal ideas'.

18.7 This was communicated by Dr Mohammed to Mr Bath's GP in a letter dated 29 November when he also said that he will admit him to St Ann's for full assessment. By this time Mr Bath had absconded and been re-admitted to St Ann's (see below) and no assessment had been carried out.

18.8 He was transferred to St Ann's on 20 November where he gave a partial account of his background to the admitting doctor, omitting much of his forensic history and falsifying some of his family details. The mental state examination notes that he felt low, had some suicidal thoughts and had decreased appetite and sleep and weight loss. Paranoid ideas of the nursing staff being 'out to get him' and a 'satellite dish in his head picking up messages' were noted, along with auditory hallucinations. His insight was said to be 'good'. The doctor formed the impression that Mr Bath was suffering from depression, drug misuse and queried whether he had a personality disorder. The plan was for a low dose of haloperidol to reduce hallucinations, a different anti-depressant, CPN and social work follow up and referral to the Community Drugs Team.

18.9 He left the hospital the next morning. He was placed on leave and discharged in his absence formally on 22 November. A nursing note to the effect that he should be transferred to Dr Choudry's team did not get translated into the later discharge summary which also dealt with the next admission.

C. Second Admission, St Ann's (28 November-26 December 1995)

18.10 Six days later on 28 November, Mr Bath was admitted again to St Ann's from Royal Bournemouth Hospital having gone there and complained about hallucinations (insects and spiders) caused by an overdose of LSD and feeling very depressed. The impression was of personality disorder and drug/alcohol abuse.

18.11 He settled well and during this stay of approximately a month was generally compliant with treatment and relatively stable apart from some episodes of agitation. However, he stayed out for short occasions three times and was found to be drinking once. Mr Bath requested and was given 24 hours' leave for Christmas Day but returned two days later saying he wanted to be discharged as he had found a flat although he did not or would not give the hospital the address. He was

asked to remain so that a care package could be arranged but decided to go anyway and was discharged, absent without leave, on 26 December.

18.12 A CPA form was completed stating that he was discharged with no known follow-up address or care package. He was placed on level 1 and Dr Mohammed was the named key worker who would provide out patient follow-up. The noted diagnosis was 'depression/drug misuse'.

18.13 Dr Rowton-Lee's senior house officer wrote a discharge letter to Dr Beswick, supposedly Mr Bath's GP, on 11 January 1996 summarising the admitting doctor's assessment and advising him that an out-patient's appointment would be arranged for six weeks' time. No specific diagnosis was given but it says 'I believe that he had a drug problem and he was depressed'. A (partial) forensic history was mentioned. The address given for him was his address on admission on 28 November. There is no evidence that he was ever seen by Dr Rowton-Lee on this occasion and nor was he transferred to Dr Choudry as had been planned on 22 November. Mr Bath was no longer Dr Beswick's patient.

18.14 He failed to attend the next three out-patients' appointments arranged for him including one when he was again in hospital. He was given an appointment with the Community Drug Team on 10 January although it is not clear whether he attended or not. He was also referred to the Clinical Psychology Service on 5 January although he did not attend.

18.15 Mr Bath's GP of the time had concerns about suicide and on 9 February referred him urgently to a CPN, for assessment. He was visited by the CPN at home where he was openly using drugs with his friends and was assessed by him as not suicidal but offered an out-patient's appointment for 12 February. Mr Bath did not attend for this appointment and the CPN asked that he be offered an out-patient's appointment with Dr Mohammed the following Monday.

D. Third Admission, St Ann's (21 February-13 March 1996)

18.16 On 21 February 1996, Mr Bath was admitted to Royal Bournemouth Hospital having taken an overdose. This was the same pattern of admission as the two last admissions. He was seen by a psychiatrist from St Ann's on 22 February who noted that he was very stressed and suicidal and 'believes people can remove and insert thoughts. No thought broadcasting. Thought echo. Hears 2nd person command hallucinations - tell him to "give up" or "kill himself" ... insight thinks his distress is related to chaotic lifestyle'. He was assessed as having a 'moderate depression complicated by alcohol misuse & emotionally unstable personality'.

18.17 He was admitted on 23 February and claimed he was drinking two bottles of sherry a day and was living with a girlfriend who also had an alcohol problem. The diagnostic impression was one of acute psychosis secondary to alcohol and

cannabis abuse and he was prescribed medication to help with alcohol withdrawal. There was no mention of personality disorder.

18.18 He was confined to the ward boundaries. He was referred to occupational therapy and the psychologist again. A few days after admission he cut his left arm badly. He intermittently expressed suicidal ideas and after a particularly serious threat to take his own life it was agreed by ward staff that he should be on 'orange obs[ervations]' so that he would not be overly aware that he was being watched. There was a query as to whether he would be placed on section 5(2) if he attempted to leave the hospital. Dr Rowton-Lee was to be consulted for his agreement to this course of action.

18.19 On 1 March, after further self harming behaviour Mr Bath went missing for 24 hours and was brought back by the police having been found on top of the Bournemouth International Conference building. Section 5(2) was not used.

18.20 He left St Ann's on 13 March and was discharged in his absence the same day 'therefore discharged from CPA follow up for no compliance (never turns up for OPD appointments)'. The discharge letter to his GP on 19 March gave the diagnosis as psychotic episode secondary to alcohol and illicit drug abuse and indicated that he was prescribed temazepam, among other drugs, on discharge. He had requested help in addressing his past sexual abuse and the possibility of a psychological referral was discussed. His past avoidance of CPA follow-up was noted but he was allocated to Gary Hawker, social worker and the same CPN who saw him in February 1996. Dr Choudry was to be asked to take over his care.

18.21 Mr Hawker had undertaken assessments on Mr Bath between February and May 1995 and had 'dormanted' the case (chapter 16). He had since moved to another area and so forwarded the summary to the Bournemouth Central Office from where a team manager wrote to Mr Bath and invited him to contact the duty officer if that would be helpful. Mr Hawker told us that he had not been contacted prior to being allocated to Mr Bath on this occasion.

18.22 There is no further mention of the CPN in the notes and we can only assume that he never made contact with Mr Bath. We have been unable to trace the CPN for further comment.

E. Fourth Admission, St Ann's (1-7 June 1996)

18.23 Mr Bath was admitted to St Ann's again on 1 June. The admitting doctor's assessment was of amphetamine abuse/dependence, personality deficits with a possible depressive illness. He was thought to need detoxification and help with his drug problems and was to be confined to ward boundaries for 72 hours. On the ward he presented with a now familiar pattern of mood changes, tearfulness, requests for medication, intermittent agitation and voicing of suicidal intent.

18.24 On the morning of 5 June, Mr Bath was reported missing and he was discharged by Dr Mohammed in the early evening. Late afternoon the next day Mr Bath returned to St Ann's and was re-admitted. After extensive rest he left the ward on the evening of 7 June without notifying staff.

18.25 A CPA form was completed naming Dr Rowton-Lee as key worker and placing Mr Bath on level 1. It records a diagnosis of substance abuse and indicates that the unmet needs were for personal support and psychological therapy. He was to be followed up in out-patients by Dr Rowton-Lee and a review date of 17 July was set. Dr Rowton-Lee's verbal agreement only was obtained to this CPA.

F. Fifth Admission, Old Manor Hospital (9 June 1996)

18.26 The available records indicate that Mr Bath went to stay with his mother in her sheltered accommodation in Shaftesbury for at least part of this period. In the early hours of the morning of 9 June he was admitted to Salisbury District Hospital from his mother's flat after an overdose of diazepam. Initially he had refused to go to hospital and the police were asked to attend to help escort him there. He was found to have a knife which was taken from him before being transferred to Old Manor Hospital. Later that evening Mr Bath had apparently left that hospital and re-appeared at his mother's where the locks had been changed. He was taken back to Old Manor Hospital.

18.27 He again returned to Mrs Bath's flat. On 12 June, an entry in Mrs Bath's Social Services file noted that she was very upset 'because her son was creating problems'.

G. Sixth Admission, St Ann's (10 June 1996)

19.28 At 7 30 p.m. on the evening of 10 June he was returned to St Ann's following an informal transfer from Old Manor Hospital in Salisbury. He expressed dissatisfaction at returning to Merley Ward and made it clear to staff that 'he would be out of here soon'. Just under 24 hours later he again disappeared from the hospital and was discharged by Dr Mohammed the next day. On 13 June, the Signpost Housing Association wrote to Mrs Bath reminding her that her son was causing disturbance to other residents and stating that they would have to consider whether she was breaching the terms of her tenancy agreement.

18.29 There is one discharge summary which covers the admissions to St Ann's from 1 to 10 June. It notes that Mr Bath had been living rough since March and then with his sister, drug abuse, feelings of paranoia and auditory hallucinations and agitation following withdrawal from amphetamine abuse. He was treated with large quantities of chlordiazepoxide (a benzodiazepine indicated in the treatment of anxiety and acute alcohol withdrawal) and chlorpromazine (anti-psychotic). He was low in mood.

H. Seventh Admission, Old Manor Hospital (13-18 June 1996)

18.30 On the evening of 13 June, the Emergency Duty Team of Wiltshire Social Services faxed the Mental Health Team at Old Manor Hospital to inform them that Mr Bath had been referred to the hospital by Mrs Bath's GP in Shaftesbury and that he had been admitted to the hospital that day as a voluntary patient. However, he was threatening and aggressive and considered a high suicide risk and had said that he wanted to leave. He was therefore detained under section 5(2) MHA to await assessment the next day.

18.31 On 14 June, the Old Manor Hospital Mental Health Team requested a Dorset Approved Social Worker to liaise re an assessment for detention under section 2 or 3 MHA. Contact was made with Alexis Smith and Val Hall in Dorset. Mr Bath is noted as being 'still allocated to' the former. It is not clear when the initial allocation might have happened and at this stage St Ann's appeared reluctant to have him back. Although it was noted that 'liaison with Alexis required' there is no record that she ever met Mr Bath. We have been unable to trace either Ms Smith or Ms Hall for further comment on this episode.

18.32 He was ultimately discharged from the section 5(2) and transferred to St Ann's as an informal patient on 18 June under the care of Dr Mohammed (see below). He was not assessed for admission under MHA at St Ann's.

18.33 Mr Bath's Old Manor Hospital discharge letter dated 2 July stated that he had a diagnosis of amphetamine abuse and outlined his numerous admissions and absences without leave and re-admissions. It advised that an out-patients appointment would be offered.

I. Eighth Admission, St Ann's/Old Manor Hospital (18-19 June 1996)

18.34 After his transfer to Branksome Ward at St Ann's on 18 June, he complained of feelings of anger, depression and voices in his head telling him to hurt people. There is a note that he attacked a visitor and members of staff because he heard voices telling him to do so which were assessed as second person auditory hallucinations inside his head. He claimed to have broken up his mother's flat in Shaftesbury and to have pinned her to the ground. He said he was using amphetamines very heavily which made him feel better by blocking his feelings and stopping the voices in his head. He was prescribed clopixol.

18.35 He had an outburst on the ward, kicked a door and threw furniture around. This led to him being restrained. He was paranoid on the ward and reported hallucinations in which he was told to hurt others although he said that he did not have to obey these voices. A diagnosis of personality disorder with psychotic symptoms was made.

18.36 The next day an entry in the medical notes stated that he 'kicked off last night' and 'if he misbehaves again ... discharge immediately ... not to be put on Section ... if he refuses call the police to evict him'. He absconded from the hospital on 19 June and was readmitted on 22 June having walked for one and a half days to his mother in Shaftesbury.

J. Ninth Admission, St Ann's (22 June-3 July 1996)

18.37 On 22 June, Mr Bath was admitted to St Ann's from his mother's having again broken up some of her belongings. He said he felt angry, had not slept or eaten, was using cannabis, amphetamines and alcohol. He presented as distressed, in low mood, agitated, shaking, expressing thoughts of self-harm and experiencing voices. There was a referral to a clinical psychologist and a DSS referral form regarding income support and homelessness.

18.38 By 27 June he was again feeling agitated and on 1 July requested ECT. On 28 June the psychologist wrote back to say that he thought Mr Bath's problems 'have a flavour of dual diagnosis' and that the specialist nurse in this area might be better equipped to help. The clinical notes state that he absconded and the notes suggest that ECT had to be delayed on 1 July because he had had a drink. However, the nursing record indicates that he did have ECT later that day. He absconded on 2 July and was discharged in his absence the next day.

18.39 The discharge letter to his GP dated 23 July stated that he had a diagnosis of personality disorder with drug abuse. The letter concluded:

'Shane will be sent an outpatient's appointment. It has to be said that Shane had had numerous admissions in the last month or so and has always absconded from hospital. He has had a lot of effort put into his care but does not seem willing to follow this up. It has to be said that people are losing patience'.

18.40 There is a CPA form dated 3 July. Dr Mohammed is recorded as the key worker. Mr Bath is once again on level 1 and the next review date is 14 August. There is no reference to the last CPA and the impending review on 17 July. There is no diagnosis recorded and the identified treatment/care needs states only that he was discharged in his absence 'after going AWOL'. The plan was for out-patients follow up with Dr Mohammed.

K. Tenth Admission, St Ann's (6-12 July 1996)

18.41 Mr Bath appeared at Chelsea and Westminster Hospital A & E with a deep laceration of his arm on 6 July. It would seem that he had travelled to London with his brother and been wandering around. He reported that he had been hearing voices telling him to harm himself and had cut his arm with a razor blade. He was hearing voices telling him to kill himself.

18.42 On the same day he was transferred back to St Ann's. The previous diagnoses of personality disorder and amphetamine abuse were noted. He again complained of auditory hallucinations, and voices telling him to go and 'self destruct'. It was planned to give him two more sessions of ECT. He underwent ECT on about two occasions. On 12 July he absconded and was discharged in his absence.

18.43 The discharge letter on 22 July is brief. It notes a diagnosis of alcohol and drug abuse and personality disorder. It states that Mr Bath had complained that he felt very depressed on admission although it is not possible to see where this is recorded. It also mentioned that he had stolen money from other patients before leaving the hospital. He was sent an out-patient's appointment for 27 August which he failed to attend.

18.44 There is a very partially completed CPA form. It does not identify a key worker, level, treatment or care needs. It only states that he went 'AWOL from ward without informing staff about plans-discharged in absentia following advice from Dr ... No CPA follow up possible'.

18.45 Through August Mr Bath was reported by Mrs Bath's social worker to be living with one of his brothers. He saw a GP, Dr Hattersley, on 20 August. The GP note is difficult to read, but we were told that he was 'depressed, weepy and agitated' and 'coming down from speed'. After a discussion with Dr Mohammed, Mr Bath was to be seen on Merley Ward the next day. There is no record of this happening. Otherwise we have no record of his activities for this month except that he turned up at the Homeless Persons Project in Southampton on 30 August and was admitted to Royal South Hants Hospital on 1 September.

L. Eleventh Admission, Department of Psychiatry, Southampton (1-5 September 1996)

18.46 On 1 September, Mr Bath was admitted to the Department of Psychiatry at Royal South Hants Hospital, Southampton following request from a local GP. The admission/discharge summary summarised what was known of his history (presumably via St Ann's) including the recent pattern of frequent admissions and re-admissions, some of his forensic background, and his diagnosis of personality disorder with alcohol and drug misuse. He expressed ideas of anger, low mood and aggression to others. His claims of psychotic phenomena such as thought-broadcasting and auditory hallucinations did not convince the psychiatrist examining him and he was said to appear 'as if acting low'. A plan was formed to find him hostel accommodation and resume his depot medication but he absconded on 5 September and was discharged in his absence without a CPA on 11 September.

M. Twelfth Admission, St Ann's (11-13 September 1996)

18.47 Mr Bath was arrested by police in Bournemouth on 10 September after turning up in Shaftesbury and claiming to have stolen £10,000. This proved to be a fabrication on his part and he was admitted the next day to St Ann's after examination by Dr Mohammed. This was at the insistence of the social worker who had acted as an appropriate adult at the police station. She had been concerned at his apparently deluded state. Her information was that he was a chronic schizophrenic and she was of the view that a MHA disposal was required. He complained of a now familiar mixture of drug dependence, auditory hallucinations, depression, paranoia and agitation.

18.48 On 13 September, he was believed to have stolen a fellow patient's money from his wallet. The circumstantial evidence supporting this allegation was very firm but he reacted strongly to the allegation. St Ann's asked for police attendance and he was arrested, removed and discharged from the hospital. During the arrest he assaulted a policeman (see chapter 22).

18.49 A discharge summary from Dr Rowton-Lee's senior house officer was sent to his GP on 27 September. This again contained a diagnosis of personality disorder with alcohol and drug abuse. It expressed scepticism as to the existence of auditory hallucinations. It advised that an out-patient's appointment would be sent to his brother's home, his most recent address. He appeared mentally stable at this time and was not displaying any psychotic symptoms.

COMMENTS

- **Information-gathering and communication**

18.50 As before there was no attempt to verify and bring together Mr Bath's history during this period. Even within this series of admissions there was no reference back to the immediately preceding admission and, therefore, poor continuity of care. There was no attempt to corroborate important information concerning forensic background or key personal details. Discharge summaries were of a poor quality and sometimes sent to the wrong GP.

- **Treatment**

18.51 Mr Bath was offered detoxification, anti-psychotic medication and anti-depressants and ECT. We have already said (chapter 12) that our expert advice has questioned the use of ECT and we echo that here.

18.52 Mr Bath was also referred to the psychology service and the Community Drug Team. The former never got to grips with him and passed him on because of his 'flavour of dual diagnosis'. He was then lost to the service. It is also surprising that his request for help with alleged sexual abuse was effectively ignored. The approach was inconsistent and reactive.

18.53 The involvement of consultant medical staff is also very limited during this time. We have been able to identify one ward round where Dr Rowton-Lee was present. There was also no formal transfer of Mr Bath to Dr Choudry's team when this was planned on discharge. Dr Choudry did not see him at this time.

18.54 Mr Bath was seen mostly by Dr Mohammed at St Ann's in this period. Dr Mohammed joined Dr Rowton-Lee's team as a staff grade psychiatrist in 1992 and as an associate psychiatrist in 1993. The latter is a career grade psychiatrist falling in seniority between consultant and senior registrar. Dr Mohammed has at least 16 years experience as a psychiatrist but no formal training in forensic psychiatry although he took the opportunity to work in some secure units in the United Kingdom prior to working at St Ann's.

- **Multi-disciplinary/agency work**

18.55 There was no multi-agency work or any real effort to engage with Mr Bath in the community. This calls into question the operation of the CMHTs at this time. He was never allocated to one. Contact with Social Services was absent. In spite of the fact that Mr Bath was making frequent and intense demands on the mental health and other services during these 10 months nobody took the initiative to stand back and consider with the other agencies involved how his care might be more effectively managed.

- **MHA**

18.56 There would have been grounds on this occasion and at other times during this period for Mr Bath's detention under section 2 MHA for assessment of his mental disorder. His psychotic symptoms were not properly assessed. He had self-harmed, been aggressive and threatening and had a knife removed from his possession. He was considered to be a high suicide risk. This was abundant evidence of a mental disorder of a nature or degree which warranted detention in hospital for assessment in the interests of his own health or safety and also with a view to the protection of others.

18.57 Hospital admission as an informal patient took account of his willingness to be admitted to hospital, but ignored his failure to remain in hospital and his abuse of the facilities. He regularly absconded after a short time and breached ward rules. This would have been the time to hold a multi-disciplinary meeting and either make a firm decision that he was not to be admitted and allowed to abuse the hospital system, or that if he was to be admitted then this should be under a section of the MHA in order to make it a meaningful event in an attempt to secure his compliance with assessment and treatment and after-care arrangements. There was sufficient history available to inform the admitting staff at St Ann's that without such a measure little would be achieved.

18.58 Whether the decision had been to admit to hospital or not, what was required was evidence that a proper decision had been taken with all relevant facts being taken into account and documented. There was a repeated failure to do this.

Dr Mohammed, who had known Mr Bath since his admission in 1993 under sections 48/49 and then section 37 MHA said that little had been achieved under those sections and 'so this is why we felt all the time in these discussions with the team as an MDT that probably formal admission will not serve anything really for Shane. We will give him asylum, we will give him everything he wants, but on an informal basis, and he will come back to us ...'.

18.59 We do not find this to be a constructive approach, nor have we been able to find evidence of this issue being discussed at multi-disciplinary team meetings. Any approach based purely on the treatability of the personality disorder failed to take into account other aspects of his presentation and the possible co-existence of a depressive illness and the fact that there had been no formal assessment of treatability.

18.60 We also do not think that the repeated crisis admissions afforded to Mr Bath were a thoughtful use of resources in this instance. It gave Mr Bath the opportunity to mis-use the services on offer.

• Supervised discharge

18.61 Since 1 April 1996 it has been possible to provide after-care under section 117 MHA under supervision (sections 25A-25J MHA, inserted by the Mental Health (Patients in the Community) Act 1995). Detention under sections 3, 37, 47 or 48 MHA is, therefore, a prerequisite to this form of after-care. This is a medically-led form of guardianship which additionally carries a power to 'take and convey' those subject to it 'to any place where the patient is required to reside or to attend for the purpose of medical treatment, occupation, education or training' (section 25D (4)) (although it carries no power to treat or detain in the community). It is aimed at those 'revolving door' patients with health needs in the community, especially those likely to default on medication leading to a deterioration in their condition.

18.62 This provision is unlikely to have been appropriate for Mr Bath even if he had been detained under the MHA. The power to 'take and convey' is at first attractive, but without a power to detain a persistently non-compliant patient the alternative is to re-admit to hospital for treatment. There are clear difficulties with this approach for a personality disordered patient. The process of likely deterioration is unlikely to be as swift as with a patient defaulting on medication and the need for immediate treatment in hospital less marked.

• CPA levels and non-compliance

18.63 Forms were, in the main, filled out but only after a fashion and not followed up. After-care was usually attempted by means of the out-patient appointment which was by now known to be ineffective and the practice of offering such appointments to a patient without fixed accommodation and who had absconded from the hospital is highly questionable.

18.64 It is true that Mr Bath was extremely unco-operative at this time. He was usually noted to have insight into his problems and on one occasion blamed his chaotic lifestyle for his difficulties. He used the hospital system like a hotel, agreeing to admission or using it briefly to rest and then absconding.

18.65 Mr Bath was only ever marked as being subject to a level 1 of the CPA. Dr Mohammed confirmed that he was considered to be more of a risk to himself than to others and a secure facility was not thought to be necessary. There is no evidence that there was any consideration of the appropriate CPA level and evidence we have heard agrees that this was not the correct level.

18.66 On current Dorset Community NHS Trust guidance (from March 1998) Mr Bath would have been subject to at least a level 2 on the basis of forensic history, but more probably a level 3 (people known to be currently or potentially at risk of committing suicide, severe self-neglect or committing acts of serious violence to themselves or others) with consideration of inclusion on the supervision register. This would have made him subject to joint Health and Social Services reviews every three months and where level 3 is indicated, a monthly face to face meeting between the service user and key worker. Otherwise a defaulting patient is subject to an immediate review.

18.67 Reviews are indicated where there is a significant change in the clinical picture, change in key worker, if the service user defaults or refuses treatment, prior to a case being dormanted and discharge from the service.

18.68 The current criteria of the Dorset Healthcare NHS Trust are slightly different and we think more confusing because inclusion on a particular level is partly defined by exclusion from another level. So, for example, level 1 users are those 'not meeting criteria for levels 2 and 3' and those having contact with one mental health clinician and 'meeting the service specific criteria for Severe Mental Illness where risk assessment indicates a high(red) level of risk in any risk category may be at level 1 at the clinician's discretion'. It includes any service user subject to section 117 and in contact with only one clinician also at the clinician's discretion. Level 2 is for 'all service users not at level 3 who are subject to section 117 aftercare and are in contact with more than one mental health clinician or if in contact with only one clinician, where the clinician feels that level 2 is appropriate'. Level 3 is for all those 'on the Supervision Register including those subject to supervised Discharge'.

18.69 The above is confusing. The definition of Severe Mental Illness is one which is promulgated by the DHA and makes no mention of personality disorder. Applying the above to Mr Bath level 1 may have been within the policy at the clinician's discretion.

18.70 For a defaulting patient on level 1, a key worker is to make 'all reasonable efforts (including a home visit where appropriate and at least one offer of further contact ... in all cases) to re-establish contact ...'. On level 2 a review is to be convened

within 10 days with assertive efforts to make contact with the service user. Otherwise reviews are six-monthly on level 1, within six weeks of discharge and at least every six months on level 2 and within six weeks of discharge and at least every three months on level 3.

18.71 We think the criteria for inclusion in CPA potentially excludes individuals with personality disorder and substance misuse. This is for all service users accepted by specialist mental health services which would include a person admitted to hospital with a personality disorder, but excludes, amongst others, those requiring specialist addiction services (other than those with dual diagnosis), and dual diagnosis does not include personality disorder. For a discussion of CPA see chapter 28. There can be little doubt that non-compliance is not a reason for failing to follow CPA procedures. The opposite is correct. It means that reviews and multi-disciplinary meetings are all the more important.

18.72 What difference CPA procedures and a level 2/3 might have made in the longer term is open to speculation. Its importance is in keeping sight of all the relevant factors and raising the profile of a difficult service user who posed a risk not only to himself, but also to others.

• Risk assessment

18.73 The risk screening form produced to us by Dr Rowton-Lee and currently in use by him is reproduced at Appendix E. In our view it shows that Mr Bath would have scored in many of the boxes for 'suicide' and most of them for 'violence to others'. Guidance attached to the form indicates that the 'high' risk category is reserved for those presenting an immediate risk in the area considered and 'moderate' is where 'a clear risk had been identified but the threat is not immediate'. Both categories have implications for future management and care plans. At this time we would accept that a reasonable analysis of Mr Bath's risk would have been a 'high' risk of suicide and a 'moderate' risk of violence to others. This had changed since 1993/94 when it is likely that he presented a high risk of violence to others.

• Social Services

18.74 DSS input into Mr Bath's care over this period was very limited.

18.75 Mr Hawker referred Mr Bath on to the Bournemouth Central office on 26 March 1996, forwarding a copy of the discharge letter of 19 March 1996. Mr Hawker has confirmed in his evidence to us that he had 'dormanted' Mr Bath's case after he had finished working with him in April 1995, therefore it was technically still open to him. There had been no discussion with him on this occasion prior to his being allocated. A team manager from the Bournemouth Central Office wrote to Mr Bath on 4 April 1996 inviting him to contact the duty officer if he would find it helpful. There was no further attempt to contact Mr Bath or to allocate a new social worker to him.

18.76 Mr Bath intermittently but frequently stayed at his mother's flat in Shaftesbury throughout much of this period. Mrs Bath's social worker made attempts to get in touch with Ms Alexis Smith, supposedly Mr Bath's social worker at St Ann's hospital, during June 1996 but with success on only one occasion according to the records available to us. We have not been able to make contact with Ms Smith and there is no record of her ever making contact with Mr Bath.

18.77 On two occasions in June, while at St Ann's, Mr Bath referred himself to Social Services for assistance with obtaining benefits and on one occasion for help with finding accommodation. His benefits were sorted out but it is not clear what assistance, if any, was given regarding accommodation.

18.78 In November 1996, Mr Bath was arrested on two occasions, once on a charge of burglary and once on a charge of actual bodily harm. On each of these occasions the police interviews took place in the presence of an 'appropriate adult'. Social workers provided by Social Services acted as the appropriate adult in each case.

18.79 Given that Social Services maintained (and maintains) a team of social workers at St Ann's at the time it is noteworthy how little they were involved in decisions about his after-care, and this is a serious failure as he came to their attention on numerous occasions and for several different reasons. He also came to their direct attention on several occasions for different reasons. There was only ever one assessment of his social care needs pursuant to section 47 of the 1990 Act (March 1995 after discharge from Forston Clinic) and this was a breach of duty on the part of Social Services. It may be that concerns about his likely compliance with any supervised accommodation provision, for example, were such as to limit any serious assessment of his needs. However, his needs in this and other social care areas should have been fully considered and noted before being dismissed as unrealistic. At the least the social care options should have been fully assessed and recorded.

18.80 Further, the information held on Mr Bath's Social Services file is sparse. At the time that he was seen at the police station by an 'appropriate adult' he was treated as a chronic schizophrenic. For such a regular user of the services, one would have expected that no more than a quick glance at his records by any duty worker should have revealed the extent and type of his contact with them and the Health Service. This was not the case and there was no information on Social Services files from St Ann's until 1997.

18.81 While Mr Bath had few personal care needs and was capable of finding his own accommodation he was also a risk to himself and the public by virtue of his way of life and might have benefited from a more focused assessment of his accommodation and occupation needs together with a consideration of the supervision necessary for both of these.

18.82 There was no effort to manage Mr Bath effectively in the community. Without this the repeated hospital admissions were a serious waste of resources. In this context, as fortunate as Mr Bath was to be repeatedly admitted to hospital, it is difficult to applaud the fact that he was offered a bed at times of crisis.

- **CMHTs**

18.83 Mr Bath was never allocated to a CMHT. In our view the fact that he came to the attention of social workers who happened to be attached to a CMHT does not demonstrate the proper functioning of CMHTs, nor any active allocation to after-care by them. The evidence available to us does not show that there was any team-work involved, as opposed to ad hoc social work input. (See also comments at 10.83 and 19.43 in this regard.)

N. RECOMMENDATIONS

17. The Health Authority, the NHS Trusts and Social Services should jointly review and audit:

(a) their capacity to engage and sustain service contact with difficult to manage patients, including MDOs and those with substance misuse problems, in both hospital and community settings and consider the development of a more assertive method of supervision (see chapters 7 and 9, recommendation 7(b); chapter 27);
(b) the use of crisis admissions to hospital for this client group;
(c) the use of and criteria for CPA levels.

See also chapter 10, recommendation 9.

Chapter 19

WEYMOUTH TO EXETER: 1997

- Second long period of contact with Social Services in Dorset
- Last contact with Dorset services
- CMHTs
- Housing
- Drugs
- Social Services and CPA across counties

A. Introduction

19.1 Mr Bath's last period of prolonged Social Services contact in Dorset and his last known contact with Dorset services was in March 1997 (Weymouth) before he moved to Exeter.

B. Michael's Night Shelter

19.2 Since 1998 Anne Milner has been a Specialist Community Mental Health Nurse (Homelessness) under the Mentally Ill Initiative employed by Dorset Healthcare NHS Trust and is affiliated to four CMHTs in the Bournemouth area: West, East, North and Central.

19.3 Her remit was to cover Michael's Day and Night Shelter for three hours a week. At the time of her involvement with Mr Bath, however, she was also attached to Bournemouth Central CMHT but this had no bearing on her role at the Shelter and she would direct clients to their own GP/CMHT as appropriate. Clients not registered with any CMHT were seen by Dr Rowton-Lee if they were mentally ill and did not necessarily come under Bournemouth West CMHT resources.

19.4 Information-gathering was confined to the information volunteered by the client and then contact with the CPA co-ordinator at St Ann's, assuming they were under CPA, or whatever other agency had been mentioned by the client. There was no system in place for easily accessing information from other CMHTs. Thus information-gathering was then a time-consuming process which could easily have taken up the whole of Ms Milner's three hours for just one client if performed painstakingly.

19.5 Ms Milner met Mr Bath at the Shelter on 28 October 1996. He had been referred to her by Dr Turnbull, GP, in connection with reducing his chlorpromazine medication. Dr Turnbull had two sessions a week at the Shelter. Ms Milner remembered Mr Bath from her time on the addiction ward at St Ann's in 1992/93. In her proforma assessment of him she recorded his psychiatric diagnosis as opiate addiction. He was denying suicidal ideation at that time.

19.6 In a written statement to us, Dr Turnbull said that he believes that he prescribed chlorpromazine 50 mgs three times a day for Mr Bath. He said that although he did

not have his notes to hand, 'being somewhat familiar with his past history including that of psychosis I did not regard his request as unreasonable'.

19.7 Ms Milner passed on Mr Bath's request to the medical team on 31 October in time for his next out-patient appointment with Dr Rowton-Lee on 18 November. This would have been done at the weekly CMHT meeting to Dr Rowton-Lee or to Dr Mohammed and ended her role with him at this time. She told us that in her current role she would be able to be more assertive in her contact with him, but that in three hours there was not the time to follow him up together with her usual caseload.

19.8 She did not see Mr Bath again until 3 February 1997. Once he dropped out of contact she would not have continued to seek background information about him but she had already advised him to seek assistance from the East Dorset Drugs Advisory Service and the South Wessex Addiction Centre.

19.9 Mr Bath failed to keep the appointment with Dr Rowton-Lee and a subsequent one with Dr Mohammed. Copies of this correspondence was sent to her.

C. Housing

19.10 A housing support form was handed over to Dr Mohammed to fill in on Mr Bath's behalf on about 31 October. This is the first indication that Mr Bath may have made an application for housing, although none of the housing agencies which we have spoken to have any record of any such application being made. At that time it would have been the role of the resettlement officer at the Shelter to find him accommodation, assuming he was then homeless. Now it would be Ms Milner's role at the Mentally Ill Initiative to do so with the assistance of the social worker if special needs were involved.

COMMENTS

19.11 There is no evidence that an application was made at this or any other time for housing by Mr Bath.

D. CMHT and Michael's Night Shelter, 1997

19.12 Ms Milner did not see Mr Bath again until 3 February 1997. In the interim he was seen by the court diversion scheme at Poole Magistrates' Court by Dr Rowton-Lee and Ian Oxborrow on 26 November. He had been arrested for failing to appear at court. He was assessed as not showing any signs of mental illness and having fabricated the previous signs which had resulted in the assessment being arranged.

19.13 On 3 February he asked Ms Milner for a referral to a CPN as he was injecting amphetamines. She agreed to refer him to Dr Choudry, the addictions specialist, either through his GP or Dr Rowton-Lee. Mr Bath was also advised again to seek

assistance from the East Dorset Drugs Advisory Service and the South Wessex Addiction Centre. He was homeless and the Shelter was trying to find him accommodation.

19.14 Ms Milner confirmed in evidence to us that Mr Bath was seen primarily as a person with a drug addiction problem although she took account of the contribution of his personality to his anti-social behaviour.

19.15 Mr Bath also wanted a report for the courts. He wanted to speak to his solicitor and she asked him to make a telephone call from her office in her presence. He purported to do this and put the telephone down saying that 'he wasn't there'. A few seconds later a woman rang the Shelter asking who had telephoned her. Her telephone had rung and she had used the 1471 facility to trace the call. Mr Bath looked embarrassed and it was clear to her that he had made the call to this woman and not his solicitor.

19.16 Mr Bath failed to keep an appointment with Ms Milner at the Shelter on 6 February and it was decided that he be monitored at the Out Patients Department. by Dr Choudry or Dr Mohammed in the short term who could make a decision as to the need for CMHT involvement. Ms Milner felt that he would benefit from help through the addiction services. The notes show, however, that he failed to attend once again at an out-patient appointment on 11 February with Dr Mohammed.

19.17 As far as she was concerned he next emerged on 3 March when she was informed by the staff at Michael's Shelter that he had been arrested. This was not accurate information. As far as we are aware he was not arrested for another week or so (see below).

E. Weymouth CMHT

19.18 Mr Bath, now aged 28, was seen by Dr Judith Townsend, staff psychiatrist at Blackdown Hospital in Weymouth, as an out-patient on 25 and 28 February. He failed to attend on the 26 February and 11 March. He presented himself initially as Shane Bartlett and gave his date of birth as 21 March 1973.

19.19 Blackdown Hospital (or Mental Health Centre) is part of the Dorset Community NHS Trust and in West Dorset. It is a small community psychiatric hospital with 11 beds, a day hospital with day care provision, an out-patient clinic and a CMHT base with social workers and CPNs on site. Dr Townsend is the main staff grade doctor on the premises and there are four consultants from Forston Clinic with access to the hospital.

19.20 The referral to Blackdown Hospital was made by Sandra Gardiner at the Weymouth CMHT and she and Dr Townsend performed a joint assessment. He had been referred to her from WAVES having presented there with no fixed abode and apparently no memory of what had happened to him recently. The date of birth

given to WAVES was 29 March 1972. He had stated that he was schizophrenic and in need of medication.

19.21 The WAVES project in Weymouth is part of The Children's Society, a voluntary society of the Church of England and is described as a youth advisory centre.

19.22 Accommodation had been found for Mr Bath in a Social Services approved bed and breakfast facility by Ms Gardiner on 25 February. She also referred him for occupational therapy where he was seen on three occasions: 28 February, 3 and 10 March. On 7 March, there is a message that he had been arrested. On 14 March, it was noted that he was presumably at court as he did not come. On 27 March she noted that he had not been seen again, but was reported to be living near Exeter.

19.23 Sandra Gardiner made calls to St Ann's, Dorset Health Care Trust for GP listings, MenDOS, Blackdown and Forston, but there was no record of Shane Bartlett. Dorset Lodge had a match for 1992 and provided a probation officer's name. They had indicated that his name may in fact be 'Bath' .

19.24 His mental state examination by Dr Townsend (from a transcript of the manuscript note provided by Dr Townsend) was as follows:

'Appeared to be reasonably kempt and appearance OK. He seemed tense and slightly restless and said that he was confused and possibly depressed. He seemed in affect to be sad and distressed and looked very unhappy. He said that he heard voices-one was like an angry judge inside his head and the others were nice but sad voices. He felt that he had moments when he was falling down a pit. He also described hallucinations of seeing spiders spinning webs in the carpet. He felt that Chlorpromazine helped him. He had no sleep because his mind wouldn't switch off. He has not been eating. He self harmed multiple times and overdosed on tablets. He was changeable during the interview, changing his mind about tablets and his mood varied from moment to moment'.

19.25 The diagnosis was 'probable personality disorder-borderline type'. The plan was to provide chlorpromazine in a daily short term basis and investigate his history at St Ann's.

19.26 On 26 February, Dr Townsend wrote to Sandra Gardiner summarising her assessment and concluding 'In some ways you can't say this adds up to a schizophrenic type illness but certainly for a borderline personality disorder where there seems to be hysterical elements, a possible fugue state but this also could be drug induced. I suspect the latter to be the most likely source of his current problems but he cannot remember abusing drugs at all'.

19.27 It was on 26 February that Sandra Gardiner confirmed, after a call to the Michael's Shelter, that his real name was Shane David Bath and his date of birth. A telephone

call to St Ann's then revealed that he had numerous previous admissions and she received two discharge summaries for admissions in July and September 1996.

19.28 On 28 February, he admitted to Dr Townsend that he had lied about his identity and date of birth. He provided a history of six months of LSD and speed and bad memories of childhood in care. This included some information about his family and his forensic history. He had said that he had been violent in the past but there is no mention of arson. He mentioned that he was well-known to Dr Rowton-Lee and at the Forston Clinic and had been subject to a section 37 MHA. A revised diagnosis was 'drug induced psychosis in the background of personality disorder' and it was planned to monitor him as an out-patient with limited day care.

19.29 The 'previous notes' were then accessed. It is not noted where precisely these came from, although Ms Gardiner had obtained two discharge summaries from St Ann's from July and September 1996. The diagnosis of sociopath, 'unreliable historian and known to steal, never engages help' is noted. Dr Townsend told us that she would have seen the Forston Clinic notes which would have arrived after a few days and possibly the discharge summaries obtained by Ms Gardiner. As far as we can see there are no notes from St Ann's with the Blackdown records. She said that the process of obtaining notes was very cumbersome and the result was that she never knew the degree of violence in Mr Bath's past and was unable to carry out any proper risk assessment. The failure to attend on 11 March is noted to be due to his having been arrested for non-payment of fines. No summary of this contact was sent to St Ann's for their records.

19.30 Sandra Gardiner was to arrange a CPA meeting once contact with his previous social worker had been made. This established that the last social worker to be involved with him was one who saw him only briefly in relation to advice on benefits.

19.31 On 4 March, she discovered from that social worker that 'a medical file' referred to a history of GBH and arson and his landlady was informed of the latter. This file was never seen by Ms Gardiner and the St Ann's information on the social services files is limited to the discharge summaries obtained by her. We have been unable to obtain any information from the landlady directly about her facilities, but have been told by others that she was considered a very capable landlady. She provided guest house accommodation and had numerous chronically mentally-ill patients. It has also been described as 24-hour supported accommodation. She was described as 'very competent' and able to supervise the taking of medication, which she did for Mr Bath as well as helping him with his benefits.

19.32 Contact with Caroline Kinsella who conducted a police check revealed an outstanding warrant for Mr Bath's arrest 're serious assault in Poole'. This was confirmed by the police. By 10 March, Mr Bath had been arrested, but in relation to warrants for non-payment of fines. He was held overnight and appeared in court. He said he would return to Mrs Watkins. Ms Gardiner planned to arrange a CPA meeting on his return.

19.33 He had not returned by 14 March and on 17 March she received a telephone call from the Housing Homeless Action group in Exeter saying the Mr Bath had arrived there over the weekend. She noted that she filled them in on his background and the work done in Weymouth. She did the same with Pat Clewer, social worker from Exeter, when he called the next day.

19.34 On 18 March, Ms Gardiner contacted Dr Mohammed and expressed her concerns at the CPA level which Mr Bath was on i.e. level 1. Her note records that she suggested that there be a joint strategy plan for his management in the 'likely event that he will return to either Bournemouth or Weymouth'. Dr Mohammed had responded that he would be prepared to see him at any time in the future should he return. To us she said that she would have expected him to be on at least a level 2 and says that she was surprised at Dr Mohammed's lack of interest in a joint management plan.

19.35 Dr Mohammed was unable to recall this conversation. When asked what his response might have been had concern been expressed about the CPA level Mr Bath was on at the time, he said that he would have expected him to be on level 2 at least if not 3. He does not remember being asked about the joint strategy meeting, but thought that it would have been a good idea.

19.36 The Poole Fines Office said that Mr Bath had not attended there on 13 March and there was a further warrant out for his arrest in relation to his non-appearance. Ms Gardiner informed Shilhay Hostel in Exeter of the warrant. She informed the police of Mr Bath's whereabouts and MenDOS of the aliases being used by him. His alias at that time was Shane Cummings and date of birth was 21 March 1963.

19.37 Ms Gardiner wrote a detailed closing summary on 8 April. In this she summarised her contact with Mr Bath and that she had discovered that he was well known to services in Bournemouth, Southampton and Poole. Discussions with various workers involved with him had revealed that he followed a pattern of moving to different towns, accessing mental health services, agreeing to care plans and then leaving and starting the process elsewhere. The reason for closure of the case was recorded as being that he had now left Dorset. She noted that he would have access to mental health services should he return but that 'caution will need to be exercised over the implementation of any care plans to ensure Shane's motivation and commitment to comply'.

19.38 This was Mr Bath's last direct contact with Dorset mental health services.

COMMENTS

- **Social Services and CMHT**

19.39 This was the second longest period of contact between Mr Bath as an adult and the Social Services. The first was that with Gary Hawker in early 1995. We are impressed by the efforts of Sandra Gardiner. Hers has been the most assertive

approach demonstrated on behalf of Mr Bath. Unfortunately, once again, as with others her efforts were undermined by the lack of information available to her from his past. She did well to overcome the initial difficulty presented to her by the use of an alias very quickly. Thereafter, the discharge summaries from St Ann's, whenever she might have read them, offered her little to enable a risk assessment. She obtained a verbal communication from a previous social worker about GBH and arson but with no details.

19.40 She did not have the child care records, but it is also very unclear what of the other Social Services records she had available to her. She said that she would have had access to these records and the CMHT secretary initiated access. The reality seems to be that without the full medical file the information with Social Services was incomplete. After all they had not been involved in many of his admissions to hospital. Their role overall seems to have been more peripherally involved with benefits and not any substantial involvement. This highlights how poorly multi-disciplinary working was being implemented for Mr Bath.

19.41 Ms Gardiner was the only person to consider a joint strategy for Mr Bath's reappearance in the county and her assessment in that regard was entirely reasonable. Unfortunately, her assertive approach was rather deflated by her perception of Dr Mohammed's response to that idea. He did not deal with it and so she felt that he had rejected it. We accept her version of this exchange which she has documented.

19.42 The last CPA form for Mr Bath is dated 3 July 1996 and is contained on the St Ann's file. There is no copy that we have been able to find on the Social Services file and Ms Gardiner was at a loss to explain how she had found out about it. On it Dr Mohammed was noted as the key worker and the level is marked at '1'. The next review was to be on 14 August. On 12 July, it was noted that Mr Bath had gone 'awol' from the ward and had been discharged in his absence. 'No CPA follow up possible'. No further action was taken on this plan until February 1997.

19.43 The point has been made to us by Dorset Social Services that this is an example of CMHT working and of Mr Bath's 'allocation' to a CMHT. This is not, in our view, what emerges from the documentation, or the evidence we have received, without much reconstruction with hindsight. We have seen no unified CMHT documentation and the impression is of a fragmented approach with a generally low level of Social Service input (see also comments at 10.83 and 18.83).

- **Handover to Exeter**

19.44 In the event, Mr Bath did not return to the services in Dorset and so any joint strategy put in place would not have been used. However, we agree that it was the way forward and it should have provided her with much more information which could have been passed on t o Exeter and Pat Clewer.

19.45 NHS Executive Guidance (HSG(94)27) specifically provides that there should be a hand-over of care when a patient moves from one area to another in order to maintain continuity of care. 'The patient remains the responsibility of the original team until a hand over has taken place and has been recorded in writing'. This did not happen, nor is it provided for in the policy documents.

- **Information-gathering**

19.46 We do not think that the full medical file from St Ann's was ever obtained. The Forston Clinic file contained only documents relating to the 1993 admission. These were Dr Rowton-Lee's report of 3 October, June Copeland's of 6 September and Rachel Kidner's probation report. From the evidence we heard from Dr Townsend and Sandra Gardiner, we are not satisfied that this material was available to them.

19.47 We are concerned that when a request was made for past information, all that was provided were the two discharge summaries (July and September 1996). Ordinarily and had those summaries been complete we would hope that this would be sufficient, but it was not on this occasion. The summaries contained nothing about Mr Bath's forensic history and offered no more than a snap shot of his presentation at that time (see chapters 9, 10 and 11). We think that Ms.Gardiner may have felt the need for a joint conference to be more urgent had she known the full extent of Mr Bath's background.

F. RECOMMENDATION

18. The NHS Trusts and Social Services should review policy and training on the hand-over of care to another area when a client moves in accordance with existing national guidance.

Chapter 20

EXETER: 14 MARCH-18 JULY 1997

- Stable and trouble-free period
- Imperfect communication between Dorset and Devon services

A. Introduction

20.1 Mr Bath presented to services in Exeter on Friday, 14 March 1997 and left the area in July although he re-appeared very briefly with Ms Sullivan at the hostel where he had stayed on 11 November. He travelled there from Weymouth where he had been in contact with Health and Social Services (chapter 19).

20.2 The services that he accessed during his time in Exeter included the nursing service at a day centre for homeless people, a local housing action group, a CMHT duty service, a CMHT social worker specialising in work with homeless people, the Exeter Drug Project and a direct access hostel for homeless men. He was also referred to a GP who referred him to a consultant psychiatrist although neither saw him. Information about his progress or lack of it was regularly exchanged between various city-based services at the Inter-Agency Homeleness Forum which met monthly.

B. St Petroc's

20.3 On Friday 14 March, Mr Bath travelled to Exeter and presented himself to the nursing service at St Petroc's Centre, a day centre for homeless people. He was seen by Ms Sarah Hammond, one of two half-time nurses, employed by Exeter Community and District NHS Trust, at the centre.

20.4 He told Ms Hammond that his surname was 'Cummings', that he was a 'paranoid schizophrenic' but had no memory of any psychiatrists he had seen nor of any facilities or places where he might have seen psychiatrists although he mentioned coming from Southampton. He said that he was receiving an injection of depixol medication every fortnight, was on chlorpromazine, and should have been taking temazepam but was reluctant to do so. Ms Hammond was shown old lacerations on his wrists and was told by Mr Bath that he had a history of self-harm. He complained of a history of blackouts, waking incontinent of urine and the television sending him messages even when switched off. She was concerned by what he had told her.

20.5 Following this consultation Ms Hammond formed a plan to refer him to the local CMHT at Meadow House for assessment, to the 'Homeless Action Group' for help in finding accommodation (possibly bed and breakfast), to contact the FHSA in Southampton to track down whether he had had a GP there and to contact St Dismas, St Petroc's equivalent in Southampton to see if he had stayed there. She also advised Mr Bath to return to the nurses at St Petroc's for feedback after his interview at the CMHT. In her evidence Ms Hammond said:

'My main concern was the entire presentation. I have to be perfectly honest. Somebody walks in to you and sits down during an interview and discloses that they are on depixol IM, alarm bells start ringing in your head and you think "They must have some knowledge base to articulate this information in the first place", and also another reason for referring him to duty was that they do have access to IT, which we do not have, and that I was also sending him up there with the hope that he may be entered into the computer system ... Due to patient confidentiality issues, we are not able to access the IT system to see if anything does come up'.

20.6 Mr Bath contacted Ms Hammond at St Petroc's on the following Monday, 17 March. She spoke to Ms Ragalsky, a nurse at Meadow House who had assessed Mr Bath as being in no immediate danger and not requiring any assessment under the MHA. Mr Bath told Ms Hammond that Dr Townsend from Blackdown Hospital in Weymouth had treated him in the past. She contacted Dr Townsend who advised her that he had used aliases e.g. Sean Bartlett, had a known history of violence and attention-seeking behaviour. Dr Townsend described him as having a 'sociopathic personality disorder'. Ms Hammond in her evidence said that she did not ask Dr Townsend for any notes or documentation because she would have expected difficulties in obtaining them:

'No, it is incredibly difficult. Again, I think it is because of the position we are in and the location that we are in. A lot of reluctance from other agencies to release information'.

20.7 She advised us that if she had been told about previous admissions to St Ann's or Forston Clinic she would have contacted those services. She spoke to the social worker at the CMHT with a special responsibility for homeless people, Mr Pat Clewer, that day and asked him to liaise with other agencies regarding further information.

20.8 Mr Bath called in to the nursing service at St Petroc's on 21 March and again on 25 March seeking treatment for a wound on his right eyebrow. He told the nurse on duty that he was no longer living at Palace Gate and had moved out to live in a tent with other tent dwellers in the 'Double Locks' area of the city. He presented to the nursing service at St Petroc's with a variety of physical complaints on another four occasions before his last visit on 18 July when he was given condoms. This was his last known contact with the Health Service before the homicide.

C. Meadow House: the CMHT

20.9 Mr Bath was seen by Ms Sandra Ragalsky, the CMHT duty worker, on the afternoon of 14 March, having been referred there by Ms Hammond. We have been advised that Ms Ragalsky formed the view that Mr Bath was not showing any signs of active psychosis but was concerned about his lack of money and a place to stay. She referred him that day to the Homeless Action Group (HAG) for assistance with his accommodation needs. HAG apparently made enquires with Dorset Social Services which suggested possible mental health and risk issues.

20.10 Ms Ragalsky discussed him with Mr Clewer, social worker with the CMHT. He had discussed Mr Bath with the managers of both HAG and Palace Gate, a direct access hostel for homeless men in Exeter. Each shared information (arising from HAG's enquiries with Dorset Social Services) with Mr Clewer which raised concerns about self-harm, drug/alcohol use and violence including arson. In view of this Mr Clewer decided that bed and breakfast would not be an appropriate accommodation option and agreed with Palace Gate (which had/has 24-hour waking cover) that they would accept him if he was sober and Mr Clewer agreed to stay involved.

D. Psychiatric Assessment

20.11 Because very few of those who accessed St Petroc's services would be registered with a GP there is an arrangement with local GPs whereby the centre's nurses can refer service users with health needs to GPs on a rota basis. Ms Hammond from St Petroc's wrote to Dr Bradley-Smith, the GP on the rota for that week, on 17 March drawing attention to the medication Mr Bath was on and mentioning his reported blackouts. She concluded her letter with 'Thank you for seeing Shane'. In evidence Ms Hammond told us that it was her intention that Dr Bradley-Smith should actually see Mr Bath, assess him and, hopefully, refer him on to the sector consultant psychiatrist, Dr Keith Lloyd.

20.12 On 19 March, Dr Bradley-Smith wrote to Dr Lloyd requesting 'your fairly early involvement with this chap ... However, I have fears about this chap's mental state and hence my request for your early involvement'.

20.13 Dr Caitriona Crowe, at the time was senior register to Dr Lloyd. In evidence she stated that to the best of her recollection Dr Lloyd handed her the letter from Dr Bradley-Smith dated 19 March and asked her if she would obtain background information for him as 'we needed to be aware of the man in case he presented'. She telephoned Dr Rowton-Lee's secretary at St Ann's and requested that they fax on any information they held on Mr Bath.

20.14 Dr Crowe made a note dated 20 March on Dr Bradley-Smith's referral letter which confirmed that she had requested information to be faxed through. It seems that Dr Crowe believed that the purpose of obtaining the information was to have the necessary background facts in case he presented to the specialist service rather than as background for a current assessment via an out-patient appointment or a home visit. She accepts that Dr Bradley-Smith's request was for him to be seen rather than to hang fire in case he presented to the service but thought she was following the consultant's instructions:

'I was not under the impression that he (Dr Lloyd) expected me to see the patient or, indeed, that he was going to see the patient, because his actual words were "We need to be aware in case he presents". It was not in response to this referral "We are going to go now and see him", which is unusual. Usually we would

respond by saying "We will send an outpatient's appointment immediately"... I did not have any order or suggestion that I was going to see him. His (Dr Lloyd's) words were "in case he presents" and not at all "Off you go and see him"'.

20.15 Dr Crowe confirmed to us that she did see faxes from St Ann's and that they were in her in-tray but presumed that they were there to await a possible presentation by Mr Bath.

20.16 At no time while he was in Exeter did Mr Bath see a psychiatrist. Dr Crowe has advised us that while she did not see anything from the (Exeter) notes which indicated that Mr Bath wanted a psychiatric referral, had the full history (as now evident) been available to her at the time he would probably have been referred to the Butler Clinic, the local medium secure unit, for a forensic opinion.

20.17 Dr Crowe was candid in her evidence:

'I regret that I am unable to offer an explanation as to why this young man was never seen by me in outpatients as was originally intended. I hope it will be apparent from the details given above that I was readily available to see outpatients at short notice and this would be my usual practice. I have carefully perused all the available notes and diaries, and can find nothing to explain why an appointment was not made following receipt of the incoming information which I requested'.

E. Mr Pat Clewer

20.18 Mr Clewer made contact with Ms Gardner, the social worker at Blackdown Hospital by telephone on 17 and/or 18 March. Ms Gardner's notes indicate that she spoke to him on 18 March. Mr Clewer believes from memory that he first spoke with her about Mr Bath on 17 March and then re-checked some of the details with her on 18 March.

20.19 In either event Ms Gardner informed him that there was no diagnosis of schizophrenia and that he had a psychopathic personality disorder with drug abuse. Mr Clewer's notes indicate that she advised him of a conviction of GBH although he advised us in evidence that no other information about assaults was passed over. Ms Gardner stated that 'The information that I would have passed on to them was everything that I knew basically'. This information was not confirmed in writing. The only risk factor apart from the GBH conviction that Mr Clewer was apparently aware of at this stage was the arson incident at the resettlement centre in Southampton.

20.20 Mr Clewer interviewed Mr Bath at St Petroc's day centre on 18 March. In evidence Mr Clewer stated:

'He was surprisingly relaxed and chatty. He didn't smell of alcohol or show any obvious signs of drug use. He reported that he had moved into Shilhay (Palace

Gate) the previous evening. We discussed what I knew about him so far, including a fire attack on a fellow hostel resident some years before. He was generally lucid about events though was quite evasive about dates and places ... Although he was fairly open, it was at times quite difficult to work out what was embellishment and what was factual'.

20.21 Mr Bath told Mr Clewer that he was not sure whether or not he wanted to settle in Exeter but he would stay at Palace Gate for a while and then move on. He said he felt more relaxed. Mr Clewer advised him that he could discuss any longer term plans with him at a future stage. He has said in his statement to us that he had no reason to consider an assessment under the MHA as he was co-operating and was not at the moment threatening himself or others.

20.22 Mr Clewer considered that he had established useful contact with Dorset Social Services, that there was sufficient information for the moment, and his intervention would be limited to offering Mr Bath and Palace Gate support, monitoring his mental state and movements until the point where it was apparent that he was wanting to stay in Exeter. He believed that Palace Gate was the most appropriate place to accommodate, monitor and assess Mr Bath. He copied the notes of his conversation with Dorset Social Services to Palace Gate, HAG, and CMHT duty. Mr Clewer checked with the duty service at the CMHT to ensure that a GP appointment was still on course and arranged to see Mr Bath at St Petroc's on 26 March.

20.23 Mr Bath did not attend for his appointment with Mr Clewer on 26 March. Mr Clewer contacted Palace Gate and was told that he had left them the previous Friday. On 3 April, Mr Clewer raised Mr Bath at an Inter-Agency Homelessness Forum (IAHF) meeting. It was thought that he had most likely moved to the 'Double Locks' area by the canal and was living in a tent there. He was again discussed at the IAHF meeting on 1 May where it was reported that he had made contact with the Exeter Drug Project.

20.24 Mr Clewer's next meeting with Mr Bath was on 4 June when he saw him at Palace Gate. He reported his drug/alcohol use as being minor and stable and as being still not decided whether he was going to settle in Exeter or not. An appointment was made for two weeks' time.

20.25 Mr Bath failed to make the arranged appointment with Mr Clewer on 25 June. Staff at Palace Gate told Mr Clewer that Mr Bath had been spending a lot of time with his girlfriend, Ayse (Sullivan) and they thought that they had left for London to look for a flat:

'They reported that on this recent stay he had been a pleasure to have around and that they were sorry to see him go but they did not know which part of London he had gone to'.

20.26 Mr Clewer said in his evidence to us that he only heard about Ms Sullivan from Palace Gate the day before Mr Bath and she left for London on 25 June. He did not know that she was in care or had recently been in care and never met her. If he had had any suspicions that she was in this position he said that he would have advised the Child Protection Team from Social Services.

20.27 Mr Clewer raised Mr Bath at the IAHF meeting on 3 July, where Palace Gate reported that he had been back for a couple of days to pick up his belongings. Mr Bath had indicated to staff that he was thinking of applying for a job in a hostel in London (whereabouts was unknown). This was the last Mr Clewer heard about Mr Bath until the homicide.

20.28 In retrospect Mr Clewer felt that the tone and impact of Mr Bath's actions prior to 1994 had not come across to him. While further information about how violent and out of control he had been at times would have increased his anxiety and vigilance, without the benefit of hindsight, it would not have changed his management plan in relation to services that might have been offered to Mr Bath nor, as he was not aware of Ms Sullivan's existence until Mr Bath was leaving, would it have been likely to lead to practical action to protect her.

20.29 Without knowing what part of London he was decamping for Mr Clewer advised us that it would have been difficult to communicate with services in London.

20.30 Mr Clewer said that he had brought the subject of Mr Bath up at 'sector' meetings where the sector psychiatrist, Dr Keith Lloyd would normally be present but he did not make any referral. However, he did confirm to us that he would have expected a referral to take place and understood that Mr Bath's temporary GP, Dr Bradley-Smith had requested such an assessment.

F. Palace Gate Hostel

20.31 The Palace Gate Hostel is a direct access hostel for homeless men in Exeter. It has 35 beds and is managed by the Exeter Shilhay Community Ltd, a registered charity. The Shilhay Community comprises three homes, Palace Gate, a life and social skills hostel and a move on hostel. Its main objective is to provide accommodation for men who are street homeless. Palace Gate provides 24-hour care including waking night cover.

20.32 Mr Bath was first referred to Palace Gate on 17 March from St Petroc's day centre. The managers understood that he had been staying in bed and breakfast over the weekend but this was not a satisfactory arrangement because of an arson offence. They were informed that he had a personality disorder and a history of intermittent drug and alcohol abuse, that he had a number of offences including the arson offence. As a consequence he was initially put under half-hour observation.

20.33 On 18 March, Ms Gardner at Blackdown Hospital had offered the additional information that there was a risk of violent behaviour when under the influence of drink and/or drugs. Mr Clewer telephoned the hostel to say that Mr Bath was a volatile young man who needed a gentle but firm approach. He was booked in that day but left two days later saying that he was going to live in a tent on the outskirts of the city.

20.34 Mr Bath booked back in again on 30 March and stayed there until 9 May when he told staff that he was going to Bournemouth for a few days. This was agreed provided he phoned in every two days. This he did not do, so his bed reservation was cancelled on 13 May. On 16 May, he returned and booked in, leaving again on 18 June to travel to Poole for a court case. Palace Gate confirmed with Poole Magistrates' Court that he had not appeared to answer charges and he did not appear again at the hostel until 21 June.

20.35 On 21 June, Mr Bath made contact with Palace Gate and said that he wanted a change of clothes. He remarked on having a new girlfriend (Ms Sullivan), and that as a consequence he was a changed man. Two days later on 23 June, he appeared outside the hostel with his girlfriend and on 24 June booked out. On 26 June, he informed staff that he was thinking of going to Peckham, South London, with his girlfriend although he was uncertain about this. On 28 June, he booked in again.

20.36 He was booked out on 1 July having not claimed his DSS benefit for his stay. Palace Gate were advised that there was a warrant out for Mr Bath's arrest for failing to attend court.

20.37 There was no more contact until 11 November, when he came into the hostel and briefly spoke to the cook. She described him as 'looking well' and 'smiling from ear to ear'. This was the last contact with services in the Exeter area.

20.38 While at the hostel Mr Bath was reported generally to be helpful and polite although on one occasion he slammed a door and on another exhibited inappropriate feelings towards a female member of staff. He was able to take the advice offered by staff about these matters and dealt with them appropriately.

20.39 They stated to us that they would not have 'interfered' with any relationship such as the one between Mr Bath and Ms Sullivan unless they had reason to believe that she was under age.

COMMENTS

- **Exeter services**

20.40 The services in Exeter were responsive and helpful to Mr Bath and much effort was made to pull together an accommodation and care package for him at very short notice. This was a remarkably stable and trouble-free period for him and it may be that his newly-formed relationship with Ms Sullivan improved his mood and outlook.

20.41 Both the nursing services at St Petroc's and Mr Clewer showed an awareness of risk factors, formulated specific service interventions and devised appropriate plans for his monitoring and review. They generally demonstrated a highly professional approach to his care. While he was not seen by a psychiatrist there is little doubt that if it had been agreed he should have been he would have been seen quickly.

20.42 But, yet again, problems were apparent in getting and/or communicating key information about Mr Bath. The experience of St Petroc's nurses was that they would not be given access directly to his background history and so they relied on intermediaries like Mr Clewer or a GP. Mr Clewer believed that he had not understood the full tone or impact of Mr Bath's actions from his discussions with Ms Gardner. Key background information sent from St Ann's to Dr Lloyd in Exeter was not forwarded to the GP, to Mr Clewer, the St Petroc's nurses or to Palace Gate. However, the available information should have alerted them to the need for fuller information in writing about his forensic background. This is likely to have led to a full risk assessment and a strategy for the management of the identified risk. It is unlikely that a referral to the local forensic service would have been deemed appropriate in the light of his stable presentation at this time.

20.43 The staff at Palace Gate accepted Mr Bath and he indicated by various means that he enjoyed most of his time there, which for him was very unusual. Palace Gate's systems for assessing risk and accessing key information about residents were inadequate and we are told that they are in the process of remedying this problem. They were able to put Mr Bath under close observation initially as they did have some of the vital information about him, for example, the arson and his propensity to violence under the influence of drink and drugs. By all accounts, however, he was a pleasant and co-operative resident. The difference from his presentation the previous year could not be more marked and yet the only change would appear to have been his relationship with Ms Sullivan.

Chapter 21

EASTBOURNE: AUGUST 1997

- Missing persons procedure
- Assault
- Domestic violence and prosecution policy

A. Introduction

21.1 Mr Bath's precise movements around August 1997 are not known. Having moved to London with Ms Sullivan, they turned up in Eastbourne possibly due to the objections of her family to the relationship. She was reported as a missing person to the police by her brother and sister. They emerged again when he assaulted Ms Sullivan in Eastbourne and was arrested. He was not prosecuted for this assault but was instead transferred to Poole, Dorset in response to outstanding warrants for his arrest.

B. Missing Persons

21.2 It is not known precisely when Mr Bath and Ayse Sullivan travelled to Eastbourne, Sussex, but by 21 August 1997 he was in custody at Eastbourne Police Station for having assaulted her.

21.3 On 15 August 1997, on returning from his grand-mother's funeral in Ireland, Darren Sullivan reported his sister Ayse as a missing person to the Metropolitan Police. The form produced as a result of his report (Form 584) clearly identifies her as 17 years old at the time. It provides a brief physical description of her. The circumstances included on the form were that she had been living with a 32-year-old boyfriend, Shane Bath, who had threatened to kill her and that they were both possibly taking drugs. It says 'Mr Bath can be violent towards her'.

21.4 There is nothing on the form to indicate that she was subject to the care of the Social Services.

21.5 We were told by Detective Inspector Moore of Sussex Police that the Form 584 is 'very much a standard form which is probably used by all forces with one or two slight differences' and that most of the details contained on it are entered on to the police national computer (PNC). The contents of the 'circumstances' section are not entered on to the computer.

21.6 Although this form did find its way into the possession of the Sussex Police, it is not normal practice for them to receive it nor is it clear when it came into their possession. It would have been the responsibility of the Metropolitan Police to cancel the PNC entry.

21.7 The form was cancelled on 21 August 1997 at 04.57 hours. There is no reason given for the cancellation on the form nor are the circumstances in which the missing person was found set out.

C. Assault

21.8 Police officers responded to a '999' call received from a telephone box on 20 August at about 23.40 hours. The computerised log (CAD) shows that the complainant was initially a 'Sean Bartlett', who said that he had been assaulted by two men. He also said that there was a warrant out for him.

21.9 They arrived at the scene at 23.47 and found that the male seemed to be all right, but that a female had been assaulted. The details of the assault are noted in various different documents. The CAD printout notes at 05.25 that:

'The caller Shane Bath has been arrested for assaulting his girlfriend Ayse Sullivan at the Reef Hotel. Following that assault he was restrained by other lodgers of the Reef during which he suffered a blow to the face causing no apparent injury. He then ran out of the Reef and made the call to police. Ayse Sullivan has suffered what amounts to an ABH but has declined to assist in a prosecution. This ABH has been crimed. Ayse is 17 yrs and has been reported as a misper [sic] by her sister in London. Her sister, Rebecca ... and brother Darren ... will be attending the Reef Hotel later today to collect her and return with her to London. Shane Bath is wanted on a no bail warrant in Poole, Dorset and will be escorted there later today'.

21.10 The crime report accords with the above and records the injuries as a black eye and bruising to the left hand side of Ms Sullivan's face. She was taken to hospital by ambulance. The police officer's note book entry records 'Shane Bath put foot on throat and struck me in face'. It sounds as if this description was provided by Ms Sullivan herself.

21.11 Ms Sullivan did provide a brief statement in which she confirmed that she was punched in the face by Mr Bath resulting in the injuries already noted above. It states that she will not support any police action. Statements were not taken from anyone else.

21.12 We have been unable to clarify how his real name was discovered. It may have been due to Sandra Gardiner informing MenDOS and others, possibly including the police, of the aliases he was using in March 1997 but a police national computer check at 01.51 indicated that he was wanted on charges of assault on police, theft and failing to appear and by the time that he arrived at the police station his real name and date of birth were known.

21.13 The incident was closed at 08.31 on 21 September 1997 when he was transferred to Poole Magistrates' Court. The warrant referred to charges of theft and two assaults committed at St Ann's in September 1996.

D. Custody Record and Prosecution

21.14 Mr Bath arrived at Eastbourne police station at 00.41. The custody sergeant was PS Wigglesworth. On being detained Mr Bath is recorded as admitting the assault and saying 'I'm sorry doing what I've done to my girlfriend'.

21.15 He told the police that he was a paranoid schizophrenic and on medication for depression. He told them that he was suicidal and showed them the many marks on his arms. He was sobbing and requested a doctor and social worker.

2116 At 01.12 he saw a Dr Ludwig who noted a psychiatric condition and that he was withdrawing from alcohol. He left a dose of largactil to be given at 08.00 and said that he was fit to be detained and was not to be interviewed before 08.00. We do not understand the rationale for this practice.

21.17 At 05.05 it is recorded that Ms Sullivan would not take any further action and that the basis for detention had changed to the warrant for Poole. A decision had been taken not to pursue the assault. At 08.20 he was handed over to Premier Prison Service who transported him to Poole. An exceptional risk form accompanied him which drew attention to the fact that he was reasonably suspected of an 'extremely violent nature', 'may have suicidal tendencies', 'physical illness or mental disturbance'. This form followed him through to prison.

21.18 Sergeant Wigglesworth told us that Sussex Police has a strong policy on the prosecution of domestic violence and he confirmed that this incident would have fallen into that category. He said that efforts would have been made to persuade Ms Sullivan to co-operate with a prosecution although they are also anxious to give victims an option and if they choose to prosecute, then they receive the wholehearted support of the police. There is no record on any of the documents that we have seen which includes the custody record, the crime report, the incident log and reporting officer's notebook, of any such attempts to persuade Ms Sullivan.

21.19 DI Moore confirmed that the Sussex Police take a 'robust' approach to domestic violence. He reluctantly used the term 'positive arrest policy' which refers to the fact that the offender will be arrested in the first instance, but the follow-up will depend on the circumstances of each case. In relation to cases in which the victim refused to prosecute he said that 'If there was some other evidence and the matter was felt sufficiently serious enough, then of course the mere fact that the victim does not wish to proceed with the matter does not necessarily prevent some form of action through the courts along different lines ... Other eye witness evidence, for instance..., but it would have to be a decision for the Crown Prosecution Service (CPS) at the end of the day'.

21.20 It was his view that if those who had helped to restrain Mr Bath had in fact witnessed the assault then it could have been proceeded with subject to input from the CPS. He hoped that the fact of the outstanding warrant in Poole had not been

influential in the decision not to prosecute Mr Bath for the assault on Ms Sullivan and said that 'A matter requiring attention locally would always take precedence over any other matters and the individual concerned would not be taken to Poole until the matters in Sussex had been finalised'.

21.21 We were told that on the basis of the above a decision might have been taken to charge Mr Bath for the Eastbourne offence. Mr Bath would probably have been released on bail and been immediately re-arrested on the Poole warrants and escorted there leaving the Eastbourne matter pending. After the Poole matter was dealt with, he would then be brought back to Eastbourne. Both matters could then have been dealt with.

21.22 Further, as a crime report had been raised the matter would remain on the crime information system in Sussex for the next eight or nine years. The paper record would be destroyed after four years.

21.23 We were told that once a person reported missing to another police force is found the normal procedure would be to inform that force and send a message, usually by telephone cancelling the report. It is, therefore, a matter of chance whether or not the two officers involved in the telephone call discuss the circumstances in which the person was found. There is no procedure for sending a report on the circumstances in which a person was found. Equally, the Metropolitan Police did not seek any further information of those circumstances. We were also told that the form that the Sussex police themselves use does have a section in which the circumstances in which a person was found can be entered.

COMMENTS

- **Missing persons**

21.24 We consider this to have been an important event. Ms Sullivan was known to be only 17 years old and clearly a vulnerable person, found in circumstances where she had been assaulted by her boyfriend who was reported to have threatened violence towards her before. We find it surprising that there was no method of formally reporting the circumstances in which she was found to the Metropolitan Police. Her contact with the Social Services was not recorded at that time and so it is unlikely that they would have been contacted immediately, but there is a possibility that had the full facts been known it may have led to the matter being reported to the Social Services back in London.

- **Prosecution policy**

21.25 We think that the decision not to prosecute was taken very quickly and without sufficient consideration of the fact that Mr Bath had admitted the assault and also that there were likely to have been other witnesses to the injuries being caused who were not interviewed.

21.26 We cannot help feeling that the decision not to prosecute was influenced by the existence of the outstanding warrant in Poole, although Sergeant Wigglesworth

denied this and DI Moore expressed the hope that this was not the case. There is also no evidence that Ms Sullivan was encouraged to press charges.

21.27 Sergeant Wigglesworth made it clear that information of Mr Bath's past convictions would have been available. If that is so, his history of violence would have been revealed and we do not think it wise that once that was known, this charge of assault should have been allowed to go unprosecuted.

21.28 We think that statements should have been taken from the other residents of the hotel and that the opinion of the CPS should have been obtained at the least.

21.29 Our advice from a senior prosecutor with the CPS is that the relationship between Mr Bath and Ms Sullivan would appear to bring the case within the CPS policy on domestic violence and that the evidential test would be satisfied if witnesses other than the victim saw the offence and the offender admitted it. Assuming that Mr Bath did not plead guilty to any charge, his admission would clearly have had to satisfy the test of admissibility under the Police and Criminal Evidence Act 1984.

21.30 The CPS Policy for Prosecuting Cases of Domestic Violence (August 1995) defines 'domestic violence' in the following way:

'any form of physical, sexual or emotional abuse which takes place within the context of a close relationship. In most cases, the relationship will be between partners (married, cohabiting or otherwise) or ex-partners'.

21.31 We think that the relationship between Mr Bath and Ms Sullivan undoubtedly falls within this definition. Our reading of that policy is that a prosecution would have been within it in this case, however, that decision is likely to have been influenced by the existence of the warrants in Poole where there was a strong likelihood of a custodial sentence or diversion into health care due to mental disorder.

21.32 Further had a prosecution taken place it is likely that the sentence would have been low, for example, a Conditional Discharge or a sentence to run concurrently with the one passed in Poole.

E. RECOMMENDATION

19. The Home Office should consider the benefits of standardising missing persons forms throughout the country. When the person is found and the form is to be cancelled a report should be sent back to the originating police force detailing the circumstances in which the person was found, what action is to be taken and any special features such as vulnerability which may require action on the part of that original police force.

Chapter 22

POOLE: SEPTEMBER 1997

- Prosecution in Poole
- Prosecution of warrants
- Sentencing
- Prison

A. Introduction

22.1 Mr Bath was transferred from Eastbourne to Poole in custody. He was sentenced to 12 weeks' imprisonment for two assaults committed while he was being arrested at St Ann's Hospital in September 1996.

B. Prosecution in Poole

22.2 Mr Bath was sentenced to 12 weeks' imprisonment at Poole Magistrates' Court on 15 September 1997. He had been in custody since 21 August when a warrant issued by Poole Magistrates was executed in Eastbourne and he was transferred to Poole. He was released from prison on 26 September.

22.3 The court register shows that Mr Bath was before the court for three offences committed on 13 September 1996, one of theft of a wallet, one of common assault and one of an assault on a police constable. These were offences committed at St Ann's Hospital. The first was discontinued and he was sentenced to eight weeks' imprisonment to run concurrently for the other two.

22.4 The statements indicate that he attempted to punch a police constable in the head and then head-butted him on his right temple which bled. He kicked another police constable on her right forearm as she tried to restrain him while he was on the ground.

22.5 He also faced three charges of failing to surrender to custody on having been released on bail on 26 November 1996, 21 March 1997 (charged on 28 May) and 19 June (charged on 21 August). The second of these was discontinued and he was sentenced to four weeks' imprisonment for the other two to run consecutively to the eight-week sentence.

22.6 It will be remembered that Mr Bath was arrested in March 1997, when he turned up at Weymouth, on what were considered to be 'serious assaults', but disappeared to Exeter before they could be prosecuted (chapter 20). Later in May he was before the court at Bournemouth following an allegation of disposing of a television set belonging to a landlord. He had been arrested in Exeter and brought to Bournemouth. He was to appear at Poole on a 'separate matter' which would have been these assaults. The appropriate adult at the police station at that time noted that the police did not seem to want to pursue the matter with any vigour and he was to be transferred to Poole.

22.7 Chief Inspector Michael Mytton of Dorset Police provided us with a useful chart of the various warrants and court appearances made by Mr Bath between September 1996 and September 1997 and we reproduce it here below with his kind permission. This chart was produced from Dorset Police computer records and the Magistrates' Courts results lists which are sent to the police periodically.

22.8 Chart of warrants and court appearances between September 1996 and September 1997.

Date	Action/ Information
10 September 1996	Arrested for burglary at Boscombe.
11 September 1996	Released to St Ann's Hospital without charge.
13 September 1996	Arrested at St Ann's Hospital for theft and assault on police officers. Bailed to appear at Poole Magistrates' Court on 25 October 1996.
17 September 1996	Arrested at Bournemouth for assault at Michael's Shelter. Released four hours later without charge.
25 October 1996	Failed to appear at Poole Magistrates' Court. Warrant issued (31 October 1996) backed for bail.
26 November 1996	Arrested on warrant (Poole computer record shows no longer backed for bail). Taken to Magistrates' Court. Bailed to 10 December 1996.
10 December 1996	Failed to appear at Poole Magistrates' Court. Warrant issued (13 December 1996) backed for bail.
17 March 1997	Arrested at Weymouth on warrant (+ four non-payment warrants)
18 March 1997	Taken to Court. Released on bail to Poole Magistrates' Court 21 March 1997.
21 March 1997	Failed to appear at Poole Magistrates' Court. Warrant issued (4 April 1997) not backed for bail.
27 May 1997	Arrested in Exeter for theft but not charged.
28 May 1997	Brought to Bournemouth Police Station. Detained on warrant issued
4 April 1997	Appeared at Court same day. Remanded (on bail?) to Poole Magistrates' Court 19 June 1997.
19 June 1997	Failed to appear at Poole Magistrates' Court. Warrant issued (28 June 1997) not backed for bail.
21 August 1997	Arrested Eastbourne for ABH on Ayse Sullivan (proceedings?) and detained on Dorset warrant issued on 28 June 1997.
21 August 1997 28 August 1997 04 September 1997	Appeared at Poole Magistrates' Court and remanded in custody until 15 September 1997.
15 September 1997	Poole Magistrates' Court. Case finalised: total penalty 12 weeks imprisonment.

COMMENTS

22.9 The regularity and optimism with which Mr Bath was released on bail given his record of non-appearance is striking, the result was that the prosecution of the September 1996 assaults dragged on and his record shows a gap in convictions of two years between June 1995 and September 1997. Yet in that time he committed at least four assaults of which only two were prosecuted. He was not prosecuted for an alleged ABH at a newsagents on 17 September 1996 or for the assault on Ms Sullivan.

22.10 Similarly, as Chief Inspector Mytton commented, in that September 1996 period Mr Bath was arrested for burglary and released to hospital, whereupon two days later he was back in police custody following a theft and two assaults. He was then released on bail and allegedly committed a further assault and was released without charge. He moved from a situation of incarceration and relative security and treatment in hospital to liberty within a period of seven days having committed a variety of offences in that time.

C. Sentencing by Poole Magistrates' Court

22.11 The court register contains the following entry:

'No Pre-Sentence Report (PSR) considered as magistrates determine it is not necessary to do so. Mr Bath's legal rep had urged the court to sentence today without a report and a 'stand down' report from the duty probation officer confirms he is not suitable for a community penalty and agrees that sentence should proceed forthwith in view of the defendant's mental health. Reasons for imprisonment: Justices satisfied that offences are so serious that only a custodial sentence is justified because the offences involve violence and assaults on 2 police officers, and also 2 charges of failing to attend court without reasonable excuse which has delayed proceedings. Credit given for guilty plea'.

22.12 Mr Bath made three appearances in court prior to sentencing on 15 September. The above indicates that in that time no pre-sentencing report was obtained and the only probation input was what is referred to as a 'stand down report'. We have been told that this means that the duty probation officer will have made a verbal report to the court based on a perusal of the file. There is no record in the probation file of this happening or what precisely was said.

22.13 The delay in sentencing may have been caused by the fact that initially Mr Bath pleaded not guilty to the assault charges. There is a letter from his solicitor which also states that he had written to Ms Sullivan at Mr Bath's request, informing her that he will be released from custody very shortly. We do not have a copy of that letter and so do not know its precise terms. We believe that this is likely to be the letter that members of her family refer to as being sent by the Probation Service notifying her of his release back to her address.

22.14 Between 21 August and 26 September 1997, Mr Bath was detained at HMP Dorchester. Those records show that he was seen at the health care centre on six occasions in that time. The first was his initial assessment of his mental state on arrival and the last certifies that he is fit for discharge. Of the other four only two relate to concerns over his mental state.

22.15 The daily supervision and support record is otherwise unremarkable.

22.16 The first entry in the inmate medical record ends 'Here for psychiatric reports according to inmate'. This is not confirmed elsewhere, although this seemed to be Mr Bath's impression as it is noted that he referred to it again later. He had also told them that he was a paranoid schizophrenic although it was noted that there were no psychotic symptoms. The doctor's impression was that he had 'an inadequate personality disorder showing no evidence of mental illness at this stage. Prone to self harm at times of crisis'.

22.17 His relationship with St Ann's is recorded and the need to get some history from them is noted. He was prescribed chlorpromazine and procyclidine. On 25 August he was threatening to cut himself. The only other entry which makes any reference to his mental state is on 11 September when he was complaining of not being able to sleep. No evidence of depression is found and 'certainly no evidence of (psychiatric) illness'. However, the a melleril prescription was changed to amitryptiline. The exceptional risk form initiated by Eastbourne Police is in the prison records.

COMMENTS

- **Sentencing**

22.18 Mr Bath was expecting to have psychiatric reports prepared for sentencing while on remand. There was no request for reports and at court immediate sentencing was urged. A 12 week sentence allows for no probation follow-up. He was destined simply to be released from prison and to go wherever he pleased.

22.19 The magistrates would not have been aware of the recent assaultative behaviour for which Mr Bath had not been prosecuted. Otherwise it is reasonable to assume that they had a full history of his antecedents available prior to sentencing.

22.20 The court register makes it clear that they were aware of his history of mental health problems. The offences for which he was before them were after all committed at St Ann's. They had very little other information before them. We consider that it is very unsatisfactory for a person with Mr Bath's history to be sentenced on the basis of so little information. This is so even where the defendant is pressing for an immediate disposal and has spent some time in custody on remand.

22.21 However, there is nothing to indicate that Mr Bath was suffering from a mental illness or disorder of a nature or of degree that made the use of a disposal under

the MHA a possibility. A Probation Order with a condition of treatment or residence may have been a possibility but would have required his co-operation.

22.22 Our probation expert expressed surprise at how short a sentence was passed on Mr Bath and we too initially were of the same opinion. We feel, however, that this opinion is one which is probably formed with the benefit of hindsight. At the time, there was nothing recorded against Mr Bath since 1995. While the offences were considered serious enough to merit a custodial sentence, there were no significant aggravating features. On the other hand in mitigation, factors to be taken into account were that the offences were old, he was a vulnerable individual and his eventual guilty plea.

Chapter 23

91 MARDEN SQUARE, SOUTHWARK: DEATH OF AYSE SULLIVAN ON 23 NOVEMBER 1997

- Southwark Social Services

A. Introduction

23.1 It has not been possible to trace Mr Bath's precise whereabouts throughout 1997. We know that he was in Exeter until July 1997. His GP records show that he had gone back to Weymouth at the end of July and was seen by a GP on 26 July. In all probability this was the last time that he was seen by a GP in Dorset. The reason for this attendance is not recorded and it does not appear that he was prescribed any medication.

23.2 Devon Social Services arranged accommodation for Ms Sullivan in London through Southwark Social Services as part of her leaving care arrangements. She travelled up to London from Exeter on her own in about May to find housing and by most accounts moved into the flat in Marden Square in August.

23.3 Marden Square was a one-bedroom flat on an estate and owned by Southwark Council.

23.4 Later in August she and Mr Bath went to Eastbourne. There is a suggestion that this was because Mr Bath was not getting on with her family in London and that there had been some altercations between them. On 21 August he was arrested by Sussex Police having assaulted her and transferred to Poole to answer charges of assault. Thereafter she refused to press charges against him (chapter 22). He was later sentenced to a total of 12 weeks' imprisonment for various offences.

23.5 Ms Sullivan's family had tried to persuade her not to resume her relationship with Mr Bath on his release from prison. He, however, had written her letters saying how sorry he was for what he had done and that he would not repeat his behaviour. He wanted them to resume their relationship. He and his solicitor (on his instruction) wrote to her informing her of his release date which was 26 September. On or shortly after his release they were together again at Marden Square.

B. Southwark Social Services

23.6 Ms Sullivan was referred to the Southwark Leaving Care Team by Devon Social Services in September 1997. She was seen by a duty social worker who carried out an assessment of her needs on 17 September. The main problems identified at that time were that she had no furniture apart from a borrowed mattress and there were outstanding repairs to be done to the flat.

23.7 There is nothing noted about physical injuries to Ms Sullivan's face or bruising. It is likely, therefore, that whatever bruising had been caused to her face by Mr Bath on

21 August had disappeared by that time. We find it difficult to believe that the duty social worker would not have made a note of any bruises seen on Ms Sullivan's face, nor of any explanation offered for the same. Ms Sullivan requested the support of the Leaving Care Team.

23.8 She was then referred to Yvonne Haye, a social worker with that team, in October 1997 and she remained her social worker until Ms Sullivan's death. She made seven home visits between 7 October and 19 November. Of those visits she saw Ms Sullivan three times and Mr Bath was also present twice on 31 October and 19 November. At no time did Ms Haye have any professional involvement with Mr Bath. She had no background information about him. We were told that young people are difficult to work with and that it is necessary to build up trust before questions of a personal nature, for example, about relationships can be broached.

23.9 Ms Haye described her role as being to provide 'advice, assistance and befriending to young people leaving care'. This is a statutory role under the children Act 1989 which arises once a young person in care has reached the age of 18. Involvement thereafter is voluntary and dependent on the co-operation of the young person which would have influenced the approach of the social worker, there being no power to do anything other than offer advice. In this case Ms Sullivan had requested assistance.

23.10 Southwark Social Services had no knowledge of the incident in Eastbourne in August. Ms Haye told us that Ms Sullivan never mentioned anything to her about violence from Mr Bath and in fact had hardly mentioned him prior to her meeting him on 31 October. She was concerned about what appeared to her to be needle marks on the inside of his arms. Ms Sullivan told her that she was not using drugs and Ms Haye said that she was left feeling concerned that Mr Bath may be using drugs and how that might impact on their relationship. However, she did not feel able to discuss it with them at that time and there was nothing to make her think that he had been violent towards Ms Sullivan. Her impression was that they were happy together.

23.11 On 19 November, Ms Haye met Ms Sullivan and Mr Bath again at the flat. He seemed upset and agitated that day and they were arguing. Ms Sullivan said that he did not live there and she only allowed him to use her address to sign on. According to other witnesses this was an untrue statement and he was living there.

23.12 On this date Ms Haye also noticed a black mark on the inside of Ms Sullivan's eye. According to Ms Haye's note Ms Sullivan said that 'her boyfriend would walk out the flat rather than hit her if they had an argument. Ayse got a wet piece of tissue and rubbed her eyes asking me if the mark had gone, but it was still there'. Up to that point she was beginning to have concerns about what was going on in the relationship, but Ms Sullivan seemed genuinely surprised when the mark was mentioned. Ms Haye thought that it could equally have been a 'bruised vein' as opposed to a black eye and was persuaded that there was nothing to worry about.

23.13 When asked about the risk of violence Ms Haye said that she felt that there was a 'risk of possible arguments, violent arguments but I cannot assess how violent that could be. I do not feel a sense of violence as to how this has ended up, but maybe arguments within that'. She did not consider that taking drugs might lead to more violent behaviour than arguments. Her judgement was influenced by the fact that Ms Sullivan did not seem to be afraid of Mr Bath and seemed to be in control of the situation.

23.14 We were told that had there been a reason to be concerned efforts may have been made to investigate more about Mr Bath's background. Had she known only about the assault in August 1997 then Ms Haye would have raised the matter with Ms Sullivan, but any decision to leave the relationship would have had to be Ms Sullivan's. She would not have intervened with Mr Bath or engaged Social Services on his behalf.

23.15 Ms Sullivan spent the evening of 22 November at her brother Darren's playing cards. She seemed to be her normal self, but would not have been expected to complain about Mr Bath in front of her brother. She and Mr Bath had been seen earlier that day at Marden Square by Louise Townsend, Darren's girlfriend. Again everything seemed normal, but Ms Sullivan had to ask Mr Bath for permission to go round to play cards that evening.

COMMENTS

23.16 Apart from the well-documented episode in Eastbourne, members of Ms Sullivan's family say that Mr Bath hit their sister on more than one other occasion resulting in his being hit by her brother and a cousin in retaliation. We think, therefore, that it is likely that the mark under Ms Sullivan's eye was a bruise. We cannot criticise Ms Haye, however, for her judgement in this matter. Given her level of knowledge at the time, it was a reasonable one which we think might have been made by many others in her position. Ms Sullivan demonstrated a clear determination not to let Ms Haye know the whole truth.

23.17 We have deliberately not called for documents relating to or investigated the services provided to Ms Sullivan, that being outside our terms of reference. We are, however, aware of some of the background to her being taken into care and this indicates that she was a vulnerable individual who displayed some behavioural difficulties.

23.18 We are conscious that we have been unable to consider what may be an important aspect of this case and we hope that Devon and also Southwark Social Services have undertaken a review of the care and treatment that Ms Sullivan received and their arrangements for young people leaving care.

C. Sunday, 23 November 1997

23.19 We have been provided with the full prosecution bundle and all statements taken by the police by defence solicitors acting for Mr Bath and with his permission. The following account of the events of this day is taken primarily from the prosecution summary of the case which formed the basis of his plea of guilty to murder.

23.20 On 23 November, neighbours heard Mr Bath and Ms Sullivan arguing from about 8.50 a.m. in the morning. The argument continued sporadically until about 1.15 p.m. At one stage Mr Bath was seen on the balcony of the flat shouting to be let back in. He said that he had gone out for half an hour to cool down and when he returned he was locked out. She opened the door to throw his clothes out saying 'Get out'. He appears to have got back in to the flat at this point.

23.21 His account indicates that the argument had been intense. The police records note fresh bruises and bite marks on him. He remembers that she hit him with a pole or iron bar and that he then grabbed the bar from her. He does not recall hitting her and the next thing he remembers is that she was lying on the floor. He picked her up and put her on the sofa. She was not breathing. He remembered lighting three candles and then he closed the windows, locked the door and left the flat. At about 2 p.m. a neighbour got a strong smell of gas on walking past the door to number 91.

23.22 Between 2 and 2.20 p.m. there was a loud explosion in the flat. Flames and smoke engulfed the flat and glass was blown from the windows. At about 2.20 p.m. Mr Bath walked into Rotherhithe Police Station and said that he had killed his girlfriend. He described how they had argued and fought with the metal bar. He appeared upset and was crying.

23.23 He did not remember interfering with the gas supply, but later accepted that he had turned the gas supply on knowing that the pipe had no cap on it. The post-mortem report says that Ms Sullivan died from head injuries. Her body was subsequently burned by the fire in the flat and formal identification of her body was performed with the aid of dental records.

23.24 Mr Bath was medically examined at the police station on several occasions. He was tearful and anxious, but considered fit to be detained. He showed no signs of psychotic illness. He was remanded in custody to HMP Belmarsh on 25 November.

23.25 Toxicological analysis of blood and urine samples from Ms Sullivan and blood taken from Mr Bath are inconclusive as to any role played by drugs or alcohol in the death of Ms Sullivan. They show that both of them had taken cannabis at some time prior to her death, but due to the time over which its residue remains in the blood stream it is not possible to say whether or not they would have been under the influence of cannabis at this time.

23.26 The time at which Mr Bath's blood sample was taken precludes any conclusions as to the role of alcohol and other drugs. Low traces of benzodiazepines indicate that he would not have been under their influence at the time of the offence and had in fact been prescribed and taken diazepam at the police station to calm him down.

23.27 The psychiatric examinations performed at the police station on 23 November do not refer to any suspicion of intoxication and it is unlikely that Mr Bath was under the influence of drugs or alcohol at this time.

Chapter 24

HMP BELMARSH: MAY 1998

- Guilty plea and sentence
- Forensic psychiatric assessments

A. Indictment and Sentence

24.1 Mr Bath was charged with murder and arson intending or being reckless as to the damage to property (section 1(1) and (3) of the Criminal Damage Act 1971). On 14 May 1998 he appeared at the Central Criminal Court before His Honour Judge Pownall QC. The charge of arson was amended to arson with intent to endanger life (section 1(2) and (3) of the Criminal Damage Act 1971). Mr Bath pleaded guilty to both charges. The facts of the offence were summarised to the judge by the prosecution and he was referred to four psychiatric assessments of Mr Bath.

24.2 Mr Bath received the mandatory sentence of life imprisonment for the murder. There was a concurrent sentence of nine years' imprisonment for the arson. In passing sentence the judge said: 'what you did was quite dreadful and has brought to an end a young life. It is quite clear to me that you are mentally ill and indeed I hope that you will be treated for it, if that is possible'. At the time of writing Mr Bath has yet to receive notification of the tariff sentence which he must serve for the purposes of deterrence and retribution and before any question of parole can arise.

B. Psychiatric Assessments

24.3 These were produced by three consultant forensic psychiatrists: Dr Ann Barker, visiting psychiatrist to HMP Belmarsh, Dr A Payne, from Broadmoor Special Hospital, Berkshire and Dr A Maden, of the Dennis Hill Unit, Bethlem Hospital, Beckenham, Kent. We believe that the fourth report before the judge must have been one from Dr Rowton-Lee dated 1 December 1997 and which simply recounted the history of contact between Mr Bath and St Ann's Hospital.

24.4 Dr Barker produced a review of Mr Bath's history of admissions to hospital, record of convictions and contacts with various services. All three reports show how difficult it is to obtain a coherent history from Mr Bath himself. Whilst many of the details are accurate there are always discrepancies. These relate, for example, to when and how his stepfather died and other details relating to his early history. Later, on remand at HMP Belmarsh, he resumed fabricating stories about his family saying, for example, that his brother had died. He is also inconsistent about whether or not he had abstained from amphetamines prior to the murder.

24.5 There is unanimity over the diagnosis of a severe personality disorder which amounts to a psychopathic disorder within section 1(2) MHA and that this amounts to an abnormality of mind due to inherent causes (section 2 of the

Homicide Act 1957). Both Drs Payne and Barker are of the view that this is a disorder which would justify a finding that his mental responsibility for the act was substantially impaired. Dr Maden expressed the view that 'his personality disorder is an important cause of his difficulties within relationships, and an important cause of his difficulties in coping with stress'.

24.6 It is also agreed that his early childhood experiences are likely to have had a significant impact on the development of the personality disorder. Dr Maden states that the symptoms of personality disorder include 'chronic feelings of depression and tension, "voices", and repeated acts of self-harm. The voices are best considered as pseudo-hallucinations, rather than the true hallucinations which characterise schizophrenia'. In support of the latter he says that although Mr Bath insisted to him that he heard voices all the time, there was no evidence that he was being distracted by the voices throughout the interview. Dr Payne believes that these psychotic symptoms warrant further investigation. There is no suggestion that Mr Bath is currently also suffering from a mental illness.

24.7 Both Drs Payne and Barker mention the 'blackouts' which first emerge in his contact with Dorset in April 1997 when he was seen by Dr Townsend in Weymouth. Dr Payne's view is that the description of them does not suggest epilepsy. However, they both consider that further investigation is merited.

24.8 Dr Payne's report was requested by Dr Barker on the issue of whether Mr Bath's condition would be amenable to treatment. He recommended an assessment of Mr Bath in hospital under an interim hospital order (section 38 MHA) if found guilty of manslaughter or under a transfer direction from prison (section 47 MHA) if convicted of murder. As he presents a grave risk to others he recommended that any assessment be carried out in conditions of maximum security. Mr Bath has now been transferred to Broadmoor under a transfer direction with restrictions (sections 47/49 MHA).

Chapter 25

SUMMARY OF KEY EVENTS IN SHANE BATH'S HISTORY

- Early childhood
- Arson in 1988
- Hospital Order in 1993
- February 1995: CPA meeting
- 1995-1996: numerous hospital admissions
- Prison and probation
- Eastbourne 1997: assault on Ms Sullivan
- Southwark Social Services

A. Introduction

25.1 Mr Bath had a long history of contact with the services over a period of almost 20 years from when he entered local authority care. This chapter considers the key episodes in his history in terms of the development of his mental disorder and the responses to him by the many services with which he had contact.

B. Early Childhood

25.2 This is a very informative period in Mr Bath's life. There are clear features, for example the dysfunctional family, sexual abuse, local authority care, which could be seen as predictive of a future anti-social personality disorder or likely to contribute to the development of one. We believe that in many cases such as this, an analysis of childhood experiences would reveal a similarly predictive background.

25.3 In our view, the value of this is that early intervention, via, for example, a family support scheme offering assistance to the family unit, may offer a route to an effective long-term strategy aimed at preventing the development of personality disorder and promoting beneficial family relationships. This needs to be further researched and we endorse the Government's proposals in this regard (see 'Supporting Families' summarised at Annex E to the joint Home Office/Department of Health consultation document, Managing Dangerous People with Severe Personality Disorder (July 1999) and also the First Report of the Home Affairs Select Committee on dangerous severe personality disorder in March 2000).

25.4 The childhood information would have been important not only to the diagnosis of personality disorder in adulthood, but also to subsequent risk assessments (or prior to the introduction of formal risk assessment, considerations of dangerousness).

25.5 The only information about this period which filtered through to his adult files was that which he provided himself initially to Dr Sedman in 1987. This was incorporated into his reports and referred to throughout Mr Bath's history.

C. Arson in 1988

25.6 Even though we do not criticise the diagnosis of personality disorder made by Dr Sedman, we have been critical of the way in which the diagnosis was reached and of his analysis that medical treatment in hospital had nothing further to offer Mr Bath, which he based on the early periods of in-patient care. These were brief, did not include any formal assessment of 'treatability', nor was there any opportunity to assess his response to any treatment which was attempted. The history of care which he refers to was additionally not researched.

25.7 There was also an increase in Mr Bath's dangerousness at this time and we have found that insufficient account was taken of this fact. Risk assessment was not widely used as a formal clinical 'tool' until after about 1994, but considerations of dangerousness have been for some time and are an integral part of mental health services, including practice in general psychiatry.

25.8 As a result, while a Restriction Order was unlikely at this time, an interim Hospital Order or Hospital Order were real options.

D. Hospital Order in 1993

25.9 The robbery committed by Mr Bath in April 1993 was a drug-related crime. His ensuing self-harm and supposed 'bereavement' led to his transfer under section 48 of the MHA to St Ann's where the diagnosis of depression was not substantiated. Although Mr Bath's behaviour is likely to have made any assessment of his mental state and dangerousness difficult initially, there can be no excuse for the failure to arrive at a proper diagnostic or risk formulation. The RSU at Ravenswood House and the CFT in East Dorset were involved in assessing him at this stage.

25.10 The poorly formulated medical management and treatment are reflected in the court reports of Dr Rowton-Lee. We think that management was unco-ordinated and hampered by an unnecessary lack of information. Much time was wasted on grief counselling when a simple check would have revealed the lie; nursing staff had interviewed Mrs Bath who was alive and well. The role of the RSU was also confusing and we are still unclear as to the purpose of this referral.

25.11 There was also confusion over Mr Bath's 'treatability'. Although initially the psychologists cast doubt over their ability to help him, the report at sentencing appears to suggest otherwise and says that he needs a lot of input from multi-disciplinary staff. This is the closest there was to any formal assessment of his 'treatability' although it was not expressed as one.

25.12 Mr Bath was not considered to be a risk to others which we think was probably wrong even if the level of that risk may have diminished over subsequent years. He had shown himself to be very aggressive on the ward and apart from during the

index offence itself, had been carrying a knife earlier in the year and making threats against his ex-wife and her partner. The probation report was strong on the need to offer protection to others.

25.13 Again our conclusion is that the likelihood of a Restriction Order is too speculative and now too distant in time to enable a confident judgement on any effect on the eventual outcome. We have concluded that not to recommend a Restriction Order, even on all the information potentially available, was probably within the limits of acceptable practice. The decision to make a Restriction Order is ultimately for the court.

25.14 The discharge arrangements were inadequate in the extreme and the failure to use section 117 MHA to plan his after-care was stunning and a breach of statutory duty. Whatever work was done during this admission was not followed up on subsequent admissions. This must be wasteful of resources and show poor continuity of care.

25.15 This whole episode demonstrates a poor understanding of the MHA from the making of the Hospital Order through to his precipitous discharge from hospital without proper follow-up. It leaves us to question whether Dr Rowton-Lee and his team, including the CFT, had taken on more than they could cope with and more than their expertise could in reality stretch to (see chapter 27). They were let down by the RSU which did not address the issue of dangerousness.

25.16 This episode also illustrates the other failures repeated with disappointing regularity throughout his history: multi-disciplinary working, communication, history checking, Social Services involvement, discharge summaries (see Appendix G for the full list). These were failures even in 1993.

E. CPA Meeting in February 1995

25.17 This took place at Forston Clinic in West Dorset. It is the only documented CPA meeting for Mr Bath. The eventual plan, which included psychology assessment, was not a bad one even though there was no key worker explicitly identified. Although Dr Veasey did not follow the letter of the CPA procedure, doing so is unlikely to have made any practical difference to the actual plan or to the follow-up.

Mr Bath was very unco-operative and in the absence of any powers of coercion there was little to be achieved. He was still a risk to others.

25.18 We do not advocate statutory powers of coercion in the community for this group of clients. It is our view that if powers under existing mental health legislation (MHA) cannot be invoked and no criminal offence has been committed, then the proper approach must be a rigorous application of the principles of CPA together with more assertive techniques of monitoring and supervision in the community (see chapter 28).

F. Numerous Hospital Admissions, 1995-1996

25.19 This was a very disturbed period in Mr Bath's life when he was in and out of hospital like a yo-yo. There were nine admissions to St Ann's. These were all crisis admissions and our conclusion is that there was sufficient evidence of mental illness at this time to admit him formally for assessment under section 2 at the least on several occasions.

25.20 There was, however, no attempt to manage his care and treatment strategically. CPA was not properly used and there was no continuity of care from one admission to the next.

25.21 Had he been admitted to hospital under the MHA and been discharged under section 117 or had CPA been properly used then it is difficult to judge what effect there might have been on his behaviour in the long term. In the short term, his contact with Ms Sullivan may have been delayed.

25.22 Once again the gamut of failures which we have identified throughout is on display during this period.

G. Prison and Probation

25.23 Mr Bath received one sentence of youth custody and three sentences of imprisonment. In the early years between 1989 and 1992 he was not dealt with as a mentally disordered offender. Apart from the last sentence of 12 weeks in September 1997 the others were for periods from nine to 18 months. These involved much probation input and effort and some attempts to liaise with community mental health services. On each occasion, however, he lapsed into his anti-social behaviour fairly soon after release and regardless of arrangements made on his behalf.

25.24 For example, the probation officer Sue Staddon made a concerted effort to find Mr Bath accommodation and to have him followed up by the Community Forensic Team in East Dorset on his release from prison in October 1995, but her efforts were thwarted by Mr Bath's own actions (see chapter 17).

25.25 Interestingly, although we have very few prison records, we have been told that Mr Bath was never subject to any disciplinary adjudication while in prison. This suggests that his anti-social behaviour, save for self-harm, was confined to his time living in the community or in hospital. We resist the notion, however, that long-term incarceration was the only solution.

H. Assaults by Mr Bath on Ms Sullivan

25.26 The assault upon Ms Sullivan in August 1997 stands out as an event which many will see as predictive of her eventual death. We now know that she had shown

evidence of other assaults by Mr Bath in the form of bruising to her face, but we also know that she was very taken with him and he with her. Intervening in their relationship would have been difficult and her family's efforts to do so had been unsuccessful.

25.27 We have criticised the decision not to obtain statements from witnesses to this assault and to charge Mr Bath with it. However, our advice from the CPS is that there must be some doubt as to whether a prosecution would have followed where there was a strong likelihood of a custodial sentence for the assaults on police in Poole. The courts apparently take a more serious view of assaults on police than on a girlfriend which would have merited only a low sentence, if not a conditional discharge, or a sentence to run concurrently with that passed in Poole.

25.28 The upshot is that even if he had been prosecuted for the assault in Eastbourne, he is unlikely to have received a term of imprisonment greater than he did receive in Poole. Even if he had done so, there was nothing stopping him from returning to live with Ms Sullivan on release and a tragedy at a later date would not have been prevented.

25.29 A court is not bound to ask for psychiatric reports in a case involving a mentally disordered offender. At this time there is no evidence that Mr Bath would have fulfilled statutory admission criteria to hospital even if he had been assessed under the MHA.

25.30 The only other influential factor here which we have been able to identify is the knowledge that Ms Sullivan was only 17 years old. Questions asked as to her welfare by either the Sussex or Metropolitan Police would probably have uncovered the fact of her involvement with Social Services and have alerted the police to the need for further communication with those responsible for her.

25.31 We do not think that this would have been an over-protective measure for a 17-year-old who was just leaving care and was warranted by the circumstances.

I. Social Services Responsible for Ayse Sullivan

25.32 Ms Sullivan was referred to Southwark Social Services by Exeter. They first saw her in September, two months before her death. It is very unlikely that in that time they would have been able to take any sufficient action to keep Mr Bath away from Ms Sullivan, even if they had known about the assault in August or that he had a psychiatric history.

25.33 She was allocated to Yvonne Hay in October and she saw her three times before 23 November 1997. In that brief time she told us that she had some concerns but was monitoring the situation. There is a difficult balance to be struck between allowing an individual sufficient autonomy to make their own decisions, gaining trust, offering advice and discreet supervision. We accept that Ms Haye's approach was a proper one.

J. Conclusion

25.34 These key episodes highlight the many deficiencies in the overall approach to Mr Bath's care. These relate to fundamental areas of practice including psychiatric and social care, risk assessments and follow-up arrangements in the community. Collaboration between disciplines and agencies was thin and most importantly, there was no cohesive strategy in relation to his treatment and management. The following chapters aim to deal with these points in more detail.

POLICY AND ISSUES

Chapter 26

PERSONALITY DISORDER: MENTAL HEALTH ACT 1983

- The MHA
- Policies and Other Material

A. Introduction

26.1 In this report we are concerned with those individuals who are considered to suffer from a severe personality disorder and are difficult to engage with services. There is an ongoing debate about the place of personality disorder (or psychopathic disorder in the terms of the MHA) within the mental health services and the concept of 'treatability' within the MHA, given the uncertainty over the diagnosis of personality disorders and whether they are susceptible to treatment. For an overview of the issues relating to psychopathic/personality disorder and 'treatability' we have included an extract from the report of Dr Brian Thomas-Peter prepared for this Inquiry at Appendix I. We are also aware that the MHA is under review but will confine our comments to the law as it currently stands.

26.2 It is our collective experience that once 'labelled' with a diagnosis of personality disorder, local mental health services are often reluctant to engage with an individual and it is assumed that they are untreatable. This is for a multiplicity of reasons which include the difficulty of managing patients with behavioural problems, but also the lack of consensus over 'treatability' and often a lack of facilities in terms of secure wards and treatment options.

26.3 We believe that Mr Bath was just such an individual and that the services were reluctant over or unsure how far to become involved with him and at least partly unwilling to do so.

26.4 We are convinced, however, that the proper approach is to perform a full assessment of the disorder and its 'treatability', if necessary under a compulsory section of the MHA, and this should be addressed clearly in the policy documentation of the NHS Trusts and Social Services. In saying this we accept and endorse the position that an informal admission with full agreement between the patient and care team must be the first option. We are also acutely aware that Parliament has yet to sanction the detention of a person in hospital simply as a means of protecting the public. In this chapter we consider the possibilities for the admission of this group of individuals to hospital under the MHA.

B. The MHA

26.5 Personality disorder is not a mental illness within the MHA but comes within the category of psychopathic disorder. Neither compulsory admission for assessment

(section 2 MHA), nor admission to hospital from court for assessment or under an interim Hospital Order (sections 35 and 38 MHA) require the 'treatability' test to be satisfied, unlike admission for treatment under section 3 (civil treatment order) and 37 (Hospital Order):

'in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition (section 3(2)(a) and section 37(2)(a)(i))'.

26.6 There is, therefore, nothing to inhibit an admission to hospital for assessment of the 'treatability' of a mental disorder under section 2 (although this is limited to a period of 28 days). Thereafter, detention cannot be continued under section 3 (or in other circumstances under section 37) for medical treatment, unless the condition is deemed to be treatable.

26.7 'Medical treatment' under the MHA is widely defined to include 'nursing, and also includes care, habilitation and rehabilitation under medical supervision' (section 145). The breadth of this definition is not diminished when applied to the 'treatability' test and a regime of supervised care which has the effect of preventing deterioration of the symptoms of the disorder, even if not the disorder which gives rise to them itself, could in an individual case be sufficient to fulfil the test (Reid v. Secretary of State for Scotland [1999] 2 WLR 28, HL).

26.8 Compulsory supervised care of individuals with severe personality disorder in hospital to prevent the deterioration of symptoms which, in the case of someone like Mr Bath, would include episodes of self-harm and violence, has, therefore been sanctioned by the courts. Taking a robust approach this aim could be pursued under section 3 or 37 MHA.

26.9 This argument is not without controversy. There is a strong body of opinion which considers it to read into the MHA that which is absent, disregarding the uncertainties surrounding the existence of effective treatment options and producing an artificial analysis enabling the detention of a personality disordered individual in circumstances where there is no express legislative authority to do so.

26.10 One view is that this is too broad and no different from locking a person up in hospital when they are no longer responding to, or are refusing, treatment, for the protection of the public; hospitals are not prisons. Others state that the therapeutic environment alone may encourage the refusing patient to change his or her mind about participating in treatment.

26.11 Dr Brian Thomas-Peter talked of the need to address Mr Bath's motivation to change before dealing with his more specific problems such as his drug abuse (see chapter 27). Adopting this approach to the meaning of "treatability" may allow this to take place but is likely to have required long-term in-patient facilities. It must be recognised that in offering treatment to this group, a long-term perspective will be necessary.

26.12 The reality in Mr Bath's case (as with many others) was that due to the co-morbidity of his personality disorder with depressive illness and, particularly in 1996, symptoms of psychosis, the use of the MHA for admission for assessment followed by treatment is likely to have been more straightforward (see chapter 18).

C. Policies and Other Material

26.13 Dorset Healthcare NHS Trust produced a discussion paper on the treatment of personality disorders in October 1998 which refers to a 'considerable debate' within the Trust on the issue of personality disorder while agreeing that it is important that the needs of this client group be addressed. The paper contrasts the views of the Home Secretary that it is 'unacceptable for psychiatrists not to offer treatment for people with personality disorder' with an opinion received by the Trust from an independent psychiatrist that 'the treatment of personality disorders is a waste of resources'.

26.14 The discussion paper acknowledges that there is a duty to reduce suicide rates which will necessarily include an involvement with personality disordered patients who present a high suicide risk. What is not mentioned is a duty to assess and manage risk to others as well. It continues that there is consensus amongst clinicians that one of the main functions of the service is to carry out an assessment in order to confirm diagnosis.

26.15 Our evidence from the DHA, which is confirmed in this discussion paper and elsewhere, is that the mental health services in Dorset are focused on patients with severe mental illness, the working definition of which does not include personality disorder. The DHA has agreed with both Trusts that 75 per cent of the caseload of the CMHTs should meet this definition. It has been left up to the Trusts as to whether they take on personality disordered patients within the remaining 25 per cent of their caseload.

26.16 Our findings suggest that this is not happening and that severely personality disordered patients are not being allocated to CMHTs, thus limiting work in the community to agencies such as CADAS where appropriate, or the CFT.

26.17 The Dorset Healthcare NHS Trust discussion paper on the subject indicates that in agreeing a definition of 'severe mental illness' with the DHA they did agree that CMHTs would work with 'other people with mental illness, including personality disorders'. It is acknowledged that this does not make it clear whether only those with a co-morbidity of mental illness and personality disorder are included.

D. Conclusion

26.18 The MHA allows admission to hospital of those with personality disorders for assessment. Admission for treatment may be possible where supervised care will prevent deterioration or address a person's motivation to change. The process of

discharge is then likely to depend on the level of risk posed by that individual to others or to himself, because continued treatment (in its widest sense) in hospital can be justified if it is likely to prevent a deterioration in terms of violent or aggressive behaviour to self or to others. In our view, that this is not expressly sanctioned by the MHA is an inherent difficulty in the wide interpretation of 'treatability' in Reid (26.7 above).

26.19 The DHA and Trusts should decide what use they wish to make of such an approach. In any event, whether as an in-patient or not, what is required is a fully collaborative process with each agency playing its part to formulate combined aims for assessment, treatment and management, including the management of risk. We do not think that such an approach would constitute a waste of resources. Full training of all staff, both hospital and community-based, on the nature and needs of personality disorder is essential. The DHA and the Trusts must set out clearly the level of their commitment to personality disorder in policy, materials and resources. We acknowledge that this is a specialist and resource-intensive undertaking.

E. RECOMMENDATIONS

20. The DHA, NHS Trusts and Social Services should set out clearly the level of their commitment to assessment and, where appropriate, treatment of personality disorder.

21. The NHS Trusts and Social Services should ensure full training of staff, hospital and community-based (CMHTs, CFT and community drug teams), on the aetiology of personality disorder, application of MHA and assessment and management in the community.

See also chapter 9, recommendation 9.

Chapter 27

MENTALLY DISORDERED OFFENDERS IN THE COMMUNITY

- CFT
- CADAS
- Social Services and CMHTs
- Assertive community support

A. Introduction

27.1 Mentally disordered offenders, such as Mr Bath, are entitled to a full range of local psychiatric services in the community. The CPA applies equally to those leaving prison or referred to the specialist psychiatric services from elsewhere in the criminal justice system (HC(90)23).

27.2 Services in Dorset have expressed their commitment to key principles of the Reed Committee Report (Joint DoH and HO Review of Health and Social Services for Mentally Disordered Offenders (November 1992)) and in particular with regard to caring for MDOs in the community where possible and under conditions of no greater security than is justified by the degree of danger presented to themselves or to others.

27.3 In pursuance of this there has been a court diversion scheme in operation in Dorset since 1992, one of the key components of which is the Community Forensic Team in East Dorset. Throughout his long history of contact with Dorset services, Mr Bath had surprisingly limited involvement with the CFT (chapters12-14) and he only encountered court diversion more latterly in 1996.

27.4 The majority of community support he received was from either the Probation Service or CADAS. Although our main criticisms of the CFT relate to a period in 1993, and Dorset Health Commission produced a document entitled A Review of Mentally Disordered Offenders and Sex Offenders (April 1994) which acknowledged a number of our concerns, we still have concerns about its proper functioning and position within the overall services today. We are also concerned at the poor involvement of Social Services and CMHTs.

B. Community Forensic Team (East Dorset)

27.5 The CFT had more dealings with Mr Bath than did MenDOS in West Dorset. MenDOS has fewer resources than the CFT and offers only a short-term assessment and treatment service. However, Caroline Kinsella of MenDOS has a strong background in forensic work, a feature which was lacking in the CFT staff.

27.6 We heard evidence that the Community Forensic Team in East Dorset developed as a pilot project in 1991/1992 in response to the national exhortations, led by the Home Office, that Health Services developed projects to divert mentally

disordered offenders from the criminal justice system into the care of Health and Social Services.

27.7 This is an award-winning service which has been praised as a positive development and we too commend its development at such an early time. The April 1994 review document is an impressive one and raises many pertinent issues for service improvement with which we agree. These include the best model of leadership, integration with wider community services such as drug services, the need for strong consultant psychiatric input, access to housing and beds, resources, relationship with the Regional Forensic Service, absence of social work input, the level of forensic knowledge and availability of training in forensic services.

27.8 It applauds the success of the inter-agency work and co-operation undertaken. This does not accord with our findings in relation to Mr Bath. We think that the time is probably ripe for a further review of these services with the April 1994 document as a starting point.

27.9 The key issues for us are: leadership, forensic training, integration and the use of CPA.

27.10 Leadership of the CFT was unclear to many of those with whom the team dealt. It was led by Dr Grace Leung, consultant psychologist, and Dr Rowton-Lee describes himself only as a 'friend' of the team. Dr Stone from the RSU at Knowle Hospital was 'amazed' to discover this as his impression had been that Dr Rowton-Lee led the team.

27.11 Neither Dr Leung (nor Dr Rowton-Lee) had any formal forensic training or background. Up to the time of her nomination to lead the CFT she had been exclusively involved in the rehabilitation of mentally ill patients in the community. During her first year she travelled to North America to gain experience in forensic psychology and risk assessment, by attending conferences for a few days at a time. She became an affiliated member of the Division of Criminal and Legal Psychology of the British Psychological Society, but was not at the time she gave evidence to us, a Chartered Forensic Psychologist.

27.12 Dr Rowton-Lee, in his evidence to us, told us that he had never received any formal training in forensic psychiatry, and did not consider himself to be a specialist forensic psychiatrist. Rather, he had many years experience of attending Portland Young Offenders Institution and had previously been a member of the Parole Board for England and Wales. There is evidence that he was widely regarded as a "forensic" psychiatrist.

27.13 As with earlier psychiatric assessments, here again there was no coherent formulation of Mr Bath's psychopathology and offending behaviour by the CFT. If the problem is a perplexing one, or simply difficult to unravel, there is nothing wrong with saying so.

27.14 Although based at St Ann's Hospital, operationally the CFT hovers between health, community and criminal justice agencies. Its status as a 'specialist mental health service' and so its relationship to the CPA is undefined. Mentally disordered clients who are accepted by the CFT should be subject to the CPA.

27.15 We have already commented on the fact that Mr Bath was never allocated to a CMHT and that the criteria excluded personality disorder. Community team follow-up for Mr Bath was non-existent and largely undertaken by CADAS up to 1995. Thereafter, we have been unable to find an explanation for why the CFT were never involved in, for example, 1996 when Mr Bath was in and out of hospital.

27.16 In 1995, Dr Rowton-Lee was approached to undertake follow-up in the community for Mr Bath on his release from prison. He responded that once he was out, the CFT would follow him up (he had offered it similarly in 1994, unsuccessfully). However, he was never seen by the CFT and in spite of the best efforts of Sue Staddon, probation officer, Mr Bath did not stay at Creek House, a hostel affiliated to the CFT, more than one night and very soon ended up back at St Ann's under Dr Rowton-Lee's care where again he was not seen by the CFT.

27.17 Sue Staddon had tried to get an assessment made by a community team prior to Mr Bath's release from prison. This was unsuccessful. Dr Veasey was unwilling to have him back at Forston Clinic and so Caroline Kinsella was unable to carry out any assessment. As the CFT were volunteered to take this role on, it was for them to carry out an assessment of Mr Bath prior to his release. This would have provided the best opportunity to prevent him from disappearing once in the community.

27.18 The evidence we have received indicates that the CFT is far from a fully integrated service working and communicating with other agencies seamlessly. Mr Bath's case has not given us the chance to assess the way in which the different disciplines within the team worked together, but our expert has criticised the lack of a proper formulation of Mr Bath's psychopathology and offending behaviour and importantly the lack of a risk assessment. We have already commented on the use of an untrained psychology assistant to undertake the assessments, the supervision of whom was also open to question (chapter 13).

27.19 Community forensic services must be fully resourced and run by trained and competent staff in order to be truly effective. It is clearly essential that in this sensitive area of practice proper leadership by skilled clinical staff is provided. Anything less is likely to lead to a service which is unclear as to its own capabilities and limitations. There may equally be an over-reliance on it by other services with

no forensic expertise and with unrealistic expectations as to its effectiveness with difficult clients.

C. CADAS

27.20 Drug abuse was a persistent feature of Mr Bath's presentation to the mental health services for which he received in-patient treatment at St Ann's Hospital and Forston Clinic. In the community Mr Bath was in intermittent contact with the Community Alcohol and Drugs Advisory Service (CADAS) from 1988 to 1995. This service is managed by the Dorset Community NHS Trust. The period of most significant contact was from 1989 to 1992.

27.21 He had no contact with community drug services in East Dorset, but was treated by Dr Choudry as an in-patient on two occasions.

27.22 CADAS provides a comprehensive assessment, counselling and treatment service for people with alcohol or drug problems across the west of Dorset. In 1999 it had seven CPNs, 2.5 social worker posts and a probation officer. There is no medical attachment to the team. On the whole we have been impressed by the commitment of this service to Mr Bath and its efforts on his behalf.

27.23 Ms Lorraine Tritton, now clinical team leader at CADAS, informed us in evidence that CADAS uses a range of therapeutic methods including motivational interviewing (a counselling and harm reduction approach), and the alcohol addiction model (the 'Minnesota' model or 12 step programme to recovery). The addiction model requires total abstinence on the part of the person afflicted as he or she is believed to have a genetic or in-built problem with alcohol-'one drink, one drunk' .

27.24 CADAS training information describes motivational interviewing as a reflective technique which relies on personal choice and self realisation.. The client is viewed as able to control and choose his use of alcohol and other drugs, the worker focuses on eliciting the client's own statement of concern regarding use. Implicit is the assumption that it is the alcohol or other drugs which are causing the client's problems rather than vice versa.

27.25 CADAS staff put themselves out to help Mr Bath for a considerable time but we question the validity of the therapeutic approaches they had to offer him which were always likely to fail without the help of other agencies, e.g. psychological intervention from the CFT, to address the issue of motivation.

27.26 It should have been apparent shortly after starting work with Mr Bath that motivational interviewing was unlikely to be an effective approach to change behaviour in a severely personality disordered person for whom, as with other services, a more assertive approach might have had greater success. At the time there were no other options available for community treatment of alcohol and drug

problems in the area and it is understandable why CADAS was looked to for assistance in West Dorset.

27.27 Ms. Lorraine Tritton advised us that until 1998 the policy was that if someone had a defined mental illness and was under the care of a psychiatrist as well as receiving CADAS services the key worker would come from the mental health services. This system has now changed so that both services would work together to manage someone's care but because Mr Bath did not have a defined mental illness CADAS worked with him largely independently.

27.28 Over the time Mr Bath was in touch with CADAS there was little liaison or continuity between its services and the wider mental health services. The only contact was at the point of referral by those services with CADAS. As Ms Tritton confirmed, it often felt as if they were working in isolation.

27.29 This may have been contributed to by the fact that Mr Bath was viewed as presenting primarily with a drug problem. A consultant from Blackdown Hospital wrote to CADAS on 22 February 1989 that 'his drug dependency is only symptomatic of the underlying personality problem'. Thus tackling the drug problem without there having been any evaluation of the 'treatability' of the personality disorder seems wasteful of time and resources.

27.30 Our expert advice is that people with personality disorder do not commonly see the need for personal change. The nature of an anti-social personality disorder includes a high probability of confrontation and resistance to establishing a therapeutic alliance. Any treatment should first target a person's motivation to change rather than using the lack of such motivation as a reason for exclusion from services. Unwilling clients can sometimes be motivated by skilled therapists and so extended attempts to engage patients should be undertaken before deciding that an offender is 'untreatable' (see also chapter 26).

27.31 Failing to consider the whole problem led to a compartmentalised approach. Mr Bath did not fit into a formal 'mental illness' compartment, so he was placed into the 'substance misuse' box and treated accordingly. It is trite but true to say that what is required is a consideration of the whole problem and that this requires a multi-agency and a multi-disciplinary solution.

27.32 The view of Ms Brown, confirmed by Dr Fleming at Highclere, that the history of violence amounted to no more than isolated incidents of drug-related psychosis is illustrative not only of the confused medical analysis with which CADAS were working, but also of the failure to fully investigate and appreciate Mr Bath's history.

27.33 The Dorset Community NHS Trust records contain the court reports written by Dr Sedman in relation to the arson offence which outlines some of the early history. This information was either not accessed, or ignored. The picture which emerges is of a service working in isolation and in the dark.

27.34 It is also apparent that Mr Bath exploited the goodwill shown to him by CADAS to avoid punishment when he was faced with a court appearance. He candidly acknowledged to us that any attempts at 'rehabilitation' were likely to mean a lenient court disposal and on more than one occasion CADAS unwittingly colluded with his scheme. This was in spite of the fact that an association between his requests for 'help' and his forthcoming court appearances had been noted. This too might have been averted with a better understanding of his past.

27.35 We have applied our comments about the compartmentalisation of Mr Bath's drug problems also to his treatment at St Ann's by Dr Choudry, where his wider problems were not addressed. Dr Gallimore candidly told us that at Forston Clinic, where they did not have the facilities to review the whole, they addressed what they could such as Mr Bath's drug problems.

27.36 There were also no attempts to verify Mr Bath's assertions of poly-drug use through physical examination or blood/urine analysis.

D. The Role of Drug or Alcohol Abuse in Homicides

27.37 Toxicological analysis of samples taken from Mr Bath after the death of Ms Sullivan is inconclusive about the role of alcohol and drugs in her death. However, the evidence is that Mr Bath was still abusing drugs and alcohol at that time. There is now much evidence of the link between homicide and drug and alcohol misuse. One study has reported that the risk of violence among people with schizophrenia is only 8 per cent compared with 30 per cent for mentally disordered people who abused substances (M.Ward and C.Applin, Unlearned Lesson (Wynne Howard Books 1998)).

27.38 The mix of mental disorder and drugs/alcohol is a volatile one. We have already commented on the dual diagnosis criteria which exist in Dorset (see chapter 10). It does not include personality disorder and should do so. It is important that the role of illegal substances and alcohol, in particular, in homicides is not lost against a backdrop of mental disorder.

E. Social Services

27.39 The service review documentation which we have for April 1994 and December 1995 indicates that a Social Services presence on CMHTs and the CFT was achieved only slowly. Apart from that, however, social workers specialising in mental health were based at St Ann's Hospital and it is surprising that they were not more frequently involved in Mr Bath's care.

27.40 We have not uncovered any plausible explanation for this failure. We have been told that Forston Clinic was experiencing serious problems with Social Services input over the years associated with the move to community care although this is disputed by Social Services and the DHA. Nevertheless, it is the service in the West

of the county which was most responsive to Mr Bath in this respect. It was involved in the only CPA meeting on his behalf in 1995 and responded well again in 1997.

27.41 We have been left with the impression that the role of Social Services was, with the exceptions noted above, limited to specific issues such as benefits or accommodation because that was how they were used traditionally. In other words, in what was a Health-dominated service, Social Services did not take an active role in whatever multi-disciplinary work was being carried out.

27.42 We have been told that social workers were operating in CMHTs but have seen no concrete evidence of how this was being achieved. The documentation certainly does not reveal multi-disciplinary team working of this kind. What is required are unified CMHT records readily accessible to other CMHTs (see comments in chapters 10, 18 and 19). In our view there also needs to be a review of Social Services involvement at hospital level and within CMHTs.

27.43 To us this is an example of how the various policies and procedures which existed did not produce results at ground level. Further, where audits indicated poor compliance with procedures, this too failed to filter down to make any difference to the practice which we have seen (see chapter 29).

27.44 The result was that there was no assessment of Mr Bath's social care needs, for example, his accommodation needs as he was often homeless or without proper housing. (See also chapters 10 and 18).

27.45 We have also commented at various points in the Report that the Social Services records are incomplete. This point has been reinforced by the late production of a document by Dorset Social Services which was not previously available to us. We think that there needs to be an active review of record-keeping.

F. Probation

27.46 We have already commented on the value of probation assessment of risk and it is clear that there is an essential role for the Probation Service in the multi-agency assessment of individual's with severe personality disorder.

G. Assertive Community Support

27.47 We have referred throughout this report to the need for a more assertive approach to following up individuals like Mr Bath: mentally disordered offenders, who are difficult to engage with services, with a severe personality disorder, a high rating for risk (to others and to self), repeated hospital admissions and cycles of offending, homelessness, substance misuse and a history of violence. We believe that this is an identifiable group of people for whom a different service approach may be beneficial.

27.48 Our comments are inspired by the fact that all efforts to maintain contact with Mr Bath in the community were unfruitful and that those efforts were largely confined to leaving or sending letters to him at last known addresses. The approach is best illustrated in 1994 (chapter 15), when he was referred to Dorset Social Services from Hampshire and also in 1995 when the Probation Service were responsible for him after his release from prison (chapter 17).

27.49 We are aware that over the last five years or so there has been a gradual awareness that services for 'difficult to engage' service users must be configured differently if mental health services are to maximise the chances of retaining service contact. For this group, standard CPA (including section 117 MHA, where appropriate) is unlikely to work unless an assertive approach is taken, possibly by specially trained mental health staff.

27.50 The Sainsbury Centre estimates that there are approximately 45 such people per 100,000 adult population although the actual rate would vary across deprived urban and better off rural areas (Keys to Engagement (The Sainsbury Centre for Mental Health, 1998)). If this rate applied locally in Dorset then there would be roughly 250 people who needed intensive services. However, the rate will almost certainly be lower than this because Dorset has relatively low psychiatric morbidity. There might only be 100 people or fewer.

27.51 Those who are difficult to engage with services have problems beyond their diagnosis and medical treatment needs. They also have social problems and often offend against the law.

27.52 Current services often fail to meet the needs of this group. It may be that different service structures need to be considered to meet the challenges of this group and this requires further research.

27.53 While a more proactive or assertive approach to maintaining service contact by itself (e.g. seeing service users at home, at GP surgeries, regular monitoring through support services) can do much to improve service take-up, those individuals with severe challenging behaviours may need different structures/teams for the effective delivery of care and treatment such as an assertive outreach approach.

27.54 The key elements of such an approach are likely to include:

- explicit admission criteria;
- low turnover of clients;
- all needs, not just health needs, are taken fully into account;
- full responsibility for treatment service including admission to and discharge from hospital;
- responsibility for crisis services/24 hour cover;

- service is not limited to specific time periods;
- small case loads;
- team members to work within clients' own community settings and support settings and where necessary with families;
- intensity of service to be judged on a case by case basis;
- access to specialist teams e.g. employment, housing, substance misuse, psychology and forensic specialists;
- team members fully trained and committed to multi-agency/disciplinary work across traditional boundaries.

27.55 Concerns that this approach may constitute a form of unacceptable social control can, we think, be met by it being a proportionate response to a difficult and often violent group of patients otherwise destined for prison or detention under the MHA.

H. Conclusion

27.56 It is apparent to us that a more closely integrated service is required for mentally disordered offenders and particularly those who are suffering from a severe personality disorder. Mr Bath had a multiplicity of problems and a proper assessment by each relevant agency of these problems was required so that a more holistic approach could be taken and the whole problem tackled rather than only the most immediately presenting difficulty.

27.57 This requires a shift in culture whereby existing services such as Health, Social Services and Probation develop a more collaborative style of service provision with each other as well as other agencies.

27.58 A more assertive approach to community follow-up is also indicated for this group of individuals.

I. RECOMMENDATIONS

22. The DHA should review MDO services, with particular emphasis on the integration of services, including drug services, as a follow-up to the April 1994 review by the Dorset Health Commission.

23. The NHS Trusts should review the functioning of the CFT with particular reference to leadership, training, prison liaison, use of CPA and its relationship to other services.

24. The NHS Trusts and Social Services should review
(a) the role of social workers within hospital and community teams and
(b) the system of record-keeping within Social Services and community teams and the need for unified records.

See also chapters 8 and 10, recommendation 7; chapter 11, recommendation 9; chapter 16, recommendation 15; and chapter 19, recommendation 17.

Chapter 28

THE CARE PROGRAMME APPROACH AND SECTION 117 MHA

- Central Policy Framework
- CPA in Dorset
- Section 117 MHA
- Reasons for not using CPA

A. Introduction

28.1 From 1987 to 1996, Mr Bath was discharged from psychiatric hospital 32 times; 27 of these discharges happened after 1 April 1991, when the CPA first became a requirement, 21 were after May 1994, when further guidance was issued and 13 after Building Bridges was published in Autumn 1995.

28.2 Notwithstanding this, the CPA, in the sense of a multi-disciplinary meeting convened under CPA procedures, was only applied to Mr Bath on one occasion. On 1 March 1995 there was a CPA meeting at Forston Clinic to discuss after-care arrangements prior to discharge on 7 April.

28.3 A CPA form was commenced and cancelled in 1992 by Dr Choudry due to Mr Bath's lack of co-operation. One was completed at St Ann's after he had taken his own discharge on 26 December 1995 although no care plan was made other than to offer an out-patient's appointment. After he had been discharged in his absence from St Ann's on 13 March 1996 a note was made on a CPA form that he was also going to be discharged from the CPA for non-compliance (although he had not been made subject to it in the first place).

28.4 CPA audits have shown poor or inconsistent compliance with CPA since 1992/1993 with some improvement in recent years.

B. Central Policy Framework

The first Circular, 1991

28.5 The CPA was first set out in a Health Circular (HC(90)23/LASSL(90)11) in September 1990 to apply from April 1991. It required health authorities in consultation and agreement with Social Services authorities to draw up and implement systematic arrangements for assessing the needs of mentally ill people in touch with the specialist psychiatric services who could be treated and cared for in the community, and for regularly reviewing the health and social care needs of those being treated in the community.

The second Circular, 1994

28.6 In May 1994, Health Circular HSG(94)27 gave guidance on the discharge of mentally disordered people and their continuing care in the community.

28.7 This guidance set out good practice, based on the CPA, which should be followed for all patients who are discharged following referral to the specialist mental health services. It places an emphasis on risk assessment prior to discharge.

28.8 The circular sought to ensure that patients were only discharged when they were ready to leave, that any risk to the public was minimised and managed effectively, and that when they were discharged they got the support and supervision they needed from responsible agencies.

28.9 It extended the remit of the CPA to those who were mentally disordered, including those with personality disorder, not just those with mental illness.

Building Bridges, 1995

28.10 In 1995 the Department of Health produced Building Bridges: A Guide to Arrangements for Inter-agency Working for the Care and Protection of Severely Mentally Ill People. Among other aspects of inter-agency working, this document went into some detail about the way the CPA should work.

28.11 It suggested a definition of 'severely mentally ill' which, as well as diagnosis, incorporated the level of disability arising from the illness, the duration of that illness, the risk that person presented and the need for informal or formal care. It was made clear that 'diagnosis' could include personality disorder.

28.12 It recommended the adoption of a tiered CPA in order to focus treatment and care on the most severely mentally ill people and re-emphasised the importance of the CPA.

28.13 It advised that those subject to section 117 MHA after-care should also be subject to the CPA although authorities would need to identify separately patients who were receiving care under section 117 so that they could demonstrate that they were fulfiling their statutory obligations.

C. CPA in Dorset

28.14 Dr Susan Bennett, public health consultant from the DHA, advised us that originally, it was not expected that the CPA should be used for all patients with mental illnesses but rather it was targeted at the most vulnerable, including those who had been subject to a treatment order of the MHA. It seems that this interpretation of the 1991 guidance emanated from the then Wessex Regional Health Authority.

28.15 Although we have been assured that CPA policies and procedures did exist prior to 1995 we have not seen any advice to staff on the implementation of the CPA earlier than August 1996.

The current guidance

28.16 The NHS Trusts' current guidance and procedures as agreed with Social Services are comprehensive and representative of practice elsewhere. However, there is some ambiguity over whether those with personality disorder come within the framework of the CPA. Ms Linda Boland, the mental health general manager for Dorset Healthcare NHS Trust, in her evidence assured us that if someone with a personality disorder presents to St Ann's and is offered in-patient treatment they would automatically be subject to the CPA process and this was indeed attempted in 1996 for Mr Bath but in an incomplete manner.

28.17 An individual is eligible for services within the CPA if they have been accepted by the specialist mental health service and provided with a continuing plan of treatment/care. 'Specialist mental health services' does not include the 'specialist addiction services (other than in cases of dual diagnosis)'. The definition of 'dual diagnosis' in use in Dorset does not include personality disorder and we think that this gives rise to confusion where an individual has a personality disorder with problems of substance abuse. This needs clarification. It is also not clear whether clients of the CFT are included (see chapter 28).

28.18 There is a similar ambiguity in West Dorset policy.

28.19 For a consideration of CPA levels see chapter 18.

D. Section 117 MHA

28.20 Section 117 imposes a duty on the health authority and Social Services to provide after-care services for those who have been detained under sections 3, 37, 47 or 48:

'It shall be the duty of the Health Authority and of the local social services authority to provide ... after-care services for any person to whom this section applies until such time as [they] are satisfied that the person concerned is no longer in need of service' (section 117(2)).

28.21 We have already commented on the failure with regard to this section in chapter 14.

28.22 Mr Goodrum, principal officer with Social Services, has advised us that section 117 after-care should fit within the CPA but a separate process was needed to consider whether section 117 needs still applied after a given period. This accords with the advice in Building Bridges.

28.23 The current joint protocols on section 117 in both NHS Trusts place the after-care needs discussion firmly within the CPA process. Both Trusts' CPA forms require section 117 entitlement to be logged.

28.24 These seem adequate for their purpose but need to be jointly audited alongside the CPA. There is still no separate collating of information about section 117 patients.

E. Reasons for Not Using CPA

28.25 Mr Bath sometimes took his own discharge or went 'awol' and was discharged in his absence; 14 out of his 27 admissions to hospital between 1992 and 1996 were for less than seven days, and he rarely complied with any follow-up care plans on discharge.

28.26 In such circumstances the CPA may have been dismissed as unrealistic and idealistic. CPA forms were commenced but without any proper multi-disciplinary care plan, no risk assessments and no review meetings once he failed to comply with even the limited plans made.

28.27 The combination of his personality disorder with substance abuse made it doubly difficulty to follow him up after discharge. We acknowledge that even if the CPA had been adequately and consistently applied to his care and treatment it is still questionable whether he would have co-operated with any after-care plans on a voluntary basis.

28.28 Anticipated non-compliance should not stop a CPA being established, rather it should, within the format of the CPA show:

(a) that consideration has been given to various options for follow-up;
(b) list possible responses to non-compliance including hospital admission;
(c) demonstrate what risks are present if there is no compliance and how they may most effectively be reduced;
(d) how compliance or lack of it will be monitored or reviewed.

28.29 Many consultant psychiatrists nationally were (and some still are) hostile at worst, or acquiescent at best, to the CPA. The situation in Dorset seems to have been little different from elsewhere. Clinicians at the time were, by and large, not 'on board' with the CPA pre-1995 and to a significant extent afterwards.

28.30 However, CPA arrangements of some kind were in place from 1992/93, if not before. He had 13 admissions after 'Building Bridges' in 1995. It is, therefore, a matter of concern to find that he was subject to a substantive CPA on only one occasion.

28.31 To date there has been little by way of a downside if clinicians do not conform with CPA requirements and managers have been loath to press the issue. This is changing, in Dorset and elsewhere, and the CPA has become more broadly accepted as the fundamental framework for care planning.

28.32 The current Dorset guidance on the CPA does cover non-compliance although it did not when Mr Bath was in service contact. As discussed above, at the time, non-compliance often seemed to rule out the CPA.

F. Conclusion

28.33 Even though we have commented critically on the definitions in use in Dorset and the ambiguous criteria for CPA eligibility, we cannot say with conviction that the reason the use of CPA was poor for Mr Bath is because of his diagnosis of personality disorder, although this may have been a contributing factor, due to his difficult and unco-operative behaviour.

28.34 The reality is that in 1996, and before, there were attempts to use CPA on his behalf, but they were lacking in commitment and understanding of the process. We believe and have heard that much of the resistance to CPA is due to the fact that clinical teams believe that it is what they have always done and resent what is perceived as the bureaucratisation of established practice.

28.35 First, we have found little evidence of multi-disciplinary working and discharge planning prior to 1991 or after it. Secondly, even if this was otherwise, we empathise with the fears of bureaucracy and firmly believe that if the fundamental principles of information-gathering, assessment and discharge on a multi-disciplinary basis are properly applied, then such failures are unlikely to happen. What is required is not the ticking of boxes, but a thoughtful application of the principles underlying CPA. This has emerged as a problem in so many reports now that a different approach to what is fundamentally a sound method of working needs to evolve.

28.36 Having said that, however, without some level of co-operation from Mr Bath we cannot see how even a full and efficient application of the CPA by itself would have kept him in Dorset, preventing a move to Exeter and eventually to London with Ms Sullivan.

G. RECOMMENDATIONS

See chapter 5, recommendations 5 and chapter 14, recommendations 14.

Chapter 29

RISK: ASSESSMENT AND MANAGEMENT

- Risk Assessment
- Risk Management
- Level of Risk which Mr Bath Presented to Others
- Level of Risk of Self-Harm

A. Introduction

29.1 In spite of extensive contact with mental health services from 1987 to 1997, on no occasion was any formal assessment of risk performed. Sometimes the discharge letter referred to his forensic history, sometimes it did not. When this information was given it was either incomplete and/or inaccurate. There was no screening for standard risk factors nor was any other systematic attempt made to assess the level of risk he posed to himself or others.

29.2 Many witnesses to the Inquiry commented that if they had had prior knowledge of Mr Bath's full history they would have considered him to be more dangerous than they did at the time of their contact with him. The comments we have made throughout the report about information-gathering are important in this context.

29.3 As it was he was considered to be more of a risk to himself due to his numerous acts of self-harm. The Probation Service assessed him as presenting a high risk to others in 1988/1989; later, in 1995, this changed and he was considered to be more of a risk to himself.

B. Risk Assessment

29.4 A formal risk assessment for harm to others has to set out what the specific risks are; establish the historical facts relevant to violence and corroborate these; identify the precipitating or trigger factors for violence; specify what actions might be taken to increase or decrease the risk of violence; arrive at a multi-agency and multi-professional judgement about the level of risk, taking into account the consequences/acceptability of the specified harms occurring; agree professional/agency responsibilities and appropriate monitoring and review arrangements.

29.5 The starting point is an actuarial appreciation of the known historical risk factors. Secondly, that actuarial reality must be considered in the context of the known precipitating or 'trigger' factors for violence. Thirdly, the assessment must take into account any relevant mental health or social aspects of the individual's circumstances.

29.6 In fairness, awareness of risk assessment as an essential component of care planning has been highlighted only relatively recently, perhaps only since the

Clunis Inquiry in 1994 and the subsequent National Health Executive Circular, Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community (HSG(94)/27). Certainly, nearly all of the 45-plus independent inquiry reports into homicides by mentally disordered people since the Clunis Inquiry have emphasised the importance of both risk assessment and management in mental health services provision. It would not therefore be right to be too critical of the absence of risk assessment prior to 1994.

29.7 NHS Circular HSG(94)27 reminded Health and Social Services authorities that those known to have a potential for dangerous or risk-taking behaviour needed special consideration both at the time of discharge and during follow-up in the community. It reminded those responsible for such decisions that before a patient presenting 'special risks' was discharged, they needed to show that this could be done without serious risk to the patient or other people:

'In each case it must be demonstrable that decisions have been taken after full and proper consideration of any evidence about risk the patient presents'.

29.8 However, Mr Bath was still not subject to any form of formal risk assessment by the NHS or Social Services at any time during his 12 admissions to hospital between November 1995 and September 1996. Neither was there a formal risk assessment after he had decamped for Exeter following his contact with the services at Blackdown Hospital in early 1997, although his social worker, Ms Gardiner, did inform Exeter mental health staff about his forensic history and expressed concern that he was only marked as being a level 1 on the existing CPA form (see chapter 18 on CPA levels).

29.9 The only agency which did undertake a formal assessment of risk was the Probation Service which held two internal 'high risk' conferences on him in 1988 and 1995.

29.10 The General Manager for Mental Health Services in the Dorset HealthCare NHS Trust, Ms Boland, advised us that development work on risk assessment started around 1995. In May 1997 a risk policy was produced together with guidelines for risk assessment, the piloting of a risk-screening process and indicators for risk.

29.11 The Dorset Community NHS Trust produced similar guidance for their staff on risk assessment in mental health services in 1998.

29.12 Social Services have now agreed joint policies with the NHS Trusts on risk and these have been put in place supported by training. However, at present though there is no single risk assessment tool in use across the county.

C. Risk Management

29.13 If violence has occurred then the context of that violence needs to be understood and strategies put into place to reduce the chances of it happening again.

In Mr Bath's case it was clear that violence on his part could be triggered by alcohol and/or drugs, a shortage of money, wanting drugs, having no accommodation, having access to a weaker victim, arrest, being criticised. Little was done to try and manage those specific situations or to agree on agency/professional responsibilities for risk management.

29.14 There was hardly any cross-agency discussion of the risk issues concerning Mr Bath. There was a CPA meeting only once and consequently there were few opportunities to share information and consider how risk might be managed most effectively.

D. Level of Risk which Mr Bath Presented to Others

29.15 Even good quality risk assessment will not, of course, totally eliminate risk. Individuals usually retain the freedom to direct their own lives. In the community especially there are severe limits on how far it is possible to influence let alone control what people do. However, what is known is that a well-informed risk assessment enables those working with someone in the community to make effective and defensible decisions about their management.

29.16 It is known that personality disorder with a substance misuse problem increases risk considerably over and above a personality disorder by itself.

29.17 Recent research suggests that there are key factors which can be used to predict violent recidivism. Simplified the key factors are:

- separation from at least one biological parent;
- severe childhood maladjustment or conduct disorder;
- history of alcohol problems;
- marital status at time of index offence;
- many criminal charges prior to index offence;
- breach of court condition e.g. probation prior to index offence;
- significant period of unemployment;
- living alone at time of index offence;
- been to prison;
- history of violent offences prior to index offence;
- under 39 years of age;
- meets criteria in DSM 111 for personality disorder;
- high score on Hare Psychopathy Checklist Revised (PCL-R);
- low IQ;
- attitude to crime.

29.18 Mr Bath meets virtually all of these criteria. He was reported to have attempted arson when 8 years old, aged 11 he set fire to his mother and stepfather's home, assaulted a 3-year-old girl at 11, was aggressive to children at school, stubbed a lighted cigarette out on a girl's arm at school, assaulted three female members of care staff while at the children's home, was convicted of possession of a weapon in

a public place aged 16, assaulted a fellow resident of a hostel and his girlfriend of the time aged 17.

29.19 In his adult life Mr Bath was convicted of nine separate offences of violence including one offence of arson and one offence of robbery and theft in which he threatened a shopkeeper with a 12 inch knife. In addition he assaulted nursing staff and patients at St Ann's and his GP. He assaulted his brother, his ex-wife and Ms Sullivan. Police officers were attacked on some occasions. However, it was almost four years between the robbery with a knife in April 1993 which led to a section 37 MHA Hospital Order, and his next offence of violence for which he appeared in court in September 1997. There was also a two-year gap between convictions for violent offences between an assault in the police in 1990 and the robbery in 1993. Of course, there were also assaults on nursing staff during this time for which he did not appear in court but his violence was episodic over time rather than frequent.

29.20 By any objective criteria Mr Bath was a patient at a high risk of committing a serious or grave offence. Our advice from Dr Brian Thomas-Peter is that there was a 90 per cent chance of such an offence being committed, although this would vary over time depending on the existence of de-stabilising or disinhibiting factors. He said:

'If you tot the actuarial components of this man, that he has used violence, that he has a personality disorder, that he has substance abuse, there is a query about his having a mental illness, that he has a whole string of offences behind him, this is a very, very, worrying picture of somebody who would by the most cursory of views be considered to be at high risk of re-offending seriously'.

29.21 However, in 1995 the Probation Service assessed him to be more of a risk to himself. On the basis of the four-year gap in convictions for violence between 1993 and 1997, this is difficult to criticise.

E. Level of Risk of Self-Harm

29.22 It is undoubtedly correct that as well as the risk he posed to others he was also a great risk to himself. He frequently behaved recklessly and often deliberately harmed himself, usually by self-lacerating or overdosing. Between 1987 and 1997 he was reported to have cut himself, overdosed on prescribed and non-prescribed drugs or otherwise tried to harm himself 29 times. Mostly, these self-harm attempts were not serious, although on occasion the lacerations were quite deep or the overdoses said to be large.

29.23 Clinicians and staff were (on the basis of the information usually in their possession, understandably) more conscious of the risks he presented to himself than to others although they were usually (and probably rightly) sceptical about any intention he might have had actually to kill himself.

F. Conclusion

29.24 There is no need to emphasise the importance of risk assessments. Even pre-1994 there was little excuse for not conducting a proper assessment of his risk at the time of his admission under section 48 and then 37 MHA in 1993. Again it seems that the lack of information-gathering obscured the issues of risk in this case so that by 1996 considerations of his risk to others were significantly diminished.

G. RECOMMENDATION

25. The DHA, NHS Trusts and Social Services should:
(a) jointly review and audit their arrangements for risk assessment and management including agency policies, risk screening, guidelines and training for staff, assessment methods and management strategies. This should also include advice on assessment and management of the non-compliant patient
(b) review joint policy and procedures and develop a single risk assessment tool across the county.

See further:

*The Diagnostic and Statistical Manual IV-301.7(A)

*J Monahan and H Steadman (eds), Violence and Mental Disorder: Developments in Risk Assessment (University of Chicago Press, 1994)

*V L Quinsey, Harris, Rice and Cormier, Violent Offenders: Appraising and Managing Risk (American Psychological Association, Washington DC, 1999)

*J H Ritchie, The Report of the Inquiry into the Care and Treatment of Christopher Clunis (HMSO, London, 1994)

*R D Hare, The Revised Psychopathy Checklist (Multi-Health Systems, Toronto/Ontario, 1991)

Chapter 30

ACCOMMODATION

- Access to Housing
- Availability of Suitable Housing
- Previous Inquiries

A. Introduction

30.1 From the moment that Mr Bath left care and throughout his contact with mental health services thereafter, he had difficulties with his accommodation which would often precipitate a crisis leading to hospital admission. He was quite often of 'no fixed abode' and slept 'rough'. At other times he would go back to his parents' and after the death of his stepfather, to his mother's sheltered accommodation, or to his brother or sister. On occasions he was accepted into probation hostels: Weston Hostel or Dorset Lodge. When he married he was given local authority housing in Southampton with his wife and baby. Latterly, in 1997, he was placed by Social Services with a landlady in Weymouth and then in a hostel in Exeter before moving to London with Ms Sullivan.

30.2 Except in 1997, his behaviour at the various places where he stayed was invariably extremely disruptive and he caused a great deal of concern. He had always had difficulties at his family home and these culminated in his setting fire to it in 1987. Thereafter he exhibited destructive behaviour in a hostel in Weymouth and after the fire in the resettlement hostel in Southampton finding accommodation for him became understandably more difficult. The most sustained efforts in this regard were by the Probation Service.

30.3 In all this time Mr Bath never made any application for housing on his own behalf. He was rarely referred to Social Services for help with his accommodation from hospital. This resulted in an assessment of his needs only on one occasion in 1995. Thereafter, the referrals which are recorded in the hospital notes do not appear on Social Services records. His housing needs were rarely addressed on discharge from hospital.

B. Access to Housing

30.4 Mr Bath returned to his mother's accommodation a number of times and on three occasions (March 1989, January 1992 and early 1995) North Dorset District Council (the Council) notified Mrs Bath of the possibility of legal action against her to ensure that he left. There was never any assessment of Mr Bath's own accommodation needs by Social Services at these times, nor did he make any application for accommodation directly to any of the housing authorities in Dorset. This was the only time he came into contact with any housing authority.

30.5 Since September 1994, the Council has not been a direct provider of primary services to people with mental health problems. It is responsible for maintaining a Housing Needs Register (Housing Act 1996, Part VI) the administration of which is currently contractually undertaken by Signpost Housing Association. The Council transferred its housing stock to Signpost Housing under the voluntary transfer initiative prompted by the then Department of the Environment. Four out of the six district councils in Dorset have transferred their houses to housing associations. There are five other housing associations throughout Dorset.

30.6 Since April 1993, the Social Services have been under a statutory duty to assess an individual's need for community care services with the aim of ensuring that all support needs are identified, not only needs for which the Social Services authority is responsible (section 47 of the National Health Service and Community Care Act 1990). Government guidance issued in September 1992 emphasised the need for housing authorities to play a full part in this process together with Social Services departments and health authorities so that each discharge their responsibilities effectively (Circular 10/92 (Department of Environment) and LAC(92)12 (Department of Health), Joint Circular on Housing and Community Care).

30.7 There is no direct obligation on the Council to assess Mr Bath in the absence of an application for housing. Once one was made it would have come under an obligation to assess Mr Bath's own housing needs as a vulnerable homeless person under the provisions of the Housing Act 1985.

30.8 Expert evidence received by the Inquiry states that had Mr Bath presented for a housing assessment he is likely to have been deemed 'vulnerable' under the Housing Act 1985 and subsequently also under the Housing Act 1996. The Homelessness Code of Guidance first issued in 1991 and revised in 1996 also sets out the expectation of joint working between housing, social and health services. This was certainly not happening before 1996 in North Dorset.

30.9 The Viner Report (Dorset, March 1996) recommended that there should be increased awareness of the routes which should be followed in dealing with housing applications by persons with mental health problems and that this could be achieved by the provision of formal guidelines and appropriate training. This applies here.

30.10 Poor liaison between Housing and Social Services was also identified in that Report. We have been told that a response to this is gradually being put in place and that housing officers from Signpost Housing Association have now attended joint training sessions with NHS and Social Services staff. A joint assessment form is also being produced to be used by all housing officers, Social Services staff and health staff in CMHTs.

30.11 The need for accommodation is a recurring theme in Mr Bath's history and he also presented this need to Health and Probation Services. There is no evidence of any effort to liaise with the housing authorities in response to this need. It was only in 1995 that his discharge from hospital was preceded by a consideration of his housing needs. This came to nothing as the only housing deemed suitable was a fully staffed and supported hostel and he had already blotted his record in these by behaving destructively. These issues have been raised more generally in the District Audit Report of Housing Aspects of Community Care for 1997/1998.

30.12 Our findings underline the need to priorities communication and training between housing, Health, Social and Probation Services. Mr Bath's housing needs should have been taken into account by Social Services at the time of managing the crises at Mrs Bath's accommodation. Mr Bath was not offered any appropriate support by Social Services on these occasions. This indicates a problem of communication within the Social Services department as well. Social workers acting for Mrs Bath did not refer Mr Bath for an assessment of his need for Social Services assistance or for housing.

30.13 There is now a Housing and Community Care Co-ordinator whose job it is to link with the district councils and CMHTs. This was one response to the Viner Report. This post will not plug the gap where someone, like Mr Bath, is not assigned to a CMHT.

C. Availability of Suitable Housing

30.14 Had an application or reference been made for housing it is unlikely that suitable long-term supported accommodation would have been available for Mr Bath. David Morgan, the head of Housing and Community Services at the North Dorset District Council, told us that there is no specific accommodation for those with alcohol/drug problems, nor for mentally disordered offenders in North Dorset. Such accommodation would be sought in liaison with the Social Services and Community Mental Health Teams because Social Services have access to their own accommodation and also within other housing agencies in the conurbations of Bournemouth and Poole as North Dorset is very rural.

30.15 Mr Bath was on occasion placed in short-term supported accommodation at 5 Carlton Road North, Weymouth (24-bedded and 24 hour-supervised Dorset Social Services rehabilitation hostel for people with mental health problems), Weston Hostel, Weymouth (probation hostel with a close working link with MenDOS), Creek House/Dorset Lodge, Bournemouth (24 hour-supported accommodation provided by Bournemouth Churches Housing Association latterly with a close working link with the CFT and the Probation Service) and Social Services landlady accommodation. On each occasion he misbehaved, thereby ensuring that he would not be re-admitted in the future.

30.16 The Dorset Community Care and Supported Housing Group is a multi-agency group comprising social services, district and borough councils, health, probation and housing corporation services. It is looking at planning and prioritising bids for new development and the need for a more accurate and comprehensive assessment of need and trends. Gaps in supported housing have been identified with two-thirds of what is currently available being situated in Bournemouth and Poole. There is also an important gap in high care and specialist provision, a category into which Mr Bath would have fitted. However, the impression we have gained is that mentally disordered offenders are excluded from these categories which relate mainly to single young people and high care for the elderly.

30.17 The joint multi-agency strategy for MDOs across Dorset for 1997/1998 identifies accommodation as a key factor in the successful treatment and rehabilitation of MDOs. It is proposed to monitor the accommodation needs and provision to identify deficiencies for this group and to assist future planning and development. There is no plan to increase the specialised provision through the Creek House Unit or bail hostels, the stated aim being to improve access to emergency and long-term accommodation. Consultation on this was to have been completed by September 1998.

30.18 Mr David Joannides, the Director of Social Services for Dorset Social Services and prior to 1997 the Deputy Director of Dorset County Council Social Services Department, told us that despite the MDO housing priority there is no fully developed strategy on providing housing for individuals like Mr Bath who display difficult behavioural traits, although wider housing needs for the mentally ill are being tackled. He said that they had not resolved the question of whether it was best to house difficult and chaotic individuals such as Mr Bath together under one roof or not.

30.19 Even once bricks and mortar are produced, resources in terms of specialised staffing requirements, are very much an issue yet to be resolved.

D. Previous Inquiries

30.20 The importance of varied housing provision in order to maintain good mental health and minimise risk has already been identified in previous Inquiry reports (Rooney, 1992; Clunis 1994), as has the need to involve housing authorities when making discharge arrangements (Carr, 1997) and we adopt and endorse recommendations made on those issues.

E. Conclusion

30.21 Housing assessment and provision is central to planning and managing the care of mentally disordered offenders, yet is often not sufficiently prioritised by either mental health services or housing authorities as evidenced by the number of Inquiries in which this has featured as an issue. It may be that imposing a positive obligation on housing authorities in this regard will add the required impetus to raise housing for MDOs as a priority need.

F. RECOMMENDATIONS

26. The NHS Trusts, Social Services and housing authorities should:
(a) review current training and implementation of multi-agency working with housing associations with a view to enabling early identification of mentally disordered people with housing needs;
(b) priorities provision of specialised long-term housing for MDOs;
(c) instruct housing officers to offer support and advice on routes of access to accommodation to individuals in need of housing.

27. The Government should consider new legislation to impose a positive obligation on housing authorities to assess and provide housing for MDOs.

Chapter 31

THE ROLE OF GENERAL PRACTITIONERS

- Personality Disorder and Drug Dependency
- Continuity of Care
- Discharge Letters
- Link with CMHTs and CPA

A. Introduction

31.1 Mr Bath was involved with numerous General Practitioners (GPs) throughout his time in Dorset and also in Southampton. He often consulted GPs on the basis of a temporary registration. It is clear that on most occasions he used this service to obtain prescriptions of drugs, and in particular benzodiazepines and psychotropic drugs, which he abused.

31.2 Many other Inquiry reports have commented on the role of GPs in caring for those with mental health problems and we have endeavoured to draw upon those where relevant.

31.3 Our expert advice is that on the whole the care offered to Mr Bath by GPs was in keeping with good medical practice as defined by the General Medical Council. Mr Bath's peripatetic existence made it difficult to offer him a streamlined GP service and discharge summaries were on occasion sent to the wrong GP.

B. Personality Disorder and Drug Dependency

31.4 In April 1995, Dr Surridge quite properly circulated a letter to all GPs in Dorset describing Mr Bath and urging them not to prescribe further drugs for him. In spite of this, Mr Bath was frequently prescribed drugs by GPs. He quite often used tactics which are well known to drug abusers such as demanding a prescription on a Friday afternoon when it was less likely that checks on background would be carried out. The GP's position is made more difficult if the individual is actively withdrawing at the time.

31.5 Our expert advice is that GPs often have little training in looking after demanding clients with a history of personality disorder and drug dependency. The training is aimed at trust, kindness and compassion. This leaves a doctor vulnerable when faced with a patient who lies and is determined to get the doctor to provide drugs to feed an illegal habit.

31.6 The willingness to prescribe large quantities of psychotropic drugs to Mr Bath is open to criticism. However, GPs are unlikely to have the capacity to monitor drug use by, for example, urine tests, and are more likely to give a patient the benefit of the doubt when told that a prescription has been lost.

31.7 Our expert advice is that such patients are a real problem for GPs. In addition to their manipulative behaviour, they present a potential danger which can make doctors and their staff fearful. Mr Bath did on one occasion assault his GP.

31.8 We have been told that the level of supervision which such patients require is inappropriate in general practice due to the need to engender trust and is better provided by specialist mental health services. Even so, GPs are likely to remain a point of contact between specialist services and patients. What is required is that those GPs most in contact with difficult and manipulative patients, probably in densely populated urban areas, need to develop a more robust approach, including a healthy scepticism. We have evidence that this has happened in the case of at least one GP in Dorset.

C. Continuity of Care

31.9 Mr Bath's peripatetic existence and use of temporary registration to obtain drugs made it relatively easy for him to manipulate GPs into complying with his demands. There is no expedient system of communication between GPs in an area and the process of obtaining previous notes is slow.

31.10 One solution to this is a centrally held electronic health record which will enable health professionals to access records remotely and quickly.

D. Discharge Letters

31.11 We have drawn attention to the poor discharge summaries throughout this report. This is one of the most important documents in a psychiatric record and should enable the patient's complete history to be assimilated with minimum of effort and time. It is an essential document when a request is made for information from another service, in communicating with an individual's GP and with those who subsequently have care of that individual.

31.12 In this respect we endorse the recommendations made in other Inquiries and in particular the Campbell Inquiry (HMSP, July 1988), the Rooney Report (North Thames Regional Health Authority, December 1992) and the Armstrong Inquiry (Tees District Health Authority, June 1996).

31.13 We are especially keen to see that the form and content of discharge summaries is made more uniform and consider that a template with the appropriate headings would guide clinicians, making the omission of important elements less likely and reducing the time taken to supervise summaries produced by junior staff. Our expert in this area has provided us with such a template and we reproduce it at Appendix H.

31.14 It is important that instances of violence or threatened violence should be properly documented by providing sufficient detail of the incidents and more than just that there was 'one aggressive episode'. This applies also to general references to 'violent forensic history'.

31.15 The failure to produce proper discharge summaries leaves a GP in a vulnerable position when faced with a potentially dangerous client or a manipulative one when he has not been alerted to the need to exercise caution when prescribing drugs. The GP also provides a valuable point of communication for agencies making it all the more important that they hold accurate and up-to-date information.

E. Link with CMHTs and CPA

31.16 Mr Bath was never allocated to a CMHT and there are no CPA documents in the GP records. The indications from what we have seen are that GPs were not involved in the CPA. A GP was invited to attend the CPA meeting held by Dr Veasey on 1 March 1995 but did not do so. We are not in a position to come to a firm conclusion about the role of GPs in the CPA in Dorset but are concerned from what we have seen that despite their links with CMHTs, their active involvement in multi-disciplinary work is limited.

31.17 The need for GPs to attend section 117 MHA meetings and play a full and active part in multi-disciplinary work was emphasised in the Clunis Report (HMSO, 1994) and we re-iterate it here.

Chapter 32

COMMUNICATION, CONFIDENTIALITY, INTERNAL INQUIRIES

- Communication and confidentiality
- Internal inquiries

A. Systems of Communication

32.1 The process of gathering information, researching a patient's history and communication between agencies would be simplified if there was ready access to past and present notes of all kinds: medical, Social Services, CMHT, CFT, CADAS etc. True multi-agency collaboration requires ease of access to information across traditional agency boundaries.

32.2 Ideally there are two requirements: good systems of communication should enable easy access to an agency's history with an individual as well as enabling it to be provided to other interested parties when appropriate. The main difficulty in allowing unobstructed access to information is confidentiality.

B. Confidentiality

32.3 Confidentiality is at the core of the relationship between doctors, social workers, CPNs, probation officers and their clients. It is designed to allow a trusting therapeutic relationship to develop between patient and carer. The basic principle is that an individual who breaches confidentiality by revealing information obtained in confidence may be liable in damages for any loss suffered by the patient as a result.

32.4 Where issues of risk to others are concerned then the need to maintain confidentiality must be balanced against the need to protect those at risk from harm. Although the time has not yet arrived when notions of confidentiality can be abandoned altogether in the pursuit of a safer society, we believe that the balance is firmly in favour of disclosure where an assessed risk to others is involved and the aim of disclosure is understood. Each situation must be addressed on its individual merits.

32.5 We have not encountered any specific difficulties in Dorset with regard to confidentiality. MenDOS seeks to overcome any potential problems by the use of a consent form 'for the collection and sharing of information'. The client is asked for his/her written permission for MenDOS to obtain information from other sources to assist in their assessment. The form also expressly says that a refusal to sign does not exclude them from support, but will be reflected in their report and 'may limit the help we can offer you and may affect the outcome'.

C. Internal Inquiries

32.6 Our terms of reference require us to consider the scope and effectiveness of internal inquiries. This was recently addressed in the Viner Report (Dorset, 1996). We endorse the recommendations made in that report and do not seek to duplicate those comments here.

CONCLUSIONS

Chapter 33

RECURRING THEMES AND CORE PRINCIPLES

- Recurring Themes
- Returning to First Principles
- Resources
- Integration of Services

A. Introduction

33.1 Mr Bath suffers from a severe anti-social personality disorder and has probably done so since before he was a young adult and his childhood experiences would today be predictive of the likely development of such a disorder. This has resulted in a chaotic and disturbed life style involving drug abuse, criminal activity and an intense reliance on services across the board. He has been admitted to hospital under mental health and general services on numerous occasions. He has been dealt with by probation and other criminal justice agencies, as well as a nascent CFT. He has also on occasion displayed symptoms of depression and psychosis, the latter usually being attributed to his drug abuse.

33.2 The problems which Mr Bath presented to the mental health services are not uncommon in mentally disordered offenders with a personality disorder. The 'treatability' of Mr Bath's personality disorder was never formally assessed and is only now being addressed at Broadmoor Special Hospital. This is an important aspect of this case.

33.3 We have commented on and criticised various aspects of the care which Mr Bath received from the services in Dorset (see list at Appendix G), many of these have emerged in previous inquiry reports. Our view is, however, that there is no direct causal link between these matters and the death of Ayse Sullivan. Although we stated in our introductory chapter that the question of the prevention of her death is inevitably what has guided this Inquiry, we are only too aware that some tragic accidents cannot be prevented and that is a fact which as a society we must learn to accept.

33.4 We have conducted a careful investigation into the care of Mr Bath. He was offered in-patient care on countless occasions usually in response to a crisis. He also had sustained involvement from the Probation Service and CADAS.

33.5 Those who did have contact with him almost invariably demonstrated a great deal of goodwill and effort in trying to offer him assistance. Most of these efforts were thwarted by Mr Bath himself and it is often difficult to see what might have made a difference. He was extremely unco-operative and non-compliant with services both in hospital and in the community.

33.6 However, it is important to note that in the year leading up to the killing, Mr Bath had become a more stable individual. There were no recorded episodes of self-harm and no admissions to hospital.

33.7 His last direct contact with Dorset services was in March 1997, eight months before he killed Ms Sullivan and in that time he had moved to Exeter and then to London. He was never seen by nor sought out services in London.

33.8 In considering whether Ms Sullivan's death could have been prevented it must be remembered that she too was a vulnerable young person and subject to Social Services care outside Dorset. It has not been within our remit to investigate the care afforded to her.

33.9 A number of the criticisms which we have made in this Inquiry relate to matters which are repeated throughout Mr Bath's contact with the services and for that reason we have called them recurring themes. Many of these are fundamental to the proper functioning of a mental health service. They have also been highlighted time and again in the reports of other Inquiries and we have identified some of them as core principles.

B. Recurring Themes

33.10 The recurring themes in this report start in hospital with the **failure to gather information** about Mr Bath. Much of what was known from one admission to the next and of his childhood history in particular, was obtained from Mr Bath himself. Information from one admission rarely fed into the next and this was particularly true of St Ann's Hospital. There was little or no attempt to verify his background in terms of personal or psychiatric history.

33.11 Information-checking and gathering is the basis of all good practice without which any subsequent assessments must be inherently flawed. A repeated failure to do this results in half-truths and mis-information gaining credibility. Rigorous fact-checking also highlights areas of special concern such as risk and is important in not minimising the seriousness of past criminal offences and putting them into a historical context rather than viewing each incident on its own. An easily accessible source of information-family and friends-was neglected in this case, except on one occasion when Mrs Bath was interviewed, but the information gleaned from her was not used in subsequent assessments.

33.12 Poor information leads to the **poverty of the assessments**, including **risk assessments**, by **Health and Social Services**. In this case Social Services assessments were rare. Assessments were often hampered by Mr Bath himself and the fact that many of his admissions to hospital were too short to allow any meaningful assessment to take place. On other occasions, however, they were either restricted to specific problems, such as drug abuse, or simply not done.

There is no sense of a **holistic approach**, but rather a reactive and piecemeal one with limited **inter-agency communication**. **Multi-disciplinary work** was also very limited.

33.13 The diagnosis of personality disorder carried with it unassessed assumptions about 'treatability'. This probably reflects the confusion which exists nationally about whether personality disorders are treatable and where such individuals fit within the system.

33.14 We are less critical of the assessments carried out by the **Probation Service** and **CADAS** although there should be stronger **inter-agency** links with the latter. **Social Services assessments** by Gary Hawker and Sandra Gardiner were also limited by lack of information and lack of access to information. Otherwise, there is a stark absence of significant Social Services involvement altogether.

33.15 **Social Services** infrequent involvement in any formal assessment of Mr Bath is a striking feature of this case. Their limited participation occurred only when sought and then, apart from Gary Hawker and Sandra Gardiner, it was passive and ineffective. The Social Services files do not even record some of the few referrals which were made from hospital.

33.16 There were no **MHA assessments** for compulsory admission to hospital at all and an apparent reluctance to use or consider using MHA. There was an over-reliance on an apparent willingness to be admitted to hospital informally. This resulted in regular absconding or discharges against medical advice before any proper assessment or treatment had been formulated.

33.17 **CPA and discharge planning** was particularly poor or more usually non-existent. Mr Bath was a difficult client to engage in the community as in hospital. There was a perception that due to his non-compliance there was little point in planning future care and convening review meetings.

33.18 He was never allocated to a **CMHT** in East or West Dorset. The fact that those social workers who did have contact with him were attached to CMHTs was a matter of coincidence and, with the possible exception of Sandra Gardiner, was not designed to engage him in proper follow-up or multi-disciplinary decision-making. The criteria operated by CMHTs focuses care on the severely mentally ill. **CPN** follow-up was ineffective and Mr Bath would disappear from services only to reappear usually during his next crisis. As a mentally disordered offender we would have expected a greater role for the **CFT** in his care than was apparent, but its position within the Dorset services lacks clarity.

33.19 Mr Bath was offered unstinting **crisis management**, but **continuity of care** from one admission to the next was non-existent.

33.20 It has been suggested by some, including Dr Rowton-Lee, that had Mr Bath had the same opportunity for crisis admissions to hospital in London as he had been given in Dorset, then this tragedy may not have happened. We cannot accept that proposition. There is no evidence that at the time of the killing he was experiencing a crisis similar to those which litter his history in Dorset. On the contrary, he had a place to live and additionally, the toxicology analysis and assessments of Mr Bath subsequent to the killing do not confirm a link between drugs and this tragedy.

33.21 While we accept that there is a role for crisis admissions in a mental health service, we do not accept that repeated crisis management offers any long-term solutions to a client like Mr Bath; it leaves the hospital and its staff open to manipulation and abuse.

33.22 Allied to the above is the lack of any assessment of Mr Bath's **housing needs**. His crises were on many occasions linked to his homelessness. There was clear difficulty in identifying appropriate supported housing due to his arson conviction and a lack of long-term supported accommodation for mentally disordered offenders throughout the county.

33.23 This case was clamouring for a **multi-disciplinary** and **multi-agency decision** on the future care to be offered including systematic and regular reviews of such a demanding patient.

C. Returning to First Principles

33.24 There is documentation which has been jointly produced by the NHS Trusts, Social Services and DHA which shows that many of the failings which we have identified were known, resulting in much policy material attempting to remedy perceived problems. Thus, we have seen a Review of Services for People with Mental Illness (1995) and a Review of Mentally Disordered Offenders and Sex Offenders (1994), both of which acknowledge failings and espouse service aspirations, but without any noticeable difference in the services received by Mr Bath.

33.25 Information-gathering, inter-agency communication and multi-disciplinary work are amongst the most frequent areas of criticism in other Inquiry reports. They form the cornerstone of a good mental health service and were sadly lacking in the care of Mr Bath.

33.26 A commitment to these core principles should, in our view, encourage the natural flow of good practice whether in terms of risk assessments, discharge planning or more assertive community follow-up, because they would automatically identify those individuals who are most vulnerable or present the most risk.

33.27 There is also a need for responsible adherence to national and local policies and procedures which, together with an understanding and an application of the core principles above, underpin mental health practice using the strong framework provided by the MHA, CPA and care management (NHS and Community Care Act 1990). This will facilitate proper assessments, management plans and where appropriate, treatment, to be undertaken.

D. Resources

33.28 We have throughout our investigations been concerned with the issue of resources in terms of the financial commitment to the services being provided and many of our recommendations do have implications in this regard. Funding is always an issue and resources are invariably stretched. However, we have not uncovered any particular deficiency in this respect save in the area of housing (chapter 31) where funding specifically for housing for MDOs has yet to be found.

E. Integration of Services

33.29 Mr Bath was in contact with services across the board. He had direct contact with the Health and Social Services, Probation Service, CFT and CADAS. He had indirect contact with the housing authorities of North Dorset.

33.30 It is trite to say that active co-operation and information-sharing between all agencies is essential. This includes identifying needs and securing resources and facilities, monitoring success and resolving problems (Home Office Circular 122/95). Cross-agency co-operation should now be at the heart of multi-disciplinary working.

33.31 We think that it is now just too simplistic to say that a person is the problem of one service or another, whether it be Health or Social Services or criminal justice agencies, and this is equally so when they leave an area and cross a county/service boundary. Thus, with clients such as Mr Bath, it can no longer be acceptable to say 'let the law take its course' or vice versa; there must be an attempt at the joint resolution or understanding of problems, and this includes the protection of the public.

33.32 Closely allied to the integration of services is the issue of managing treatment programmes across agencies. It is all too easy to have policies, procedures and review documents which appear thoughtful and rigorous, but do not resonate to the services at ground level.

33.33 It is all too easy for administration and not clinical process and outcome to become the focus of management and this is where commitment to the fundamental principles and aims of service provision are important. We cannot say that our findings in this case are conclusive of all services in this regard, but they have given rise to a grave suspicion that these comments do apply widely in Dorset.

F. Conclusion

33.34 If a serious violent offence had been committed by Mr Bath following his poorly planned discharge from the Hospital Order in late 1993 (chapter 25), there are likely to have been serious repercussions for the Dorset mental health services due to poor planning and after care at that time. If such an offence had occurred later in his history, for example, in 1996 or during the early part of 1997, when he was repeatedly admitted to hospital without proper assessment, follow-up or planning on discharge, then this too would probably have been blamed on the services in Dorset.

33.35 Serious incidents, while always extremely regrettable, can, however, be properly defended if there are sound policies and procedures and fully integrated services and where at least a commitment to the principles underpinning good practice can be demonstrated. Without an understanding and acceptance of such principles, the policies and procedures are unlikely to be implemented in an effective and committed way.

33.36 If practice is based on sound principles then it is our firm belief that mental health services cannot and should not be criticised for declining to act as gaolers for those with behavioural disorders or for failing to provide the public with absolute protection from serious harm.

33.37 Our broad conclusions are that Dorset mental health services should:

(a) clarify the commitment to personality disordered clients by clarifying the services available to them and the need to offer proper assessment and, if appropriate, treatment;
(b) ensure, by redefining their eligibility to services, that there is no confusion over the application of MHA, CPA and care management to personality disordered clients;
(c) emphasise the need to understand and follow the principles of service and care underpinning MHA, CPA, risk assessment and care management, and not just the need for bureaucratic adherence to the same;
(d) consider the development of a more assertive approach for clients who are difficult to engage with services in the community;
(e) reconsider the use of crisis management for this client group;
(f) create an integrated and holistic service for mentally disordered offenders in the community with special emphasis on those with personality disorder and substance abuse problems, so that the CFT/MenDOS, CMHTs and drug agencies such as CADAS operate collaboratively;
(g) review the role of social workers in psychiatric hospitals and in Community Mental Health Teams;
(h) priorities the provision of long-term supported housing for mentally disordered offenders.

LIST OF RECOMMENDATIONS

Note: All references to 'the NHS Trusts' are to the Dorset HealthCare NHS Trust and the Dorset Community NHS and the 'Social Services' refers to all social services departments now in Dorset.

Chapter 4

1. The Health Authority and Social Services should review:
   (a) how its children and adolescent mental health services can most effectively be accessed by Social Services and other agencies, for example, schools, for children in need of assessment and treatment;
   (b) the level of its investment in mental health services for families, children and adolescents.

2. Social Services should:
   (a) review the effectiveness of its arrangements for young persons leaving care including arrangements for assessment, follow-up and service engagement;
   (b) develop a joint policy, procedures and liaison arrangements with the NHS Trusts for assessment and follow-up, where appropriate, by the adult mental health services for those young persons leaving care who may have significant mental health needs.

3. The NHS Trusts should produce evidence-based advice for clinicians on the prescription and administration of neuroleptic drugs to those under the age of 18 years.

4. The Department of Health should identify research-based interventions into families with histories of dysfunction and deprivation with a view to offering assistance at the earliest stage aimed at preventing and managing the development of early childhood conduct disorders and possible associated personality disorders.

Chapter 5

5. The NHS Trusts and Social Services should reinforce the key principles of information gathering, inter-agency communication and multi-disciplinary working and their application to MHA, CPA and care management through training, guidance and supervision chapters 27 and 28.

Chapters 6 and 13

6. The NHS Trusts and Social Services should offer training and guidance on the provision of court reports, emphasising the need for accurate information, a consideration of risk factors (including the need for section 41 MHA where appropriate) and an outline of the range of possible sentencing options available to the court.

Chapters 7 and 9

7. The Dorset Probation Service should review its multi-agency working procedures with a view to:
   (a) ensuring that all other agencies involved, or likely to be involved, in the care of an individual, are alerted to an evaluation of high risk and that information pertaining to that evaluation is shared with the agencies identified;

(b) combining with other agencies to develop and provide assertive community supervision particularly to those individuals with a poor history of co-operation with services. (See also recommendation 17(a))

Chapter 10

8. The NHS Trusts should review their methods of independently testing and verifying the variety and extent of drug misuse by individuals and to incorporate best testing practices into its assessment and monitoring protocols.

9. The NHS Trusts and Social Services should strengthen existing policy on the treatment, assessment and management of patients with a dual or multiple diagnosis or other complex needs including personality disorder with a view to ensuring that they are not excluded from services/CPA. (See also recommendation 17(a) and recommendation 22).

10. The NHS Trusts should:

(a) include a section in every patient's file which contains a summary of the background history, corroborative evidence and indicators of risk;

(b) ensure that copies of MHA section papers are kept on a patient's file for easy access (see recommendation 13) ;

(c) seek advice on the redesign of the discharged against medical advice forms and scrutinise their use.

11. The NHS Trusts should review the use of section 5(2) MHA.

Chapter 12

12. The NHS Trusts should review the use of ECT to ensure compliance with the MHA and the Code of Practice.

Chapter 13

13. The Department of Health should consider amending the standard forms of medical recommendation used for section 37 MHA to ensure that section 41 MHA is addressed in the same form.

(See also recommendations 6 and 10(a) and (b))

Chapter 14

14. The NHS Trusts and Social Services should jointly review and audit arrangements for CPA and section 117 MHA joint after-care (see chapter 28).

Chapter 15

15. NHS Trusts and Social Services should review the system for the referral of clients between them.

Chapter 17

16. The Department of Health and the Home Office should jointly issue guidance on:
(a) the need for information sharing between the Prison Health Service and the NHS for MDOs returning to the community from prison;
(b) extending the CPA process to include the Prison Health Service as a specialist mental health service thereby ensuring that after-care arrangements are in place on release from prison.

Chapter 18

17. The Health Authority, the NHS Trusts and Social Services should jointly review and audit:
(a) their capacity to engage and sustain service contact with difficult to manage patients, including MDOs and those with substance misuse problems, in both hospital and community settings and consider the development of a more assertive method of supervision (Recommendation 7(b) and recommendation 22);
(b) the use of crisis admissions to hospital for this client group;
(c) the use of and criteria for CPA levels.

(See also recommendation 9)

Chapter 19

18. The NHS Trusts and Social Services should review policy and training on the hand-over of care to another area when a client moves in accordance with existing national guidance.

Chapter 21

19. The Home Office should consider the benefits of standardising missing persons forms throughout the country. When the person is found and the form is to be cancelled a report should be sent back to the originating police force detailing the circumstances in which the person was found, what action is to be taken and any special features such as vulnerability which may require action on the part of that original police force.

Chapter 26

20. The DHA, NHS Trusts and Social Services should set out clearly the level of their commitment to assessment and, where appropriate, treatment of personality disorder.

21. The NHS Trusts and Social Services should ensure full training of staff, hospital and community-based (CMHTs, CFT and community drug teams), on the aetiology of personality disorder, application of MHA and assessment and management in the community.

(See also recommendation 9)

Chapter 27

22. The DHA should review MDO services, with particular emphasis on the integration of services, including drug services, as a follow-up to the April 1994 review by the Dorset Health Commission.

23. The NHS Trusts should review the functioning of the CFT with particular reference to leadership, training, prison liaison, use of CPA and its relationship to other services.

24. The NHS Trusts and Social Services should review
(a) the role of social workers within hospital and community teams and
(b) the system of record-keeping within Social Services and community teams and the need for unified records.

(See also recommendations 7(b), 9, 15 and 17(a) and (b))

Chapter 28

Recommendations 5 and 14.

Chapter 29

25. The DHA, NHS Trusts and Social Services should:
(a) jointly review and audit their arrangements for risk assessment and management including agency policies, risk screening, guidelines and training for staff, assessment methods and management strategies. This should also include advice on assessment and management of the non-compliant patient
(b) review joint policy and procedures and develop a single risk assessment tool across the county.

Chapter 30

26. The NHS Trusts, Social Services and housing authorities should:
(a) review current training and implementation of multi-agency working with housing associations with a view to enabling early identification of mentally disordered people with housing needs;
(b) priorities provision of specialised long-term housing for MDOs;
(c) instruct housing officers to offer support and advice on routes of access to accommodation to individuals in need of housing.

27. The Government should consider new legislation to impose a positive obligation on housing authorities to assess and provide housing for MDOs.

Appendix A

CHRONOLOGY

Key Dates and Events in Shane Bath's History of Contact with Local Services

Early History

21 March 1968	SB born in Boscombe near Bournemouth.
1974	Seen by Dorset Child Guidance: intractable behaviour disorder.
18 December 1979	Two x theft of cycles, handling. Remanded into local authority care by Bournemouth Juvenile Court (JC).
30 January 1980	Care order by Bournemouth JC.
21 March 1984	Totton JC: Actual Bodily Harm (ABH). Conditional Discharge for 12 months.
19 September 1984	Bournemouth JC: loaded air weapon in public place. £200 fine.
20 September 1985	Bournemouth Magistrates' Court (MC): ABH. £50 fine.
24 October 1985	Bournemouth MC: ABH. £50 fine.

1987

21 January 1987	First admission to St Ann's Hospital with two year history of depression. (Dr Sedman). Informal status.
24 January 1987	Discharged due to bad behaviour.
01 July 1987	Admitted to Southampton Accident and Emergency Department (A&E) with cut wrist. St Ann's advise diagnosis is mainly personality disorder with some psychotic features.
02 July 1987	Transferred to St Ann's.
08 July 1987	Discharged from St Ann's.
10 July 1987	Fire at family home. No charges against SB. No admission to St Ann's.
22 September 1987	Living in hostel in Weymouth. Seen as out-patient at Blackdown Hospital.
19 October 1987	Contact with police over attempt to throw himself off roof of hostel.
20 October 1987	Released by police.

07 November 1987	Admitted to Royal Victoria Hospital, Boscombe having been found in gutter with cut on head.
12 November 1987	Admitted to Poole General Hospital with cut wrists. Transfer to Old Manor Hospital, Salisbury.
18 November 1987	Transfer to St Ann's for assessment.
19 November 1987	Discharged from St Ann's. Severe personality disorder with little to be gained from in-patient treatment.

1988

19 February 1988	Out-patient appointment with registrar to Dr Sedman. Thrown out of parental home/injunction.
22 March 1988	Court report by Dr Sedman for charges relating to nuisance calls and damage to a fire engine while in hostel at Weymouth. No recommendation for medical disposal.
23 April 1988	Arrested for setting fire to magazine under mattress of hostel resident in Southampton. Remanded into custody.
15 June 1988	Arson. To be remitted to Bournemouth MC to be dealt with earlier charges.
23 June 1988	Amended court report of Dr Sedman. Recommendation unchanged.
05 September 1988	Sentenced for arson and other charges by Bournemouth Crown Court (CC). Nine months Youth Custody (YC) in total. Probation High Risk conference. SB assessed as 'high risk, very high risk'.
09 September 1988	Released on youth custody licence under probation supervision.
15 December 1988	Theft from electricity meter: Bournemouth MC.

1989

20 February 1989	Admitted to Hospital, Weymouth with cut wrist. Discharged himself. Problems with accommodation. CADAS to help.
06 April 1989	Admitted to Forston Clinic, Dorchester. Serious incident at mother's accommodation and seen at police station prior to admission. Referral to drug dependency services (Wessex Regional).
25 April 1989	Discharged from Forston. Taken to Face to Face by CADAS but did not remain there.

31 May 1989	Living in Gillingham (with sister) and awaiting place at detox unit.
06 June 1989	Guilty plea to burglary of Methodist Church at Gillingham. Assault on police when arrested. Probation report being prepared.
10 July 1989	Remanded in custody by Southampton MC for burglary.
31 July 1989	Bailed to detox unit and turned away as arrived later than arranged.
07 November 1989	Sentenced at Gillingham MC: ABH, burglary non-dwelling and assault on police: 12 months probation. Supervised in Southampton mainly. Wife and baby.

1990

30 January 1990	SB back in Gillingham and contact with CADAS.
01 March 1990	Seen by probation in Blandford, Dorset.
14 June 1990	Probation concerns over violence towards partner and potential for violence towards baby.
August 1990	Living in council accommodation in Southampton.
17 October 1990	GP referral to Forston Clinic following temazepam overdose.
26 October 1990	Failed to attend at Forston Clinic. Being assessed by CADAS.
19 November 1990	Not been to CADAS sessions for a few weeks.
23 November 1990	Probation child protection conference in Southampton. Child not at risk.
18 December 1990	Gillingham MC: assault (90 hours Community Service Order (CSO)) and breach of Probation Order. Wife left over Christmas.

1991

16 January 1991	At HMP Dorchester on remand for 26 burglaries, some committed with his sister.
19 April 1991	Dorchester CC: 18 months imprisonment. CSO revoked.

1992

10 January 1992	Released from HMP Dartmoor.
21 February 1992	Contact with CADAS.

19 February 1992	Contact with Forston Clinic.
20 February 1992	Taken off probation high risk register.
12 March 1992	CADAS file closed.
27 March 1992	Bournemouth MC: Theft. Fine.
21 April 1992	Admitted to Poole General Hospital A&E. Temazepam overdose.
22 April 1992	Admitted to St Ann's (Dr Choudry). Alcohol problem with drugs.
26 April 1992	Placed on section 5(2) MHA.
28 April 1992	Discharged from St Ann's against medical advice (AMA). Long standing history of personality disorder with psychopathic features. Known to abuse alcohol and drugs. DNA CADAS.
05 June 1992	Admitted to Forston Clinic. Dr Gallimore.
24 June 1992	Discharged from Forston Clinic.
29 June 1992	Weymouth MC: criminal damage. Conditional Discharge 12 months.
02 July 1992	Multi-disciplinary liaison meeting organised by housing department.
08 July 1992	Admitted to Poole General Hospital after over-dose of phenytoin, amphetamines and benzodiazepines.
13 July 1992	Discharged from Poole General Hospital.
	Cut wrists and tried to jump off bridge. Stopped by police. At Bournemouth A&E cut wrists and tried to swallow blade. Requesting admission to St Ann's.
17 July 1992	Admitted to St Ann's.
22 July 1992	Absconded from ward.
23 July 1992	Failed to return and discharged AMA in his absence.
20 November 1992	Death of real father (and step-father).

1993

10 January 1993	Admitted to St Ann's for detox. (Dr Choudry). Seen at police station in Bournemouth where presented himself having taken a knife to stab ex-wife. Attacked brother. Thrown out of home.
12 January 1993	Transferred to Poole General Hospital during detox due to bronchopneumonia.
18 January 1993	Transferred back to St Ann's from Poole General Hospital.
15 February 1993	Informed that he was HIV negative.
16 February 1993	Back to Poole General Hospital for bronchopneumonia.
19 February 1993	Back to St Ann's.
11 March 1993	Discharged himself from St Ann's AMA.
	Admitted to Poole General Hospital after over-dose: heroin and temazepam.
12 March 1993	Admitted to St Ann's from Poole General Hospital.
22 March 1993	Social work report (first available as adult) incorrectly mentions foster parents and three children of his own.
25 March 1993	Discharged from St Ann's in his absence.
23 April 1993	Bournemouth Central police station on charge of robbery and carrying a knife. Remanded to HMP Exeter.
01 July 1993	Committed to Bournemouth Crown Court (CC) from Bournemouth MC for trial: robbery, burglary and theft.
04 August 1993	Section 48 MHA report.
05 August 1993	Second section 48 MHA report.
13 August 1993	Transfer direction from Exeter to St Ann's under Dr Rowton-Lee.
14 August 1993	Transfer took place.
18 August 1993	Cut wrist with razor.
24 August 1993	Punched staff nurse and attacked patient.

25 August 1993	Electro-Convulsive Therapy (ECT).
31 August 1993	ECT
06 September 1993	Dr Rowton-Lee brief report to court that assessment not complete.
	Report by assistant psychologist in Community Forensic Team (CFT) following referral by probation service.
September 1993	Behavioural disturbances on ward.
03 October 1993	Dr Rowton-Lee court report. Needs assessment and treatment to continue under section 48 MHA.
04 October 1993	Bournemouth CC: SB arraigned and guilty pleas entered. Remanded in custody for reports to St Ann's.
19 October 1993	Assessed by Dr Stone at Ravenswood, Regional Secure Unit.
21 October 1993	Dr Stone recommended probation order with condition of psychiatric treatment as in-patient.
10 November 1993	Doing well. Occupational therapy and anger management.
19 November 1993	Psychology report (CFT).
22 November 1993	Section 37 MHA Hospital Order to St Ann's.
17 December 1993	Absconded from St Ann's.
20 December 1993	Returned to St Ann's in company of brother and with police. Discharged from CFT.
22 December 1993	Discharged from St Ann's in his absence. Community psychiatric nurse (CPN) subsequently arranged but no contact made. No section 117 MHA after-care meeting.

1994

3 February 1994	Discharged by CPN from his case load.
16 February 1994	Due at Dorset MC.
07 April 199	Admitted to St Ann's (Dr Rowton-Lee). Unable to cope. Informal via police. Tried to hang himself on admission. Transferred to Dr Choudry. Treated with ECT.

27 April 1994	Discharged from St Ann's. Final diagnosis: personality disorder. CPN to be informed. GP letter says diagnosis is addiction.
2 June 1994	Admitted to Royal South Hants Hospital after over-dose of temazepam.
5 June 1994	Discharged from Royal South Hants Hospital. Taken to police station under section 136 MHA.
19 August 1994	HMP Winchester. Seen by Dr Rowton-Lee as had tried to hang himself on admission. Awaiting trial on credit card fraud. Contact with Wessex Project.
20 September 1994	Given Conditional Discharge in court for 12 months. Referral to Department of Social Security (DSS).
03 October 1994	Royal Bournemouth Hospital A&E. Over-dose. Admitted.
04 October 1994	Discharged from Royal Bournemouth Hospital.
14 November 1994	Social worker unable to keep appointment.
08 December 1994	Admitted to Forston Clinic (Dr Veasey). Over-dose. Court case pending.
20 December 1994	Failed to attend DSS meeting.
22 December 1994	Discharged from Forston Clinic.
30 December 1994	Admitted to St Ann's. Feeling suicidal.

1995

09 January 1995	Absent without leave (AWOL) from St Ann's.
11 January 1995	Discharged from St Ann's in his absence.
12 January 1995	Possible admission to Old Manor Hospital, Salisbury.
18 January 1995	DSS closing summary.
20 January 1995	Seen at St Ann's.
09 February 1995	Admitted to Old Manor Hospital. Over-dose of vodka and drugs.
10 February 1995	Discharged from Old Manor Hospital to mother's address.
13 February 1995	DSS referral by sister due to accommodation difficulties.

14 February 1995	Admitted to Forston Vlinic (Dr Veasey). Reportedly threatening to kill mother.
16 February 1995	DSS contacted by Forston Clinic for urgent CPA due to accommodation needs.
01 March 1995	Multi-disciplinary CPA meeting at Forston Clinic.
07 March 1995	Discharged from Forston Clinic into police custody for credit card frauds. Further contact with DSS and MenDOS.
23 March 1995	Removed from CPA because in trouble with the law.
30 April 1995	Care management assessment.
04 April 1995	Letter to all GPs in East Dorset about SB telling them not to prescribe further drugs due to over-doses. Copied to police and various hospitals.
18 April 1995	DSS case 'dormanted'.
30 April 1995	Arrested for burglary. Remanded in custody.
07 May 1995	In court. Guilty plea.
14 June 1995	HMP Guys Marsh from Dorchester.
15 June 1995	Dorchester MC: 12 months prison (to 26 October).
06 October 1995	HMP Channings Wood Hospital. Dr Rowton-Lee asked if he would undertake follow up on release on 27 October. To be followed up through CFT.
	Stayed one night at probation hostel on release from prison.
17 November 1995	Admitted to Royal Bournemouth Hospital with over-dose of amitriptyline.
20 November 1995	Transfer to St Ann's.
21 November 1995	Discharged from St Ann's.
28 November 1995	Re-admitted to St Ann's from Bournemouth General Hospital for assessment of clinical depression.
26 December 1995	Discharged from St Ann's in his absence. Out-patient with Dr Mohammed.

1996

09 February 1996	Urgent request to see CPN. No follow-up seven weeks after discharge caused SB frustration. Arranged out-patient appointment next week.
12 February 1996	SB failed to attend out-patient appointment.
21 February 1996	Admitted to Royal Bournemouth Hospital after over-dose of amitriptyline. Impression of acute psychosis secondary to alcohol and cannabis abuse.
23 February 1996	Transferred to St Ann's.
12 March 1996	Discharged himself from St Ann's. Never keeps out-patient appointments. Allocated CPN but never seen. Also to social worker who had moved area and subsequently not seen by anyone else.
31 May 1996	Emergency referral to Dr Rowton-Lee.
01 June 1996	Admitted to St Ann's after amphetamine over-dose.
05 June 1996	Absconded from St Ann's.
06 June 1996	Re-admitted to St Ann's.
07 June 1996	Absconded again.
10 June 1996	Re-admitted from Old Manor Hospital and absconded for third time. Admitted to Salisbury District Hospital A&E after over-dose with diazepam. Admitted to Old Manor Hospital then transfer to St Ann's and back to Old Manor Hospital after absconding.
13 June 1996	Admitted to Old Manor Hospital. Contact with DSS.
19 June 1996	Discharged from Old Manor Hospital and transferred back to St Ann's (Dr Mohammed).
20 June 1996	Absconded and walked to mother's address. Mother's social worker attempted to contact social worker nominated on SB's behalf.
22 June 1996	Admitted to St Ann's by ambulance. Absconded.
01 July 1996	Admitted to St Ann's (for ECT) and absconded. DSS (benefits).
03 July 1996	Discharged from St Ann's in his absence. CPA discharge form level 1.

06 July 1996	Admitted to St Ann's from Chelsea and Westminster Hospital. Absconded.
08 July 1996	Admitted to Poole A&E with cut on arm. Discharged into GP's care.
12 July 1996	Discharged in his absence from St Ann's after admission on 6 July.
27 August 1996	Failed to attend St Ann's out-patient appointment.
01 September 1996	Admitted to Royal South Hants Hospital.
11 September 1996	Discharged from Royal South Hants Hospital in his absence. Admitted to St Ann's after assessment in police cells.
13 September 1996	Arrested by police at St Ann's and discharged after he stole patients wallet and assaulted policeman.
17 September 1996	Failed to attend St Ann's out-patient appointment.
28 October 1996	Seen at Michael's Night Shelter.
18 November 1996	Failed to keep appointment with Dr Rowton-Lee.
25 November 1996	Failed to attend appointment with Dr Mohammed at King's Park.
26 November 1996	Seen by Dr Rowton-Lee with CPN in cells as part of court diversion in apparently catatonic state. No signs of mental illness. Arrested for failing to appear at court.

1997

03 February 1997	Seen at Michael's Night Shelter seeking referral to a CPN. Needs court report. GP asked for referral back to Dr Choudry.
11 February 1997	Failed to attend St Ann's out-patient appointment.
26 February 1997	Emergency assessment at Waves Youth Resource Centre in Weymouth. Gave name as Bartlett. Referred to DSS and Blackdown Hospital (Dr Townsend).
05 March 1997	Living in DSS approved landlady accommodation in Weymouth.
11 March 1997	Name established as Bath. Arrested last Friday.
14 March 1997	At St Petroc's in Exeter.
19 March 1997	Recent admission under Dr Townsend at Blackdown Hospital.

	Weymouth CMHT received a message that SB in Exeter and using name of Cummings under different date of birth.
08 April 1997	DSS closing summary.
05 June 1997	At Shilhay Hostel, Exeter.
July 1997	Seen by GP. Paper referral to Dr Choudry by Dr Rowton-Lee.
August 1997	Move to London.
21 August 1997	In Eastbourne with Ayse Sullivan and arrested for assault on her. Not Charged. Transferred to answer earlier charges in Poole under warrant.
15 September 1997	Sentenced at Poole.
18 September 1997	Failed to attend clinic to see Dr Choudry. Asked GP Dr Turnbull to assess and refer if necessary.
26 September 1997	Back to London to AS's flat after six weeks in Dorchester Prison for assault in Poole.
23 November 1997	SB killed AS. He hit her over head with metal bar. Turned on gas, lit candles and set fire to their flat. Gave himself up to Rotherhithe police.
14 May 1998	SB pleaded guilty to murder and arson with intent to endanger life. Mandatory life sentence. Subsequently transferred to Broadmoor Special Hospital, Berkshire for assessment.

Appendix B

TERMS OF REFERENCE

Dorset Health Authority

TERMS OF REFERENCE FOR EXTERNAL INQUIRY INTO THE CARE AND TREATMENT OF SHANE DAVID BATH

1. To examine all the circumstances surrounding the care and treatment of Mr Shane Bath, in particular:

   - the quality and scope of his health, social care and risk assessments;
   - the circumstances relating to admission, treatment and the decision to discharge Mr Bath from any relevant health and social service institutions and to comment upon:

     * the suitability of those placements in view of Mr Bath's history and assessed health and social care needs and clinical diagnosis;
     * the clinical and operational organisation and the quality of care provided in those institutions and in the community;

   - the suitability of his treatment, care and supervision, in respect of:

     * his assessed health and social care needs;
     * his assessed risk of potential harm to himself or others;
     * any previous psychiatric history, including drug and alcohol abuse;
     * the number and nature of any previous court convictions;

   - the extent to which Mr Bath's care corresponded to statutory obligations, the Mental Health Act 1983 and other relevant guidance from the Department of Health and local operational policies;

   - the extent to which his prescribed care plans were:

     * effectively delivered;
     * complied with by Mr Bath;
     * monitored by the relevant agency;

   - the history of Mr Bath's medication and compliance with that régime.

2. To consider the adequacy of both the risk assessment procedures applicable to Mr Bath and the related training provided for all staff involved in Mr Bath's care.

3. To examine the adequacy of the collaboration and communication between all the agencies involved in the care of Mr Bath or in the provision of services to him, including Dorset HealthCare NHS Trust, Dorset Community NHS Trust, Bournemouth and Dorset Social Services, Dorset Probation Service and Mr Bath's GP.

4. To review the structure of the internal inquiries into the care of Mr Bath.

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

6. To prepare an independent report and make recommendations to the Dorset Health Authority and Social Services Departments in Dorset.

Appendix C

INQUIRY PROCEDURE

1. All sittings of the Inquiry will be held in private. The press and other media will not be allowed to attend.

2. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

   A) of the terms of reference and the procedure adopted by the Inquiry;
   B) of the areas and matters to be covered with them;
   C) requesting them to provide written statements to form the basis of their evidence to the inquiry;
   D) that when they give oral evidence they may raise any matter they wish which they feel might be relevant to the Inquiry;
   E) that they may bring with them a lawyer or member of defence organisation, friend, relative, colleague or member of a trade union, provided no such person is also a witness to the Inquiry;
   F) that it is the witness who will be asked questions and who will be expected to answer;
   G) that their evidence will be recorded and a copy sent to them.

3. Witnesses of fact will be asked to affirm that their evidence is true.

4. Any points of potential criticism concerning a witness of fact will be put to that witness, either orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

5. A press statement inviting anyone with relevant information to contact the Inquiry has been issued and the Inquiry may invite such persons to make written or oral submissions.

6. Representations may be invited from relevant professional bodies, agencies and individuals as to present arrangements for persons in similar circumstances to Shane Bath and as to any recommendations they may have for the future.

7. Those professional bodies, agencies or individuals may be asked to give oral evidence about their views and recommendations.

8. The findings and any recommendations of the Inquiry will be presented in a report and made public by the Health Authority.

9. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as disclosed within the body of the Inquiry's final report.

10. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the report and any recommendations will be based on those findings.

Appendix D

LIST OF WITNESSES

NB Job descriptions relate to the time of contact with Mr Bath and may have changed subsequently.

ORAL EVIDENCE

Family members

1. Mrs E. Bath

Health Services

Dorset HealthCare NHS Trust

2. Dr M Rowton-Lee, Medical Director, Consultant Psychiatrist, St Ann's Hospital
3. Dr N Choudry, Consultant Psychiatrist, Addictions Specialist, St Ann's Hospital
4. Mr J S Cunningham, CPN, CFT
5. Dr H Y Mohammed, Associate Psychiatrist, St Ann's Hospital
6. Dr G Leung, Consultant Clinical and Forensic Psychologist, CFT
7. Mr I Oxborrow, CPN, CFT
8. Dr G Sedman, Consultant Psychiatrist, St Ann's Hospital (retired)
9. Mr M Manners, Nurse, St Ann's Hospital
10. Ms R Morgan, Ward Sister, St Ann's Hospital
11. Ms A Milner, Community Mental Health Nurse

Dorset Community NHS Trust

12. Dr D Veasey, Consultant Psychiatrist, Forston Clinic (retired)
13. Dr G Gallimore, Consultant Psychiatrist, Forston Clinic
14. Dr J M Townsend, Staff Psychiatrist, Blackdown Hospital
15. Ms C Kinsella, CPN, MenDOS

Other

16. Dr R. Hattersley, GP, Bournemouth.
17. Dr C A S Crowe, Senior Registrar in Psychiatry, Exeter Community and District NHS Trust
18. Ms S Hammond, Community Nurse, St Petroc's Centre, Exeter Community and District NHS Trust
19. Dr J H Stone, Ravenswood House RSU
20. Dr M Humphreys, Consultant Psychiatrist, Old Manor Hospital, Wiltshire

Social Services

Dorset

21. Mr G Hawker, Social Worker, Ferndown CMHT (also Shaftesbury and Wimborne)
22. Ms S Gardiner, Social Worker, Weymouth and Portland CMHT
23. Ms J Powell, Senior Practitioner, Ferndown CMHT
24. Mr S Witheyman, Social Worker, Dorset County Council

Other

25. Mr P Clewer, Social Worker, Exeter CMHT
26. Ms Y J Haye, Social Worker, London Borough of Southwark

Probation Service

27. Mrs P Rance
28. Mrs R Newman
29. Ms S Newall
30. Ms S Staddon
31. Mr S Freemantle

Police

32. Chief Inspector Michael Mytton, Dorset
33. Detective Inspector Kevin Moore, East Sussex
34. Police Sergeant Clive Wigglesworth, East Sussex

CADAS

35. Ms L Tritton

Managers

36. Mr I Allured, Assistant Director of Commissioning for Mental Health and Learning Disabilities, Dorset Health Authority
37. Dr S Bennett, Consultant in Public Health Medicine, Dorset Health Authority
38. Ms L Boland, General Manager, Dorset HealthCare NHS Trust
39. Mr T Archer, General Manager, Dorset Community NHS Trust
40. Mr D Joannides, Director, Dorset County Council Social Services
41. Mr B Goodrum, Policy Officer, Dorset County Council Social Services
42. Mr D Morgan, Head of Housing and Community Services, North Dorset District Council

Experts

43. Ms Liz Parkes, Strategic Commissioning Manager (Mental Health), Surrey County Council.
44. Dr Brian Thomas-Peter, Director of Psychological Services, Reaside Clinic, Birmingham
45. Ms Gill MacKenzie, Chief Probation Officer, Gloucestershire Probation Service

WRITTEN STATEMENTS ONLY

Health Service

46. Dr D Dick, Consultant Psychiatrist, Blackdown Hospital, West Dorset
47. Dr D Dayson, Consultant Psychiatrist, Department of Psychiatry, Royal South Hants Hospital
48. Dr D G Walbridge, Consultant Psychiatrist, Department of Psychiatry, Royal South Hants Hospital
49. Mr M Das, Clinical Psychologist, Dorset HealthCare NHS Trust
50. Dr P M Fleming, Consultant Psychiatrist, Director, Wessex Regional Drug Dependency Service
51. Dr E Mendelson, Ravenswood House RSU
52. Dr S Smith, Registrar in Psychiatry, St Ann's Hospital, Poole
53. Mr A Johnstone, Health Care Assistant, St Ann's Hospital, Poole
54. Ms L Winstanley, Occupational Therapist, St Ann's Hospital, Poole
55. Mr D Ford, Fair Access Managers, Lewisham and Guys Mental Health NHS Trust

General Practitioners

56. Dr S Horner
57. Dr S Daddy
58. Dr G N Pervical
59. Dr J M Gallagher
60. Dr G Bradley-Smith (Exeter)
61. Dr R Sales
62. Dr P Turnbull
63. Dr G A Langsdale
64. Dr C Hewetson
65. Dr J Surridge

Social Services

66. Mr G Baker, Social Worker (appropriate adult), Bournemouth East CMHT
67. Ms M Wainwright, Social Worker (appropriate adult), Dorset County Council
68. Ms B Evans, Team Manager, Dorset County Council
69. Mr J Saxey, Child Protection Team, Dorset County Council
70. Ms A Purvis, Team Manager, Salisbury CMHT, Wiltshire

Housing

71. Ms M C Tavernor, Sheltered Housing Supervisor, North Dorset District Council (and now Signpost Housing Association)
72. Mr A R W Adams, Chief Housing and Environmental Officer NDDC/Chief Executive, Signpost Housing Association
73. Mr B Miller, Head of Housing Management NDDC/Director of Housing Services, Signpost Housing Association
74. Ms H Jenkins, Senior Housing Officer, NDDC/Housing Manager, Signpost Housing Association
75. Mr K Hayward, Housing Officer, NDDC/Signpost Housing Association
76. Ms M J Christopher, warden, The Pavilions (now with Signpost Housing Association)
77. Mrs A Watkins, Landlady, Weymouth

Probation Service

78. Mr D Ireland, Dorset
79. Ms M Kelly, Hampshire
80. Mrs S Garnett, Dorset
81. Ms J Vickers, HM Prison Service, Exeter Prison

Dorset Police

82. Sgt J L Blake
83. Sgt P Cheverton
84. Sgt J Ledden
85. WPC C A Cummins
86. PC A Minto
87. PC A Turner
88. Insp. B C Tucker
89. PC T J Beal

90. PC M Tibbles
91. PC D M Dale
92. PC D P Mann
93. PC S Cotton

Other

94. Ms P Dearden, WAVES, The Children's Society
95. Mr N Wilson, CADAS
96. Ms N Brown, CADAS
97. Mr A H Chapman, HM Prison Service, Directorate of Dispersals Support Unit
98. Ms B Swyer, Forensic Service Manager, The Wessex Project, Hants

Experts

99. Dr S Bailey, Consultant Adolescent Forensic Psychiatrist, Salford NHS Trust
100. Dr K Rix, Consultant Forensic Psychiatrist, High Royds Hospital, West Yorkshire
101. Dr A Payne, Consultant Forensic Psychiatrist, Broadmoor Special Hospital
102. Professor Gournay CBE, Professor of Psychiatric Nursing, Institute of Psychiatry, Denmark Hill, London
103. Dr D Cox, general practitioner, Assistant Director of Studies in General Practice, Institute of Public Health, University of Cambridge
104. Mr B Topping-Morris, Head of Nursing, Caswell Clinic, South Wales
105. Mr J Revell, Branch Crown Prosecutor, Dorset
106. Mrs T Alafat, Director of Housing and Strategic Development, Royal Borough of Kensington and Chelsea

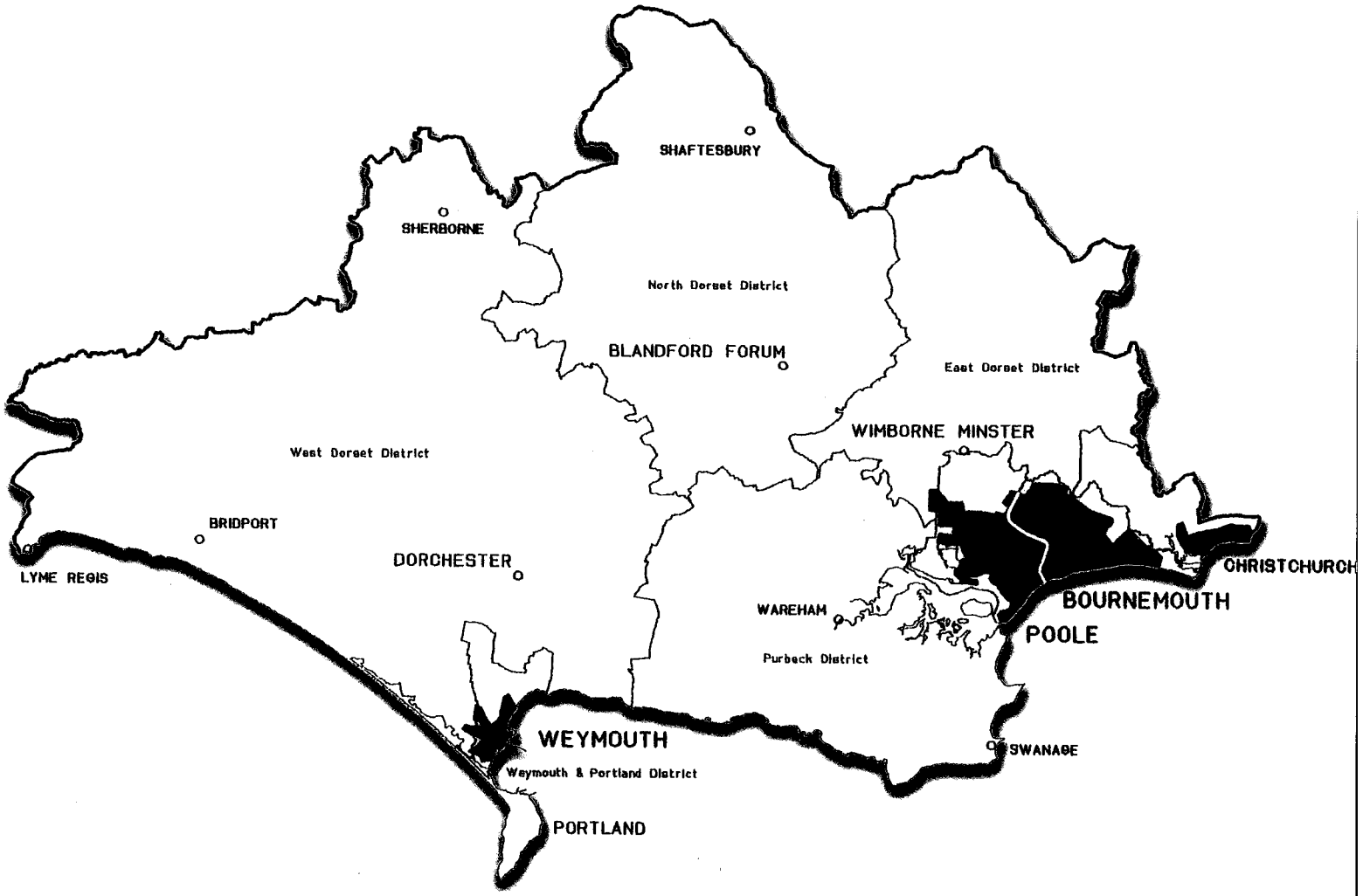
Managers

107. Mr H Capron, Principal Officer, Bournemouth Social Services

The Inquiry Chair and Co-ordinator also met informally with members of Ayse Sullivan's family. Members of the Inquiry Panel were able to speak to Ms J Brant, senior hostel worker, Palace Gate Hostel, Exeter and Mr D Laban, manager/director, Exeter Shilhay Community, by telephone.

Appendix E

MAP OF DORSET



Appendix F

RISK SCREENING FORM

Dorset HealthCare NHS Trust Risk Screening Form (2000 Version)

DORSET HEALTHCARE NHS TRUST
BOROUGH OF POOLE ADULT SOCIAL SERVICES

MENTAL HEALTH ADULT RISK SCREEN

DATE:_____

Complete this form following a clinical assessment of the patient. Place a tick in each box which is relevant. Risk is being assessed in three separate areas: suicide, violence to others, self neglect/vulnerability to abuse. You are asked to judge in each of these three areas whether risk is low, moderate or high. Items in bold suggest at least a moderate level of risk. Protective factors such as a supportive social environment may reduce risk. The overall level of risk is not just a matter of adding up the ticks, but should be based on the full clinical assessment including personal observations and experience of the patient. If you are in doubt as to the level of risk, ask a senior colleague.

Patient's Name:

Male/Female: **Age:**

Designation:

Diagnosis:

Previous admissions: None ☐ One ☐ Two or more ☐

Previous compulsory admissions: None ☐ One ☐ Two or more ☐

Vulnerable Others

Children	**Yes*** ☐ **No** ☐
Vulnerable adult	**Yes*** ☐ **No** ☐
Lone carer	**Yes*** ☐ **No** ☐

***If yes, is an appropriate action in the management plan** **Yes** ☐ **No** ☐

VIOLENCE TO OTHERS

1. **Currently threatening/hostile/ suspicious/ agitated** ☐
2. **History of violent acts** ☐
3. **Delusional ideas or auditory hallucinations about harming others** ☐
4. Alcohol/drug misuse ☐
5. Availability of weapons ☐
6. Vulnerability of potential victim ☐
7. Antisocial personality factors (including violent/sexual/racist interests) ☐
8. Poor adherence to care plans ☐
9. Poor impulse control ☐
10. Morbid jealousy ☐

RISK LEVEL **LOW** **MODERATE** **HIGH** (circle one)

SUICIDE

1. **Current suicidal ideas or plans** ☐
2. **Delusional ideas or auditory hallucinations about harming self** ☐
3. **Hopelessness** ☐
4. Recent acts of deliberate self harm, past history of suicide attempts ☐
5. Alcohol/drug misuse ☐
6. Psychiatric diagnosis (particularly affective disorders, schizophrenia, eating disorders) ☐
7. Demographic factors (male, living alone) ☐
8. Medical illnesses ☐

RISK LEVEL **LOW** **MODERATE** **HIGH** (circle one)

SELF NEGLECT/VULNERABILITY TO ABUSE

1. **Current self neglect or abuse** ☐
2. **History of self neglect or abuse** ☐
3. Carer not coping (mental/physical illness, alcohol/drug misuse, previous poor relationship) ☐
4. Social network places individual at risk ☐
5. Poor housing/homeless ☐
6. Poor adherence to care plans ☐
7. Few social contacts/recent losses ☐
8. Alcohol/drug misuse ☐
9. Poor memory ☐

RISK LEVEL **LOW** **MODERATE** **HIGH** (circle one)

Completed by ..... Designation .....

Appendix F

RISK SCREENING FORM

RISK POLICY

1. The Trust risk screen (overleaf) is not by itself a risk assessment. Risk assessment follows a full clinical assessment of the patient. This assessment will be documented in the clinical notes. The Trust risk screen highlights key areas to be covered as part of this assessment. Once a judgement about risk is made, a management plan specifically directed at reducing the risk (where necessary) should be recorded in the clinical notes.

2. The assessment and clinical management of risk is an integral part of standard practice. A good risk assessment depends crucially on the clinician having taken an adequate history and made an appropriate clinical examination. Where possible information should be sought from other informants or sources. Information from previous clinical records should be sought.

3. The purpose of the Trust risk screen is to highlight important factors known to increase risk in the areas of suicide, violence to others and self neglect/vulnerability to abuse. A detailed risk assessment may well involve a wider range of factors than those highlighted.

4. The assessment of risk is an attempt to identify the possibility of an adverse event. If risk is identified an appropriate management plan should be implemented in order to minimise the risk.

5. The judgement as to the level of risk is a clinical judgement which varies over time. It is important to specify the risk of what and to whom, and over what timespan.

6. Risk assessment often requires multidisciplinary involvement. Good communication is essential both for the assessment and management of risk.

7. Once the clinical assessment has been completed risk should be summarised as High, Moderate or Low. This is a clinical judgement which has clear implications for management.

8. HIGH RISK: There is an immediate risk in the area considered. Action to minimise the risk needs to be taken that day. Management will always involve discussion with a senior clinician and will usually be multidisciplinary in nature.

   MODERATE RISK: A clear risk has been identified but the threat is not immediate. Time is available for a multidisciplinary discussion. A care plan will be drawn up within 3 days to attempt to minimise the risk.

   LOW: Risk may be low or absent. Action may be ongoing review, measures to prevent deterioration, or discharge from specialist services.

9. An assessment of high or moderate risk will result in a care plan which is directed at minimising that risk. This care plan will usually follow multi-disciplinary discussion. A clear link needs to be made between the risks identified and the measures within the care plan to reduce such risks.

10. If the clinician is in doubt as to the level of risk he/she should consult with a senior colleague and err initially on the side of safety. In complex cases a multidisciplinary case conference might be helpful in clarifying the level of risk and determining appropriate management.

11. Risk may change and will need to be assessed at a number of points. The screen should be used at all initial assessments, on admission and discharge from in-patient areas, at level 2/3 CPA reviews, and on transfers between parts of the service. The keyworker is responsible for completing the risk assessment.

12. If vulnerable others are identified on the risk screen, the care plan should include appropriate management to enhance their safety. The needs of children are paramount, and should be discussed with Social Services colleagues within CMHTs or in the Children & Families Department when necessary.

LMW
18/01/99

Appendix G

MAIN AREAS OF COMMENT AND CRITICISM: ALPHABETICAL LIST

( ) = relevant chapter

- Accommodation (7, 8, 10, 16, 19, 30)
- CMHTs (10, 18, 19, 27)
- Community forensic service (13, 27)
- Continuity of care (14, 15, 18)
- CPA and prisons (17)
- CPA, discharge arrangements and follow-up in the community (10, 14, 16, 18)
- Court reports (6, 13)
- Crisis management (5, 18)
- Discharge against medical advice procedure (11)
- Discharge summaries (10,11, 31)
- Electro-convulsive therapy (12,15)
- History checking and information gathering (5, 6, 10, 16, 18, 19)
- Integration of community drug services (8, 9, 27)
- Inter-agency communication (7, 17, 33)
- Leaving care arrangements (4)
- Missing persons procedures (21)
- Multi-disciplinary work (14, 18, 33)
- Prosecution policy (21)
- Psychiatric assessments and dual diagnosis (5, 10, 13, 15, 18)
- Risk assessments (6, 7, 8, 9, 13, 17, 18, 29)
- Sentencing (6,13, 22)
- Social services involvement (5, 8, 10, 15, 16, 18, 19, 20, 27)
- Use of Mental Health Act 1983 (5, 10, 13, 18, 26)

Appendix H

DISCHARGE SUMMARY

Template, Dr K. Rix, High Royds Hospital, Leeds

DISCHARGE SUMMARY **Unit No:**

CONSULTANT: **SHO:**

NAME AND ADDRESS OF PATIENT: **DATE OF BIRTH:**

GENERAL PRACTITIONER:

ADMITTED: **DISCHARGED:** **DATE SENT:**

REASON FOR AND MODE OF REFERRAL:

HISTORY OF PRESENT ILLNESS:

PREVIOUS MEDICAL HISTORY:

FAMILY HISTORY:

PERSONAL HISTORY:

PREMORBID PERSONALITY:

PHYSICAL EXAMINATION:

MENTAL STATE EXAMINATION:

Appearance and behaviour:

Talk:

Mood:

Thought Content:

Abnormal beliefs/perceptions:

Cognition:

Insight:

Reaction to patient:

INITIAL DIAGNOSIS:

DIFFERENTIAL DIAGNOSIS:

INVESTIGATIONS:

TREATMENT AND PROGRESS:

FINAL DIAGNOSIS:

FINAL FORMULATION:

INFORMATION GIVEN TO PATIENT/RELATIVES:

CARE PROGRAMME: (Care co-ordinator:)

PROGNOSIS:

Appendix I

PSYCHOPATHIC DISORDER

Report to the Inquiry by Dr Brian Thomas-Peter (Extract)

I.1 This Report has been prepared with the substantial assistance of written evidence presented to the Committee of Inquiry into the Personality Disorder Unit at Ashworth Special Hospital under Judge Fallon, by Professor Ron Blackburn and the British Psychological Society. The Fallon Inquiry was itself helpful in providing some background information. None of the interpretation of that information, opinions expressed in the present report or recommendations are necessarily supported by the Fallon Committee of Inquiry.

A. Brief History of the Term 'Psychopathic Disorder' in England and Wales

I.2 The term first appeared in the Mental Health Act 1959, defined in section 4(4) as:

'A persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient concerned and requires or is susceptible to medical treatment'.

I.3 In the Mental Health Act 1983 it was redefined omitting reference to treatability. As redefined in section 1(2) it means:

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

I.4 'Treatability' now appears in section 37(2)(i) in the following terms:

'... the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment, and in the case of a psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition'.

I.5 The changes wrought by the 1983 Act did not resolve all the criticisms that had been levelled at the use of 'psychopathic disorder' from the beginning. The Butler Report (Committee on Mentally Disordered Offenders (Cmnd. 6244, 1975), paragraph 5.13) observes:

'This definition carries no implication that psychopathic disorder is a single entity, any more than does the definition of sub-normality in section 4(3) of the Act. Neither "psychopathic disorder" nor "sub-normality" is a specific diagnosis; they

are generic terms adopted for the purpose of legal categorisation and capable of covering a number of specific diagnoses, although in the case of the psychopathic disorders reliable specific diagnoses have still to be developed'.

I.6 A number of arguments were put forward for deleting the term from the 1983 Act to which the Butler Committee referred. They include:

- the 'circular argument', that the concept infers mental disorder from antisocial behaviour while purporting to explain the antisocial behaviour by mental disorder;
- labelling people psychopaths is stigmatic, harmful and indelible, and in practice makes those so labelled more difficult to handle, both in institutions and the community;
- some psychopaths act normally for some of the time, and there may be no clear distinction between their behaviour and that of other offenders not diagnosed as psychopaths. The concept is part of a general attempt by a secular society to replace moral expectations of behaviour by medico-scientific explanations;
- psychiatrists disagree about the meaning of the term and about the diagnosis of particular cases. Some would limit it to a narrow group of dangerously antisocial individuals. Others seek to extend the concept to cover inadequates of all description, 'those with alcoholism and drug addiction, those with sexual and marital disorders and those with employment disorders'.

I.7 The Butler Report made the point that differences of opinion among psychiatrists as to the diagnosis of psychopathy, and as to susceptibility to treatment, would not be prevented by deletion of the term.

I.8 In the end the Butler Report rejected replacing 'psychopathic disorder' with 'personality disorder' because of their difficulty in drafting a usable definition of 'personality disorder'. Curiously, no definition of the term 'mental illness' was attempted or seemed possible since again mental illness was a large group of dissimilar disorders and no comprehensive short definition was possible. This difficulty however did not obstruct the inclusion of 'mental illness' in the 1959 or 1983 Acts, as it prevented the inclusion of the term 'personality disorder'.

B. Personality Disorder, Psychopathy and Dangerousness

I.9 The relationship between personality disorder and dangerous behaviour is complex, and often indirect. Personality disorders do not 'cause' antisocial behaviour (or other problems) in any straightforward sense. Rather they may contribute to antisocial acts through the development of a deviant lifestyle, inappropriate ways of dealing with problems when they arise, or the tendency of the person to create difficulties in their relations with others. A diagnosis of personality disorder is therefore rarely sufficient to explain a serious offence. An understanding of the contribution of personality disorder to serious offences requires a detailed analysis of the circumstances surrounding the criminal act. In many cases (eg sexual assaults, repetitive violence), the offending behaviour itself may need to be the focus of treatment as much as the deviant personality traits associated with it.

I.10 It is important to distinguish between psychopathic disorder, and personality disorders. These terms are often used interchangeably in Britain but refer to different groups of problems and people. In European psychiatry, 'psychopathic personality' was originally a generic description for what are now identified as personality disorders. For several decades, however, North American clinicians and researchers have limited the term of psychopathic disorder to a specific form of personality disorder defined by personality traits such as egocentricity, callousness, lack of empathy, and impulsivity (Cleckley 1941).

I.11 Personality disorders are currently defined as enduring patterns of cognition, emotion, interpersonal behaviour, and impulse control that are culturally deviant, pervasive and inflexible, and lead to distress or social impairment. Personality disorders are extreme variations of normal personality traits and represent the combined influence of genetic and environmental factors. The maladaptive traits by which personality disorders are recognised are generally assumed to arise from adverse conditions in early development (eg abuse, inadequate parenting), but this is unlikely to apply equally to all forms of personality disorder. For any individual, the origins of personality disorder have to be constructed retrospectively, and this is guided by theoretical models and research evidence. Research on the origins of personality disorder remains limited, and although some theoretical models are popular (eg psychodynamic, attachment theory, social learning, interpersonal), no single theory enjoys universal support.

I.12 There are two diagnostic systems used for the classification of personality disorders: Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD), both describing a range of personality disorders. These systems are not without their problems. The reliability of diagnosis of these disorders is poor in that there is low agreement between different instruments designed to measure personality disorder, and measuring the same group of patients over a relatively short space of time reveals poor temporal reliability. There are high levels of co-morbidity of personality disorders, indicating that the descriptive features of several personality disorders overlap and diagnosticians cannot easily discriminate one from another. Diagnosis has little predictive validity in terms of providing information about likely treatment outcome. Finally, diagnosis has little utility in terms of indicating the appropriate treatment type (Tyrer 1992; Tyrer and Johnson 1996).

I.13 Personality disorders as defined in DSM-III/IV and ICD-10 include classifications that incorporate antisocial conduct but are wider in scope than this.

I.14 ICD-10 describes dissocial personality disorder (F60.2) as:

'Personality disorder characterised by disregard for social obligations, and callous unconcern for the feelings of others. There is gross disparity between behaviour and the prevailing social norms. Behaviour is not readily modifiable by adverse experience, including punishment. There is a low tolerance to frustration and a low threshold for discharge of aggression, including violence; there is a tendency to

blame others, or to offer plausible rationalisations or the behaviour bringing the patient into conflict with society'.

I.15 DSM-IV describes antisocial personality disorder as:

'A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15 years, as indicated by three (or more) years of the following:

- failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
- deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- impulsivity or failure to plan ahead
- irritability and aggressiveness, as indicated by repeated physical fights or assaults
- reckless disregard for the safety of self or others
- consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
- lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated, or stolen from another
- the individual is at least 18 years
- there is evidence of Conduct Disorder with onset before the age of 15 years'.

I.16 While these classifications, in either system would appear most likely to encompass those patients classified under the MHA category of 'psychopathic disorder in special hospital', the only systematic survey of that population questions this (Coid 1992). Using a structured interview to diagnose DSM-III personality disorders among male psychopathic disorder patients at Broadmoor, he found the following frequencies: borderline-56%; narcissistic-45%: antisocial-38%; paranoid-28%; dependent-20%; schizotypal-19%; passive-aggressive- 16%; compulsive-14%; histrionic-13%; schizoid-13%; avoidant-8%. Most patients met criteria for more than one personality disorder. The important points of these figures are that legal psychopaths are obviously heterogeneous in personality disorder; and no single category of personality disorder predominates.

I.17 Research has established that the most valid means of identifying this specific clinical category of psychopathic personality is the Psychopathy Checklist-Revised (PCL-R: Hare 1996). This assessment procedure is based on a semi-structured interview, and now forms the basis for most research on psychopathy. As it is also a relatively good predictor of criminal violence, it is used widely in risk assessment with offenders. The items used in this appraisal are rated according to specific criteria between 0 and 2, and it has been determined that those who score greater than 30 meet the criteria for psychopathy (Hare 1991). The items of the PCL-R are:

- Glibness / superficial charm
- Grandiose sense of self worth
- Need for stimulation / proneness to boredom
- Pathological lying
- Conning / manipulative
- Lack of remorse or guilt
- Shallow affect
- Callous/lack of empathy
- Parasitic lifestyle
- Poor behavioural controls
- Promiscuous sexual behaviour
- Early behaviour problems
- Lack of realistic, long-term goals
- Impulsivity
- Irresponsibility
- Failure to accept responsibility for own actions
- Many short-term marital relationships
- Juvenile delinquency
- Revocation of conditional release
- Criminal versatility

I.18 Research in the special hospitals clearly shows that of those classified as having psychopathic disorder only a minority are 'psychopaths' in the specific sense (Blackburn 1993; Coid 1992). Coid (1992) found that only 23% of males and 31% of females in the legal category met PCL-R criteria of psychopathy.

I.19 The legal category of 'psychopathic disorder' bears little resemblance to this specific concept of psychopathy, dissocial personality disorder or antisocial personality disorder, and does not denote a clinical entity. As the Butler Committee noted:

'The class of persons to whom the term "psychopathic disorder" relates is not a single category identifiable by any medical, biological, or psychological criteria'. It follows from this that questions about the treatability of personality disordered patients should be distinguished from questions about the treatability of clinical psychopaths.

C. The Treatability of Psychopathic and Personality Disordered Patients

I.20 There can be little doubt that the value of treatment remains a very contentious issue, and this is exacerbated by the paucity of appropriate outcome evaluation, with existing studies tending to be of poor methodological quality. One major problem facing researchers is the difficulty in identifying appropriate measures of

outcome. For this disparate group, there are various outcomes that one might wish to achieve through treatment, including reductions in recidivism, hospitalisation, and symptom severity, and increases in community adjustment and quality of life. A second problem is that psychological treatment needs to be guided by an established theory of personality and personality change (Benjamin 1998), but because research on the development of abnormal personality remains relatively underdeveloped, there is no universally accepted treatment model. Different forms of personality disorder may also require different methods.

I.21 In the past, there has been a tendency towards pessimism regarding the treatment of personality disorders, however, there is currently cause for cautious optimism. One approach to working with the personality disordered has been to focus upon the specific problem behaviours-predominantly offending behaviours-exhibited by the individual. Cognitive-behavioural interventions have been used in the treatment of sexual offending (Armentraut and Hauer 1978; Marshall and Barbaree 1990); the modification of problem drinking (Longabaugh et al 1994); and anger and violence (Renwick et al 1996). Such procedures have some degree of proven efficacy with general offender populations, and there remains considerable scope for their application and evaluation with mentally disordered offenders.

I.22 Recently, the literature testifying to the potential benefits of cognitive-behaviour therapy with personality disordered individuals has begun to flourish (Beck 1996; Fleming and Pretzer 1990; Young and Lindeman 1992). Most evaluative studies have focused upon its application with borderline personality disordered patients, especially in the form of dialectical behaviour therapy (Linehan 1987), and provide some evidence to support its application (Kern et al 1997; Koerner and Linehan 1992; Linehan 1993). More generally, similar outcome evidence is becoming available for other variants of cognitive-behaviour therapy applied in respect of other specific personality disorders (eg Bux 1992; Coon 1994; Davidson and Tyrer 1996; Greenberg 1992).

I.23 While this evidence is encouraging, the strength of evidence can only be put at the level of 'promising'. A survey by Shea (1993) noted that very little is known about successful treatment for personality disorders. It has to be emphasised that this is not the result of failures to demonstrate treatment effectiveness, because few systematic treatments of personality disorders have as yet been attempted. This reflects factors such as the continuing problems in the classification and assessment, few theoretically-based treatment models, different disorders demanding different treatments, very few centres focusing on treatment and research of personality disorders and a poverty of training in this area among most professional staff.

I.24 Although there is an extensive clinical literature on the treatment of so-called 'psychopaths' in maximum security hospitals or prisons, recent reviews of the literature conclude that most reports of treatment are methodologically deficient and typically fail to define 'psychopaths', treatment goals, or treatment programmes (Blackburn 1993; Dolan and Coid 1993; Losel 1998). Blackburn (1998) draws two conclusions from this. First, a few studies suggest that clinical psychopaths do not respond very favourably to traditional therapeutic interventions (eg individual psychotherapy, therapeutic communities), but there is insufficient evidence to support the opinion of some clinicians that 'nothing works'. Secondly, there is preliminary evidence that some offenders with personality disorders (mainly those who are not clinical psychopaths, and this would include most legal psychopaths in special hospitals), do change with psychological treatment.

I.25 Long-term outcome studies of special hospital patients focus mainly on reoffending (Murray 1989). The better studies indicate overall reoffending rates of about 40%, and rates of around 15% for further serious (violent) crimes. These rates are somewhat lower than those for released prisoners, but direct comparisons are hazardous. Higher rates of reoffending are generally found for legal psychopaths compared with mentally ill offenders. A follow-up of Park Lane patients, for example, found that 55% of legal psychopaths reoffended, compared with 21% of the mentally ill: for serious re-convictions, the rates were 26% and 10% respectively (Bailey and MacCulloch 1992).