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REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MR K.K

JANUARY 1999

Executive Summary

This is a summary of the report of the independent inquiry team commissioned by Enfield & Haringey Health Authority to look into the care and treatment received by Mr KK from health and social services leading up to the killing by Mr K of his wife on 16 August 1997. Mr K was convicted of murder at the Central Criminal Court on 4th March 1998.

The inquiry was chaired by Alison Gulliver, Barrister. The other members of the panel were:

Dr Alex Buchanan, Consultant Psychiatrist
Lotte Mason, Social Services Consultant
Jane Mackay, Independent Health Care Consultant

The inquiry took place from May to December 1998 and its report was submitted to Enfield & Haringey Health Authority at its meeting on 28th January 1998.

Copies of the full report are available on request from:

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Chronology

KK was born in Ireland in June 1953 and moved to England when he was three years old. He left school at the age of 15 and married his wife when he was 16 and she was 18. They had two children, a daughter born in 1970 and a son born in 1972. Haringey Council were involved with the family as early as 1980, when the daughter was placed on the child protection register.

Mr K physically abused his wife and children over a long period. Mr K rarely worked. His wife supported the family while he spent her money on drink and drugs. On occasions his wife had to beg for money for food and steal from shops.

Mr K's criminal record began in 1966 when, as a juvenile, he was convicted of theft and store breaking. In 1971 he was fined for actual bodily harm and carrying a firearm with intent to commit an offence. In the same year he was convicted of robbery and put on probation. In 1972 he was sentenced to three months in prison for burglary and in 1979 he received a two year suspended sentence for blackmail. In 1982 a further suspended sentence was imposed for assault with intent to resist arrest. More recently he was convicted of being drunk and disorderly, possessing a knife in a public place and causing criminal damage.

In August 1990 Mrs K left her husband and he attempted suicide by gassing himself. He was treated in Friern Hospital, N11. A diagnosis of psychopathic personality disorder was made by the duty doctor, who planned to keep him in hospital for assessment. Mrs K arrived the following day and demanded to take him home. Mr K was advised to remain in hospital but he discharged himself. He was offered but refused an outpatient appointment.

In August 1991 Mrs K again left her husband. Again she returned home because he tried to kill himself.

In May 1992 Mrs K left home and Mr K took an overdose of tablets and cut both his wrists. Later that month he was visited in Friern Hospital by his parents and, against medical advice, discharged himself. He returned to the hospital after five days, was given medication and told to return if he felt suicidal. Several days later he was admitted after claiming he had taken an overdose but vomited the tablets up. He was discharged three days later. Within 10 days he was back in Friern following a further suicide attempt.

During this period in hospital Mr K punched two patients. He told a doctor that he still felt like harming other people and himself. In a long interview he stated that he no longer wanted to kill himself but that he would like to kill his wife and daughter. Psychiatric Senior House Officer (a) noted:

"He is ruminating about finding them (they are in hiding) and has been trying to get friends of hers to tell him where she is. Would stab her and has a knife at home (was carrying it last week)."

The police were informed of Mr K's expressed intentions. In July he discharged himself but her was readmitted in August following another overdose. He discharged himself the following day.

During the period February to October 1992 Mrs K sought and received psychiatric help herself.

By March 1993 she had returned to live with Mr K.

From September 1992 to March 1994 Mr K saw his GP frequently. He had occasional outpatient appointments at Friern, but failed to attend others.

In January 1995 Mr K was referred by his GP to St Ann's Hospital, N15. There was no response to the letter but an appointment was later made for May 1995. Mr K said his main problem was irritability due to lack of sleep. At an appointment in July he reported that he still felt violent and had thoughts saying "hit him, hit him". He was referred to the psychology department with a view to him participating in an anger management course.

In December the psychology department wrote to Mr K asking whether he still wanted an appointment. On 28 December he saw a psychiatric SHO who wrote to the psychology department. They offered Mr K an appointment on 1 February 1996, which Mr K did not attend. He was offered another appointment on 26 February which he also failed to attend. Nor did he attend outpatient appointments in February and April 1996.

In May Mr K attended an outpatient appointment and complained that none of the interventions which had been offered were any good and that he always saw a different doctor. He had never wished to be referred to the psychology department. He was given medication to help him sleep and the address of a counselling service for violent men.

On 8 July 1996 Mr and Mrs K attended an outpatient clinic. He was told his appointment had been cancelled and he should come back in a month. He became angry and shouted at staff, who called the police. He was detained under Section 4 of the Mental Health Act (emergency provisions) and admitted to St Ann's. The following day he was reviewed and allowed leave. He did not return the following day and Mrs K rang to say they could not afford the bus fare.

He failed to attend a second review meeting and he was formally discharged with a prescription and an appointment on 31 July, where the doctor judged that he was "considerably improved".

Mr K missed various outpatient appointments over the period up to January 1997, when he admitted that he had "knocked his wife about" over Christmas. He was referred to an anger management course. In February he returned a questionnaire to the psychology department. No appointment was made. In May he was offered an appointment with a clinical psychologist the following month.

On 25 May Mr K attended an outpatient clinic and reported that his wife had left him without warning. He was not actively suicidal but was worried he might become so.

Mrs K had visited the local area housing office on 15 May and reported her husband's violence towards her. She stated that she was afraid her husband would find out she was planning to leave and kill her. On 18 May she requested an emergency housing placement and she was provided with bed and breakfast accommodation. On 11 August she was granted the tenancy of a one bedroom flat.

On 10 June 1997 Mr K was referred to the Alexandra Road Crisis Unit, N8, a facility managed by Haringey Council Social Services Department, which had only just opened.

A care plan was formulated for him and by 15 June Mr K told staff he was feeling more positive. However, by 17 June he was down in mood and told staff he was thinking of visiting his daughter. On 18 June he said he was feeling very angry towards his wife.

During the late afternoon/early evening of 19 June, Mr K began making threats in respect of his wife and daughter. He said he was going to kill his daughter and his wife and then himself. Notes made by a member of staff said:

" was calm and his eyes were icy cold when he described how he was going to drive a knife through his daughter's stomach then he would go to a tall building and jump... Since (Mr K) has been here he has been making threats to kill his family, however last night he looked and sounded as if he meant it."

Another member of staff reported a conversation with Mr K later that evening:

"(Mr K) talked about his wife. It was a conversation that lasted about two hours, throughout which time he said he wanted to kill his wife, and he wanted to commit suicide....I remember asking (Mr K) to think about the consequences of that kind of behaviour. At that point ... I sensed something from (Mr K) which I had never sensed before in the entire experience of me working in psychiatry. When I asked him that question to think about the consequences of what he was considering doing, he just smiled in a very chilling way. It was horrible... I felt frozen myself. It was chilling.

This member of staff was initially concerned for his own safety, but thought he saw the effects of alcohol on Mr K wearing off and he was reassured that he only wanted to deliver a note for his wife to his daughter. He considered calling the police but felt reassured that Mr K could not harm his wife because he did not know where she was living. The following morning Mr K left Alexandra Road at 6.45 am.

Later that day it was reported to staff at the unit that Mr K had been arrested for the alleged abduction of his daughter's husband and his granddaughter at knife point.

He appeared before magistrates on 21 June. The Crown Prosecution Service objected to bail and he was remanded in custody for nine days. At the next remand hearing on 30 June Mr K's solicitor made an application for bail. The police advised against bail on the grounds that there were substantial fears that Mr K would fail to surrender, commit further offences, interfere with witnesses and harm himself.

The Crown Prosecution Service did not oppose bail on the grounds that they believed the principal witnesses did not want to give evidence and thus it was likely that the case would have to be dropped, and that Mr K now had an address out of the area where he could stay.

Bail was granted by the stipendiary magistrate on condition that Mr K lived with his parents at Clacton-on-Sea, Essex, did not communicate with the prosecution witness or his wife, did not come within the perimeter of the M25 except to meet his solicitor by prior appointment, and provided a surety of £2000.

On 11 July Mr K's solicitor applied to vary his conditions of bail. This was refused.

Throughout the period during which Mr K stayed at his parents' house he took no medication and did not see a doctor. A week before he killed his wife, Mr K said that he found out from a friend where she was staying. On 13 August 1997 he travelled to London. He spent the night in his flat. The following morning he went to look for his wife. He went to a pub and had four or five pints and smoked some cannabis. Having left the pub he saw Mrs K walking along the road. There was an argument and he stabbed her. He said he could not remember doing this. The next day he gave himself up to police.

Following the incident an internal inquiry was carried out, steered by Enfield & Haringey Health Authority, and a report was produced in April 1998, with recommendations.

Findings of the panel

The principal finding of the inquiry panel is as follows:

"We are of the view that even if things had been done differently by the Trust or Social Services, it is unlikely that the tragic death of Mrs K would have been avoided."

"In our view the one matter which would have made a significant difference to the outcome of events was if Mr K's application for conditional bail on 30 June 1997 had been opposed and refused."

Further findings of the panel are summarised below:

- **The panel could not glean the full extent of the Social Services Department's involvement with the K family due to the lack of records.**

- **They were satisfied that Mr K was frequently very violent to his wife and children, drank heavily and used cannabis regularly. He exercised control over the whole family and Mrs K and the children were frightened of him; their fear made them reluctant to seek outside help.**

- **Mr K was correctly diagnosed at Friern Hospital as having an anti-social personality disorder. Such disorders are difficult to treat. His management was made more difficult as information from his family was limited. It was more than coincidence that Mr K was found each time he attempted suicide.**

- **Mr and Mrs K's GP was not made aware of the physical violence in the family. Only one consultation, in August 1991, refers to this. Mrs K was reluctant for social services to become involved.**

- **There was a delay of over four months between the GP's 'urgent' referral letter to St Ann's Hospital and Mr K being seen there. This was too long.**

- **Mr K's treatment was made more difficult because he lied to doctors, refused psychological treatment, took medication erratically, frequently discharged himself against medical advice and was violent to other patients and aggressive to staff. It is commendable that the team treating Mr K persevered in offering him outpatient appointments despite this.**

- **Mr K was critical of the fact that he was seen by a series of junior doctors. This is an inevitable consequence of the training system, which rotates posts every six months. Further consideration needs to be given to the conflict between training needs and the need of patients for continuity of care.**

- The panel considered that there were too many demands placed on the Consultant Psychiatrist's time. This demand plus the very high bed occupancy rate (often as high as 140%) gave the panel the view that there should be a formal review of junior doctors (on rotation) patients lists to ensure patients are appropriately managed.

- When Mr K was detained under Section 4 of the Mental Health Act 1983 the cause of his behaviour was too much alcohol rather than mental illness. In the circumstances the decision was entirely acceptable, but a second medical recommendation should have been sought as soon as he was admitted and a social circumstances report should have been prepared by the social worker. This was possibly a missed opportunity for a social worker to speak to Mrs K and possibly to offer support to her and/or Mr K.

- The Care Programme Approach policy introduced in Haringey in March 1996 was confusing and difficult to understand. Mr K's care plan dated July 1996 was inadequately completed. His care plan should have been reviewed at an early opportunity, although it is unlikely that it would have significantly altered the care he received.

  The panel were of the view that the 1996 CPA policy was confusing and difficult to understand. They were also of the view that the new joint CPA introduced in June 1998 was equally confusing. They understood that a review of the policy was due to take place and should be done as a matter or urgency.

- It is not clear whether Mrs K was invited to attend care plan meetings on 10 and 11 July 1996; she should have been. Because Mr K acknowledged that he lied to doctors it was important that attempts were made to speak to Mrs K to assess his needs and the risks he posed. Not many attempts were made to speak to Mrs K, but she may not have been willing to provide additional information.

- The risk which Mr K presented to himself and others was not adequately considered at the time his care plan was drawn up or at any time afterwards.

- At the time that she compulsorily detained Mr K it should have been apparent to the Consultant Psychiatrist that at the very least Mr K posed a risk to his wife when he was drunk. Further inquiries should have been made.

- At this time there were no Trust guidelines on risk assessment or risk management. Such guidance was issued in June 1997.

- There is a need for social services to offer counselling and support in cases of serious domestic violence, particularly where the perpetrator is in receipt of mental health services.

- We were very concerned by the delays between referrals made to the psychology department and appointments being offered to patients. Delays of four to six months are too long.

- There was confusion as to who was primarily responsible for prescribing drugs for Mr K, the Consultant Psychiatrist or his GP.

- The quality of Mr K's psychiatric care was reasonable. It was based on a correct diagnosis, involved a course of treatment which followed accepted principles and included maintenance of contact in order to offer increased levels of support, including a hospital bed or supportive accommodation where necessary.

- We have doubts as to whether patients such as Mr K, who suffer from complex anti-social personality disorders, can or should be managed by community general psychiatric teams. We are aware this issue is under review at national level.

- We were very impressed by the experience of the staff from the Wood Green Area Housing Office. They met Mrs K's immediate needs by providing her with emergency accommodation.

- The housing staff received considerable information from Mrs K about the violence to which she was subject. Sadly this was not passed onto any other agency and, in particular, those treating Mr K. One of the most perplexing features of this case is that the Housing Department held information which, had it been passed on, may have had a significant bearing on the management of his case. We do not blame the staff concerned. Traditionally the Housing Department has not shared information with other agencies.

- We feel that in cases such as this, where the victim claims to be in fear of her life and the perpetrator is under the care of another agency, there are grounds for the Housing Department communicating relevant information to that other agency.

- When he was referred to Alexandra Road the information used to assess the risk that Mr K presented was inaccurate and insufficient, putting staff at Alexandra Road at a disadvantage. This no doubt applies to most referrals to Alexandra Road. It is important that fully informed risk assessments are made in these cases to aid the management of clients.

- Alexandra Road staff currently receive just three hours training on risk assessment, mainly focused on suicide.

- A revised risk assessment form seeks information only for the previous two years. In our view this is insufficient.

- The referral to Alexandra Road was appropriate. However, it is essential that the decision to accept clients is made independently of the referrer. Because of the high pressure on acute psychiatric beds referrals could be made because of the lack of an available bed.

- The daily log at Alexandra Road was difficult to follow. This has now been improved.

- The staff who had to deal with Mr K did not appear to have received adequate training to manage the situations which arose; for example, a member of staff accompanied Mr K to the pub despite the fact that he was highly emotional and volatile and alcohol was likely to aggravate the situation.

- The support and advice given on the evening of 19 June 1997 by the Service Manager for Haringey Mental Health Services to the shift leader at Alexandra Road, Housing Manager (b), was not satisfactory. Housing Manager (b) told the Service Manager that Mr K was threatening to kill his wife and she thought he meant it. The Service Manager's `wait and see approach' was not an effective way of managing the problem. She should either have gone to Alexandra Road herself or called out the duty social worker to make an emergency mental health assessment.

- Residential Social Worker (d), later that night, made an error of judgement in not waking Housing Manager (b) for advice. However, we do not criticise him for the way he handled the very difficult situation in which he found himself; it was the responsibility of those managing Alexandra Road to ensure there was a written risk management policy in place. The latest draft policy, dated May 1998, says: "Management will be responsible for the drawing up of clear procedures and guidelines for risk assessment and risk management". We were not provided with any guidelines.

- A formal on call system is necessary to ensure that out of hours support is always available.

- The threats made by Mr K should have been reported to the police and recorded in an incident log. This incident should have immediately prompted an internal review.

- Police attended Alexandra Road on 20 June and searched Mr K's room but did not interview staff. Had they taken statements they would have known of the threats Mr K had been making. This information could have been passed to the CPS and may have had a bearing on Mr K's bail applications.

- Staff said they did not volunteer information to the police because of client confidentiality. If this is correct it is misconceived: safety of members of the public should outweigh client confidentiality.

- In failing to prescribe Mr K's regular medication, his care in Pentonville Prison fell below an acceptable standard. He should also have been referred for a psychiatric opinion.

- CPS Lawyer (a) was in error in failing to check with the police whether Mr K's daughter and son-in-law were willing to give evidence before agreeing to conditional bail for him. There is absolutely no evidence which we are aware of to support the contention that these witnesses were unwilling to give evidence.

- Given the nature of the offences and the information from the police CPS Lawyer (a) should have strenuously opposed conditional bail. Had he done so, there is a possibility that Mr K would have been remanded in custody.

- It was inappropriate for the CPS to be reassured by the condition of bail that required Mr K to live outside the area where his likely victims lived. He had already shown a willingness to track people down.

- Insufficient regard was had to Mr K's mental health needs at the remand hearings. No attempts were made to establish whether he was receiving treatment and how that would be affected by him living away from home.

- We were alarmed by the brevity of the endorsements on the CPS file at to what happened at the various remand hearings.

- **We had many concerns about the procedure adopted by the internal inquiry. No clear terms of reference were drafted and the inquiry took the form of group discussions involving managers who had contact with Mr K. Such a process should be as objective as possible.**

- **We are concerned about the lack of progress in implementing the recommendations of the internal inquiry.**

Recommendations of the panel

The panel made a total of 20 recommendations for action arising out of their findings. In summary, these are:

1. The Trust should ensure that consultant psychiatrists review their junior doctors' lists regularly and note the review in each patient's notes.

2. The Trust and the Social Services Department should make clear precisely whose responsibility it is to obtain a second medical recommendation for the purposes of converting Section 4 of the Mental Health Act to Section 2.

3. The Trust should ensure that the use of the Act is stringently monitored and the Code of Practice is followed.

4. Staff involved in the Act should receive regular refresher training.

5. The Trust should have a policy dealing with detained patients who are absent without leave which complies with the Act Code of Practice.

6. The Trust should rewrite the CPA policy and guidelines.

7. The Trust should ensure that all staff involved in CPA receive regular refresher training.

8. The Social Services Department should clarify its eligibility criteria for long term mental health cases. If the term `severe and enduring' mental health problems, or a similar term, is used, its definition must be clearly understood. In particular, whether individuals with anti-social personality disorder are eligible needs to be clarified.

9. Social Services should consider allocating resources to offer counselling and support in cases of serious domestic violence.

10. The Trust should revise the current system within the psychology department of offering patients assessment appointments only when treatment places are available.

11. The Trust should ensure that GPs and consultants communicate in writing confirming who is prescribing what medication to a patient.

12. The Housing Department should draw up guidelines dealing with the communication of information to other agencies.

13. The Social Services Department should require all agencies referring to Alexandra Road to include a risk assessment form completed by a suitably qualified and experienced professional who is familiar with the patient.

14. The Social Services Department should ensure that all Alexandra Road staff who will be assessing referrals have comprehensive risk assessment training.

15. The risk assessment form for Alexandra Road should not limit information to the last two years.

16. All Alexandra Road staff should receive regular training in risk management.

17. A risk management policy or guidelines should be implemented for Alexandra Road detailing the steps to be taken in a crisis.

18. Untoward incidents at Alexandra Road should be recorded in a separate log and an untoward incident policy should be introduced.

19. The Trust and Haringey Council should implement a joint confidentiality policy as a matter of priority.

20. The Trust should revise its untoward incident policy, setting out in unambiguous terms the procedure to be followed.

Minority opinion into the care and treatment of Mr KK

Dr Alex Buchanan has produced a minority report on the case which is available with the full report. A number of key extracts follow:

I agree with the description of Mr K's case contained in the report and support many of the recommendations. I have, however, formed a different view of the degree to which it was reasonable to expect health and social services to have managed the risk which Mr K presented.

...

Psychiatric care has traditionally been provided to voluntary patients with few conditions. Poor attendance, inconsistent background information and poor compliance with prescribed treatments are common problems... In Mr K's case the lack, or inconsistency, of background information made it difficult to assess his mental state and his irregular attendance and failure to take his prescribed treatment made it difficult to monitor changes in his mental state... He was setting an agenda that the services would not have set, yet care was not withdrawn.

...

No...court order had been imposed in Mr K's case. For all but 72 hours of the period covered by the report he was either a voluntary patient or, for the final six and a half weeks when he chose not to seek help, not a patient at all. Given the difficulties which his case presented it did not surprise me that the services involved were failing to manage...the risk which Mr K presented to others. The health and social services were not responsible for those difficulties and their failure to manage the risk to others did not prevent me from concluding that they offered a good standard of care.

...

Two broader questions arise in relation to psychiatric practice in Mr K's case... The first is whether it can ever be appropriate for clinicians to provide care to a patient who presents a risk where they are unable to manage that risk... It follows that there will be cases where care should be provided, as it was in this case, when risk cannot be managed.

The second is whether routine general and community psychiatric practice should change to emphasise risk management in all cases...The probation service has altered its `advise, assist and befriend' ethic to one under which public protection and risk management are paramount...

It may be that publicly funded psychiatric and social services will follow a similar path. The question of whether or not they should do so is critical to the future of these services...

There is no empirical evidence that the benefits of such an approach would outweigh the costs. A patient has to be in contact with services before any help could be provided... The larger the number of conditions which attend the provision of care to voluntary patients, the larger will be the numbers deterred from seeking such care.

REPORT OF THE INDEPENDENT INQUIRY TEAM INTO THE CARE AND TREATMENT OF MR K. K

TO ENFIELD AND HARINGEY HEALTH AUTHORITY

Index

Chapter 1

THE INDEPENDENT INQUIRY

1. This report arises from the fatal stabbing of Mrs K by her husband on 16 August 1997. Prior to this incident Mr K had been receiving mental health services from Haringey Healthcare NHS Trust ("the Trust") and Haringey Social Services Department. In Haringey the Social Services and Housing Departments of the Council operate under one directorate, but for simplicity, in this report the Departments are often referred to separately.

2. Where a person who has been in contact with the mental health services commits a homicide it is necessary to hold an independent inquiry (NHS Executive, HSG (94) 27).

3. Our terms of reference are set out in full in Appendix A. The procedure followed by the Inquiry is found at Appendix C. In the narrative text of the report, bold type denotes a quotation from the documentary or oral evidence which we received. Our comments and recommendations appear in italics.

OVERVIEW

4. Mr K received psychiatric care intermittently from August 1990 onwards. In this report we have focused on the care he received from 1995 when he first became a patient of the Consultant Psychiatrist. He was seen in out-patient clinics on a relatively regular basis between May 1995 and June 1997. He had one very brief in-patient admission to St Ann's Hospital, London N15 in July 1996, when he was admitted under Section 4 of the Mental Health Act 1983.

5. In May 1997 Mrs K left her husband. He became acutely depressed and reported suicidal thoughts. On 10 June 1997 he was admitted to a crisis unit, known as "Alexandra Road", which is managed by the Haringey Social Services.

6. On 19 June 1997, Mr K told staff at Alexandra Road that he wanted to kill his wife. The following day Mr K left Alexandra Road and allegedly abducted his daughter's husband and his granddaughter at knife point in an attempt to find out from his daughter where Mrs K was living. Mr K was arrested late in the afternoon on 20 June 1997. He appeared before magistrates on 21 June 1997 and was remanded in custody for 9 days. At the next remand hearing on 30 June 1997, Mr K's solicitor made an application for bail subject to various conditions. This was not opposed by the Crown Prosecution Service and Mr K was remanded on bail to live with his parents in Clacton on Sea, Essex.

7. On 16 August 1997, Mr K left his parents' house and travelled to London. He had managed to find out where his wife was living. He confronted her in the street and then stabbed her to death.

8. In the following pages of this report we examine in particular the care which Mr K received from the Trust and Haringey Social

Services Department. We comment when we consider that the care provided was inadequate or could be improved upon. However, at the end of the day, we are of the view that even if things had been done differently by the Trust or Social Services, it is unlikely that the tragic death of Mrs K would have been avoided.

9. In our view the one matter which could have made a significant difference to the outcome of events was if Mr K's application for conditional bail on 30 June 1997 had been opposed and refused.

Chapter 2

MR K AND HIS FAMILY

10. Mr K was born on 10 June 1953 in Ireland. He was the second eldest of 5 boys. He had a younger sister who died during infancy. The family moved to England when he was 3 years old. We know very little about Mr K's early life. Members of his family were invited to come and speak to us but they declined to do so; we did receive a letter from Mr K's father which provided us with some background information. Mr K himself is an unreliable historian; for example, in August 1990, when he was briefly admitted to Friern Hospital, he told a doctor that he did not like school, truanted frequently and was often in trouble. However, in July 1992 Mr K's father informed doctors that his son was never in trouble at school and had a brilliant mind but had never given himself a chance.

11. Mr K also gave doctors contradictory versions of his early home life. In 1990 he described his parents as having been "the best parents in the world". However, later on in 1992 he claimed that his father had been very violent towards him as a child, particularly when drunk. On the same occasion he described his mother as a good parent who was subservient to his father, yet in 1996 he told another doctor that his mother was as violent as his father, the only difference being that she could not catch him.

12. Mr K left school at the age of 15. He married Mrs K when he was 16 years old (she was 18 at the time). They had two children, a daughter who was born in 1970, and a son, born in 1972. The

family lived in Haringey in accommodation provided by the Council. We do not have very much information about the family unit. We do know that as early as 1980 Haringey Social Services Department were involved with the family; the daughter was on the non-accidental injuries child protection register. Social Services have been unable to locate any records whatsoever relating to the family.

Comment

13. We are aware that Social Services also had intermittent and brief contact with the K family in later years; for example in 1997 a duty social worker arranged emergency accommodation for Mrs K. We have been unable to glean the full extent of the Social Services Department's involvement with the K family due to the lack of records.

14. Most of the information we do have regarding life in the K family home comes from statements provided to the police after Mrs K's death. These paint a very grim picture of Mr K physically and mentally abusing his wife and his children over a long period of time. He regularly flogged the children with a leather belt, punched and kicked them. When his son's cat caught fleas Mr K was so angry that he put the cat in a bin liner, took it into the garden, held the cat's head against a concrete wall and smashed it with a club hammer.

15. On one occasion when Mr K lost his temper he threw a pair of scissors at his wife which stuck in her leg. He frequently beat her

and pulled her round by her hair, eventually causing her permanent hair loss. During one beating he knocked out her front teeth. On another occasion he tried to strangle her; when his daughter tried to intervene she was punched in the face.

16. Mr K exercised complete control over the family. He always monitored their movements. They, in turn, were too scared of him to report what was going on. Both children left the family home in 1991 to live independently.

17. Mr K rarely worked. Mrs K supported the family. He took her money and spent it on drink and drugs. He drank and used cannabis regularly. Mrs K had to go to desperate lengths to obtain sufficient money to feed and clothe the family, including begging for money and food and shoplifting.

18. Mr K's own account of his employment history is rather different. In 1990 he told doctors that he had worked in the past as a builder, a driver and a guitarist. He claimed that he had just lost his job as a chauffeur working for his brother's business. In 1992, his father confirmed that Mr K had at times worked as a session guitarist. What is clear to us is that Mr K was unemployed from 1990 onwards.

19. The description of life in the K family home given above is confirmed by a number of other documents which were made available to us by Haringey Housing Department. A brief note of the Social Services child protection case conference, held in December 1980, in respect of Mr and Mrs K's daughter (which is in the Housing file) refers to Mr K's violent and threatening behaviour and Mrs K's repeated attempts to borrow money from school staff. It was decided that the daughter's name should remain on the

register because of the violent nature of her father. On the same file there is a letter from a probation officer who was involved with Mrs K between 1984 and 1986 as a result of her committing a number of thefts. The letter states:

> **"The trigger for these offences was sheer financial desperation, arising from marital difficulties of the most complex kind wherein funds were diverted from basic family needs. To my knowledge her husband was continuously unemployed and they relied entirely on state benefits, with the result that the normal low level of such income was often reduced to a disastrous extent....The fact seemed to be that she lived in a domestic atmosphere where she was in considerable fear and while I do not recall ever seeing physical harm done to her, her demeanour alone was evidence enough of the extreme psychological pressure she was under. It was a source of concern to us that she continued to tolerate the situation, but she did so, it appeared out of a sense of duty, and, as I remember, concern for her husband as well as her two children."**

20. Mrs K herself gave a very similar story to the Haringey Housing Department in 1997, when she was seeking alternative accommodation having left her husband. She reported that he had subjected her to violence over many years including black eyes, having bottles smashed over her head, being dragged across the room, having her hair pulled out and being beaten with an umbrella and the back end of a knife. She also said that Mr K had knocked out her front teeth. She stated that she had never been allowed to seek treatment for her injuries and that she only saw her GP once the injuries had recovered.

21. Mr K's violent nature is reflected to some extent in his criminal record which goes back to 1966 when, as a juvenile, he was convicted of theft and store breaking. In 1971 he was fined for offences of committing actual bodily harm and carrying a firearm with intent to commit an offence. In the same year he was also convicted of robbery and put on probation. In June 1972 Mr K was sentenced to 3 months imprisonment for burglary. In 1979 he received a 2 year suspended sentence for blackmail. In 1982 a further suspended sentence was imposed for assault with an intent to resist arrest. The most recent offences were being drunk and disorderly, possessing a knife in a public place and causing criminal damage in 1994.

22. Mr K has consistently bragged that he has a string of convictions. In August 1990 he told a doctor that he had 30-40 convictions including **"armed robbery"** and **"discharging a firearm in a public place"**. He also claimed that he had stabbed a **"few people"**. He has described himself in the past as moody, very aggressive and impulsive.

Chapter 3

MR K'S MENTAL HEALTH CARE 1990 TO 1994

Mr K's Admission to Friern Hospital in 1990

23. At the beginning of August 1990 Mrs K left her husband, taking their daughter with her. Mr K had no idea where they had gone. He rapidly became very depressed, suffering from poor sleep and eating little. On 5 August 1990, Mr K attempted suicide by gassing himself. He was found unconscious on the floor by his son who had apparently rushed home following a telephone call from his father who said he was going to kill himself.

24. Mr K was initially taken to the North Middlesex Hospital and from there admitted to the Friern Hospital, London N11. On admission, he complained to the duty doctor that he was feeling depressed as a result of his wife's departure and losing his job as a chauffeur. He claimed that he only drank occasionally, although up to 5 years ago he had been a heavy drinker, and he said he never used illegal drugs. He stated that he had a long criminal record including a number of serious violent offences, including use of firearms and armed robbery. He also claimed to have stabbed a few people. On admission his demeanour was offhand and **"slightly menacing"** but he was no longer actively suicidal. Mr K explained why he had tried to take his own life: **" I just did it because everything got on top of me. I was very depressed and very angry. There was no one else around, so I took it out on myself."**

25. A diagnosis of psychopathic personality disorder with impulsivity and poor impulse control was made by the duty doctor who planned to keep Mr K in hospital so that his mental state could be fully assessed. Such an assessment did not prove to be possible. In the early hours of the following day, 6 August 1990, Mrs K and one of Mr K's brothers arrived at the hospital and demanded to take him home. Mr K was interviewed and advised not to leave, but he ignored this advice and took his own discharge.

26. Mr K was offered an out-patient appointment following this admission but he did not take up the offer.

Mrs K's Departure in August 1991

27. In August 1991, Mrs K again left home with her daughter. They were housed in temporary bed and breakfast accommodation by Haringey Council. According to Housing records, Mrs K returned home because Mr K tried to kill himself.

28. On 30 August 1991, Mrs K told her GP that she had left home because her husband was abusive and **"physically violent"**. She also had problems at work as she had been charged with stealing from her employer. Her GP told us that Mrs K had been his patient since 1985 and this was the first time that she had ever mentioned to him that her husband was physically abusing her. He referred her to a community psychiatric nurse (CPN).

29. On 2 September 1991, Mrs K had a further appointment with her GP. She told him that she had **"made it up"** with her husband.

30. Mrs K was seen by the CPN on 19 September 1991. At the consultation Mrs K denied feeling depressed and did not admit that she had any problems, despite describing her difficult domestic circumstances. No follow up appointment was arranged although Mrs K was told that if she required any help she could contact the CPN again.

31. It is not clear whether Mr K was admitted into Friern when Mrs K left home in August 1991. There are no medical notes relating to such an admission. However, when Mr K was admitted to Friern in May 1992, he told doctors that he had been admitted there seven months previously.

32. Following Mrs K's return home, Mr and Mrs K applied to the Housing Department for a housing transfer on the ground that the property they were living in was too big for them as their children had left home. On 2 December 1991, they moved to a one bedroom 1st floor flat in Wood Green.

Mr K's Admissions to Friern Hospital in 1992

33. Mr K's next psychiatric contact was in May 1992. On 21 May 1992, Mr K took an overdose of tablets and cut both his wrists. This was precipitated by Mrs K leaving home again some 10 days earlier. He was apparently found by a friend who saw blood on the carpet and forced an entry into the flat. He was taken to the North Middlesex Hospital and transferred to Friern Hospital on 22 May 1992, where he was admitted to ward 23 under the care of Consultant Psychiatrist (a)'s team. Mr K told the locum Psychiatric

Senior House Officer that he had not been sleeping or eating and had been drinking heavily. He described himself as being aggressive and feeling angry at times and admitted that he had hit his wife on a few occasions but not recently. The locum Psychiatric Senior House Officer queried whether the suicide attempt was an attention seeking exercise and a ploy to get Mrs K to return.

34. On 23 May 1992, Mr K was visited on the ward by his parents. He wanted to leave with them. He was interviewed by the duty doctor to assess his mental state. He admitted that he hoped that his suicide attempt would bring his wife back. As there were no grounds for detaining Mr K compulsorily, he discharged himself against medical advice. Once again he was offered an out-patient appointment the following week which he declined.

35. Five days later Mr K returned to ward 23 complaining that he was unable to sleep and that he was worried that if he did not get any sleep he would try to kill himself. He had been drinking heavily since his discharge and had heard nothing from his wife. He was seen by Psychiatric Senior House Officer (a), and given a 3 day supply of temazepam and advised to return to the ward if he felt suicidal.

36. On 9 June 1992 at 2.30 a.m., Mr K was seen at the front entrance of the Hospital. He said that he was feeling suicidal and that he had taken an overdose of tablets at 4 p.m. the previous day. He refused to attend the Casualty Department at the North Middlesex Hospital; he said he had vomited all the tablets up.

37. Mr K was assessed by the locum Psychiatric Senior House Officer who felt that his threats of suicide were manipulative and were being made in an attempt to gain admission. He noted:

> **"I am sure that his recent break up of his marriage is causing him distress, but I do believe that his suicidal ideation, is to facilitate his admission to Friern. I do not feel that his depression is significant enough to warrant admission in itself - nor do I feel that this is the reason for his suicide thoughts. I do however feel that he is very much aware of what he wants, and is using this as a lever to give me no alternative other than to admit him. I am equally sure, that if I did not admit him - he would do something to harm himself to prove that he should have been admitted."**

Mr K was admitted.

38. On 10 June 1992, Mr K was reviewed on the ward round. It was noted that he was not depressed and that he was being provided with respite care in the light of his acute suicide risk. By 12 June 1992, Mr K was feeling **"o.k.".** He was discharged on that day with a 7 day supply of temazepam and he was given an out-patient appointment for 4 weeks' time. On this occasion the diagnosis given to Mr K was anti-social personality disorder with impulsive and aggressive behaviour.

39. Within 10 days of his discharge, Mr K was back in Friern Hospital following a further suicide attempt. On 19 June 1992 he took another overdose of tablets and cut his wrists in the bath with a razor blade. This time he was **"found by chance by a flat mate who happened to see lights on and came in."**

40. He was admitted to Friern Hospital on 21 June 1992 from the North Middlesex Hospital. He was preoccupied with thoughts of his wife. He blamed his children, particularly his daughter, for the break up of his marriage. He said:

> **"..I feel like killing her - I see myself getting hold of her and stabbing her or something....I know its irrational....don't know where she lives but I know where she works."**

41. Nursing staff noted that during the first few days of his admission Mr K was quiet and kept to himself. He frequently left the ward: On 23 June 1992 he returned to the ward after a trip out smelling strongly of alcohol. After a few days Mr K started socialising with other patients although he was noted to be **"manipulative"** at times.

42. On 29 June 1992, Mr K was reviewed. He said that he became depressed when he was not doing anything; in order to avoid this, he spent his time being active, but this in turn made him feel irritable. He accepted that drugs would not solve his problems. He said that he had lied to doctors and that he would lie to a therapy group. He could see no point in attending such a group.

43. On 30 June 1992, Mr K was seen by a medical student who took a long and detailed history from him. He described how he had violent urges which led to him picking fights. He said that when he felt depressed he became violent and felt like committing suicide or hurting somebody. He also described having nightmares of himself committing violent acts **"E.g his wife returns home and although he wants to hug and kiss her and say he loves her,**

instead he stabs her repeatedly and throws her out of a window".

44. Later the same day Mr K punched a fellow patient after allegedly being provoked.

45. Mr K was involved in a second violent incident with another patient on 2 July 1992. On that occasion he punched the patient in the face.

46. Initially Mr K's discharge was planned for l0 July 1992, but this was deferred as he claimed that he had no suitable accommodation to go to; he said he became depressed when he returned to his old flat, and that his only alternative was to throw himself off a tall building. After 10 July 1992, Mr K spent increasing periods of time off the ward.

47. On 14 July 1992 Mr K told Psychiatric Senior House Officer (b), that he still felt like harming other people and himself. On 18 July 1992, Mr K had a long conversation with Psychiatric Senior House Officer (a). He stated that he no longer wanted to kill himself but that he would like to kill his wife and daughter. Psychiatric Senior House Officer (a) noted:

> **"He is ruminating about finding them (they are in hiding) and has been trying to get friends of hers to tell him where she is. Would stab her and has a knife at home (was carrying it last week).**
>
> **Though he sounds v. calculatedly violent, the agenda is that he wishes to stay on the ward - i.e. may be laying it on a bit thick. On balance, it does not seem worth pressurising him to go as he does seem to be at**

some genuine risk of an impulsive act of violence, and feels that being able to stay here reduces the risk of that."

48. The police were informed of Mr K's expressed intentions. They indicated that they could not take any immediate action but would be aware of the threats and that Mr K might be carrying a knife should an incident occur.

49. On 21 July 1992, Mr K's father was interviewed at the hospital. He described his son as a **"normal boy"** who was **"full of fun"** and had **"no problems"**. He said that Mr K was never in any trouble at school and was a bright boy who had failed to fulfil his potential. He described Mr K as always having a violent temper. He stated that Mr K had been arrested and had been on remand once but had never served a prison sentence. According to his father, Mr K boasted a lot and could not be trusted to tell the truth, for example, about the amount he drank.

50. A note in Mr K's medical records for 22 July 1992 indicates that the day hospital was no longer willing to take him (he started there on 20 July) as he had been making threats to another patient. Mr K denied this.

51. On 28 July 1992, Mr K left the ward. He returned on 30 July 1992 and stayed overnight and left again early in the morning on 31 July 1992 taking all his personal belongings with him. He was formally discharged later the same day and given an out-patient appointment for one month's time.

52. In fact Mr K was re-admitted to Friern Hospital on 7 August 1992. He had taken another overdose on 4 August 1992 and was found

unconscious by his brother. He spent a few days in the North Middlesex Hospital and was then transferred to Friern Hospital. By 8 August 1992 Mr K was complaining that he could not remain on the ward because it made him feel worse. He took his own discharge against medical advice later the same day.

Mrs K's Departure in 1992

53. On 5 February 1992 Mrs K saw her GP. She was depressed because of **"family problems"** but she was not willing to see a psychiatrist because her husband would not allow her to do so.

54. On 10 June 1992, Mrs K wrote to her GP asking for help. She said that she had left Mr K and was living in a women's refuge in Slough. She described how she was feeling very depressed and almost suicidal. She asked her GP to refer her to a local Slough psychiatrist. On 23 June 1992, Mrs K had an appointment with her GP. She was distressed and said that she had problems with her husband. The GP prescribed dothiepin but did not refer Mrs K as she had requested. The GP explained to us that Mrs K had told him that she would inform him of her new address which he needed in order to refer her to a psychiatrist. The GP's note of the consultation on 23 June concludes **"Will let me know her new address"**. The GP told us that Mrs K never forwarded her new address to him so he could not make the referral.

55. On 4 July 1992, Mrs K registered with a new GP in Slough, GP (a). She saw him on 10 July 1992. She again asked to see a psychiatrist. She said that she had been battered by her husband

and emotionally blackmailed. She referred to the fact that Mr K had tried to kill himself but always let somebody find him.

56. GP (a) referred Mrs K to the local psychiatric team. She was seen by Consultant Psychiatrist (b) on 18 August 1992. She was said to be suffering from depression and he referred her to a social worker for counselling.

57. On 13 August 1992 Mrs K wrote to the Wood Green Area Housing Office asking for advice in respect of the joint tenancy of the flat and requesting alternative accommodation. She specifically requested that her current address in Slough was not revealed to anyone apart from the housing officer handling her enquiry. On 26 August 1992, Mrs K was interviewed by Housing Manager (a). She confirmed that she had left home in May after her husband had threatened to throw her out of a window. Initially she had stayed with her son and then moved to a women's refuge in Uxbridge. Mr K had tracked her down and threatened her so she was transferred to another women's refuge in Slough where she remained until 29 June 1992. She then moved into a flat in Slough with her son, but the lease was due to expire in December and she had nowhere to go after that. Slough Council refused to rehouse her as they considered that she was intentionally homeless. She said that she had issued divorce proceedings against her husband in June 1992.

58. When giving evidence to us, Housing Manager (a) was able to recall the interview with Mrs K. She gave us a graphic description of Mrs K: **" She looked much older than she was; somewhat sunken, though not overly. She was skinny; and she was tiny. You could have picked her up; she was very little."** She said Mrs K's description of her marriage was **"a horrendous story"**.

59. Mrs K also told Housing Manager (a) how her husband was obsessive about knowing where she was going at all times to the extent that he sometimes stopped her from going to work.

60. Housing Manager (a) prepared a report recommending that Mrs K be offered housing outside Haringey. The report summarised the violence which Mrs K had been subjected to:

> **"Whenever Mr K. had no money to buy drugs he would become violent towards Mrs K. and this started approx. 9 months after the marriage and continued throughout. At first the violence was an occasional slap. It then escalated to the point where Mrs K. suffered multiple bruises and lacerations on a regular basis. Mrs K has just recently completed dental treatment to remove the remainder of her teeth and have new dentures both top and bottom fitted as a result of the beatings over the years...Mr K. consistently terrorised Mrs K. and the children of the family. Her daughter has had to ask her employer to move her to a different branch so that her father is unable to find her.....Unfortunately, Mrs K has never sought an injunction against Mr K as she has always been terrified of what he would do if he found out. She was never allowed to go to the Doctor/Hospital when she was injured for the same reasons."**

61. Housing Manager (a) told us that she believed Mrs K's account of her marriage and the violence she had suffered. She said that in her experience (she has worked as a housing officer since 1987) women who suffer serious domestic violence normally remove

themselves from the situation before approaching the Council for alternative accommodation.

62. Consultant Psychiatrist (b) saw Mrs K again on 9 October 1992. By this date the criminal charge of stealing from her employer had been dealt with and she had received a suspended sentence of imprisonment. He felt that she was doing very well considering her past experiences. He noted that she was not keen to attend support groups or anything of that nature. He arranged to see Mrs K in one month. So far as we are aware, Mrs K did not attend any further appointments with Consultant Psychiatrist (b).

63. Before Mrs K received an offer of alternative accommodation from Haringey's Housing Department, she informed Housing Manager (a) that she had a job offer out of London and could stay with friends. Housing Manager (a) advised Mrs K to take up this offer as it could take a long time for the Council to find her housing outside Haringey.

64. We do not know whether there really was a job offer and the option to stay with friends or whether Mrs K took up these opportunities. We do know that by 22 March 1993 she had returned to live with Mr K.

Mr K's Out-Patient Care August 1992 to March 1994

65. Mr K failed to attend the out-patient appointment made for him on 26 August 1992 following his discharge from Friern Hospital. He was not offered a further appointment.

66. From September 1992 to the end of 1993, Mr K saw his GP, almost on a monthly basis. He complained of insomnia and depression. The GP prescribed dothiepin and sleeping tablets.

67. On 6 July 1993, Mr and Mrs K both saw the GP. Mr K complained of insomnia and Mrs K explained that he was withdrawn at times and on occasions aggressive. The GP referred Mr K to Consultant Psychiatrist (a)'s team at Friern Hospital.

68. Mr K was seen by Consultant Psychiatrist (a)'s Registrar on 17 August 1993. The Registrar was of the view that Mr K wanted to make changes to his life but in order to so he needed help with his low mood and sleep problems. The Registrar's impression was that Mr K had a mild depressive illness but that he was far more co-operative than previously. The Registrar prescribed a short course of temazepam to help Mr K sleep and the anti-depressant amitriptyline.

69. Mr K failed to attend his next out-patient appointment on 14 September 1993. However, he did attend on 12 October 1993 when he was again seen by the Registrar. He reported that he had stopped taking his antidepressant medication when it ran out. The Registrar provided him with a repeat prescription for amitriptyline and a short course of temazepam. He also wrote to the GP asking him to renew the prescription for amitriptyline when it next ran out.

70. Further out-patient appointments were made for Mr K on 6 November and 14 December 1993 and 1 February 1994 all of which he failed to attend. However he did see his GP on 3 December 1993. He said that he had had an altercation with Mrs K and had become aggressive again. He saw his GP again on 26

January 1994 when he complained that he had not been well over Christmas. He claimed that he had been talking to himself and could not remember anything.

71. He was seen again in out-patients on 29 March 1994. He complained that he was only getting 3 hours sleep a night because his mind could not switch off. The doctor prescribed a further short course of temazepam and repeated the prescription for amitriptyline. He noted that Mr K was probably addicted to temazepam. A further out-patient appointment was arranged for 6 weeks' time. It is not clear whether this further out-patient appointment, or any others during 1994, were attended by Mr K as there are no other out-patient notes for 1994.

Comment

72. The only person we interviewed who was involved in Mr K's care between 1990 and 1994 was his GP. The history set out above is taken largely from Mr K's medical records.

73. We are satisfied that Mr K was frequently very violent to his wife and their children. He drank heavily and used cannabis on a regular basis until at least the early 1990's. There is evidence to suggest that intermittently he drank heavily right up to the death of his wife. He was unemployed most of the time and relied on Mrs K and, at a later date, his children for financial support. He exercised control over the whole family and always wanted to know

where they were. Mrs K and the children were frightened of him; their fear made them reluctant to seek outside help.

74. *Following his admissions to Friern Hospital in 1990 and 1992, Mr K was we believe correctly diagnosed as having an anti-social personality disorder. Such disorders are difficult to treat. Mr K's management was made more difficult as information regarding his condition from members of his family was limited. During the period of his admissions Mrs K had separated from him, and as a result she was not available for medical staff to contact. Even if she had been we are doubtful that she would have willingly disclosed what had been going on at home, given her apparent fear of her husband and her loyalty to him. Furthermore, it is likely that Mr K was presenting with symptoms intending to influence the behaviour of others, in particular his wife and those treating him. We feel that it is more than coincidence that Mr K was found by a member of the family or a friend each time he attempted suicide. Blood tests performed after Mr K's overdose on 19 June 1992 failed to reveal traces of the paracetamol tablets which he had allegedly taken. Both the locum Psychiatric Senior House Officer and Psychiatric Senior House Officer (a) felt that Mr K might be manipulating them to ensure that he was admitted to and remained in hospital.*

75. *The GP was aware that Mrs K was the subject of domestic violence. He told us that he thought the abuse was predominantly verbal and that he had never witnessed any signs of physical violence towards her. This accords with Mrs K's statement to Housing Manager (a) that her husband did not allow her to seek medical attention for any*

of the injuries he inflicted on her. It seems that Mrs K did not reveal to the GP the true nature of the violence to which she was subject. The first and only reference of actual physical violence by Mr K in Mrs K's GP records is the note of the consultation on 30 August 1991. The GP followed this up by referring Mrs K to the CPN. A letter from the CPN to the GP, dated 19 September 1991, summarises her meeting with Mrs K. It outlines a number of problems which Mrs K had, but makes no reference to domestic violence by Mr K. We suspect that Mrs K again underplayed the nature and extent of the violence to which she was subjected.

76. *The GP told us that he recognised that Mrs K required support. He said that normally in such circumstances he would refer a patient to Social Services but he did not do that in Mrs K's case as she was reluctant for Social Services to become involved.*

Chapter 4

MR K'S OUT-PATIENT CARE JANUARY 1995 TO JULY 1996

77. In 1995 the provision of mental health services by Haringey Healthcare NHS Trust was reorganised. The catchment area for the Trust was divided up into five geographical sectors. A sector team was responsible for the provision of community mental health services in each sector. Mr K lived in the Wood Green sector. His Consultant Psychiatrist was, and is, a consultant for the Wood Green sector. She is extremely experienced having been appointed as a consultant in adult psychiatry in 1981. From January 1995 to December 1996 she worked part time as a clinician. In December 1996, the Consultant Psychiatrist was appointed clinical director. Since then she has spent approximately half her working week doing clinical work and the other half attending to her management responsibilities. The Consultant Psychiatrist shares her clinical work in the Wood Green sector with an associate specialist who has recently been promoted to Consultant grade. So far as her clinical commitments are concerned, the Consultant Psychiatrist usually has 28 in-patients to care for. She also has 2 out-patient clinics a week during which she sees about 13 people in total.

78. The Wood Green sector serves a population of approximately 50,000 people. The Wood Green sector team is based at Canning Crescent, a community mental health centre which was opened in 1994. During the inquiry process we visited Canning Crescent; the facilities there for patients are very good, well maintained and located in a pleasant environment.

79. The Wood Green sector team comprises two consultants working part time, junior doctors, approximately 6 social workers and 6-8 community psychiatric nurses. The sector team also has direct access to a psychologist for a number of sessions a week.

80. On 19 January 1995, the GP referred Mr K to Consultant Psychiatrist (c), a consultant psychiatrist at St Ann's Hospital. The referral letter stated that Mr K had recently become very agitated and was suffering from sleep disturbance. No response was received to this letter. On 27 March 1995 the GP sent a second copy of the letter. It was forwarded to the Wood Green sector team at Canning Crescent and Mr K was given an appointment with the Registrar to the Consultant Psychiatrist.

81. The Registrar saw Mr K on 24 May 1995. Mr K complained that his condition had deteriorated over the previous 6 months. He was feeling increasingly irritable and felt his main problem was lack of sleep. He stated that his wife had left him several times in the past because he had hit her. He said he could no longer handle alcohol though he used to drink up to 20 pints a night. He admitted to occasionally smoking cannabis. He told the Registrar that he had an extensive forensic history including offences of firearm possession, robberies and theft and he claimed that he had received four or five prison sentences of up to a year.

82. The Registrar summarised the history she had been given and her impression of Mr K in a letter to the GP dated 24 May 1995:

> **"My impression was that there was some evidence of a depressive illness with diurnal mood variation and early morning wakening. However there is also evidence to**

suggest an impulsive personality disorder and I note that when he was last seen a year ago, he was addicted to temazepam."

83. The Registrar prescribed Mr K a mood stabiliser, carbamazepine, and arranged to review him in six weeks.
The Registrar saw Mr K again on 14 July 1995. He said that he felt a bit better, but the carbamazepine made him feel too sleepy. He reported that he still felt quite violent and had hit someone who had said the wrong thing to him. He had had thoughts saying **"hit him, hit him. "** Sometimes he was able to resist such thoughts and other times he was not. The Registrar reduced the dose of his carbamazepine and referred Mr K to the Psychology Department with a view to him participating in an anger management course.

84. The referral letter from The Registrar to the psychologists is dated 24 July 1995. On 8 August 1995, the Psychology Department wrote to Mr K stating that they would contact him with an appointment in due course and asking him to complete a very basic questionnaire giving details of his date of birth, his ethnic origin and his GP. Mr K completed the form on 11 August 1995 and returned it to the Psychology Department.

85. On 13 December the Psychology Department wrote to Mr K asking whether he still wanted an appointment. He was asked to respond by 2 January 1996. So far as we are aware Mr K did not respond directly to the psychologists. However, he had an out-patient appointment with Psychiatric Senior House Officer (c), on 28 December 1995. Psychiatric Senior House Officer (c)'s summary of the consultation is found in a letter to the GP dated 10 January 1996. She stated:

"Mr K acknowledged that he found it extremely difficult to handle any stress, and that as a result he has been treating his wife very badly, shouting at her and on occasions hitting her for matters which were not in any way her doing....[Mr K] on this occasion seemed extremely keen to talk about his past, and felt it would be helpful to ventilate some of his feelings in regular counselling sessions."

86. Psychiatric Senior House Officer (c) repeated Mr K's prescription for carbamazepine and, in addition, prescribed a three day supply of temazepam to help him sleep. On 10 January 1996, she wrote to the Psychology Department following up an assessment appointment for Mr K. On 19 January 1996, the Psychology Department wrote to Mr K offering him a psychology appointment on 1 February 1996. Mr K failed to attend the appointment and he was offered a further appointment on 26 February 1996 which he also did not attend. Similarly, Mr K failed to attend his out-patient appointments on 23 February 1996 and 15 April 1996.

87. On 21 May 1996, Mr K saw Psychiatric Senior House Officer (d) for an out-patient appointment. He was aggressive and complained that none of the interventions which he had been offered were any good and that he always saw a different doctor. His carbamazepine supply had run out a week previously, but he said that it did not help him in any event. He perceived that lack of sleep was the root of his problems and claimed temazepam was the only thing that helped him get to sleep. He stated he had never wanted to be referred to the Psychology Department because it was not any use. Psychiatric Senior House Officer (d) concluded that there was little point in re-referring Mr K to the

psychologists because of his lack of motivation. Psychiatric Senior House Officer (d) discussed Mr K with the Consultant Psychiatrist who advised that there was little by way of alternative medication that he could be offered. Psychiatric Senior House Officer (d) did not renew Mr K's prescription for carbamazepine, but she did prescribe zoplicone to help him get to sleep. She also sent him the name and address of a counselling service for violent men.

Comment

88. *There was a delay of over 4 months between the GP's referral letter, which was marked "urgent" and Mr K being seen by the Registrar. We understand that the introduction of the sector teams and the corresponding change in consultant responsibilities may have contributed to the delay. Whatever the reason, the delay in Mr K being seen was too long.*

89. *At the time of his contact with Wood Green sector services Mr K was recognised as a man with an abnormal personality. He also abused alcohol and drugs. He was correctly diagnosed as suffering from an anti-social personality disorder with depressive episodes. A number of factors made the management of Mr K's care particularly difficult:*

-Mr K said that he lied to doctors. He gave different and inconsistent histories to different doctors.

- Mr K refused to try any form of psychological treatment. He had said that he would lie in any form

of group therapy and was of the view that there was no point attending such sessions.

- Mr K took his medication erratically. He told us that when he felt better in himself he stopped taking the medication.

- Mr K frequently discharged himself from hospital against medical advice; often spent long periods out of the hospital when he was an in-patient and irregularly attended out-patient appointments.

- he was violent to other patients in hospital and could be aggressive and menacing to staff.

The difficulties were compounded by the fact that Mrs K was not actively involved in the management of her husband's care.

90. *It is commendable that the team treating Mr K persevered in offering him out-patient appointments despite his poor and erratic attendance and the other management difficulties which he presented.*

91. *Mr K was himself critical of the fact that he was seen by a series of junior doctors. This is an inevitable consequence of the current system for training junior doctors who rotate posts every six months or so. Although not falling within our terms of reference, we think that further consideration needs to be given as to how the potentially*

conflicting training needs of junior doctors and patients' needs for continuity of care can best be met.

92. *In our view Mr K's care could be properly managed in out-patients by junior doctors (senior house officers and registrars) with appropriate consultant support.*

93. *Mr K's medical records only make one reference to his case being discussed with the Consultant Psychiatrist during this time and that was on 21 May 1996. However the Consultant Psychiatrist told us that she recalled seeing Mr K on several occasions in the out-patient clinic with her junior doctors, despite the fact that such meetings were not recorded.*

94. *We feel that too many demands were placed on the Consultant Psychiatrist's time. Although her case load was not unusual, case loads of this level, together with the very high bed occupancy rate at St. Ann's Hospital (which is often as high as 140%), made it difficult to deliver optimum care.*

95. *In our view, it is most important that where junior doctors are rotating every 6 months, a Consultant should regularly review the junior doctors' patient lists to ensure that the patients have been appropriately managed. The Consultant Psychiatrist told us she carried out such a review every time one of her juniors moved on. It would be good practice for a note confirming that such a review has taken place to be made in the patient's records.*

Recommendation

The Trust should take steps to ensure that:
(a) consultant psychiatrists review their junior doctors' patient lists regularly, and
(b) a note confirming that a review has taken place is made in each patient's notes

Chapter 5

ADMISSION TO ST. ANN'S HOSPITAL, 8 JULY 1996

96. On 8 July 1996, Mr K attended Canning Crescent with Mrs K for an out-patient appointment. He said he had run out of medication three days previously.

Comment

97. We are not sure what medication Mr K had run out of. When he was seen by Psychiatric Senior House Officer (d) on 21 May 1996, she had only prescribed zoplicone. So far as we are aware Mr K had not been taking carbamazepine since mid-May 1996.

98. According to Mr K, on arrival at Canning Crescent he was told that his out-patient appointment had been cancelled and that he should come back in one month. Mr K became angry and started shouting at staff who called the police. On hearing the disruption, the Consultant Psychiatrist came out of her out-patient clinic. Given his aroused and disturbed state, she decided that Mr K should be detained under Section 4 of the Mental Health Act 1983. In her evidence to us, she described the situation in the following terms:

"He had been drinking and was loud and quite overtly disturbed. He was demanding food from the cafeteria which was half-closed. His wife was concerned that he had been making threats towards her. She was worried about him. I felt at that time, because he was over aroused and in a disturbed state, although much of that was due to alcohol, I did not really want him to go home with her in the state he was in. So I proceeded with a section 4."

99. Section 4 of the Mental Health Act 1983 provides an emergency procedure for the compulsory admission of a patient to hospital for assessment. Section 4 is intended to cover emergency situations where there is insufficient time to obtain written recommendations from two registered medical practitioners that the patient be admitted. Under Section 4 it is sufficient if one medical practitioner, preferably one acquainted with the patient, recommends that he or she be admitted and detained in hospital. The maximum period for which a patient can be detained under Section 4 is 72 hours.

100. The Consultant Psychiatrist signed the Section 4 medical recommendation form at 4 p.m. She recommended that Mr K should be detained in the interests of his own health and with a view to protecting other persons. An Approved Social Worker completed the application form for Mr K's admission for assessment at 4.10 p.m.

101. Mr K was then taken to St. Ann's Hospital, accompanied by his wife, where he was seen by the duty doctor and admitted to Finsbury Ward. Mr K was insistent that he felt well and should not be in hospital. At about 7 p.m. Mr K was informed of his legal

rights and status by Staff Nurse (a), his allocated named nurse, in accordance with Section 132 of the Mental Health Act 1983.

102. On 9 July 1996, Mr K was reviewed by the Consultant Psychiatrist on her ward round. He said he felt a lot calmer and attributed his behaviour the day before to drink. He said that he wanted to go home as he was missing his wife. The Consultant Psychiatrist agreed to him being given leave until 11 a.m. the following day when he was to return to see the Consultant Psychiatrist so his condition could be reviewed. He was prescribed a 2 day supply of carbamazepine, temazepam and haloperidol. Mr K repeated his complaints about seeing too many doctors and the Consultant Psychiatrist agreed to follow up his care for the time being. Social Worker (a) also attended the ward round. She recalled that Mrs K was also present. Social Worker (a) explained that no social needs for Mr K were identified by her, or anyone else, which required her involvement.

103. Mr K failed to attend the review meeting with the Consultant Psychiatrist on 10 July 1996 and so as a patient detained under the Mental Health Act, he was effectively absent without leave. Mrs K telephoned the ward and explained that they could not afford the bus fare to get to St Ann's Hospital. A further appointment with the Consultant Psychiatrist was arranged for the following day, 11 July 1996. Again Mr K failed to attend. In Mr K's absence, the Consultant Psychiatrist discharged him from hospital (the 72 hours for which he could be detained under Section 4 expired at 4 p.m. on 11 July 1996). She sent a prescription to Mr K for a 3 week supply of carbamazepine, temazepam and haloperidol and she arranged to see him in her out-patient clinic on 31 July 1996.

Comment

The Mental Health Act

104. *The cause of Mr K's behaviour appeared to be too much alcohol rather than mental illness. The Consultant Psychiatrist told us that she could not remember any other occasion when she had used Section 4 of the Mental Health Act 1983 in circumstances such as these. She said:*

> ***"I just felt it was a responsible thing to do under the circumstances at the time. I thought there might be more to it than just the alcohol but by the time he had slept it off he was back to normal again".***

105. *The clinical team were faced with a predicament; whilst they knew that the primary diagnosis was personality disorder and that Mr K's behaviour was likely to be the result of drink, they could not be sure. In the circumstances, the decision to detain Mr K under Section 4 was entirely acceptable. However, we do have concerns about subsequent events whilst Mr K remained detained under Section 4 of the Mental Health Act 1983.*

106. *The Code of Practice on the Mental Health Act 1983 issued by the Department of Health and Welsh Office provides:*

> ***"If a patient is admitted under section 4 an appropriate second doctor should examine him as soon as possible after admission, to decide whether the patient should be detained under Section 2."***

107. *We are concerned that some of the witnesses we heard from (nursing and managerial) were unclear as to who was responsible for obtaining a second medical recommendation under Section 4 of the Act. We variously heard that it was the responsibility of the keyworker, the consultant or duty doctor, and "the nurse in charge". In fact, the Code of Practice stipulates that it is the responsibility of the approved social worker who makes the application for admission to ensure that the second medical recommendation is obtained.*

108. *The Consultant Psychiatrist explained to us that she did not press for a second medical recommendation on the evening of 8 July 1996 as she thought it preferable for a second doctor to see Mr K when her team were on duty and in a position to provide information. In our view, in order to comply with the Code Of Practice recommendation that a second doctor examine a patient admitted under Section 4 "as soon as possible", a second medical recommendation should have been sought by the approved social worker as soon as Mr K was admitted to St. Ann's on 8 July 1996.*

*109. We understand the Consultant Psychiatrists's decision not to proceed with a second medical recommendation on 9 July 1996 in the light of Mr K's **"return to normal"**. However, once the Consultant Psychiatrist was satisfied, as she clearly was on the morning of 9 July 1996 that Mr K was not **"sectionable"**, she should have immediately discharged his compulsory detention under Section 4 as opposed to granting leave.*

110. When a patient is compulsorily detained under section 4, it is good practice, as set out in the Code Of Practice, for a social circumstances report to be prepared by the approved social worker who made the application for the admission. Such a report apparently was not prepared in this case. This was a missed opportunity for a social worker to speak to Mrs K and possibly to offer support to her and/or Mr K. The recommendations of the Code of Practice should have been followed.

111. The failure to prepare a social circumstances report does not appear to have been identified at the time by the Mental Health Act administrator responsible for monitoring the use of the Act.

112. When Mr K failed to re-attend St. Ann's on 10 July 1996 for the review meeting with the Consultant Psychiatrist he was formally a detained patient who was absent without leave. During the course of the Inquiry we asked to see the Trust policy detailing the actions to be taken when a detained patient goes absent without leave. The policy was not produced for us.

Recommendations

The Trust and the Social Services Department should make clear to all staff involved in the use of the Mental Health Act 1983 precisely whose responsibility it is to obtain a second medical recommendation for the purpose of converting section 4 of the Mental Health Act to Section 2.

The Trust should take steps to ensure that the use of the Mental Health Act 1983 in the Trust is stringently monitored by the Mental Health Act administrator, thereby ensuring that the good practice set out in the Code of Practice is followed.

The Trust and the Social Services Department should ensure that staff involved in the use of the Mental Health Act 1983 receive regular refresher training in respect of the requirements of the Act and good practice in implementing those requirements.

The Trust Mental Health Act administrator should ensure as a matter of priority that the Trust has a policy dealing with detained patients who are absent without leave which complies with the recommendations of the Mental Health Act 1983 Code of Practice and that staff are familiar with the terms of the policy.

113. A Care Programme Approach (CPA) care plan was completed on 11 July 1996 for Mr K. The plan recorded that Mr K's social needs had not been assessed as he did not attend the care plan meeting. In the care plan it was noted that: **"[Mr K] was not considered to be at risk by the members of the multi-disciplinary team at present."** The care plan was signed by the Consultant Psychiatrist on 16 July 1996 and by Staff Nurse (a) on 17 July 1996.

Comment

The Care Programme Approach

114. A joint multi-agency Care Programme Approach (CPA) policy was introduced in Haringey in March 1996. We found the 1996 policy confusing and difficult to understand. It required an assessment of health and social needs to be made for every patient using specialist mental health services and a care plan to be drawn up. Care plans had to be reviewed every 6 months. A keyworker was to be allocated to each patient, who was required, amongst other things, to see the patient at least once a month.

115. The 1996 policy distinguished between simple care plans, for patients with simple needs, and comprehensive care plan for patients with more complex needs. Simple

care plans could be devised by a patient's named nurse whereas comprehensive care plans required an initial multi-disciplinary assessment (possibly involving the consultant, the patient's named nurse, a social worker, a CPN and the patient's GP). According to the policy a simple care plan was appropriate for patients who were seen as out-patients. Given that Mr K's needs were complex but his treatment primarily consisted of out-patient appointments (and medication) it is not clear whether, under the terms of the 1996 policy, he required a simple or comprehensive care plan.

116. *Irrespective of whether Mr K's case was treated as simple or complex, his care plan form, dated 11 July 1996, was inadequately completed. An attempt should have been made to assess Mr K's social needs even in his absence.*

117. *Given the unsatisfactory nature of the care planning meeting on 11 July 1996 (due to Mr K's non attendance), Mr K's key worker, the Consultant Psychiatrist, should have reviewed the plan with him at the first opportunity, namely his out-patient appointment on 31 July 1996. However, even if an early review of the care plan with Mr K had taken place, it is unlikely that it would have significantly altered the care which he received.*

118. *In our view the 1996 CPA policy was inflexible; for example, we question whether the requirement for all patients on CPA, including those on level 1, to meet with their keyworker once a month was practical or workable.*

119. *This provision was repeated in a new joint CPA introduced in Haringey in June 1997. Unfortunately, we found this document equally confusing. It identifies several criteria which are to be used in allocating a patient to a CPA level. However there is no guidance as to how these are to be quantified and no indication which should take priority when the application of one criterion suggests a different conclusion from the application of another. For example, the 1997 CPA policy states that to qualify for CPA level 2 a patient* ***"must be diagnosed as having a severe mental illness".*** *According to the Consultant Psychiatrist this automatically excludes people with personality disorders who are without signs of a concurrent mental illness, even those with very complicated needs; yet the Mental Health Act and Care Programme Approach Mananger told us that if a patient was a risk or had complicated needs he could be level 2 even if he did not have a severe mental illness.*

120. *Adherence to CPA policy was incomplete and less than wholehearted. We understand that a review of the CPA procedural guidelines is due to take place. Such a review is required as a matter of urgency and should include a review of the CPA policy itself.*

121. *We were told that all staff are meant to attend an introductory training session on CPA. We understand that an advanced course in key worker responsibilities is also being devised.*

Recommendations

The Trust should re-write the CPA policy and procedural guidelines in order to provide clear guidance to staff at all levels who are involved in the operation of CPA.

The Trust should ensure that all staff involved in CPA receive regular refresher training on its use.

122. *It is not clear whether Mrs K was invited to attend the re-scheduled care plan meetings on 10 and 11 July 1996; she should have been. The CPA required an assessment not only of Mr K's health and social needs, but also the risk that he presented to himself and others. Given Mr K's own admissions, which were documented in his medical notes, that he was capable of lying to doctors, it was important that attempts were made to speak to Mrs K, with her husband's consent, to obtain information from her which was relevant to assessing his needs and the risks he posed.*

123. *The Consultant Psychiatrist told us that she did speak to Mrs K before Mr K was allowed home with her on 9 July 1996. She told us:*

> ***"She gave us to believe that things were not too bad. Otherwise we would not have let him go home so quickly with her, if we had realised that she was seriously frightened of him. She was not***

behaving in the way of a wife who was seriously frightened. She was asking-pressing-to be allowed to take him home, because he would be much better at home."

However, at another point in her evidence to us the Consultant Psychiatrist said that she could not remember what contact there was with Mrs K as it was not recorded. She also told us:

"In retrospect, I would have liked to have talked with his wife much more than we did....We did try at times, but partly she was frightened about talking about him. She did not want him to feel that she was going behind his back and so it was quite difficult to engage her."

124. *From the records, there did not appear to have been many attempts to communicate with Mrs K either at the time that Mr K's care plan was drawn up or at any time thereafter. However, we accept that even if there had been further contact with Mrs K, she may not have been willing to provide additional information to the Consultant Psychiatrist or her team.*

Risk Assessment

125. *Similarly, we do not feel that the issue of the risk which Mr K presented to himself and others was adequately considered at the time when his care plan was drawn up or*

any time afterwards. When asked about her assessment of the risk which Mr K presented, the Consultant Psychiatrist told us:

> ***"He did not present as one of the more dangerous people I look after. There was no time when I had any inclination that he would be likely to kill someone, or seriously injure. That had not come out. I was not aware of any previous serious injuries to his wife because she had not indicated those."***

126. *However, the Consultant Psychiatrist was sufficiently concerned about Mrs K's safety on 8 July 1996 to compulsorily detain Mr K under Section 4 of the Mental Health Act. Even if within 24 hours of Mr K's compulsory detention the Consultant Psychiatrist was satisfied that his behaviour was largely attributable to drink, it must have been apparent to her, that at the very least Mr K posed a risk to Mrs K when he was drunk. Mr K's past history confirmed that he was capable of violence. It included two incidents when he had punched fellow patients. His history also indicated that at times of stress, for example when his wife left him, he was capable of harming himself and expressed intentions of harming others, including his wife and daughter. He had admitted to hitting Mrs K on occasions and was known to abuse alcohol intermittently and possibly drugs.*

127. *We feel that the information available indicated that there was a potential risk of Mr K injuring his wife, possibly*

seriously. It should have prompted further inquiries to be made by the team. These should have included further attempts to speak to Mrs K.

128. *At the relevant time there were no Trust guidelines on risk assessment or risk management. The situation was remedied in June 1997 when the Trust, in conjunction with Haringey Social Services, issued guidance (in the form of a policy) to staff on risk assessment and risk management in CPA.*

Chapter 6

MR K'S OUT-PATIENT CARE JULY 1996 TO 10 JUNE 1997

129. On 31 July 1996, Mr K was seen by the Consultant Psychiatrist in her out-patient clinic. He reported that initially after his discharge from St Ann's hospital he had slept better, but over the previous week his sleep had deteriorated and once again he was only managing 2-3 hours a night. He had avoided taking temazepam because he was worried about becoming addicted. He had also avoided alcohol since his discharge. The Consultant Psychiatrist advised Mr K to seek some form of employment to give him a little extra money and to boost his confidence. She recommended that he contact the MIND employment adviser. She also prescribed him carbamazepine, haloperidol, and temazepam to be taken when required. In a letter to the GP, dated 9 August 1996, updating him on Mr K's condition, The Consultant Psychiatrist stated that she had found him **"considerably improved"**.

130. Mr K did not attend his out-patient clinic on 30 August 1996. A further appointment was made for him on 18 October 1996 when he saw the Consultant Psychiatrist. His main complaints were poor sleep having run out of temazepam two weeks previously. He said he felt aggressive and agitated during the day. His prescription for carbamazepine and haloperidol was renewed.

131. Having missed his out-patient appointment on 13 December 1996, Mr K next saw the Consultant Psychiatrist on 17 January 1997. He complained of feeling low in mood. He admitted that he had

"knocked his wife about" over Christmas. He said he had felt very angry and aggressive. He said he did not punch Mrs K but flailed out at her causing bruising to her. He also admitted that he had been drinking recently. As well as repeating Mr K's prescription, the Consultant Psychiatrist also recommended an anger management course. She referred him to the Psychology Department for assessment on 28 January 1997. On 14 February 1997, Mr K was sent a letter by the Psychology Department enclosing a basic questionnaire and stating that he would be offered an appointment in due course. He completed and returned the questionnaire on 19 February 1997.

132. The Consultant Psychiatrist reviewed Mr K on 14 March 1997. Once again he had run out of medication before his appointment and felt that there was a consequent deterioration in his condition. He felt very angry and aroused by even the most trivial things. He also described periods when he had racing thoughts and was unable to express himself coherently. The Consultant Psychiatrist identified these as possibly hypomanic episodes and gave Mr K a supply of haloperidol to take when this occurred. Mr K was again given information of the Everyman Counselling Service for violent men and was provided with details of employment advisory services.

133. Following this appointment, the Consultant Psychiatrist contacted the Psychology Department regarding her referral of Mr K for an anger management course. Still no appointment was received so on 2 May 1997 the Consultant Psychiatrist asked Clinical Psychologist (a), the clinical psychologist attached to the Wood Green sector team, whether he would see Mr K. Clinical Psychologist (a) arranged an appointment for 10 June 1997.

134. On 25 May 1997 Mr K turned up at the out-patient clinic reception complaining of a lack of input from the mental health services in the community. He was seen by Doctor (a) as he claimed that he had run out of medication. Doctor (a) renewed his prescription for carbamazepine, haloperidol and temazepam. Mr K also reported that he had been feeling low since the Friday before as his wife had left him without warning. He said he did not feel actively suicidal but was worried that he might become so.

Comment

Social Services' Involvement

135. We asked the Consultant Psychiatrist why, when she knew that Mrs K was the victim of domestic violence, she did not attempt to involve Social Services. The Consultant Psychiatrist told us that Mrs K gave her the impression that she was already receiving support from Social Services. This could have been verified, but so far as we are aware it was not. The Consultant Psychiatrist did not think that Social Services would become involved because in her view Mr and Mrs K did not meet their eligibility criteria. She understood that Social Services would not become involved in "domestic violence cases".

136. We understood from Social Worker (a) that her caseload was divided up into short term and long term cases. On her visits to tne ward each week Social Worker

(a) would deal with patients' short term social problems, for example sorting out their housing and benefit needs. These patients tended not to be formally referred or allocated to her. She would help with their specific problems and that would be an end to the matter. Sensibly, eligibility criteria were not applied to these short term cases.

137. *However, eligibility criteria were and are applied to cases requiring the long term involvement of, and funding by, Social Services (long term cases). Social Services have written criteria which divide cases into high, medium and low priority. There are 9 high priority criteria, for example:*

"Clients who have experienced several hospital admissions"
"Clients who are in imminent danger of needing hospital or residential care as a result of acute mental distress or breakdown of the caring network".

However, in practice 2 simpler criteria are applied: (i) does the person have severe and enduring mental health problems? and (ii) does he/she have high priority social needs which Social Services can assist with? In order to avoid confusion amongst Social Services' staff and service users the eligibility criteria which are applied in practice by Social Services in providing long term mental health services need to be clearly identified.

138. *We understood from what we were told by Social Worker (a) that had she known of the violence which Mrs K*

was subjected to she would have tried to offer both Mr and Mrs K help. She told us:

> ***"If we had had more information on the level of violence that Mrs K was experiencing, and threats, whatever, that he had obviously made to her, then I think certainly that I would have tried to work more pro-actively in terms of getting her opinions and looking to see what sort of support of counselling services we may be able to look to offer them."***

However, the Team Leader for the Community Mental Health Team explained to us that Social Services were generally not in a position to provide support and counselling in cases involving domestic violence by patients. She said:

> ***"Our focus is very much not on offering just support in a general way now. It is very much geared to looking at packages of care, or in the terms of the CPA being the key worker co-ordinating care in the community. Whereas 10 years ago we used to do a lot of counselling, a lot of therapeutic work with clients and their families, we are not in a position to do that now unfortunately, so we would direct those clients to other counselling agencies".***

139. *During the course of the inquiry we were provided with a guide to domestic violence produced by the Housing and*

Social Services Department. It is clear from this booklet that the service provided by the Department in cases of domestic violence is currently limited to advising victims what they can do about their situation and who to contact for further advice and support. In our view there is a need for Social Services to offer counselling and support in cases of serious domestic violence, particularly where the perpetrator of the violence is in receipt of mental health services.

Recommendations

The Social Services Department needs to clarify the eligibility criteria which are to be applied in providing mental health services in long term cases. If the current written eligibility criteria are not actually applied then they should be replaced by those which are. If "severe and enduring mental health problems" (or a similar term) is to be one of eligibility criteria, steps should be taken to ensure that the definition of this is sufficiently clear to enable it to be easily applied by practitioners. In particular whether individuals suffering from anti-social personality disorder are eligible for help needs to be clarified.

There is a need for Social Services' input in cases of domestic violence perpetrated by a patient who is in receipt of mental health services. The Social Services Department should consider allocating resources to

offer counselling and support in cases of serious domestic violence.

Psychology Department

140. *Mr K was referred on two occasions to the Psychology Department for assessment for an anger management course. The first time was on 14 July 1995; following a letter from Psychiatric Senior House Officer (c), Mr K was eventually offered an appointment some 6 ½ months later on 1 February 1996. The second referral was made on 28 January 1997 by the Consultant Psychiatrist; she had to repeat the request several times before Mr K was given an appointment on 10 June 1997, some 4 months later.*

141. *We were very concerned by the delays between referrals made to the Psychology Department and appointments being offered to patients. In our view delays of 4-6 months are too long. We heard from the Psychology Services Co-ordinator who is now responsible for part of the adult mental health division within the Psychology Department, including the Wood Green sector. She told us that currently the average period of time between referral to a psychologist and assessment is 3 to 4 months and on average it is a further 2 months before the patient starts treatment, although in urgent cases patients are seen more quickly. The Psychology Services Co-ordinator told us that*

the drop out rate for patients between referral and assessment was ***"very high"****.*

142. *The system in operation in the Wood Green sector at the time of Mr K's two referrals was as follows: the patient would be sent a letter informing them that no appointments were currently available but that they would be contacted in due course. The date of the referral would be noted by the Psychology Department. The patient would also be sent a demographic questionnaire to complete. The returned questionnaires were filed by administrative staff chronologically. When a psychologist had space in his/her case load to offer a patient a course of treatment, the patients who had been waiting longest for appointments were contacted and asked if they still wanted to see a psychologist. If the patient replied affirmatively, they would be sent a questionnaire seeking further information about their circumstances and problems. Once this was returned they were allocated an assessment appointment.*

143. *It would appear that the system in the Wood Green sector has changed since June 1997. New referrals are now sent a letter asking them to confirm that they want psychology services. They have to respond positively in order to "opt into" the service. They are also sent a screening questionnaire. Once these questionnaires are returned they are assessed. We understand that in the Hornsey and Highgate sector where the Psychology Services Co-ordinator carries out her clinical work, she assesses all the forms personally. In the other sectors which the Psychology Services Co-ordinator manages this is done*

in a group meeting of the psychologists working in the sector, although the Psychology Services Co-ordinator was unable to tell us how frequently such meetings took place in the other two sectors which she manages. Patients are prioritised for appointments according to the nature of the information provided on the form. Except for urgent cases, patients are still only offered an appointment for assessment once a vacancy for treatment is available.

144. *We feel that it would be far more efficient to offer patients an assessment appointment shortly after they are referred rather than delaying such appointments until a treatment time is available. This would enable patients' needs for treatment to be assessed at an early stage and they could be prioritised accordingly. Early assessment appointments will identify those patients with priority needs and those whom the Psychology Department have no appropriate treatment to offer. It is also to be hoped that early assessment appointments would reduce the high non attendance rate of patients for assessment.*

Recommendation

The Trust should revise the current system operated by the Psychology Department of offering patients assessment appointments only once places are available for treatment. Assessment appointments should be offered to patients referred to the Psychology Department shortly after referral

145. *Mr K was referred twice to the Psychology Department for an anger management course. We heard from the Psychology Services Co-ordinator that the Psychology Department only ran such courses when they had a suitable number of referrals requiring anger management counselling. It would no doubt be beneficial if those referring to the Psychology Department were made aware of when such courses were likely to be available.*

146. *When we met him Mr K complained that the doctors were always changing his medication. He said that he would just get used to one type of drug and then he would be prescribed something new. Such complaints are entirely unfounded. Mr K was prescribed appropriate drugs to treat the symptoms which he described.*

147. *However there does appear to have been some confusion as to who was primarily responsible for prescribing the drugs. The Consultant Psychiatrist said that Mr K should have been getting his prescriptions from his GP. The GP told us that Mr K was getting his prescriptions from the Hospital, although he would provide a prescription in an emergency when Mr K had run out of medication. We asked the Consultant Psychiatrist whether she had any idea of the percentage of medication which Mr K took between June 1996 and July 1997; she told us she did not.*

Recommendation

The Trust should ensure that GP's and Consultant teams communicate in writing confirming who is prescribing what medication to a patient.

148. *The quality of Mr K's psychiatric care, in terms of what could have been expected from a general and community psychiatric team, was reasonable. It was based on a correct diagnosis, in terms of his history and mental state and a tenable explanation in psychological terms, of his symptoms and behaviour. It involved a course of treatment which followed generally accepted principles for the management of people with personality disorders and included maintenance of contact in order to be able to offer increased levels of support, through the provision of a hospital bed or supportive accommodation, where necessary.*

149. *We have doubts as to whether patients such as Mr K, who suffer from complex anti-social personality disorders, can or should be managed by community general psychiatric teams. This is not a matter falling within our terms of reference. We are aware that this issue is presently under review at a national level.*

Chapter 7

MRS K'S DEPARTURE MAY 1997

150. On 15 May 1997, Mrs K went to the Wood Green Area Housing Office where she was seen by Housing Manager (b). Housing Manager (b) recalled that Mrs K was very distressed and frightened; she wanted a housing transfer on the grounds of domestic violence. Housing Manager (b) made the following note of what she was told:

> **"Ms K states he does not allow her to leave the house, she has no friends and is no longer in contact with her children because of his behaviour. She states that he often beats her up and threatens to kill her. He blames her for his stay in Friern Barnet and has often put his hand around her throat and told her that he should kill her now rather than allow her to leave him again.**
> **Ms K was emotional and crying throughout the interview. She stated she was afraid her husband would find out she was planning to leave and kill her. She requests that he should not be contacted, or that she should not be contacted at home. It was agreed that she would ring her Housing Manager at the end of the following week. Ms K stated that she was not allowed to leave the house often and when allowed had to return promptly."**

151. On 18 May 1997, Mrs K made a call to the Social Services duty service requesting an emergency housing placement due to domestic violence. She was provided with emergency bed and breakfast accommodation.

152. On 4 June 1997, Mrs K was interviewed by Housing Manager (c). She gave a similar history to that which she had given to Housing Manager (a) in 1992. Mrs K explained that the reason why she had sought emergency accommodation since her last visit to the Housing Office was because Mr K had threatened to strangle her. Mrs K told Housing Manager (c) that her husband was under the care of Doctor (b) at Canning Crescent Clinic.

153. On 6 June 1997, Housing Manager (c) prepared a management transfer report recommending that Mrs K be offered alternative accommodation. On 11 August 1997, Mrs K was granted a non-secure tenancy of a one bedroom flat.

Comment

154. We were very impressed by the experience of the staff whom we saw from the Wood Green Area Housing Office and their line managers. They met Mrs K's immediate needs by providing her with emergency accommodation.

155. Through their discussions with Mrs K, both in 1992 and 1997, the housing officers/managers who interviewed

her obtained a considerable amount of detailed information regarding the domestic violence to which she was subject. It was known to them that Mr K inflicted serious violence on his wife, that he drank heavily, that he was receiving psychiatric care and, in May 1997, he was threatening to kill her. Sadly this information was not passed onto any other agency and, in particular, those treating Mr K. One of the most perplexing features of this case is that the Housing Department held information which, had it been passed onto those caring for Mr K, may have had a significant bearing on the management of his care.

156. *We do not criticise the staff concerned for not passing the information on. It was apparent to us from the evidence we heard that traditionally the Housing Department has not shared information with other agencies.*

157. *We feel that in cases such as this involving serious domestic violence, where the victim claims to be in fear of her life, as Mrs K clearly was when she was seen by Housing Manager (b), and the perpetrator is known to be under the care of another agency, there are grounds for the Housing Department communicating relevant information to that other agency.*

Recommendation

The Housing Department should draw up guidelines dealing with the communication of information to other agencies.

158. *Housing Manager (b) told us that she discussed with Mrs K whether she would benefit from counselling and support. Mrs K was going to go away and think about it. None of the housing managers/officers who saw Mrs K referred her to Social Services. The reason given was that Social Services' eligibility criteria are very high because of pressure on resources. We understand that generally Social Services are only willing to become involved in cases involving (i) children (ii) people with mental health problems and (iii) the elderly.*

Recommendation

The Social Services Department should consider allocating resources to offer counselling and support in cases of serious domestic violence.

Chapter 8

MR K'S REFERRAL TO ALEXANDRA ROAD

159. On 10 June 1997, Mr K saw Clinical Psychologist (a) at Canning Crescent Mental Health Centre. Mr K stated that his wife had unexpectedly left him 3 weeks previously and since then he had had a strong urge to kill himself. He described feeling angry towards his wife and children for not contacting him. He was worried that he might lose control of his feelings and kill himself. Clinical Psychologist (a) considered that Mr K was a high suicide risk. His notes of the interview record that Mr K did not want to go into hospital but wanted to go somewhere which was calm where he could be looked after. Clinical Psychologist (a) discussed with Mr K the possibility of him going to Alexandra Road Crisis Unit, London N8 ("Alexandra Road"). Mr K was positive about the idea of going to Alexandra Road.

160. At that time Alexandra Road was a new crisis centre facility managed by Haringey Social Services Department. It had previously been a long term rehabilitation unit for people with mental health problems. It first opened as a crisis centre in about June 1997. It was intended to provide an alternative to in-patient admission for patients suffering a mental health crisis. It offers short term emergency and respite services. According to the operational policy for Alexandra Road it is unable to offer services to:

"-people who are acutely suicidal

- people with whom there is a significant risk of violent behaviour

- people whose main problem is alcohol or drug abuse"

161. Clinical Psychologist (a) arranged to see Mr K the following day. In the meantime, he telephoned Alexandra Road to see whether they would consider taking Mr K. They indicated they would. On 11 June 1997, Clinical Psychologist (a) spoke to the Consultant Psychiatrist about referring Mr K to Alexandra Road. Mr K's suicidal intent and his dangerousness were raised by Clinical Psychologist (a) and discussed. Amongst the psychology notes available to Clinical Psychologist (a) were 2 psychiatric reports on Mr K dated 25 May 1995 and 15 July 1996, prepared by the Registrar and Psychiatric Senior House Officer (d) respectively, which referred to Mr K's forensic history and violent temperament. Clinical Psychologist (a) told us that the Consultant Psychiatrist did not consider that Mr K was so suicidal or dangerous that Alexandra Road would not take him.

162. On 11 June 1997, Mr K went to the assessment meeting at Alexandra Road. In attendance at that meeting were 2 members of Alexandra Road staff, Residential Social Worker (a) and Residential Social Worker (b), Psychiatric Senior House Officer (e), the Consultant Psychiatrist's senior house officer.

163. The operational policy also sets out how the referral process to Alexandra Road works. In the case of referrals by professionals the system is as follows:

"1. The referrer will contact Alexandra Road directly by telephone.

2. The referrer will give details about the client and the problems which they are facing. Staff at Alexandra Road will use a referral form to prompt the appropriate information.

3. If the referral appears appropriate the referrer will be asked to FAX or send further details e.g letters, reports and case summaries.

4. An assessment time will then be arranged at Alexandra Road for the client to attend.

5. The final decision regarding admission will be made at the end of the assessment and will be discussed with the client and the referrer."

164. The referral form consists of 4 pages. The first two pages seek basic information concerning the person being referred, for example name, address, next of kin, contact numbers for other professionals involved with them, details of the referrer. There are also sections entitled: presenting issues; psychiatric history; medication; aim of referral and post discharge plans to be completed.

165. It is clear that the referral form for Mr K has been completed by several different people, probably by various members of staff at Alexandra Road. The **"presenting issues"** were recorded as:

"Acutely depressed, getting little sleep, suicidal thoughts (lives on his own)"

His psychiatric history was:

> **"Spent 5 months in Friern in 1993"**

And the aim of the referral was stated to be:

> **"Not caring for self at the moment, needs support to do this**
> **Needs somewhere where he can talk to staff and re-establish sleep patterns."**

166. Pages 3 and 4 of the referral form deal with risk assessment. This part of the form was completed by Residential Social Worker (a) a resident social worker at Alexandra Road. Residential Social Worker (a) obtained the information to complete the form over the telephone from the Consultant Psychiatrist. The risk assessment form for Mr K contained a number of serious inaccuracies:

- the question of whether the client has been involved in any violent incidents had not been completed;
- the question as to the nature of the most serious harm caused by the client had not been completed;
- the form wrongly recorded that Mr K had never been compulsorily detained;
- it wrongly recorded that Mr K had no history of withdrawing from services or of failing to take medication;
- it recorded that he had no history of drug abuse;
- it wrongly recorded that he had never been violent to his family or other service users.

167. The nature of the risk which Mr K presented was summarised as follows:

> **"[Mr K] had two serious attempts at suicide (approx. 4 yrs ago) after the first time his wife left. Attempts involved overdose of painkillers and cutting wrists. At present [Mr K] says he has written suicide notes but he is afraid of making an attempt and fears being alone in case he acts on suicidal thoughts. He says he does not feel he will attempt suicide again as long as he has someone he can talk to - [Mr K] said he feels able to talk to someone if those feelings come up again."**

168. The assessment form was also completed by Residential Social Worker (a). This recorded that Mr K was assessed as being severely depressed with moderate sleep and eating problems. He was isolated and had little social contact. Otherwise his social circumstances were stable. Under the heading **"Any other information"** it is recorded:

> **"[Mr K] spoke mainly about his current difficulties as coping with his wife leaving and not knowing where she was. [Mr K] said he had contact with his daughter whom he said would not say where his wife was. [Mr K] said he was not coping well with this situation and needed someone to talk to about how he was feeling".**

169. We heard from Residential Social Worker (a) how, at the assessment interview, Psychiatric Senior House Officer (e) asked most of the questions, she asked a few and Residential Social Worker (b) observed. Psychiatric Senior House Officer (e) made

his own notes of the interview which record that in his view Mr K was not actively suicidal. The notes end with the following **"Plan"**:

> **" * Alexandra Rd**
> **Continue CMZ [carbamazepine]**
> **Px [Prescribe] Antidepressant VENLEFAXINE...**
> **Review next week"**

170. Residential Social Worker (a) explained to us that after the interview she and Residential Social Worker (b) discussed with other members of staff, including the manager at Alexandra Road, whether to accept Mr K. They decided to accept him.

Comment

171. The information used to assess the risk that Mr K presented was inaccurate and insufficient. It is not clear to us whether the information provided to Residential Social Worker (a) was inaccurate or whether it was wrongly recorded. Also available to those assessing Mr K were the medical reports from the Registrar and Psychiatric Senior House Officer (d) dated 24 May 1995 and 15 July 1996. They had been faxed to Alexandra Road from Canning Crescent on the morning of 11 June 1997. Both reports contained information which contradicted the information contained in the risk assessment. This should have alerted Residential Social Worker (a) and Residential Social Worker (b) to the need to make further inquiries to ascertain the true position.

172. *Staff at Alexandra Road were at a disadvantage in performing a risk assessment because they had not had any previous dealings with Mr K, did not know his full psychiatric history and did not have all his notes available to them. The same difficulties no doubt apply to most referrals to Alexandra Road.*

173. *It is important that fully informed risk assessments are made in respect of clients referred to Alexandra Road. Not only is the risk assessment relevant to the decision to accept a referral, it is also important in managing clients' care whilst they are at Alexandra Road.*

Recommendation

The Social Services Department should require all referrals made to Alexandra Road by other agencies to include a risk assessment form completed by a suitably qualified and experienced professional who is familiar with the patient.

174. *In this case the appropriate person to complete the risk assessment would have been the Consultant Psychiatrist. We understand that since June 1997 the practice at Alexandra Road has changed and professional referrers are now asked to provide information for the referral form and to complete and sign the risk assessment form.*

175. *Alexandra Road also accepts non-professional referrals, for example, where relatives bring a client in. In these circumstances, it will be necessary for the staff at Alexandra Road to perform the risk assessment. We asked staff from Alexandra Road what training they had before opening as a crisis unit and we were provided with their training records. It would appear from these that staff were given 3 hours of training specifically on risk assessment. From what we heard from members of staff this was mainly focused on the risk of suicide.*

Recommendation

The Social Services Department should ensure that all Alexandra Road staff who will be assessing referrals have comprehensive and regular training in all aspects of risk assessment including assessing the risk that clients present to their family, the public and staff.

176. *During the course of the Inquiry we were provided with a copy of a revised risk assessment form which is now used at Alexandra Road. We were concerned to note that in relation to many of the questions set out in the form, information was only required for the previous 2 years. In our view this is insufficient.*

Recommendation

The Social Services Department should amend the Alexandra Road risk assessment form so that information sought is not limited to the 2 years preceding referral.

177. *We are of the view that the referral to Alexandra Road was appropriate. However, we feel that staff at Alexandra Road relied too heavily on the views of the Consultant Psychiatrist and Psychiatric Senior House Officer (e) when deciding whether to accept Mr K. This may well have been due to the inexperience of the staff at Alexandra Road at that time; Mr K was the second client accepted at Alexandra Road. However it is essential that the decision to accept clients is made independently of the referrer. This is particularly important given the very high pressure on acute psychiatric beds within the Trust which could lead to referrals being made because of lack of availability of an acute bed.*

Chapter 9

KEVIN K'S STAY IN ALEXANDRA ROAD

178. Mr K's support co-ordinator was Residential Social Worker (a). She was responsible for devising a care plan for him and reviewing it regularly with him as well as communicating with other professionals and keeping them informed of Mr K's progress.

179. Staff at Alexandra Road work a shift system. There are three shifts: day shift -10 a.m. to 5.30 p.m.; sleep over shift - 2 p.m. to 3 p.m. the following day, with a sleeping period 11 p.m. to 7.30 a.m., and a night shift - 10 p.m. to 8 a.m.. There were always 3 staff on the premises overnight; 2 sleeping and 1 awake.

180. It is apparent from the daily log which was kept for Mr K that he soon settled into Alexandra Road.

181. On 13 June 1997, Residential Social Worker (a) spent time with Mr K formulating a care plan for him. The main issues to be addressed were his poor sleep, his poor appetite and organising an activity for him.

182. By the 15 June 1997, Mr K told staff that he was feeling more positive and beginning to plan for the future. However on 17 June 1997, Mr K was very down in mood. He told staff that he was thinking of visiting his daughter. On 18 June 1997 Mr K was reviewed by Psychiatric Senior House Officer (e) who thought

there had been a moderate improvement but that Mr K was still depressed.

183. On 18 June 1997, Residential Social Worker (a) met with Mr K to review his care plan. He told Residential Social Worker (a) that he was feeling very angry towards his wife. He told another member of staff that he thought speaking to his wife would help him get rid of some of his anger.

Comment

184. We found the daily log difficult to follow at times as notes were written in at the end of each shift. Therefore the night shift entry would sometimes come before the entry for the day preceding it, for example, staff on sleep over duty who started their shift on Monday at 2 p.m. would not write up the log for Monday until the end of the shift at or about 2 p.m. on Tuesday whereas the night shift staff for Monday night would write up the log first thing on Tuesday morning. We understand that the system has now been altered so that entries in the log are made twice a day and are in chronological order.

Chapter 10

THE EVENTS OF 19/20 JUNE 1997

185. On 19 June 1997, Residential Social Worker (b) and Residential Social Worker (c) were on sleep over duty. They started their shift at 2 p.m on 19 June. Residential Social Worker (d) was on waking night duty for the night 19/20 June.

186. During the late afternoon / early evening on 19 June, Mr K started making threats in respect of his wife and daughter. Residential Social Worker (b) made the following entry in Mr K's daily log about the threats:

> **"[Mr K] spoke at length to me last night. Most of his conversation were threats. He said he "was" going to kill his daughter and his wife and then kill himself. He was calm and his eyes were icy cold when he described how he was going to drive a knife through his daughter's stomach then he would go to a tall building and jump. He talked about how tight his chest was due to all the anger he was bottling up inside of him. Since [Mr K] has been here he has been making threats to kill his family, however last night he looked and sounded as if he meant it. He said he needed to kill someone because he "can't take it anymore". He felt he wasn't saveable so we shouldn't spend any money or time on**

him, he felt we ought to save our resources for others who might benefit from it."

187. Residential Social Worker (b) was sufficiently concerned about the threats which Mr K was making to telephone the Manager of Alexander Road at home. The Manager of Alexander Road was out and Residential Social Worker (b) left a message for her. Next she telephoned the Service Manager for Haringey Mental Health Services.

188. Residential Social Worker (b) told us that she informed the Service Manager for Haringey Mental Health Services of the threats which Mr K had been making. The Service Manager for Haringey Mental Health Services told us that she asked Residential Social Worker (b) whether she thought Mr K was serious. The Service Manager for Haringey Mental Health Services told us she was left with the impression that Mr K was **"agitated"**. Residential Social Worker (b) told us that The Service Manager for Haringey Mental Health Services said she would inform the duty social worker and Residential Social Worker (b) left the matter in her hands.

189. Residential Social Worker (b) tried to encourage Mr K to go to the gym to **"let off steam"**. However he wanted to go to the pub. He went to the pub with Residential Social Worker (c) who made the following notes of the evening in the daily log:

"In the pub he was talking about killing himself and causing some kind of harm to his wife and children. He said that he had been carrying this "feeling" for 5 weeks and the way he felt it had to be resolved. I advised him to try and move on. He had at least 3 or 4 pints in the

pub. The more he drank the more he opened up. We arrived back around midnight. Staff should be alert to [Mr K's] emotional state."

190. On returning to Alexandra Road, Residential Social Worker (c) went to bed and Mr K stayed up talking to Residential Social Worker (d), who was on night duty. Residential Social Worker (d) described what happened to us in the following terms:

"[Mr K] talked about his wife. It was a conversation that lasted about two hours, throughout which time he said he wanted to kill his wife, and he wanted to commit suicide. I was aware that he had been drinking, and I was not too sure if this had any effect on what he was saying....I remember asking [Mr K] to think about the consequences of that kind of behaviour. At that point ... I sensed something from [Mr K] which I had never sensed before in the entire experience of me working in psychiatry. When I asked him that question to think about the consequences of what he was considering doing, he just smiled in a very chilling way. It was horrible... I felt frozen myself. It was chilling. I thought "wow, he's going to kill his wife". I had that thought go through my mind. My thoughts at that time were "there is absolutely no way that I want you to leave this Unit".

191. Residential Social Worker (d) told us that initially he was concerned for his own safety, but as he continued to talk to Mr K he thought that the effects of the alcohol were wearing off and he was reassured that Mr K only wanted to deliver a note for his wife

to his daughter. Mr K asked for an early "wake up" call in the morning and went to bed.

192. Residential Social Worker (d) told us that he was in two minds about calling the police. He decided not to. He felt reassured that Mr K could not harm his wife because he did not know where she was living. He woke up Mr K early the next morning as requested. Mr K left Alexandra Road at 6.45 a.m..

193. Residential Social Worker (d) remained concerned that he should have contacted the police. He discussed this with the sleep over staff and the manager the next morning. The Manager of Alexander Road advised contacting the Community Liaison Officer who had previously visited the Unit. This task was allocated to Residential Social Worker (a) who started a day shift at 10 a.m.. Residential Social Worker (a) was unable to recall whether she did telephone the Community Liaison Officer. However, later that morning a police officer or officers attended Alexandra Road to drop off a form. We were given different accounts of the visit by different members of staff. Residential Social Worker (a) told us that she remembered speaking to the police officers in the office and asking what staff should do when someone was making threats as Mr K had done. She says the police told her that they could not do anything if someone was only making threats. Residential Social Worker (b) recalled speaking to a police officer at the front door of Alexandra Road. He did not come in but he did reassure her that had the police been contacted in respect of Mr K they would not have done anything.

194. Mr K returned briefly to Alexandra Road during the afternoon of 20 June 1997. He met up with the other client then resident in

Alexandra Road and accompanied him to a GP appointment. At about 3 p.m the other client telephoned Residential Social Worker (a) and reported to her that Mr K had been arrested. Residential Social Worker (e), telephoned Edmonton police who confirmed that Mr K had been arrested.

Comment

195. It is inevitable that there will be times when a client at Alexandra Road is at risk of harming himself or others, and that staff will be required to manage such situations.

196. Very few of the staff employed at Alexandra Road have formal mental health qualifications. In the circumstances, it is imperative that all staff are thoroughly trained in risk management, know what to do in a crisis situation and have suitable backup.

197. The staff who had to deal with Mr K on the night of the 19/20 June 1997 did not appear to us to have received adequate training to enable them to manage the situation which arose; for example, a member of staff accompanied Mr K to the pub despite the fact that he was highly emotional and volatile. Alcohol was only likely to aggravate the situation.

Recommendation

The Social Services Department should ensure that all staff at Alexandra Road receive regular training in risk management.

198. *Not all of the staff at Alexandra Road from whom we heard had a clear view of who they should contact in a crisis. In the early evening of 19 June 1997, when she needed support, the shift leader, Residential Social Worker (b), sensibly sought guidance from the Service Manager for Haringey Mental Health Services, having tried unsuccessfully to contact the manager of Alexandra Road at home.*

199. *We feel that the support and advice given by the Service Manager for Haringey Mental Health Services was not satisfactory. We are satisfied that Residential Social Worker (b) told the Service Manager for Haringey Mental Health Services that Mr K was threatening to kill his wife and that she thought he meant it. The Service Manager for Haringey Mental Health Services telephoned the out of hours duty social worker and informed her that staff from Alexandra Road might call later in respect of a client who was causing problems. This "wait and see what happens" approach was not an effective way of managing the problem. In our view, the Service Manager for Haringey Mental Health Services should either have gone to Alexandra Road to assess the situation herself or called out the out of hours duty social worker to make an emergency mental health assessment.*

200. *Residential Social Worker (d) told us that he knew he could have woken up the shift leader, Residential Social Worker (b), to discuss what to do. With the benefit of hindsight we feel that Residential Social Worker (d) made an error of judgment in not waking Residential Social Worker (b). However we do not criticise him for the way he handled the very difficult situation in which he found himself; it was the responsibility of those managing Alexandra Road to ensure that there were was a written risk management policy in place which gave guidance to staff in such situations. We are aware that the Trust, Haringey Council and other local agencies are in the process of introducing a policy entitled "Assessment and Management of Risk in Mental Health". We saw a copy of the 6th draft of the Policy which was dated May 1998. The Policy states that* ***"Management will be responsible for the drawing up of clear procedures and guidelines for risk assessment and risk management"****. We were not provided with any guidelines on risk management.*

Recommendation

The Social Services Department should devise and implement a risk management policy or guideiines for Alexandra Road detailing what steps should be taken in crisis situations such as this. Such a policy is all the more important as agency staff, who may not have had formal risk management training, are frequently employed at Alexandra Road.

201. *The Manager of Alexander Road told us that staff have her home telephone number so that they can call her in the event of an emergency. However, the Manager of Alexander Road cannot possibly be expected to always be available out of hours. If, in the event of an out of hours crisis at Alexandra Road, the first port of call for staff is to be a manager, then a formal "on call" system will be necessary to ensure that out of hours support is always available.*

202. *It is not clear to us whether the threats made by Mr K were formally reported to the police on the morning of 20 June 1997. They should have been. The matter was sufficiently serious for the Manager of Alexander Road to have spoken to the police herself.*

203. *So far as we are aware, there was, and is, no policy at Alexandra Road for handling untoward incidents. Incidents of this nature should be recorded in a separate incident log. Given the serious nature of this incident, particularly given that Kevin K left Alexandra Road and allegedly abducted members of his extended family at knife point, we are concerned that so little emphasis was placed on accurately recording the sequence of events on 19/20 June 1997. This incident should have immediately prompted an internal review, which involved the full debriefing of staff.*

Recommendation

The Social Services Department should ensure that:

(a) untoward incidents at Alexandra Road are noted in a separate log;

(b) an untoward incidents policy is introduced at Alexandra Road.

204. Later on 20 June 1997, Detective Sergeant (a) and two Detective Constables from Edmonton Police Station attended Alexandra Road and searched Mr K's room. We asked all the Alexandra Road staff who had been involved with Mr K on 19/20 June whether the police had taken statements from them following Mr K's arrest for abduction at knife point. They all confirmed that they had not been asked to provide statements. The staff did not volunteer information regarding the threats Mr K had been making to the police.

Comment

205. When police officers are invited to attend an Independent Inquiry to give oral evidence, it is the policy of the Metropolitan Police to allow the officers concerned to decide whether to attend. In this case the officers we invited to give oral evidence to us declined to do so. We do not know why staff at Alexandra Road were not interviewed and statements taken from them. Although the police strongly opposed bail, if statements had been taken, the police would have known of the threats which Mr K had been making in

respect of Mrs K. This information could have been passed to the Crown Prosecution Service (CPS) and may have had a bearing on Mr K's subsequent bail applications.

206. *Residential Social Worker (d) told us that the reason why staff at Alexandra Road did not volunteer information regarding the threats to the police was because of client confidentiality. If this is correct it was misconceived; safety of members of the public should outweigh client confidentiality. However there was no policy at Alexandra Road on disclosure of information to guide staff.*

207. *We understand that a joint draft policy on confidentiality has recently been approved by The Trust, Haringey Council, Enfield and Haringey Health Authority and various voluntary agencies. The 1996 CPA policy referred to the fact that a local joint confidentiality policy was proposed. We are concerned about the length of time that it has taken for the policy to be approved.*

Recommendation

The Trust and Haringey Council should take steps to ensure that the joint confidentiality policy is implemented as a matter of priority.

Chapter 11

MR K'S REMAND IN PENTONVILLE

208. Following his arrest, Mr K was taken before a magistrate on 21 June 1997. His solicitor applied for bail, but this was refused and he was remanded to Pentonville prison for 9 days. On arrival at Pentonville prison, Mr K was seen by a health care officer (a prison officer) who completed a health screening form in respect of him. The form recorded that Mr K had a past history of psychiatric illness and was under the Consultant Psychiatrist. The form also stated that he was taking temazepam and carbamazepine.

209. Mr K was then seen by a medical officer who noted that he suffered from depression.

210. Mr K was not referred for a psychiatric opinion, nor was he given temazepam or carbamazepine or any other drugs whilst in Pentonville.

Comment

211. The Senior Medical Officer for Pentonville prison told us in evidence that the health screening form completed on 21 June 1997 did not have details of Mr K's medication on it

(he presumed that Mr K had not given details of his medication to the health care officer). Unfortunately we did not feel able to accept the Senior Medical Officer for Pentonville prison's evidence on this point. Having seen the original of the healthcare form dated 21 June 1997 we are satisfied that it did contain specific details of Mr K's medication which must have come from him.

212. *In failing to prescribe Mr K's regular medication, his care in Pentonville fell below an acceptable standard. Steps should have been taken to ensure that prisoners receive their regular medication whilst in prison.*

213. *Mr K should also have been referred by the medical officer for a psychiatric opinion. We heard from the Senior Medical Officer for Pentonville prison that Pentonville prison has good psychiatric cover with 2 visiting psychiatrists being available to see inmates every weekday morning and 1-2 psychiatrists available every weekday afternoon. According to the Senior Medical Officer for Pentonville prison, had Mr K been referred for a psychiatric opinion, he would have been seen within 2 or 3 days at the latest.*

214. *The Consultant Psychiatrist should have been contacted for information regarding Mr K's mental health.*

Chapter 12

REMAND HEARING 30 JUNE 1997

215. On 30 June 1997, Mr K once again appeared before the stipendiary magistrate. His solicitor made an application for conditional bail. CPS Lawyer (a) who conducted the hearing. On the CPS file were the statements of Mr K's daughter and his son-in-law, dated 20 June 1997, which described in detail the alleged assaults on them by Mr K and the abduction at knife point. Also on the file was a list of Mr K's previous convictions and a document prepared by the police, entitled "Initial Remand Application Form", setting out their views on whether Mr K should be remanded in custody or on bail. The recommendation from the police was that Mr K should be remanded in custody as there were substantial fears that if he was granted bail he would: (i) fail to surrender; (ii) commit further offences; (iii) interfere with witnesses and (iv) harm himself.

216. The form contained the following information:

> "<u>Fail to Surrender</u>: **Police fear that due to the serious nature of offences charged and the very strong likelihood of custodial sentence of some magnitude being imposed if found or pleads guilty, he will almost certainly fail to surrender to bail**

Commit further offences: police fear that due to his admitted drink problem and further that he mixes medication with drink coupled with the frustration he feels with his estranged family and his admitted previous violence towards his wife and daughter that, if given bail he will almost certainly commit further offences.

Interference with witnesses: Police fear that if given bail, he is aware of the victims (x 2) and the likelihood of a custodial sentence, a strong possibility if both witnesses testify, he will almost certainly attempt to contact victims (x2) address either directly or indirectly in an attempt to prevent them giving evidence in this case. One of the witnesses makes allegations in his statement to Police that defendant has warned him not to make statements to Police or otherwise he or others would "get him"..

For his own safety: Defendant has stated during interview that due to previous marital breakups with his estranged wife, he has made attempts on his own life. He further stated in interview that if sentenced to imprisonment he "would not know what to do with himself" He has a history of treatment for mental illness and depression and due to these circumstances police fear that if given bail he may attempt to harm or kill himself."

217. We did not hear evidence from CPS Lawyer (a). However his immediate superior, branch prosecutor for Barnet and Haringey, did come and talk to us having discussed the case with CPS

Lawyer (a). She told us that CPS Lawyer (a)'s recollection was that on 30 June 1997, Mr K's solicitor represented that the 2 principal witnesses, Mr K's daughter and son-in-law, did not want to give evidence at trial and thus it was likely that the case against Mr K would have to be dropped. In the light of this representation and the fact that Mr K now had an address out of the area where he could stay, CPS Lawyer (a) did not oppose the application made on behalf of Mr K for conditional bail. The application was granted by a stipendiary magistrate and Mr K was granted bail on the following conditions:

(1) that he resided at his parents address at Clacton on Sea, Essex;

(2) not to communicate with the prosecution witnesses or his wife;

(3) not to come within the perimeter of the M25 save to meet with his solicitor by prior appointment;

(4) to provide a surety in the sum of £2,000.

218. A further remand hearing took place on 11 July 1997 when Mr K's solicitor applied to vary his conditions of bail. The application was refused.

Comment

219. In our view CPS Lawyer (a) was in error in failing to check with the police whether Mr K's daughter and son-in-law were willing to give evidence before agreeing to conditional bail for Mr K. There is absolutely no evidence

which we are aware of to support the contention that these witnesses were unwilling to give evidence at trial.

220. *Given the nature of the offences described in the witness statements and the information provided by the police in the Initial Remand Application Form, CPS Lawyer (a) should have strenuously opposed conditional bail. Had he done so, there is a possibility that Mr K would have been remanded in custody with no prospect of making a further application for bail in the magistrates court unless there was a change in his circumstances.*

221. *We feel that it was inappropriate for the CPS to be reassured by the condition of bail that required Mr K to live at an address outside the area where his likely victims lived. He was a man who had already shown a willingness to track people down.*

222. *We are concerned that insufficient regard was had to Mr K's mental health needs at the remand hearings. It was plain from the information available to the CPS that Mr K had a history of mental illness and depression for which he had received treatment. No attempts were made to establish whether Mr K was currently in receipt of treatment and what the effect of requiring him to live away from the area of his home would be on his treatment and consequently on his mental state.*

223. *We were alarmed by the brevity of the endorsements on the CPS file as to what has happened at the various remand hearings. As a result of the paucity of information on*

the CPS file we had difficulty in piecing together exactly took place at the relevant remand hearings. This may have been a one-off case of poor record keeping, but as a matter of principle full endorsements of each hearing should be made on the CPS file.

Chapter 13

30 JUNE 1997 - 16 AUGUST 1997.

224. We have very little information regarding Mr K's movements after he was released on conditional bail. He did go and stay with his parents. He told us that whilst he was there his condition deteriorated, although he said his parents did not recognise this. He told us he started to hear his wife's voice and that she told him she wanted to meet him. Throughout this period Mr K was not taking medication and did not see a doctor.

225. A week before killing his wife, Mr K says that he found out from a friend where she was staying. On 15 August 1997, Mr K travelled to London. He spent the night in his flat. The following morning he went to look for his wife; he took a knife with him. He went to a pub and had 4-5 pints and smoked some cannabis. Having left the pub he saw Mrs K walking along the road. There was an argument and he stabbed Mrs K. He says he cannot remember doing this. He gave himself up to police the following day.

Chapter 14

INTERNAL INQUIRY

226. This incident prompted an internal inquiry which should have been managed by the Trust but in fact was steered by the Health Authority. We have seen a copy of the report produced, which is dated April 1998, and have heard evidence about the procedure adopted.

Comment

227. We had many concerns about the procedure adopted by the internal inquiry. Firstly, the Trust has no clear policy governing the procedure to be followed after such an incident. The Trust has both a major incidents policy and an untoward incident policy. Both policies are confused about the circumstances in which they apply. The procedures they prescribe are different.

Recommendation

The Trust should revise its policies dealing with untoward incidents. There should be one clear policy setting out in

unambiguous terms the procedure to be followed when a serious untoward incident has occurred.

228. *We are alarmed that no clear terms of reference were drafted at the outset of the internal inquiry. One of the first steps which should have been taken is that the managers of all departments of the Trust having had recent contact with Mr K should have been asked to remove and secure all records relating to him. Statements should have been taken at an early stage from all staff involved in his care. This was not done.*

229. *The internal inquiry took the form of group discussions involving managers of the various agencies and departments which had contact with Mr K. There appears to have been a lack of focus at these meetings, which is reflected by the inordinate delay in producing a report.*

230. *We were also concerned that those responsible for Mr K's care were also directly involved in the inquiry process. Such a process should be as objective as possible.*

231. *Finally we are concerned about the lack of progress in implementing any of the recommendations made by the internal inquiry. We heard from several witnesses that there had not been a multi-agency meeting to discuss the implementation of the recommendations. Following the internal inquiry an agreed action plan should have been drawn up by all the agencies involved which allocated responsibility for implementing the recommendations and*

identified the time frame in which they were to be implemented.

Summary of Recommendations

1. ***The Trust should take steps to ensure that:***
(a) consultant psychiatrists review their junior doctors' patient lists regularly, and
(b) a note confirming that a review has taken place is made in each patient's notes [Paragraph 95].

2. ***The Trust and the Social Services Department should make clear to all staff involved in the use of the Mental Health Act 1983 precisely whose responsibility it is to obtain a second medical recommendation for the purposes of converting section 4 of the Mental Health Act to section 2. [Paragraph 112].***

3. ***The Trust should take steps to ensure that the use of the Mental Health Act 1983 in the Trust is stringently monitored by the Mental Health Act administrator, thereby ensuring that the good practice set out in the Code of Practice is followed [Paragraph 112].***

4. ***The Trust and the Social Services Department should ensure that staff involved in the use of the Mental Health Act 1983 receive regular refresher training in respect of the requirements of the Act and good practice in implementing those requirements [Paragraph 112].***

5. *The Trust Mental Health Act administrator should ensure as a matter of priority that the Trust has a policy dealing with detained patients who are absent without leave which complies with the recommendations of the Mental Health Act 1983 Code of Practice and that staff are familiar with the terms of the policy [Paragraph 112].*

6. *The Trust should re-write the CPA policy and procedural guidelines in order to provide clear guidance to staff at all levels who are involved in the operation of CPA [Paragraph 121].*

7. *The Trust should ensure that all staff involved in CPA receive regular refresher training on its use CPA [Paragraph 121].*

8. *The Social Services Department needs to clarify the eligibility criteria which are to be applied in providing mental health services in long term cases. If the current written eligibility criteria are not actually applied then they should be replaced by those which are. If "severe and enduring mental health problems" (or a similar term) is to be one of eligibility criteria, steps should be taken to ensure that the definition of this is sufficiently clear to enable it to be easily applied by practitioners. In particular whether individuals suffering from anti-social personality disorder are eligible for help needs to be clarified [Paragraph 139]*

9. *The Social Services Department should consider allocating resources to offer counselling and support in cases of serious domestic violence [Paragraph 139 and Paragraph 158].*

10. *The Trust should revise the current system operated by the Psychology Department of offering patients assessment appointments only once places are available for treatment. Assessment appointments should be offered to patients referred to the Psychology Department shortly after referral [Paragraph 144]*

11. *The Trust should ensure that GP's and Consultant teams communicate in writing confirming who is prescribing what medication to a patient [Paragraph 147].*

12. *The Housing Department should draw up guidelines dealing with the communication of information to other agencies. [Paragraph 157].*

13. *The Social Services Department should require all referrals made to Alexandra Road by other agencies to include a risk assessment form completed by suitably qualified and experienced professional who is familiar with the patient [Paragraph 173].*

14. *The Social Services Department should ensure that all Alexandra Road staff who will be assessing referrals have comprehensive and regular training in all*

aspects of risk assessment including assessing the risk that clients present to their family, the public and staff [Paragraph 175].

15. *The Social Services Department should amend the Alexandra Road risk assessment form so that information sought is not limited to the 2 years preceding referral [Paragraph 176].*

16. *The Social Services Department should ensure that all staff at Alexandra Road receive regular training in risk management [Paragraph 197].*

17. *The Social Services Department should devise and implement a risk management policy or guidelines for Alexandra Road detailing what steps should be taken in crisis situations such as this. Such a policy is all the more important as agency staff, who may not have had formal risk management training, are frequently employed at Alexandra Road [Paragraph 200].*

18. *The Social Services Department should ensure that:*

(a) untoward incidents at Alexandra Road are noted in a separate log;

(b) an untoward incidents policy is introduced at Alexandra Road [Paragraph 203].

19. *The Trust and Haringey Council should take steps to ensure that the joint confidentiality policy is implemented as a matter of priority [Paragraph 207].*

20. *The Trust should revise its policies dealing with untoward incidents. There should be one clear policy setting out in unambiguous terms the procedure to be followed when an untoward incident has occurred [Paragraph 227].*

Appendix A

Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of Mr K by the local mental health services (including primary care), in conjunction with the criminal justice services and the London Borough of Haringey Housing and Social Services, up until the murder of Mrs Janet K on the 16th August 1997, and in particular:

a) The quality and scope of his health care, social care and risk management

b) The appropriateness of his treatment, care and supervision in respect of

i) his health care and social care needs,

ii) the risk of harm he presented to others

c) The extent to which Mr K's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health including the Care Programme Approach HC(90)23, LASSL(90)11, Supervision Registers HSG(94)5 and Discharge Guidance HSG(94)27 and local operational policies and procedures.

2. To examine the adequacy of the collaboration, co-ordination and communication between and within

a) the agencies involved in the care of Mr K or in the provision of services to him

b) the agencies including the criminal justice agencies involved in his care, supervision or detention of the provision of services to him between 20 June and 16 August 1997

c) the statutory agencies and Mr K's family or any agency involved with Mr K's family.

3. To prepare a report for Enfield and Haringey Health Authority and make recommendations for the future delivery of mental health services in Haringey

Appendix B

Inquiry Panel Membership

Alison Gulliver [Chair]

Dr. A Buchanan

Lotte Mason

Jane Mackay

Appendix C

Inquiry Process

We sought and obtained Mr Kevin K's written consent to obtain all relevant documents for the Inquiry to consider, in order to investigate his care and treatment over a period of years in the 1990's. These documents included, medical, nursing, police, prison and CPS records.

We identified those witnesses who we believed were in a position to provide relevant information and invited each person to attend.

A meeting was held with staff, who were thought to be possible witnesses, to explain the Inquiry Process and give them an opportunity to ask questions.

Invitations were also extended to the families of both Mr K and Mrs K. Family members did not attend but gave us the benefit of written information which proved most useful.

The police officers involved declined to give oral evidence but some did supply written replies to questions and queries.

In advance of attending each witness was sent a letter with a copy of the Terms of Reference. This letter explained the Responsibility of the Health Authority to hold such an Inquiry and its nature. It also explained that the evidence given was confidential and would be recorded and transcribed and that each witness would receive a copy. Each witness was also encouraged to bring a friend, colleague or representative. In addition, the letter also outlined the issues which the Inquiry Team wished to hear evidence about. They were also encouraged to send written evidence and to raise any matter relevant to the Inquiry which had not been covered.

The witnesses came to the Training Centre, St Ann's Hospital, Tottenham except for Mr K and his prison healthcare doctor who we visited in Brixton Prison. We are grateful for the help afforded to the Inquiry by the staff at the hospital and in the Healthcare Centre.

All hearings were in private.

Witnesses were not asked to affirm their evidence.

The Inquiry Team was introduced to each witness, and they reminded that the discussion was being recorded and they would receive a copy of the transcript. This could then be amended, corrected or added to for completeness. The transcript was then to be returned to the Inquiry for consideration in the writing of the report. It was also pointed out that although the transcript remained confidential to the Inquiry, part or parts of it might be used to reflect particular aspects of evidence.

Furthermore, if it seemed likely that a witness might be subject to criticism then a copy of that part of the draft report would be sent to them for further comment and perhaps amendment.

Appendix D

Written Evidence

Kevin K

Hospital Medical and Nursing Records

General Practitioner Records

Psychology Department Records

HMP Brixton and HMP Pentonville Healthcare Records

Probation Records

Dr H Kennedy Medical Report

Dr P L Joseph Medical Report

Dr N Kahtan Medical Report

Dr L P Chesterman Medical Report

Mr J K Senior

Written evidence

Mrs I Booth

(Mother of Mrs K)

Written evidence

Haringey Healthcare NHS Trust

All mental health policies and procedures

Audit Review of Mental Health Services 1997

Major Incident Policy 1996

Serious and Untoward Incident Policy 1997

Draft Policy Risk Management Assessment Form and Training Manual 1998

Internal Review (into the events leading to the arrest of Mr K following the Homicide of Mrs K on the 16th August 1997) 1998

Alexandra Road Crisis Unit

Operational Policy

Staff Training Programme

Health and Safety policies

Daily Log

Haringey Council, Enfield & Haringey Health Authority

Confidentiality and Shared Record Keeping.Policy

Enfield & Haringey Health Authority London Boroughs of Enfield and Haringey

Mental Health Services for Adults of working age Strategy 1998/99-2001/01

Mental Health Service Specification 1997

Guidance on Risk Assessment for Staff working with Clients within the Care Programme 1997

Joint Care Programme Approach Policy and procedural guidelines 1997

Metropolitan Police

Mind Inquiry - Creating Accepting Communities

Written replies to Inquiry Team Questions

Haringey Community Health Council

Report of Visit to Haringey Healthcare NHS Trust 1997

Mental Health Act Commission

Report of Visit to Haringey Healthcare NHS Trust Mental Health Unit 1996 and 1997

Appendix E

Background Reading

Code of Practice mental Health Act 1983 published 1994 HMSO

Audit Commission Making a Reality of Community Care HMSO 1986

The Mental Health Act Commission sixth Biennial Report HMSO 1996

Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services chaired by Dr John Reed Dept of Health and Home Office 1991

Criminal Justice Act 1991 Mentally Disordered Offenders Health Services Guidelines NHSME 1991

The Health of the Nation Key Area Handbook - Mental Illness Dept of Health 1993

The Health of the Nation - Mentally Disordered Offenders Dept of Health 1993

Professional Conduct and Discipline Fitness to Practice General Medical Council 1993

Caring for People with Severe Mental Illness, Information for Psychiatrists Dept of Health 1993

Forensic Psychiatry; Clinical, Legal and Ethical Issues Ed Gunn J and Taylor P J Butterworth-Heinemann 1993

Introduction of Supervision Registers for Mentally Ill People HSG(94)5 Dept of Health 1994

Guidance on the Discharge of Mentally Disordered People and their Continuing care in the Community HSG(94)27 Dept of Health 1994

Audit Commission Finding a Place: a Review of Mental Health Services for Adults HMSO 1994

Report of the Dept of Health and Home Office Working Group on Psychopathic Disorder Chairman Dr John Reed Dept of Health and Home Office 1994

24 Hour Nursed Care for People with Severe and Enduring Mental Illness Dept of Health 1996

The Health of the Nation The Spectrum of Care. Local Services for People with Mental Health Problems Dept of Health 1996
Risk Taking in Mental Disorder Analysis, Policies and Practical Strategies David Carson SLE Publications 1990

Building Bridges A Guide to arrangements for interagency working for the care and protection of severely mentally ill people. Dept of Health 1995

Report of the Confidential Inquiry into Homicides and Suicides by mentally ill people The Royal College of Psychiatrists 1996

Report of the Inquiry into the Care and Treatment of Christopher Clunis Jean H Ritchie et al HMSO 1994

Report of the Inquiry into the Circumstances leading to the death of Jonathan Newby Oxfordshire Health Authority 1995

The Falling Shadow Report of the Committee of Inquiry Chaired by Lois Blom-Cooper Duckworth 1995

The Case of Jason Mitchell Chairman Louis Blom-Cooper Duckworth 1996

The Report of the Independent Inquiry into the Circumstances Surrounding the deaths of Robert and Muriel Viner Dorset Health Authority 1996

The Hampshire Report Redbridge and Waltham Forest Health Authority 1996

The Mabota Report Redbridge and Waltham Forest Health Authority 1996

Report of the Inquiry into the Treatment and Care of Raymond Sinclair West Kent Health Authority 1996

Independent External Review into Mental Health Services Boltons Hospital NHS Trust 1996

Report of the Independent Inquiry into the Care and Treatment of NG Ealing Hammersmith & Hounslow Health Authority 1996

Report of the Independent Inquiry into the Treatment and Care of Richard John Burton Leicestershire Health Authority 1996

The Report into the Care and Treatment of Martin Mursel Camden and Islington 1997

Practice, Planning and Partnership The Lessons to be learned form the Case of Susan Patricia Joughin Isle of Man 1997

Report of the Independent Inquiry following a Homicide by a Service User Bromley 1997

Report of Inquiry into the Treatment and Care of Darren Carr Berkshire Health Authority 1997

Report of the Independent Inquiry into the Care and Treatment of Peter Richard Winship Nottingham Health Authority 1997

Report of the Independent Inquiry into the Care of Doris Walsh Coventry Health Authority 1997

The Report of the Independent Inquiry into the Care and Treatment of William Scott Bedfordshire Health Authority 1997

Inquiry into the Treatment and Care of Damian Witts Gloucestershire Health Authority 1997

Mental Health Act Manual Fourth Edition Richard Jones Sweet & Maxwell 1994

Learning the Lessons 2nd Edition Mental Health Inquiry Reports published between 1969 and 1996 and their recommendations. The Zito Trust 1996

Inquiries after Homicide edited by Jill Peay Duckworth 1996

MINORITY OPINION INTO THE CARE AND TREATMENT OF MR K. K

I agree with the description of Mr K's case contained in the report and support many of the recommendations. I have, however, formed a different view of the degree to which it was reasonable to expect health and social services to have managed the risk which Mr K presented.

A number of factors made managing Mr K's case particularly difficult and contributed t his being diagnosed as suffering from a personality disorder. His wife suggested that he had been trying to mislead medical staff with respect to his suicidal ideas in 1992 when blood tests failed to confirm that he had taken an overdose of paracetamol. Later he gave different accounts of his background to different doctors. He was occasionally aggressive in the out-patient department, he refused physical examination, his stated attitude to medication was inconsistent, he took medication inconsistently and he refused to consider psychotherapy.

He left hospital against medical advice, he failed to attend some outpatient appointments, he complained about the service offered to him and he was verbally aggressive and physically violent to other patients when admitted to hospital. Managing his case was further complicated by his wife's inability, whether as a result of threats by her husband or for other reasons, to become more involved in his care and to provide information to those caring for him about his behaviour. She and his brother had removed him from hospital against medical advice.

Psychiatric care has traditionally been provided to voluntary patients with few conditions. Poor attendance, inconsistent background information and poor compliance with prescribed treatment are common problems. They do not usually lead to the withdrawal of care. In Mr K's case the lack, or inconsistency, of background information made it difficult to assess his mental state and his irregular attendance and failure to take his prescribed treatment made it difficult to monitor changes in his mental state in response to that treatment. He was setting an agenda that the services would not have set, yet care was not withdrawn.

The difficulties which Mr K's case presented are not unusual in the practice of general and community psychiatry. And the culture of providing care to voluntary patients with few conditions is a national, not a local, phenomenon which imbues a range of trades, professions and voluntary organisations. Psychiatric and social services nevertheless spend much of their time trying to manage risk. Sometimes, as when a court makes a hospital order with restrictions on discharge, they are bound to do so. The restriction order replaces the voluntary model of care with one in which care in the community, for instance, is only permitted if certain conditions are met.

No such order has been imposed in Mr K's case. For all but 72 hours of the period covered by the report he was either a voluntary patient or, for the final six and a half weeks when he chose not to seek help, not a patient at all. Given the difficulties which his case presented it did not surprise me that the

services involved were failing to manage, to any significant extent, the risk which Mr K presented to others. The health and social services were not responsible for those difficulties and their failure to manage the risk to others did not prevent me from concluding that they offered a good standard of care.

Managing risk can be divided into three stages. First, clinicians have to know all of the possible outcomes of concern, the odds of each and the circumstances in which those odds are likely to change. Second, there has to be a process of monitoring the patient and his circumstances in order that any increase in the level of risk can be detected. Finally, mechanisms must be available to intervene when the risk does increase so that the outcome of concern can be prevented.

In Mr K's case the second and third steps of managing risk were not, to any significant extent achievable. His unreliability as an informant, his inconsistent attendance, his attitude to psychiatric and social services and the failure of any members of his family to become involved in his treatment precluded monitoring the risk. His attitude to services, to medication and to psychological treatment, his behaviour in hospital and the pressure on in-patient facilities would probably have rendered futile any attempt systematically to intervene when he was a voluntary patient. And his condition was not such that staff could have relied on being able systematically to use the Mental Health Act to treat him involuntarily.

More effort could have been made, however, to achieve the first step in managing risk, risk assessment. In a service of any size it will always be possible to divert resources to such efforts, albeit with adverse consequences elsewhere. Two observations support doing so. It must be desirable for clinical decisions to be made in the light of as much information as possible. And knowing more about the nature and level of risk might allow the psychiatric service to do things, such as warning third parties, which do not amount to managing risk but are still useful.

In Mr K's case the efforts made seem to have included speaking to his wife and reviewing his records but not attempting to obtain information through a social work assessment or attempting to obtain his criminal record. It is difficult to see how a greater expenditure of resources and effort would have allowed an accurate assessment of the risk. Even if a complete assessment of risk had been
achieved the difficulties of monitoring that risk and intervening to reduce it would have limited the benefits which could have accrued.

Two broader questions arise in relation to psychiatric practice in Mr K's case, practice which bore many similarities with that of general and community psychiatry elsewhere. The first is whether it can ever be appropriate for clinicians to provide care to a patient who presents a risk where they are unable to manage that risk. In my view the prospect of a patient who presents a risk is unacceptable. It follows that there will be cases where care should be provided, as it was in this case, when risk cannot be managed.

The second is whether routine general and community psychiatric practice should change to emphasise risk management in all cases. The culture which I have described, in which care is provided to voluntary out-patients with few conditions, is not immutable. Since the introduction of its National Standards for Supervision in 1992, the probation service has altered its "advise, assist and befriend" ethic to one under which public protection and risk management are paramount. Contact with clients for whom the service does not have statutory responsibility has virtually ceased and resources are targeted on cases where intervention is seen as reducing risk to others.

It may be that publicly funded psychiatric and social services will follow a similar path. The question of whether or not they should do so is critical to the future of those services. It is one which the report, properly in my view, does not attempt to answer.

I would note that there is no empirical evidence that the benefits of such an approach would outweigh the costs. A patient has be to in contact with services before any help can be provided. Many patients are ambivalent as to whether they have a problem, ambivalent as to whether treatment can help and ambivalent as to whether they will attend. The larger the number of conditions which attend the provision of care to voluntary patients, the larger will be the numbers deterred from seeking such care.