REPORT OF THE INDEPENDENT INQUIRY

INTO THE CARE AND TREATMENT OF PAUL LEANE

A report commissioned by

Brent & Harrow Health Authority

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THE REPORT OF THE INDEPENDENT INQUIRY

INTO THE TREATMENT AND CARE OF PAUL LEANE

MICHAEL CURWEN

Chairman

DR OMAR DANIELS MB BCh. FRCPsych. DPM

Medical Advisor

LOTTE MASON

Social Work Advisor

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CHAPTER 1

INTRODUCTION

1.1 This is the report to the Brent and Harrow Health Authority of an independent Inquiry into the treatment and care afforded by the mental health services to a patient in the community, Paul Leane, prior to the manslaughter of his mother on the 30th May 1997.

1.2 The Inquiry was conducted by a Panel comprising :

Michael Curwen - a practising barrister and Recorder of the Crown Court on the South Eastern Circuit
Dr Omar Daniels - a Consultant Psychiatrist and Honorary Senior Lecturer in Psychiatry and a Mental Health Act Commissioner
Lotte Mason - an Independent Adviser in Mental Health and Learning Disability, formerly a Senior Psychiatric Social Worker and Mental Health Act Commissioner

1.3 Our **Terms of Reference** were as follows :

1. To undertake an independent review of all the circumstances surrounding the care provided to Paul Leane by health and social care agencies between 1989 and May 1997 and in particular the adequacy, scope and appropriateness of such care

2. To examine the extent to which the treatment and care provided corresponded to statutory obligations, relevant guidance from the Department of Health and local operational policies

3. To examine the quality and scope of the assessment of health and social care needs in the light of his available history, including the quality and scope of risk assessment

4. To examine the extent and nature of Care Plans provided and their delivery

5. To examine the support and supervision provided

6. To examine the adequacy of the collaboration and communication between the agencies and the professionals involved during the care of Paul Leane

7. To make appropriate recommendations

8. To prepare a report and make recommendations to Brent and Harrow Health Authority

1.4 To assist us in the performance of these tasks we invited a number of persons to give oral testimony. None of them were under any compulsion to provide us with evidence and they were allowed to be accompanied by a representative, although only two took advantage of this facility. The procedure consisted of questioning by the members of the Panel. It was informal and conducted in private.

1.5 We heard from the following witnesses (whose status is wherever possible given as it stood at the material time) :

Paul Leane

Relatives of Paul Leane

Dr Judith Kellermann - General Practitioner

Mr Edward Matt - Director of Operations, Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust

Central Middlesex Hospital

Dr Philip Harrison-Read - Consultant Psychiatrist

Dr Paul Mallett - Consultant Psychiatrist

Dr Barbara Woodhatch - Senior House Officer in Psychiatry

Dr Nada Al-Asadi - Clinician in Psychiatry

Mr George Nazer - Site Manager, Park Royal Centre for Mental Health

Brent Council Social Services Department

Mr Robert Nesbitt - Service Director, Mental Health Fieldwork

Mr John Simmons - Team Leader, Brent East Sector

Ms Kalpna Patel - Social Worker

1.6 We were additionally provided with a large quantity of written material, including documentation concerning the organisation, policies and procedures of the North West London Mental Health NHS Trust, medical records relating to Paul Leane's attendances at the Central Middlesex Hospital, his GP notes, his Social Services case records and his Probation Service records.

1.7 We are particularly indebted to Catherine Afolabi, the Inquiry Secretary, for her skill and industry in collating the documents, organising the oral hearings and co-ordinating the Inquiry.

CHAPTER 2

THE BACKGROUND HISTORY

2.1 Paul Leane was born on the 30th October 1962. He was the first and only child of Henrietta Leane, who was then about 28 years of age, unmarried and living with her immediate family. She did not divulge the identity of his father to them and it always remained a closely guarded secret to which neither Paul nor anyone else with whom he came into contact was afforded access.

2.2 The family originated in the Republic of Ireland and several of Henrietta Leane's numerous siblings and their children still live there; others are spread out across England and Wales. In about 1966 she set up home with Paul in a block of flats in Neasden, a residential suburb within the boundaries of the London Borough of Brent. She maintained a close relationship with one of her sisters, but partly for geographical reasons and partly because of her unusual personal circumstances most of the family were kept at a distance. This has inevitably led to significant gaps in our knowledge of Paul's upbringing and is likely to have diminished our insight into his behaviour and thought processes.

2.3 It is, however, clear that as a child Paul was totally dependent upon his mother and that she for her part was utterly devoted to him. That is not altogether surprising, given the continuing absence in the household of either a father figure or another child, but we have the distinct impression that in this instance the degree of inter-dependence went beyond normality. Paul clung to his mother to the point of not going out and forming relationships with other children and she kept him by her side and discouraged any broadening of his horizons.

2.4 We have little information about Paul's schooling. He had undoubted intelligence, but it does not seem to have been translated into results; he was an unremarkable student. Socially he was very withdrawn and inept, as a result of which he may well have been bullied. Outside school hours he spent the vast majority of his time at home. His only significant activity was attending church, as his mother was an ardent churchgoer.

2.5 Paul's social concerns and the over-protective attitude of his mother made him an anxious child. To that extent he may have presented as slightly unusual, but on the other hand there is nothing to suggest that he was suffering from any noticeable mental abnormality. He was regularly taken to see his General Practitioner for physical conditions of one kind or another, but the only recorded indication of a problem which might have had a psychological causation was in about 1976 when he was seen on one occasion at the Tavistock Clinic in relation to enuresis.

2.6 We have not seen or heard anything to indicate that Paul exhibited any signs of bad behaviour either as a child or during his adolescence. He was not violent or destructive and he did not come to the attention of the authorities. Of course we have no independent means of establishing what went on within the confines of his home, but we believe him to have been a quiet and well mannered child who did not resent and react to his mother's control.

2.7 From the age of 11 onwards Paul attended Finchley High School and in due course he attained Ordinary Level and CSE passes in a number of subjects. After leaving school he found employment as an administrative clerk with British Telecom. He found the work quite demanding, but initially he seems to have been able to cope. On the other hand he did not form any strong friendships with his colleagues and he therefore remained socially isolated.

2.8 In about 1984 Henrietta Leane was diagnosed as suffering from a life threatening cancer. We have little doubt that this development had a very significant impact upon Paul, in particular engendering in him a high level of anxiety. His mother fought her illness with bravery and great determination, ultimately conquering it, but she would have been under considerable pressure and Paul would have been sensitive to her suffering as well as worried that she would not be able to care for him for much longer.

2.9 By 1986 Paul's anxieties and limited lifestyle were having a marked effect upon his state of mind. On the 16th June 1986 he complained to Dr Kellermann (one of the partners in the medical practice which he attended and subsequently his General Practitioner) that he was worried about his inability to communicate and tendency to depression. It was decided that he should return a week later in order to discuss his problem further, but he did not take advantage of this opportunity to obtain assistance and he became increasingly tired and pressurised. By the end of that year he no longer felt able to work and therefore decided to give up his employment for the time being and rest.

2.10 On the 12th August 1987 Paul saw another partner in the practice, Dr James, who noted that he was worried whether he was schizophrenic. There is no objective material upon which we can conclude that he was in fact suffering from a severe mental illness at that time, but his concern that he had a split mind is a theme that recurs from time to time thereafter.

2.11 At some point during the course of 1987 Paul was referred on a private basis to Dr Peter Storey, a psychiatrist practising in Harley Street. We understand that he had two or three consultations, that the main topic of discussion was doubt which he was experiencing about his sexual orientation and that talking to Dr Storey helped him, but we have no other information in relation to these visits.

2.12 In November 1987 Paul re-applied to British Telecom for employment, but at the lower grade of clerical assistant which he thought would be less demanding and provide him with more scope to talk to colleagues, and in March 1988 he returned to work. However, his office was in South London and he was required to make lengthy journeys each day on the Underground, which he found very oppressive. He was unable to work properly and did not establish any friendships. He started going into public houses after work in the hope of talking to people there, but this was not successful either. He ended up wandering the streets before coming home with an overwhelming feeling of hopelessness.

2.13 On the 7th July 1988 he sought a referral to a psychotherapist. This was arranged, but he appears to have backed off from that course of action. Thereafter he must have said something to his employers which made them think that he had suffered a nervous breakdown in 1987. As a result they became concerned about him and on the 3rd November 1988 their Occupational Health Department approached Dr Kellermann for her opinion as to his mental condition and fitness for work. He then went to see her on the 22nd November 1988, but he assured her that he had not in fact had a breakdown and had only needed a rest (although interestingly she also noted that he had felt oppressed by religion).

2.14 In January 1989 he once again ceased working. This meant that he spent more of his time at home. It is clear that he was still at that stage very anxious about his mother, whose illness appeared to be getting worse, but we think that he had also become more resentful about her involvement in his life and reactive to the highly stultifying atmosphere within the household. In February 1989 he left home and stayed away for a period of some two weeks, residing in hotels.

2.15 Thus there were several pressures upon Paul at that time and these led him to take an overdose of aspirin on the evening of the 5th March 1989. Although this could

have been a genuine suicide attempt it is more likely to have been a cry for help, since he subsequently told his mother what he had done and was taken to the Central Middlesex Hospital for treatment in the early hours of the morning of the 6th March 1989.

2.16 Paul was admitted to the hospital and was seen by a Senior House Officer, who observed that he was very odd and kept talking about his two personalities. He was therefore referred for psychiatric investigation.

2.17. He was seen on a ward by the psychiatrist on duty. He denied that he had wanted to kill himself and said that it would not happen again. He was unable to give any reason why he had taken the overdose and declined to say why he had stayed away from home, but he asserted that he had not had a row with his mother and wanted to live with her.

2.18 Upon examination his speech was slow but rational and coherent, his mood was not depressed, his affect was appropriate and there was no formal thought disorder or any thought withdrawal, insertion or broadcasting. He had no auditory or visual hallucinations and no passivity feelings. He said that his appetite and sleep were normal.

2.19 Paul does not appear to have said anything further about his split personality and it is not obvious from the record of the discussion and examination that the point was pursued at all. When we met with him at the Three Bridges Regional Secure Unit, one of the matters into which we enquired was whether he had in fact been experiencing problems of that kind. He told us that he had thought that his mind had been split and that he had believed this had happened while he was at primary school; somebody had paid the teachers to split his conscious and subconscious mind and it had been done by terrorising him.

2.20 He also said that he had been very depressed and that :

"I also had a delusion ...that I thought I was possessed by an evil spirit and I was killing people without meaning to do so ... and at one point I thought my mother was a witch as well."

2.21 We have no way of determining, so long after the event and without independent corroboration, whether these statements are accurate. However, Paul accepted that he had not always been forthcoming about his inner thoughts when he had been seen by psychiatrists and we do not find it surprising that in 1989 he did not come across to a trained professional as obviously suffering from mental illness.

2.22 In any event the psychiatrist concluded that Paul was not mentally ill and that he could be discharged when medically fit. A note was made to the effect that he did not want psychiatric follow up and would see his General Practitioner. He then remained in hospital for a period of three days while receiving treatment for his overdose and was duly discharged when he had recovered.

2.23 On the 10th March 1989 Paul saw Dr Kellermann, who noted that he wanted to leave home and did not wish to discuss the overdose. Thereafter he did not attend at the practice for almost a year and although there were attendances in 1990 and 1991 they were for physical complaints.

2.24 In fact Paul did not leave home, although there look to have been other occasions upon which he stayed away for short periods of time. He did not again work and it seems that his mother recovered from her cancer and went back to work herself in order to bring some money into the household. In addition he had some savings and as his expenditure was low he got by without having to apply for benefits or seek help from the Social Services for the next three years.

2.25 Accordingly there was a lengthy hiatus after the hospital admission when little was happening in Paul's life. There is nothing to suggest that he was mentally ill or in need of treatment during that time. He did not take another overdose or attempt to commit suicide by any other means. He was not on any medication. However, he remained very isolated and it is clear from what happened subsequently that his underlying problems were not significantly alleviated.

2.26 The history of events over the period of almost 30 years prior to the beginning of 1992 leads us to the following central conclusions :

(i) Paul probably did not suffer from schizophrenia or any other form of severe mental illness. He did on the other hand have a highly unusual personality and in that respect can be described as disordered. He was also subject to bouts of depression.

(ii) Paul did not normally present as suicidal. Although the incident in March 1989 did mean that there was always a possibility of further life-threatening behaviour, the risk of such an occurrence was relatively low.

(iii) The relationship between Paul and his mother was abnormal and played a significant part in the formation and persistence of his odd personality. He is likely to have come to resent the control which she exercised over his life. But there is no reliable evidence of any wish to harm her and nothing to indicate that they ever came to blows. Certainly there was no reason for any third party to conclude that she was at risk.

(iv) Paul was not able to look after himself or cope with the ordinary demands of everyday life. He was withdrawn, lacking in confidence and inadequate. For these reasons he was a vulnerable individual and in need of support.

CHAPTER 3

THE CRITICAL YEARS

3.1 On the 14th February 1992 Paul went to see Dr Kellermann. He told her that he had not been working for the past three years and had run out of his savings. It seems likely that the purpose of his visit was to obtain a medical certificate so that he could start receiving benefits.

3.2 Dr Kellermann was satisfied that he was suffering from a nervous disorder and was prepared to give him a certificate. However, she quite rightly considered that he ought to be seeking psychiatric help and with his consent she therefore referred him to the psychiatric unit at the Central Middlesex Hospital. The referral letter read as follows :

"This 29-year old has been unable to work since he overdosed on Aspirin in 1989, when he needed an alkaline diuresis.

He recently ran out of all his savings and now feels he is medically unfit to pursue any work. At the time of his overdose he felt that there was too much pressure on him from his religion and possible sexual conflicts, but until now he has been reluctant to discuss his problems. He has been afraid that any documentation would affect his future career prospects.

He is still a very isolated and lonely person, whose only relationship appears to be with his mother (treated five years ago for ca uterus) and his aunt. He also describes a similar "breakdown" in 1987 for which he did not seek any help.

I am wondering whether a Day Hospital attendance would be suitable or even Group Therapy. I have discussed this with Mr Leane and I would appreciate your opinion."

3.3 The letter was addressed to a "Consultant Psychiatrist" and the case was allocated to one of the Consultants at the hospital, Dr Harrison-Read. However, for reasons to which we will advert in Chapter 5, Paul was never in fact seen by Dr Harrison-Read but only by his juniors.

3.4 Paul's first attendance at the Out-patient Clinic was on the 10th April 1992. He was seen by Dr Witcomb, a Senior House Officer in Psychiatry who was a trainee on the St Mary's Hospital Psychiatric Training Rotation. Dr Witcomb recorded his psychiatric and social history, noting that prior to the overdose in March 1989 he had felt nervous and afraid and experienced thoughts that his mother might kill him, that he had then made quite a good recovery, that just after Christmas 1991 he had felt his confidence to be slightly ebbing and started to feel depressed, that he was anxious and afraid when he had seen Dr Kellermann, but that he was now feeling much better and thinking about trying to get a job.

3.5 On examination of his mental state Paul was found initially to be slightly anxious. He described his mood as subdued but denied any suicidal ideation and did not appear to be depressed. There was no evidence of passivity phenomenon or any delusional ideas and he was considered to be cognitively intact, with good insight into his problems.

3.6 Dr Witcomb arrived at a provisional diagnosis of general chronic anxiety, with possible elements of obsessive compulsive disorder. She would therefore appear to have concluded that Paul's thoughts and fears about his mother (which had not actually been expressed to anyone else before) had been obsessive ruminations,

in other words intrusive thoughts which caused anxiety but which he recognised to be untrue or irrational and resisted.

3.7 Dr Witcomb evidently suggested that Paul should start taking medication, but he declined to have any drug treatment and so at that stage nothing was prescribed. He was given advice about a job scheme and requested to return for review in two months time (but in fact was given an appointment for one month later).

3.8 Given the terms of the referral letter, we would have expected Dr Witcomb to have at least given consideration to the suitability of attendance at the Day Hospital or group therapy. She may well have done so and rejected both of these possibilities, but there is no reference to either of them in her note or in the letter dated the 22nd April 1992 which she subsequently sent to Dr Kellermann setting out her findings and recommendations.

3.9 Shortly afterwards Paul decided that in order to forestall another breakdown he would commence taking medication. On the 28th April 1992 he communicated this decision to Dr Kellermann, who passed the information to Dr Witcomb in a letter dated the 30th April 1992. He also told Dr Kellermann that he was suffering from pain in his oesophagus on swallowing and she arranged for this symptom to be investigated.

3.10 Paul was seen again in the Out-patient Clinic by Dr Witcomb on the 8th May 1992. He told her that he was still feeling anxious. One of his main worries was financial; he was heavily in debt on his credit card and living on Income Support. Another was his pain on swallowing; he was waiting for the results of the tests and was worried that he was not being told about the results because something was seriously wrong. He reported that he was eating and sleeping well, but that he felt quite weak although not depressed.

3.11 In view of his willingness to start taking medication Dr Witcomb suggested that he should be prescribed Stelazine (trifluoperazine) 5mg at night. This neuroleptic tranquilliser was commonly used in the treatment of psychosis, but in a written submission to the Inquiry which preceded his oral testimony Dr Harrison-Read stated that in a low dosage it was also *"extensively used in the treatment of chronic anxiety, especially if the patient's personality suggested excessive suspiciousness, oversensitivity to the negative reactions of others and social withdrawal (paranoid schizoid traits) as was the case with Mr Leane."* He was sure that Dr Witcomb would have discussed the case with him and that he would have recommended the prescription.

3.12 On the 14th May 1992 Paul saw Dr Kellermann and was duly prescribed 30 tablets of Stelazine 5mg. However, he then re-attended at the practice on the 22nd May 1992 and told her that he was still anxious. She therefore increased the dose to 5mg twice daily and as a precaution added Procyclidine, a drug used to counter extrapyramidal movement disorders commonly encountered with higher doses of neuroleptics.

3.13 Despite the increased dose of Stelazine Paul went back to Dr Kellermann on the 26th May 1992 and complained that he was still agitated. This led to the further addition of another 5mg of Stelazine at night, while Procyclidine was to be taken twice daily. Thus there were two alterations to the recommended drug treatment by Dr Kellermann in the space of twelve days and the overall dosage of Stelazine was raised above the normal level for treatment of anxiety.

3.14 Paul was next seen by Dr Witcomb on the 5th June 1992, one month after his previous review (although she had again seemingly proposed an interval of two months). She noted that Stelazine was now being taken in doses of 5mg in the morning and 10mg at night, which Paul felt was helping *"a bit"*. He still appeared

to be anxious about his swallowing problem and although he was less worried about his debt, which he was paying off by small monthly instalments, he was also concerned about the need to obtain a certificate from his General Practitioner so that he could get his benefit.

3.15 Paul appeared to Dr Witcomb to be slightly flat but she did not think that he was depressed and he confirmed that he was usually more anxious than depressed. She also found no evidence of thought disorder aside of repetitiousness. She decided that he should remain on the higher dose of Stelazine. However, she advised him to discontinue the Procyclidine and only to restart it if extrapyramidal side effects actually arose. According to Dr Harrison-Read she would have been concerned that unnecessary administration of Procyclidine could have been disadvantageous, for example by causing mood elevation or addiction or possibly by predisposing to long term involuntary movement disorders such as tardive dyskinesia.

3.16 On this occasion Dr Witcomb actually specified that the review was to be in just one month's time. No doubt she was concerned to monitor the effect upon Paul of the increased dosage of Stelazine.

3.17 On the 18th June 1992 Paul was seen in the Gastroenterology Clinic, where he not only complained of epigastric pain but also said that he had a loss of power in his right arm and was experiencing right sided headaches associated with pain behind his right eye and occasional flashing lights. He was assured that although there was probably a stricture at the bottom of his oesophagus, this condition was benign and his headaches sounded like migraines. Additional oesophageal investigations were to be undertaken, but he was told that a CT scan to exclude a brain tumour was not at that time indicated.

3.18 On the 9th July 1992 (the day before the next review) Paul attended at the Brent

Social Services. His purpose was to obtain a bus pass, one way of alleviating the consequences of his impecuniosity. We note that he took this action of his own volition and that he had not been referred to the Social Services by Dr Witcomb despite the social and economic nature of his pressing problems.

3.19 In order to qualify for a bus pass Paul had to be registered as a person disabled by reason of mental disorder. The procedure for registration involved assessment by a Social Worker, who had to be satisfied that certain established criteria were met. They included the absolute requirement of confirmation by a medical practitioner that Paul was suffering from a chronic mental disorder and had been substantially and permanently disabled by it, together with acceptance by Paul that he had been permanently handicapped by the disorder and would never fully recover. He then had to meet one of four alternative requirements which related to his personal circumstances. Finally there had to be a likelihood that the benefits to be derived from registration would reduce his isolation, improve the quality of his material life or enhance his prospects of fuller integration into the life of the community.

3.20 Paul was initially seen by a Duty Social Worker, Kalpna Patel, who had been in the employment of Brent Social Services since September 1991. She had qualified as a Social Worker shortly beforehand and was relatively inexperienced.

3.21 Ms Patel recorded a fairly detailed account of Paul's existing circumstances. She noted that he was very vulnerable socially, as he had no friends and felt nervous in social settings, that he was lacking in confidence and that he was anxious about the state of his physical health. Her report also included the following passage :

"Although Paul understands his mental illness more now, at times he has not complied with medication when his mood has changed drastically. He becomes more agitated and verbally aggressive towards his mother."

3.22 On the assessment form Ms Patel ticked boxes indicating that Paul was likely to experience recurring problems requiring professional help, that he was lacking in ability to organise his basic self-care and that he was experiencing acute emotional distress in relating to others or leaving the house.

3.23 These findings highlighted aspects of Paul's personal circumstances in respect of which intervention over and above a bus pass might have been of assistance. At the very least we consider that he might have been helped by advice as to ways in which he could enhance his ability to look after himself and become independent of his mother. There was therefore a fairly obvious necessity for a full assessment of his needs. However, Ms Patel told us that she was basically focusing upon the application for the bus pass and that it did not occur to her to make any additional recommendation.

3.24 On the 10th July 1992 Paul was seen again by Dr Witcomb. He indicated that his mood was fluctuating from day to day but was more down than up, that he was waking in the early hours two to three times a week and that there was a slight reduction in his appetite. He also mentioned that soon after his last attendance he had experienced anxiety when in a crowd. Nonetheless he felt slightly better than before and Dr Witcomb decided that he could reduce the Stelazine to 5mg twice daily with a view to a further reduction in the near future. No recommendation was made about the Procyclidine, although it was noted that he had not in fact stopped taking this medication.

3.25 Dr Witcomb was informed by Paul that he had applied for a bus pass and that she would be receiving a request for a report from the Social Services. Thereafter she received what was in fact a standard form on which she was required to enter the nature and degree of Paul's illness or handicap and its effect upon his function and to state whether or not she recommended his registration. She duly completed this

form on the 14th July 1992, describing his illness as generalised chronic anxiety with a possible element of obsessive compulsive disorder, stating that his levels of anxiety were severely affecting his day to day functioning in both practical and emotional terms and recommending registration.

3.26 Paul therefore qualified for registration as a handicapped person and on the 17th August 1992 a letter was sent to him by the Area Manager of the Social Services informing him that his name had been added to the Register. He would thereby have become entitled to collect his bus pass and it was also pointed out to him that other services were available to registered persons if the conditions applicable to those services were met. The letter included the following advice :

"If at any time you feel you would like to discuss any problem you may have or would like to be considered for a particular service, I hope you will write to the Social Worker, or to me at the above address, or if you are able, to visit this office."

3.27 The file was then closed on the 20th August 1992 by John Simmons, the leader of the Social Services team for the Brent East sector. Ms Patel was a member of that team and he was therefore her supervisor. It would have been his responsibility to check that she was carrying out her functions properly. He informed us that he would only have viewed the bus pass procedure as an administrative process and he would have done no more than ensured that it had been correctly completed. He did not see it as part of his duty personally to consider whether any further assistance might be appropriate.

3.28 By this time the investigations into the swallowing problem had been completed. At the Gastroenterology Clinic on the 7th August 1992 Paul was assured that he did not actually have a stricture and that his oesophagus was normal.

3.29 Dr Witcomb had specified that the next psychiatric review was to be after an interval of six weeks. However, Paul was either not given an appointment for mid August 1992 or (if he was) it was subsequently put back. We are uncertain why this happened, but it could have been because the Senior House Officer rotation took place in the month of August. At that point Dr Witcomb was succeeded by Dr Rangel, who we understand to have had previous experience in the field of psychiatry.

3.30 On the 3rd September 1992 Paul was seen by another General Practitioner, who prescribed Stelazine on the basis of one 5mg tablet in the morning and one to two at night. This did not accord with Dr Witcomb's plan for reductions in dosage.

3.31 Paul then saw Dr Kellermann on three separate occasions between the 15th and 18th September 1992 with further complaints about headaches and swallowing. These problems seem to have become obsessional and unrelieved by reassurance.

3.32 Paul was reviewed by Dr Rangel on the 25th September 1992. The content of this review is to be found in a handwritten draft of a letter to Dr Kellermann which was prepared by Dr Rangel on the same day and which was included in the clinical notes. That was an unusual method of record keeping.

3.33 There is nothing to suggest that there had been a formal handover of the case from Dr Witcomb to Dr Rangel (nor on the occasion of subsequent rotations does there appear to have been any handover). Dr Rangel would simply have been given the case notes on the day of the review and have looked through them prior to seeing Paul.

3.34 Paul told Dr Rangel that he was feeling generally well, but that on two occasions since the previous review he had become very anxious and experienced suicidal

thoughts. He had, however, been able to control them and would not do anything to harm himself.. He did not strike Dr Rangel as anxious or depressed and she did not detect any sign of thought disorder, although as usual he was preoccupied with his oesophageal problem. He stated that he was sleeping and eating well and that he was planning to start daily walks and to assist his mother with the shopping.

3.35 Dr Rangel recommended that Paul should continue taking Stelazine twice daily, but with an additional tablet at night when he felt more anxious. This was in fact little different to what was already happening, but it did represent a distinct change to the plan formulated by Dr Witcomb and underlines the difficulty likely to be engendered by alterations in personnel.

3.36 Dr Rangel made arrangements to see Paul again in two months time and she duly saw him on the 27th November 1992. She again made no clinical note; on this occasion we are reliant upon a typewritten letter to Dr Kellermann dated the 30th November 1992.

3.37 Paul reiterated that he was feeling generally well, although he was continuing to feel anxious at times. He now seemed to be denying that he had experienced any controlled suicidal thoughts. Dr Rangel felt that his mental state was considerably improved, particularly because he was less worried about his physical problems. On the other hand he was concerned about his capacity to cope without his mother if anything happened to her. It is to be observed in this connection that he had initiated an application for Disability Living Allowance. We have the impression that much of what Paul was saying to his medical attendants during the course of 1992 was bound up with his desire to improve his financial circumstances.

3.38 Dr Rangel went on to state that Paul was still on Stelazine 5mg per day, with an extra tablet when he felt anxious, together with Procyclidine 5mg per day. We are

unable to reconcile these dosages with the higher ones which had previously been recommended and we are unsure what Paul was actually taking.

3.39 The letter concluded with an indication that Dr Rangel would see Paul again in two months time for re-assessment with a view to reducing the Stelazine.

3.40 On the 2nd December 1992 Paul again visited the Brent Social Services. On this occasion he was seeking assistance in relation to his application for a Disability Living Allowance. He was seen by a Social Work Assistant and an appointment was made for a meeting with a Duty Social Worker on the 17th December 1992.

3.41 Paul did not keep that appointment, nor did he return to the Social Services office subsequently. Mr Simmons rapidly proceeded to close the file. He told us that it would have been his standard practice to close a file in circumstances such as these in which there was a self-referral followed by failure to attend. He would not take any steps to follow the matter up. If the client came back in due course, a fresh form would be completed; if he did not, the case would have been cleared from the duty desk. Mr Simmons operated this procedure for administrative convenience in order to prevent an accumulation of old open files. In that respect he differed from his colleagues, who would never have closed the file, but he maintained that they likewise would not have been following the matter up since there would not have been time to take such action.

3.42 Paul's recollection is that following a medical assessment he did actually receive a Disability Living Allowance for a period of six months at some time between 1992 and 1994. We assume that he managed to deal with the necessary paperwork himself and for that reason did not find it necessary to seek further help from the Social Services.

3.43 The next review at the Out-patient Clinic took place on the 12th February 1993, slightly more than two months after the previous one. That would not have been of any importance were it not for the fact that at about the beginning of February the Senior House Officer rotation occurred. Accordingly Paul was not seen by Dr Rangel as intended, but by her successor Dr Nayrouz. This meant that within the first year of his out-patient care he was seen by three different junior doctors.

3.44 Dr Nayrouz recorded his findings and plan in the medical notes as well as sending a letter to Dr Kellermann. The entry was placed directly after that of Dr Witcomb for the 10th July 1992. Dr Nayrouz was no doubt confused by the record keeping of Dr Rangel, whose draft letter of the 25th September 1992 started on a new page of the notes and left a preceding gap and who had made no entry at all on the 27th November 1992. However, Dr Nayrouz probably did read both the draft letter and the subsequent typewritten letter in relation to the November review.

3.45 Paul reported that he was feeling well and that there had been an improvement in his condition. He was no longer depressed and had started to enjoy his life. He was becoming involved in social activities and mixing with more people. He did not have any suicidal ideas or plans. He had in mind that he would eventually go back to work, but for the time being he wished to continue resting.

3.46 Dr Nayrouz noted that Paul's medication was Stelazine 5mg twice daily together with Procyclidine 5mg twice daily, which was indeed his official prescription but not necessarily what he was actually taking. He was advised to decrease the doses to one tablet of each drug at night.

3.47 At the end of the review Dr Nayrouz told Paul that he would be seen again in six weeks time, but that he should make contact in the meantime if he felt worse.

3.48 The subsequent appointment with Dr Nayrouz was in fact over three months later on the 21st May 1993. At that stage Paul reported that he was still generally doing well and had a reasonably good social life, but that he did feel slightly depressed at times and would not then want to do anything. He also indicated that he was still taking Stelazine twice daily, which he felt was helping him considerably. Dr Nayrouz did not comment on his apparent failure to reduce the dosage and seems to have abandoned the earlier plan of reduction. Another drug was now added for treatment of his depression, namely Paroxetine in a dose of 20 mg daily, but with a proviso that it should be discontinued if no benefit was obtained.

3.49 On this occasion Dr Nayrouz recommended a further review in two months time, which should have enabled him to see Paul again before the next Senior House Officer rotation at about the beginning of August 1993. However, it seems likely that Paul was given an appointment for a date subsequent to the rotation.

3.50 On the 16th June 1993 Paul saw Dr Kellermann and evidently told her that he was very concerned that he might have to start work again. One possible explanation for his concern is that there was a problem with the continuation of his benefits; this would line up with his evidence that the Disability Living Allowance was terminated after six months. Dr Kellermann has also recorded that he was worried that the psychiatrist at the hospital thought he was unwell and unable to tolerate any stress.

3.51 On the 15th September 1993 Paul saw Dr Kellermann again and alarmingly said that he was occasionally hearing voices telling him to kill himself. She then made a note that he was to be seen in two months time at the Out-patient Department. We are inclined to think that whatever appointment he had been given on the 21st May 1993 had subsequently been replaced with another appointment for a much later date, namely the 17th December 1993, and that it may well have been at the

instigation of Dr Kellermann that this review was brought forward by some three weeks to the 26th November 1993.

3.52 The explanation for such a lengthy interval between reviews was provided to us by Dr Harrison-Read. The Senior House Officer who succeeded Dr Nayrouz was not able to cope with her duties and left after only a few weeks in the post. In the meantime her clinics were disrupted. Her team then had to operate as best as they could with locum cover for the remainder of her six months engagement. There was inevitably a significant dislocation of the service.

3.53 On the 26th November 1993 Paul was seen by one of the locums, Dr Laznowski. Although he stated that he felt a little better than on the occasion of his last review, it is difficult to see how this can have been the case. He was experiencing bouts of low mood on two days out of ten, was lacking in concentration and ability to communicate and so was not working, often stayed in bed all day, suffered from a fear of loneliness even when among people and sometimes felt suicidal (although there is no specific mention in Dr Laznowski's note of the voices). There were times when he felt that his mother was against him.

3.54 Dr Laznowski did not recommend any alteration to the existing medication, but he suggested that Paul should contact the Brent Counselling Service. This was a voluntary organisation to which patients could refer themselves. However, Paul did not in fact seek help from either this or any of the other numerous voluntary organisations which were available in Brent.

3.55 Paul was then reviewed again on the 17th December 1993, on this occasion by another locum Dr Sarasola. Plainly that appointment should have been cancelled, as it had been superseded by the earlier one. There was no reason at all for Paul to be seen again within a space of three weeks and we think that for him to have

returned within such a short period of time and been met with yet another new face was counter-productive.

3.56 Dr Sarasola made no entry in the clinical notes, but his observations were set out in a letter to Dr Kellermann dated the 20th December 1993. Paul reported similar problems to those communicated to Dr Laznowski, except that he did also start to speak about his sexuality and there was discussion about his need to accept that he was homosexual and then to gain confidence through a short term relationship.

3.57 Once again no changes in medication were proposed, but Dr Sarasola did suggest that Paul required something to occupy his mind and it was agreed that he would try to take up an activity such as pottery. An appointment was made for him to return for further review in two months time.

3.58 At about the beginning of February 1994 Dr Woodhatch, another Senior House Officer, arrived. This would have resolved the management problems arising out of the locum arrangements, but it must be borne in mind that Dr Woodhatch was a trainee with no previous experience in the field of psychiatry who for the first few weeks of her engagement would have required a high level of supervision from Dr Harrison-Read.

3.59 Paul was seen by Dr Woodhatch on the 18th February 1994. He brought with him a list of his existing problems. This was the first recorded occasion upon which he had produced such a list, but we do not find it at all surprising. He had by now been visiting the Out-patient Clinic for the best part of two years. He had seen no fewer than five psychiatrists; Dr Woodhatch was the sixth. A number of different symptoms of varying intensity had been described. He may have been anxious to ensure that whoever saw him on this occasion did not miss anything out.

3.60 The list comprised panic attacks, agoraphobia, feeling afraid, inactivity, inability to concentrate, a constant need for reassurance, depression and illness on two to three days of the week. These problems were duly recorded by Dr Woodhatch and she had a lengthy discussion with Paul about them.

3.61 Dr Woodhatch also noted that Paul was continuing to take Stelazine combined with Procyclidine twice daily, but that he was only taking Paroxetine on two or three occasions a week instead of once a day. It would not have been possible to tell whether he was obtaining any benefit from this drug and understandably the advice he was given by Dr Woodhatch was to take it regularly as prescribed.

3.62 At the end of the review Dr Woodhatch made a recommendation that Paul should attend at the Day Hospital for assessment. This was the first time that any of the clinicians took up the suggestion which had been advanced by Dr Kellermann in her original letter of referral. There were reasons why the Day Hospital might not actually have been regarded as the best option. However, Dr Woodhatch was in our view correct in concluding that its services could have been of assistance.

3.63 We are satisfied that the recommendation was either made by Dr Woodhatch after prior consultation with Dr Harrison-Read or was subsequently approved by him. Given the requirement for supervision, there would almost certainly at some stage have been discussion between them as to the appropriate action to be taken.

3.64 According to Dr Woodhatch the referral to the Day Hospital would have been effected orally on the 21st February 1994. The Out-patient Clinic took place on Friday afternoon and would have finished between 5.30 and 6.00 p.m., by which time the Day Hospital would have been closed. Dr Woodhatch would have been there on the following Monday morning and she would then have informed the manager that Paul needed to be seen.

3.65 If the system was operating properly, there should have been a letter from the Day Hospital to Paul either inviting him to make contact or offering an appointment. There is nothing in his records to indicate that this was in fact done, nor did he attend at or communicate with the Day Hospital. Nonetheless, the absence of any material documentary evidence does not conclusively establish that there was here a breakdown in the normal channel of communication. Grounds exist for thinking that Paul probably was approached and simply failed to respond.

3.66 On the 14th March and 7th April 1994 Paul did not attend appointments with Dr Kellermann. When he subsequently saw her on the 14th April 1994 he seemed very agitated and said that he had forgotten about those appointments. He then ceased going to the practice altogether.

3.67 In addition to referral to the Day Hospital Dr Woodhatch had arranged for Paul to be reviewed at the Out-patient Clinic after an interval of three months. However, he likewise failed to appear at his appointment on the 20th May 1994.

3.68 It seems highly likely that Paul would have adopted a similar attitude in relation to attendance at the Day Hospital. We are constrained to conclude that whereas prior to March 1994 he had generally co-operated with his medical advisers, he had now decided to manage without them.

3.69 There are various possible explanations why this happened, of which two stand out. The first is (as Paul himself put it) that he *"got fed up with it"*. This would have been a perfectly reasonable reaction to attendances at the Out-patient Clinic and at the practice which had extended over a lengthy period of time without any obvious improvement in his condition and without any end in sight. The second is that he only saw the involvement of doctors as a means of achieving financial support but no longer required their assistance for this purpose because he never

went out, his need had become minimal and it was being sufficiently met by his mother.

3.70 Whatever may have been the actual reason for the cessation of care, we consider it to have been a regrettable outcome. That is not to say that a continuation of the existing regime would have met with our approval; it was leading nowhere and was probably making Paul believe that he was more ill than in fact was the case. We do on the other hand feel that he remained in need of help and that long before he decided to go his own way he ought to have had the benefit of assessment both at the Day Hospital and by the Social Services with a view to endeavouring to find a formula for altering his life to something closer to normality.

3.71 When a patient did not attend an appointment at the Out-patient Clinic the usual procedure was to inform the General Practitioner and to send to the patient a notice of another appointment. Dr Woodhatch did send a letter to Dr Kellermann, but we have no document which establishes that a further review was offered to Paul in 1994. The next entry in the notes relates to an appointment on the 12th May 1995, a year later. This is quite extraordinary and has not been satisfactorily explained.

3.72 However, we have little reason to suppose that Paul would have been interested in returning to the Out-patient Clinic. He did not in fact attend on the 12th May 1995. He was then given another appointment for the 28th July 1995, which he again ignored. At that stage an entry was made in the notes, presumably by Dr Adrian who was the Senior House Officer from February to July 1995, that he was to be discharged. This decision would have been made following discussion with Dr Harrison-Read (who did not allow his juniors to discharge patients without his personal authorisation) and cannot be criticised. Paul could not be forced to attend at the Out-patient Clinic or to receive treatment he did not want. Moreover, as he had not been suffering from a severe mental illness or presented as a high risk

case, there was no compelling reason to take a more assertive line and press him to return.

3.73 We would, however, have expected Dr Kellermann to have been kept informed, as effectively the responsibility for Paul's care was being passed back to her and any further follow-up at the Out-patient Clinic would have been dependent upon another referral. It is therefore regrettable that neither the non-attendances nor the discharge were communicated to her, although here again we do not think that this made any actual difference to the course of events. By now she had not herself seen Paul for over one year and if she had been concerned about him she would anyway have been taking steps to re-establish contact. She assured us that she cannot in fact have felt any pressing need for action at that time.

3.74 It is of course a corollary of Paul's passivity from May 1994 onwards that he was not being prescribed medication. That is interesting, because it demonstrates that despite having taken Stelazine on a regular basis for some two years he must have felt that he could manage without it, while his attitude towards taking Paroxetine always looks to have been equivocal. The extent to which these drugs had actually been helping him is another matter. Intermittent Paroxetine may have been of no great assistance, but Stelazine 5mg twice daily certainly ought to have reduced his levels of anxiety and we are inclined to think that its discontinuance did give rise to a deterioration in his state of mind.

3.75 Paul remained of his own volition without medical attention of any kind for a period in excess of two years. During this time he seems to have done very little. He never went back to work and aside of attending church he had no meaningful activities. Contact with the outside world was limited; his life revolved around his home, where his mother ministered to his domestic needs. This was undoubtedly an unhealthy and claustrophobic situation. For Paul it was nothing new, but the

very fact that it had persisted into his thirties and that there was still no obvious escape route is regrettable.

3.76 On the 15th July 1996 Paul re-established contact with Dr Kellermann, either by letter or over the telephone. His objective appears to have been to re-activate his medication. By way of explanation for this unexpected decision he told us that his mother had become concerned about him and encouraged him to see his General Practitioner. That is interesting, as there is little in the earlier history to indicate what attitude his mother had actually taken in relation to his psychiatric treatment. Nor in fact do we have any independent source of information as to her attitude at this juncture; we do not know how Paul was inter-reacting with her.

3.77 Dr Kellermann advised Paul to come into the surgery and he did so on the 19th July 1996. However, she was unable to establish his existing problems as he kept changing the subject. She therefore thought that the best course of action was to refer him back to the hospital. In the meantime Stelazine and Procyclidine were once again prescribed, but not Paroxetine.

3.78 According to Dr Kellermann there would certainly have been a referral letter. It is not included in any of the extant records, but in any case we apprehend that it would have been short and relatively formal.

3.79 By that time there had been a significant change in the organisation of the out-patient service; it had become sectorised. Patients were seen at the hospital by one of the team of psychiatrists responsible for the area in which they resided. Paul's home was in the East Sector. The relevant team was headed by Dr Mallett and not by Dr Harrison-Read and for this reason Dr Harrison-Read and his juniors had no further input into the case. That made a difference, because there was effectively a fresh approach to Paul's treatment and care.

3.80 When Paul attended at the Out-patient Clinic on the 26th July 1996 he was seen by Dr Mallett. This was the first time that he had been reviewed by a Consultant. We were given to understand that it was not a deliberate allocation based upon a perceived need for involvement at Consultant level, but rather that it was simply the result of random selection. We cannot say that we are greatly impressed by the system, but at least it did fortuitously avoid a return to the unsatisfactory process of repeated reviews by a series of junior doctors.

3.81 Of course Dr Mallett was initially in the same position as any junior doctor would have been, in that he had no prior knowledge of the case and so had to acquire the background information from the notes. He would have been handicapped in that task by the absence of any summary of Paul's problems or chronology of his past attendances and treatment. On the other hand he was highly experienced and is likely to have required less time to undertake the preliminary work than a Senior House Officer.

3.82 Dr Mallett indicated in the course of his testimony that there would have been two matters at the forefront of his mind. One was the content of Paul's thinking and whether there was anything bizarre about it which caused concern as to his mental state. The other was his social situation and whether that was creative of problems for him. In order to assess these matters Dr Mallett would have questioned him in some detail.

3.83 It is clear that Dr Mallett did not consider Paul to be suffering from a significant mental illness. The only findings recorded in his note are that Paul was stable and that he had sexual anxiety but no panic or other anxiety. We are bound to say that this note was very short indeed and Dr Mallett conceded that it was thin and not really good enough, but we have no reason to doubt his competence as a clinician and we accept that he formed an appropriate judgement as to Paul's mental state.

3.84 As to Paul's social difficulties Dr Mallett thought that the Day Hospital would probably not be a suitable option but that it should be left open for consideration at the next review. A referral to the Social Services does not seem to have been regarded as an alternative course of action. Dr Mallett told us that Paul would not have met the Social Services criteria for being taken on by the Mental Health Fieldwork team.

3.85 In a letter to Dr Kellermann dated 5th August 1996 Dr Mallett stated that *"Paul remains with his mild sexual anxiety but very little else in the way of positive symptoms. I am seeing him again in two months for review. If there is nothing further that he wishes to take up here, I will probably discharge him."* In the meantime he was to remain on his existing medication.

3.86 Accordingly Dr Mallett adopted a quite different approach to that which had been followed between 1992 and 1994. Whereas Paul had previously been passed on from one clinician to another, with tinkering to his medication but no effective management decision, we see now a very firm hand on the tiller and selection of a course in the direction of discharge from out-patient care.

3.87 Paul was duly reviewed by Dr Mallett on the 18th October 1996. The note made on this occasion was even more minimal than before, as it merely stated that Paul was stable and had been discharged. A letter dated the 22nd October 1996 was then sent to Dr Kellermann explaining that Dr Mallett had not arranged to see Paul again as *"we seem to have very little to add to his treatment"*, but would be happy to do so should she feel it to be necessary. For the foreseeable future he was to remain on the same medication.

3.88 We are constrained to agree with Dr Mallett that there was little to be gained from re-attendance at the Out-patient Clinic. Whether Paul should have been denied the

opportunity of assessment at the Day Hospital is a rather more difficult issue. We have already indicated that he might have derived some benefit from the services available at the Day Hospital, but it also has to be borne in mind that upon perusal of the notes Dr Mallett would have concluded that he had not taken up the offer of those services in 1994.

3.89 In any event Paul's discharge was short lived, essentially because at this stage his own preference was for psychiatric attention. On the 29th November 1996 he seems to have visited the Out-patient Clinic unexpectedly without an appointment; there was no immediately preceding attendance at the practice of Dr Kellermann or further referral by her.

3.90 Before embarking upon the detail of what then happened we would point out that the notes have once again become disordered. The entries in respect of the 12th May and 28th July 1995 were made on a new page instead of below the note made by Dr Woodhatch on the 20th May 1994. Into the gap went the two short notes made by Dr Mallett on the 26th July and 18th October 1996. The note in relation to the 29th November 1996 was then put directly after the 1995 entries.

3.91 Despite the absence of an appointment Paul did obtain medical attention on the 29th November 1996. However, in the first instance it was not Dr Mallett but a junior member of his team, Dr Al-Asadi, who saw Paul. Dr Al-Asadi was a very inexperienced practitioner. She had qualified in Algeria and come to England in 1995. She had obtained a clinical attachment in neurology, followed by another at Barnet Hospital in psychiatry, but after only one month in the latter post she had moved to the Central Middlesex Hospital because it was closer to where she lived. Her engagement was similarly a clinical attachment, as she had as yet to secure her registration, and it was in its early days.

3.92 Although Dr Mallett had the benefit of a Staff Grade assistant, he did not have a Senior House Officer on his team at that time and it seems that Dr Al-Asadi was assigned to him in order to cover the junior duties. Inevitably she required a high level of supervision. She was permitted to see a patient on her own, but she then had to report back to Dr Mallett and discuss the case, so that in effect he made the management decision. Furthermore, if there was any problem he would actually proceed to see the patient himself.

3.93 Accordingly Dr Al-Asadi does not appear to have done more on this occasion than take a history from Paul and make a note of what he said. His symptoms look to have been similar to those listed by Dr Woodhatch in February 1994. Anxiety, palpitations, panic attacks, agoraphobia, difficulty in coping with other people, poor concentration, fear, depression and suicidal thoughts were all mentioned.

3.94 Faced with this dramatic presentation Dr Al-Asadi went straight to Dr Mallett. It is not entirely clear whether he saw Paul himself, but on any showing he did make the material decision in relation to the future management. This was to vary the existing drug regime for a trial period by stopping the Stelazine and Procyclidine and commencing Paroxetine in a dosage of 20mg once a day. The thinking behind the variation was that Paroxetine, which Paul had previously taken on a sporadic basis and as an additive to Stelazine, might in fact prove to be the more suitable of the two drugs to treat his anxiety and on its own would not subject him to side effects.

3.95 A corollary of the trial was that there was now a requirement for Paul to be given a further appointment. This meant that the previous plan to discharge him from attending at the Out-patient Clinic had rapidly been reversed, in reality at his own instigation.

3.96 The new plan was reported by Dr Mallett to Dr Kellermann in a letter dated the 5th December 1996. The letter also indicated that at the review consideration would be given to whether Paul would benefit from psychological help, although *"in view of the mildness of his symptoms I doubt whether we will take that forward."* This must be a reference to Dr Mallett's personal assessment of the severity of the symptoms, taking into account his own findings prior to the 29th November 1996; what Paul told Dr Al-Asadi can hardly be described as a mild problem.

3.97 On the 10th December 1996 Paul saw Dr Kellermann and expressed considerable dissatisfaction with the approach taken by Dr Mallett. He was himself convinced that he was suffering from an incurable illness and that he should never have been discharged. He gave a lengthy explanation about the reasons for his illness and his own prognosis. He said that he was feeling depressed and suicidal and that if he did commit suicide it would be by taking a drug overdose. He also indicated that he was suffering from right sided headaches.

3.98 It is difficult to assess precisely what lay behind this highly charged account, but the most likely scenario is that Paul was anxious to ensure that he continued to receive psychiatric treatment. We note that Dr Kellermann recorded both that he wanted to be seen again by Dr Mallett for an explanation as to why he had been discharged and that he would like to be seen by a different psychiatrist.

3.99 Dr Kellermann's evidence here was that she did not think that Paul's condition had materially altered. In particular she did not believe that he had any actual intention to commit suicide. This was an understandable point of view. The problem for Dr Kellermann (who was not alone in this respect) was that Paul always appeared to have an agenda; what he would say was in effect pre-determined and he would never be prepared to reveal what lay beneath the surface.

3.100 In any event Dr Kellermann clearly considered that no specific intervention on her part would take matters forward and that the next review (which she noted was to be on the 28th February 1997) should take place as arranged. Accordingly she confined herself to prescribing medication for the headaches, which she diagnosed as migraines. This medication was then altered on the 10th January 1997, as Paul complained to her that the headaches were still troubling him.

3.101 Paul's account to us of what was happening to him at around this time has a very different flavour. He maintained that because he had been taken off Stelazine his state of mind had deteriorated and he had once again started to experience ideas of a delusional nature (albeit not the same delusions as before). He described them in the following way :

"I believed it was a force created us ... and that this force, before it created the world, it sensed out something else in the universe like itself. So it sent out signals to the four corners of the universe to try to find whatever it was out there like itself. Eventually what it found was a civilisation it was going to create itself ... So it decided to create life on this planet.

And then I imagined that people were going around like robots because they were not intelligent enough to make computers and make cars and things, but their movements were controlled in order to do so. I thought ... that I was not controlled, that I was more intelligent, that I did not have my movements controlled. I was the only person that didn't.

Then I imagined that they had built rail track. Their movements were controlled and they built rail track and they came across these people that had never seen civilisation before and that was Israel and that is why it was called "Israel", because of the rail track, "is rail" you see.

So when they found these people, they brought them back to London and settled them here in houses. I thought that my mother and myself were two of those people they found as well and ... I thought that I was born under ... the star in Jerusalem where Christ was supposed to be born.

And then I thought people ... were going to come and get me and kill me or torture me and I thought my uncle was going to come and beat me up, all these things, because I was the only one who was not controlled, you see. So they were all jealous of me."

3.102 We are not in a position to determine the extent to which this account accurately reflects what Paul was actually thinking, nor do we have a very clear picture of the time scale over which the ideas developed. Suffice it to say that insofar as any of them were in Paul's mind by about the end of 1996 they were not brought to the attention of Dr Kellermann, nor could she conceivably have appreciated that he was having thoughts of this kind.

3.103 The ensuing review at the Out-patient Clinic was carried out on the 14th March 1997 (the appointment presumably having been moved). Paul was again seen by Dr Al-Asadi. He told her that he remained anxious and unable to cope with daily life and that he was waking up early in the morning approximately twice a week. He also said that he would not be able to work. What he did not say was that he was experiencing delusional ideas and there was no reason for Dr Al-Asadi to conclude that his condition was deteriorating.

3.104 Far from suggesting that the discontinuance of Stelazine had been a mistake, Paul in fact indicated that Paroxetine was helping him. Dr Al-Asadi therefore decided to increase the dosage to 30mg with a view to testing his response in due course and if necessary making a further adjustment. She also suggested that he should

seek assistance at one of the voluntary organisations in Brent which provided a counselling service.

3.105 Dr Al-Asadi was by now more experienced and she did not find it necessary to ask Dr Mallett to see Paul as well, but she is convinced that she would have discussed the case with him. That accords with his own evidence and we accept it, although the subsequent letter to Dr Kellermann dated 1st April 1997 reporting the outcome of the review (but omitting any reference to the recommendation for counselling) gives the impression that Dr Al-Asadi was making her own management decision.

3.106 Paul was given a further appointment for review in six months time. This was a fairly lengthy interval, significantly greater than had previously been considered suitable. Dr Al-Asadi told us that it would probably have been stipulated by Dr Mallett. His own evidence was not inconsistent with that, but he stated that he would not currently regard a gap of six months as appropriate and in retrospect it was too long. In particular the assessment of Paul's response to the increase in his anti-depressant medication should have been made at a much earlier point in time.

3.107 This was the last occasion on which Paul was seen by any medical practitioner before the death of his mother. It is perhaps unfortunate that the clinician at the end of the line was the most junior in status of all those who had input into his care, but to blame her for what transpired would not only be far too simplistic but also entirely wrong. She could not possibly have foreseen what Paul was going to do.

3.108 We know that Paul did not subsequently take up the suggestion of counselling. On the other hand we cannot be certain what medication he took, nor do we have a clear picture of what was going through his mind during the days leading up to the incident which has given rise to this Inquiry.

CHAPTER 4

THE INCIDENT

4.1 At about 3.00 a.m. on the 30th May 1997 Paul set fire to the flat in which he and his mother were living. Petrol was used as a catalyst and there was an explosive conflagration. Paul immediately left the premises, but his mother had been asleep in her bedroom and was unable to escape.

4.2 Residents in the block were woken up by the noise. Several of them saw Paul leaving the building and one described how she had seen a man walking quickly to the car park and then looking back at the fire and shouting something before running off.

4.3 The emergency services were summoned and the fire was extinguished. It was found that the exterior wall of the lounge had been blown out, sending debris some fifty feet into the garden area. Henrietta Leane was discovered lifeless on her bed. Her body was unmarked by the fire, but she had been overcome by the smoke.

4.4 The scene was examined by a fire investigator, who concluded that petrol had been distributed within the lounge, kitchen and hallway and probably ignited with a naked flame. A towel smelling of petrol was found just inside the lounge doorway and in Paul's bedroom there was a partially filled petrol can. It was obvious that he was the perpetrator and that he had deliberately started the fire.

4.5 For the next few days Paul could not be located. He had gone to Hampstead Heath and was living rough. However, he ran out of money and on the 6th June 1997 he went to the Camden Town branch of his bank with a view to making a withdrawal

from his account. The police were then alerted and he was arrested on suspicion of murder and taken to Kentish Town Police Station. Whilst there he started to cry and he was recorded as saying that *"I tried to commit suicide. I didn't try to hurt anybody. Is the person actually dead ? That's my mother that is, that's the person who is dead, that's the person I live with."*

4.6 Paul was then transferred to Kilburn Police Station. A representative of the Social Services was summoned to act as his Appropriate Adult and two Forensic Medical Examiners were requested to evaluate his fitness to be interviewed. Doubts appear to have been expressed and the opinion of a psychiatrist was sought. Following a lengthy examination of his mental state he must have been declared sufficiently fit, as he was in fact interviewed on the next day in the presence of the Appropriate Adult and his solicitor. No doubt as a result of advice he made no comment. He was then charged with the murder of his mother.

4.7 Initially Paul was detained in the Psychiatric Wing at Wormwood Scrubs. On the 11th June 1997 he was assessed by Dr Murray, a Consultant Forensic Psychiatrist attached to the Three Bridges Regional Secure Unit, who considered him to be at risk of self harm. On the 12th June 1997 a further assessment was carried out by Dr Gandhi, a Consultant Psychiatrist at the Central Middlesex Hospital, who was acting on behalf of the Brent Court Psychiatric Liaison Service and instructed to prepare a report for production at the Magistrates Court. Dr Gandhi was unable to elicit any gross psychotic features or cognitive deficits, but he noted that Paul had suicidal thoughts and he concurred with Dr Murray's opinion. He therefore recommended that Paul should be transferred to hospital for treatment under the provisions of the Mental Health Act.

4.8 On the 17th June 1997 Paul was admitted to the Bentham Unit at Three Bridges. It appears that he was initially treated with Paroxetine, but that from January 1998

his medication was varied by the addition of Stelazine in doses of 5mg twice daily, together with Procyclidine.

4.9 On the 1st May 1998 Paul appeared at the Central Criminal Court. His plea was one of guilty to manslaughter on the ground of diminished responsibility, which was accepted by the Crown. He was sentenced to detention under Section 37 of the Mental Health Act and a Section 41 restriction order was made. He continued to receive treatment at Three Bridges, initially in the Bentham Unit, from the 17th November 1998 on a rehabilitation ward and from the 29th November 1999 in the Pre-discharge Unit.

4.10 We are uncertain when Paul first gave a detailed description of what he had done on the night of the fire and what had led him to act in that particular way. The best account that we have been able to find is contained in a report by Dr Cox, a Senior House Officer in Psychiatry at Three Bridges. This report was prepared in about February 1999, but the account itself had plainly been given at a previous point in time. With the reservation that on any showing it was not contemporaneous with the events described, we set it out here.

"Paul had described the development of symptoms leading up to the index offence. Over a very long period of time he started to get strange beliefs which he felt were very real at the time. He thought that his neighbour's dog was going to attack him, so stayed in the house with his mother for thirteen weeks and did not go out at all. Subsequently he thought he might be Jesus and he became interested in thoughts around evolution and creation. Eventually he got to the point where he "realised" that the world and everything on it was created suddenly by "a force". He felt that this force was possibly God but possibly was not. He realised that he was the only person who knew this information and therefore felt special. However he began to feel frightened and under threat, feeling that he was in real danger

from people who were jealous of his special knowledge. Eventually he feared for his life, thought he would be killed and was terrified and tortured. He felt that the only option to escape this situation was to commit suicide.

In an attempt to commit suicide Paul describes how he poured petrol around the edge of the living room. His plan was to stand in the centre. His mother was asleep in her bedroom. Paul set light to the petrol and then panicked when the flames appeared to go in the wrong direction - at this point he ran away from the house. He slept rough on Hampstead Heath for one week and was then picked up by the police. It was only when he was picked up one week later that he discovered that his mother had died in the fire (from smoke inhalation) and he was charged with her murder."

4.11 Paul was therefore attributing his actions to the effect upon him of his persecutory ideas, which had intensified to the point of overwhelming him. He was accepting that he had deliberately set fire to the premises and indeed that this action had been premeditated, but his objective was to kill himself and not to harm his mother.

4.12 It is not part of our remit to investigate the veracity or otherwise of Paul's account of his actions and intention, nor on the basis of the material available could we undertake such a task.

4.13 An important issue for consideration is whether Paul was suffering from a severe mental disorder at the time of the incident. This was specifically addressed in a number of reports which were prepared while he was awaiting trial.

4.14 The opinion of Dr Cleary, the Consultant Psychiatrist at Three Bridges who had responsibility for Paul's care until August 1998, was that he was suffering from a schizoid personality disorder together with anxiety and depression. Dr Maden,

a Consultant Forensic Psychiatrist, also believed that Paul was not psychotic but still favoured a medical disposal. Dr Murray considered that he suffered from a pervasive developmental disorder, possibly Asperger's syndrome, although there remained a possibility of a psychotic illness. Dr Tanna, a Clinical Psychologist at Three Bridges, thought that Paul's ideas were in fact delusional. Thus there does not seem to have been unanimity in diagnosis and the case undoubtedly presented as one of unusual difficulty.

4.15 A further opinion was subsequently expressed by Dr Martin Lock, the Consultant Psychiatrist who took over the responsibility for Paul's care in August 1998, in a report to the Mental Health Review Tribunal dated the 25th February 2000. The material passages are as follows :

"The question of whether Mr Leane did suffer from a psychotic illness seems to hinge on whether the persecutory ideas he experienced, starting somewhat before the index offence and continuing for some time after his admission to the Bentham Unit, were delusional or not. The alternative suggestion is that they were over valued ideas in the context of someone with schizoid/schizotypal personality disorders and a very unusual and overprotected upbringing. It is unlikely that with the distance of time this diagnosis would become any clearer whilst Mr Leane remains on medication. Given the index offence it would not seem sensible to withdraw medication simply in order to establish the diagnosis. Mr Leane wants to remain on antipsychotic medication, does not appear to experience any side effects and therefore the diagnosis does remain in some doubt.

Whilst I can accept that Mr Leane does have some difficulty in relating to people and assessing information when communicating with others, he clearly does not suffer from a fully developed Asperger's syndrome. He has demonstrated empathy for others and the ability to put himself in the position of other people when

thinking about their thoughts and emotions. Such an inability is a core feature of Asperger's syndrome. Likewise, Mr Leane does appear to have some features of a schizoid and a schizotypal personality disorder. He does appear to be rather withdrawn. His social contact with others does often seem to be rather business like and he is certainly introspective. Mr Leane himself admits that he could easily see others regarding him as rather eccentric. It is also of note that the International Classification of Diseases' description of schizotypal disorder notes that paranoid ideas not amounting to true delusions and transient quasi-psychotic episodes and delusional-like ideas can occur without external provocation. It is therefore the existence of a schizotypal personality disorder which possibly explains the persecutory ideas Mr Leane expressed on the Bentham Unit. Whether antipsychotic medication would be likely to prevent the formation of those ideas again seems to be open to debate."

4.16 In the final analysis the likelihood is that Paul did not suffer from a severe mental illness; the balance of expert opinion lies in the direction of a personality disorder. However, the precise nature of that disorder is not completely clear. Moreover, it has to be borne in mind that the various psychiatrists who saw Paul in the Out-patient Clinic did not have as much material upon which to arrive at a diagnosis as those who assessed him after the incident. Paul had not communicated to them any strange persecutory ideas, nor did they have an opportunity to observe his behaviour in a hospital setting. They could not reasonably have appreciated that he might be suffering from something more than chronic anxiety and depression and a possible obsessive compulsive disorder.

4.17 A further question which arises is whether the incident was foreseeable. With the benefit of hindsight it is easy to postulate that Paul's circumstances had potential for an eventual flashpoint and that this might in some way involve his mother. But the psychiatrists at the Out-patient Clinic did not possess a crystal ball and they

had to assess the situation as it appeared to them at the time. They were of course aware of the fact that Paul had previously taken an overdose and he did from time to time indicate that he was experiencing suicidal thoughts. On the other hand he never went so far as actually to threaten an imminent suicide attempt and on no occasion did he give the slightest indication that he might contemplate suicide by setting fire to himself or his flat. Moreover, there was no history of arson and no evidence of a desire to kill or seriously harm his mother.

4.18 For these reasons, although there would throughout have been an obvious need to keep a careful eye open for any signs of a crisis, we do not think that anyone can be criticised for failing to anticipate an incident of the kind which occurred.

4.19 There remains the separate issue of whether the incident could have been avoided by different management of Paul's condition and problems. We shall therefore discuss in Chapter 5 the factors which influenced his care and the feasibility of alternative arrangements.

CHAPTER 5

COMMENTARY

The Structure of the Mental Health Community Services

5.1 Prior to April 1993 responsibility for the provision and management of the mental health services in the London Borough of Brent rested with the Parkside Mental Health Unit. That responsibility was then transferred to the North West London Mental Health NHS Trust (now the Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust).

5.2 The Mental Health Unit and subsequently the Trust also had responsibility for the provision and management of the mental health services in an area comprising parts of the Boroughs of Westminster and Kensington and Chelsea.

5.3 The services provided by the Mental Health Unit were purchased by the Parkside Health Authority. In April 1993 the Authority was split in two. The northern part, which included Brent but also extended to Harrow, was allocated to the new Brent and Harrow Health Authority, which purchased the services provided by the Trust in Brent.

5.4 The catchment population of Brent was approximately 240,000. It was one of the most socially deprived areas in the country. Unemployment, overcrowding and homelessness were rife and there was a marked incidence of drug abuse. These factors created a high level of mental illness.

5.5 The general adult psychiatry service for Brent was divided into two components.

Acute care was based on the beds and clinics at the Central Middlesex Hospital (primarily in what was known as the Park Royal Centre for Mental Health); there was also a small in-patient unit, Harefield Lodge in Willesden. Rehabilitative care of existing patients was undertaken at Shenley Hospital, some distance away.

5.6 A plan for the provision of community care centres in Willesden, Wembley and North Brent had been formulated, but it had not been implemented and between 1992 and 1995 no local premises of this kind existed. Out-patients were seen at the clinics at the Central Middlesex Hospital. The only other centralised facilities for them in Brent at that time were a Day Hospital and a Psychotherapy Centre in Willesden. There were in addition community mental health services in the form of intensive care, but it would appear that those services were largely restricted to patients suffering from enduring serious mental illness, the vast majority of whom had been at some time hospitalised.

5.7 The ambience at the Central Middlesex Hospital was poor. The wards and rooms were in a run down condition, they were lacking in natural light and often hot and airless, and there was inadequate space for patients and staff.

5.8 Levels of medical staff at the hospital were low. For example there were only five Consultants covering the adult psychiatric service (one of whom was the Medical Director of the Trust), whereas the workload was such as to call for some nine or ten. The number and seniority of nurses was likewise inadequate. It was not easy to find suitable staff who were prepared to work both in a poor environment and under severe pressure.

5.9 Prior to 1993 there were repeated changes in the personnel who performed the management functions at the Mental Health Unit. That was obviously unhelpful from the point of view of continuity.

5.10 There was ultimately a general improvement in the provision of adult psychiatric services from 1995 onwards. This resulted from sectorisation. Brent was divided into three sectors, namely North-West, South and East. Each sector had its own Community Mental Health team under the control of a Location Manager. The out-patient clinics continued to be held at the hospital, but the teams operated from separate premises; in Brent East, the sector in which Paul resided, those premises were in Willesden and the Social Services moved into the same building.

5.11 It took some time to get the sectorised services running in an efficient manner and we have no doubt that during the period between 1995 and 1997 which falls within the ambit of our Inquiry their operation cannot have been as good as it is today. In any event Paul does not personally seem to have derived any benefit at all from the re-organisation.

5.12 On an overall view the Trust did not have much to offer a patient such as Paul who did not present with a serious mental disorder and whose problems appeared to be more of a social nature than due to illness. He was just one of a very large number of residents in Brent with personal difficulties to whom the available facilities did not effectively stretch.

5.13 Each of the individuals interviewed who at one time or another worked for the Trust acknowledged that the situation in Brent was far from ideal. They accepted that there were internal failings in the system; to these we shall draw attention in more detail. However, two specific external forces over which they had no direct control were also singled out. One was the sheer size of the mental health problem in Brent. The other was a comparative shortage of funding, particularly in the early 1990s, creating the need for rationing of the available resources.

5.14 We have not delved in any depth into the thorny issue of financial provision and

control. The fact is that the Trust is not exceptional in having to manage within a tight budget. We do however recognise that this may to no small extent explain deficiencies in the services available to Paul.

The Care Programme Approach

5.15 The CPA came into existence in 1990 as the framework by which the new plan of care in the community was effectively to be delivered to patients. By the 1st April 1991 each District Health Authority was required to draw up and implement, in consultation and agreement with Social Services, local care programme policies to apply to all in-patients considered for discharge and all new patients accepted by the specialist psychiatric services it managed. Where psychiatric services were purchased from a Trust, the contractual arrangements were to require the Trust to adopt the CPA.

5.16 Accordingly the Parkside Health Authority was under an obligation to put the CPA into operation in Brent and the North West London Mental Health NHS Trust ought to have inherited and itself operated the local arrangements.

5.17 There were bound to be local variants in the CPA, but in principle all programmes should have incorporated systematic arrangements for assessing and reviewing the health care needs of all patients in the community and systematic arrangements, agreed with the Social Services, for assessing and reviewing the social care those patients required in order to benefit from treatment in the community.

5.18 So far as we have been able to ascertain, little was done by the Mental Health Unit to alter the practices followed at the Central Middlesex Hospital so as to ensure compliance with the CPA when new referrals were made or patients came to be

discharged. We were told that the process of implementation was ultimately set in motion in 1993 when Tom McKervey was appointed by the Trust to the post of Adult Services Operations Manager.

5.19 It took until July 1995 for the Trust and the Brent Social Services to produce an agreed written scheme of arrangements. This was contained in a document headed *"Joint Policy - Care Programme Approach and Care Management"* (annexed to our report).

5.20 There were essentially two tiers of patient (although we were informed that cases on the Supervision Register were placed into a separate category). The upper tier, which was known as Level 1, consisted of patients who had complex needs and posed a high degree of risk. The lower tier, known as Level 2, comprised all the other patients. Their needs should therefore have been uncomplicated and they should not have been at serious risk of harming either themselves or anyone else.

5.21 Level 1 patients required multi-disciplinary assessment and care planning, but those who fell into Level 2 would normally be assessed by a single professional, who would then produce a relatively straightforward Care Plan.

5.22 Our understanding is that arrangements down these lines had in fact been put into operation between 1993 and 1995. Their implementation appears to have been a somewhat slow and gradual process.

5.23 We were informed by Dr Harrison-Read that he personally had in the region of 400 general adult psychiatric patients, of whom approximately 120 would have been receiving treatment on Level 1 and the remainder on Level 2. It seems likely that the distribution would have been similar in the case of the other Consultants. In addition Dr Harrison-Read was responsible for the care of about 40 long stay

patients at Shenley Hospital shortly to be resettled in the community and some 60 patients receiving high intensity community care, all of whom were managed on Level 1.

5.24 It is clear that the majority of patients were placed on Level 2. Those patients did not usually qualify for more than review by a psychiatrist in the Out-patient Clinic or follow up by a Community Psychiatric Nurse, although some with special needs were passed on to other mental health professionals or to the Social Services.

5.25 We were concerned to establish who bore the responsibility for deciding upon the level of care which a new out-patient such as Paul was to be afforded. Prior to the establishment of the Community Mental Health teams this looks to have been the Consultant to whom the case was allocated.

5.26 When Paul was referred by Dr Kellermann to the Central Middlesex Hospital in 1992 it was Dr Harrison-Read who examined the documentation. He decided that it was a suitable case to be dealt with by his Senior House Officer, Dr Witcomb. This suggests that he regarded Paul as a patient with a low level of need.

5.27 We have no doubt that Dr Harrison-Read was the appropriate person to make the decision as to the category into which the case fell. A Senior House Officer would not always have possessed the requisite knowledge and experience to undertake this kind of task. However, an initial assessment was essential before the level of risk and need could properly be determined. For this reason we consider that Paul ought to have been seen by Dr Harrison-Read or, if that was impracticable, there should have been an established procedure whereby he discussed the case with his Senior House Officer following the initial appointment and recorded the outcome.

5.28 We were told by Dr Harrison-Read that his juniors did discuss their patients with

him and we accept that such was the usual practice. However, his involvement in Paul's management was not indicated in the notes and we cannot now determine the precise extent of his personal input into the care planning. Furthermore no express decision as to the CPA level seems to have been recorded. That is hardly surprising, as at that time the CPA had not effectively been implemented. But although steps were being taken to introduce the CPA from 1993 onwards, we have equally found no evidence to suggest that anyone then directly addressed the matter of the level at which Paul's care programme was to be provided.

5.29 Although no decision as such was recorded, the reality is that Paul was throughout the period between 1992 and 1994 treated as if he were on Level 2. He was given a series of out-patient appointments at which he reported upon his condition and progress, a mental state examination was performed, a recommendation was made in relation to his medication and he received other advice. He was never offered a multi-disciplinary assessment, nor was he referred to the Social Services or to any professional equipped to consider the non-medical aspects of his situation.

5.30 We do not think that Paul should in fact have been placed on Level 1. There were plainly innumerable patients within the catchment area who presented with mental problems of far greater severity. The overloading of the system was such that a patient whose primary symptom was anxiety and who did not seem to be seriously ill could not qualify for the higher level of care.

5.31 In the circumstances we would not have expected a multi-disciplinary assessment. On the other hand the absence of any recorded assessment at all by a member of staff with the appropriate qualifications and experience to judge Paul's needs and formulate an appropriate plan of care for him is less than satisfactory. Whereas patients such as Paul would not have fallen into Level 1, they still required more than minimal support. It was important to point them in the right direction and

obtain for them the most suitable form of assistance; it was not sufficient simply to treat them with medication and require them to attend periodically at the Out-patient Clinic.

5.32 By the time that Paul came back into the system in 1996 the Joint Policy was in force. Had he been a new patient, a decision as to the tier on which he was to be managed would have been essential. As he was an existing patient, that decision did not strictly speaking have to be made. Nonetheless, he was a fresh face for the team headed by Dr Mallett and in view of his lengthy absence we think that his case required re-assessment.

5.33 The entitlement of all patients to proper assessment and care planning had been emphasised by the Department of Health in 1995 in a Guide entitled *"Building Bridges"*. We would draw attention to the guidelines contained in section 3.2 :

"The following is intended as a guide to the way in which the CPA can be "tiered" to meet appropriately different levels of need. It is not prescriptive, and details such as the number of "tiers" and their definition in terms of levels of need and service involvement are very much at the discretion of local services.

*A **minimal CPA** would apply to patients who have limited disability/health care needs arising from their illness and have low support needs which are likely to remain stable. They will often need regular attention from only one practitioner, who will also fulfil the key worker role ... The care plan will be correspondingly very short, merely indicating the regular interventions planned and the review date ...*

*If the patient needs a medium level of support, a **more complex CPA** would be appropriate. This may be because the person is likely to need more than one type*

of service, or because their needs are less likely to remain stable. Such patients will require further needs assessment which may involve several members of the team, including (almost certainly) a psychiatrist, social worker and mental health nurse. There will need to be a discussion over the identity of the key worker; and the care plan will be more complex, requiring interventions from several members of the team, who will need to be aware of what their colleagues are doing.

Individuals with severe mental illness, suffering from severe social dysfunction, whose needs are likely to be highly volatile, or who represent a significant risk, are likely to require a ***full multi-disciplinary CPA*** *..."*

5.34 The Joint Policy contained no specific provision for patients in the intermediate category, but it was not expeditiously revised so as to bring it into line with the approach set out in the Guide. That would not have necessitated any alteration to the number of tiers, but it would have involved a change of wording with a view to ensuring that patients requiring a medium level of support did not go through the same assessment and planning process as those with a low level of need.

5.35 The absence of a revised approach may explain why in 1996 Paul did not come to be assessed by a Social Worker in addition to a psychiatrist despite the obvious significance of his social needs. However, there are also alternative explanations. One (which we will discuss in detail later) is that there were difficulties in the way of bringing the Social Services into cases of this kind. Another is that Dr Mallett was so unimpressed by Paul as not to regard him as a suitable candidate for any further CPA intervention.

5.36 As a bare minimum a careful assessment of needs and risk by a senior practitioner was required. Fortuitously Paul did actually come to be seen by Dr Mallett rather than a more junior member of the psychiatric staff. It is a pity that Dr Mallett did

not then choose to make a more detailed note of his findings, as that would have put to rest any question as to whether he was excessively dismissive of Paul's problems. However, we are satisfied that he did give the case proper attention and that while he may have been suspicious of Paul's motives in once again seeking assistance he did discharge his duty in that respect.

5.37 Given Dr Mallett's assessment of Paul as a stable patient for whom little more could usefully be done, we also think that his subsequent management of the case is understandable. No doubt in an area with less strain upon resources he might have been inclined to pursue a different approach, but he had to work within the restrictions of the service and his findings did not set Paul among those individuals for whom complex CPA arrangements were obviously essential.

5.38 Since 1997 there has been a measure of improvement in the delivery of the CPA in Brent. In 1998 a revised Joint Policy was drafted and it was subsequently put into operation. This revision perpetuated the structure of two tiers, but their ambit was re-defined. Level 1 was now to apply to *"users who are likely to need more than one type of service or whose needs are less likely to remain stable"*, while Level 2 was to be applicable to *"users who have limited disability/health/social care needs arising from their illness and have low support needs which are likely to remain stable."* We note here the deliberate utilisation of the wording in the Guide so as to include in Level 1 patients who require a medium level of support. A higher proportion of new referrals would now qualify for a multi-disciplinary assessment.

5.39 We were also informed that for all new patients the information provided upon referral is screened by a team comprising professionals from different disciplines. A decision is then made as to who should see them; they will not necessarily go to the Out-patient Clinic. Some cases are diverted to the psychotherapy services

or to the drug and alcohol counselling services. Cases which are not considered to require any assistance at all are not accepted.

5.40 We have nonetheless been left with the distinct impression that there continue to be practical limitations upon what can be achieved. The majority of patients are still getting a basic level of assessment and care on the second tier. Mr Matt told us that this tier is not actually being served very well and that outside the top tier there is very little available. This is a regrettable state of affairs which needs to be corrected if patients with moderate needs are not to slip through the net.

5.41 A more rapid and effective implementation of the CPA by the Trust might have altered the sequence of events which led to Henrietta Leane's death. Although there was certainly nothing further in the form of psychiatric input which could have made a difference, we are satisfied that Paul could have derived a potential benefit from a broader assessment of his needs and a more detailed Care Plan. Of course it is true that his social dysfunction and his unusual relationship with his mother were entrenched features of his life and we do not suppose that change would have come easily, but he could at least have been provided with support and afforded an opportunity to break out of his cloistered existence.

Staffing of the Out-Patient Clinic

5.42 Patients who were referred by their General Practitioner to the Out-patient Clinic in 1992 were allocated to a Consultant. We did not enquire into the practice of each and every one of them but concentrated upon what would happen in the event of allocation to Dr Harrison-Read.

5.43 Dr Harrison-Read had an extremely heavy workload. Approximately 250 of his

patients attended at the Out-patient Clinic. It was simply not possible for him to find the time to see all of them himself. He saw about 170 and the remainder were allocated to his juniors.

5.44 We appreciate that the division of responsibilities within a team is inevitable and that it is common practice for out-patients to be seen by a Senior House Officer. There was nothing unusual in the arrangements at the Central Middlesex Hospital.

5.45 Dr Harrison-Read told us that when he received a referral he would review the information sent to him and decide whether the case was complex or not. If it was, he would see the patient himself. He would also take on a proportion of the other cases; the remainder were seen by his Senior House Officer (or occasionally by a colleague specialising in rehabilitation psychiatry who assisted when the backlog became too great).

5.46 As we have already indicated, we consider that Dr Harrison-Read ought so far as possible to have seen new patients personally. This would have avoided the risk that an inexperienced Senior House Officer might make an incorrect assessment of the patient's mental state or needs and that the error might not then be picked up on the occasion of subsequent discussion of the case.

5.47 We cannot say so very long after the event whether it would actually have been practicable for Dr Harrison-Read to have seen Paul on the 10th April 1992. On the other hand we do think that this would have been beneficial, as little seems to have been achieved in terms of future planning at this initial appointment and Dr Kellermann was not afforded a specific response to her suggestions of possible methods of managing Paul's problems.

5.48 We see no reason why a patient without either a serious illness or a high level of

need should not subsequently have been reviewed by a Senior House Officer and we accept that it was reasonable for Paul to have been reviewed on a number of occasions by Dr Witcomb and then by Dr Rangel.

5.49 The system was such that a patient who was initially seen by Dr Harrison-Read would thereafter normally be reviewed by him; this ensured continuity of care and consistency of approach. But equally a patient allocated to a Senior House Officer would usually continue to be seen by that clinician and thereafter by successors on an indefinite basis. Consistency could still in theory be achieved, particularly as an element of supervision was always present, but there was a real possibility of differences of opinion and in any event the changes of personnel at six monthly intervals were in themselves destructive of a continuing relationship between the patient and his psychiatrist.

5.50 Accordingly it was unhelpful that within a year of his initial attendance Paul came to be seen by a third junior and that during the following year he was seen by yet another three different clinicians. The problem was of course aggravated by the need for locums to take clinics in the latter part of 1993. However, even if that had not happened, Dr Woodhatch would have been the fifth psychiatrist in the space of two years to be involved in Paul's management. In our judgement that was wholly unacceptable.

5.51 The solution to this problem would have been for Paul to have been transferred to Dr Harrison-Read after he had been attending at the Out-patient Clinic for a period in excess of one year. That would not only have avoided the stream of new faces but also ensured that his condition and needs were re-assessed at Consultant level.

5.52 Plainly a system which required a busy Consultant to see all long term Level 2 patients himself after a certain interval of time would call for alleviation of his

workload in some other way. We suggest that this might be achieved by allocating a greater number of the Level 2 cases to the Senior House Officer following the initial assessment. Without the long term patients a Senior House Officer would have more time to review the new patients and with fewer short term patients a Consultant would be better placed to accommodate those with the more enduring illnesses and disorders.

5.53 We are also inclined to think that more patients would be discharged if they were seen at Consultant level. Our understanding is that Senior House Officers do not usually have authority to discharge patients without the consent of their superiors; Dr Harrison-Read would certainly expect his juniors to obtain his approval. Of course the process of supervision means that in practice authority is obtained and we were told that nowadays there is in any event a much greater emphasis upon the desirability of discharging patients whose attendance is not resulting in any real progress and merely creating a sense of dependency. Nonetheless we would expect some lack of incisiveness on the part of Senior House Officers here.

5.54 The point is perhaps well illustrated by what happened when Paul was referred back to the Out-patient Clinic in 1996. There was still a distribution of new cases between a Consultant and his juniors. According to Dr Mallett referrals were not then screened beforehand but allocated by automated means in a random manner. That strikes us as even less satisfactory than the system described by Dr Harrison-Read, but it did result in Paul being seen by Dr Mallett. The decision in favour of his discharge then ensued with notable rapidity.

5.55 It is unfortunate that Paul once again came to be seen by a junior member of the medical staff, Dr Al-Asadi, on the 29th November 1996, but that was probably the unintended and unavoidable consequence of his unexpected return. On the other hand we question the need for the case to have remained with Dr Al-Asadi. Given

her inexperience and the fact that Paul had been seen by Dr Mallett on two earlier occasions (and possibly on the 29th November as well), we would have thought that the better course would have been to have any further reviews carried out by Dr Mallett.

Timing of Reviews

5.56 Decisions as to the interval before a patient is to be reviewed must always be a matter of clinical judgement and turn on the particular circumstances of the case. Generally speaking we would expect the interval to be short in the early days of attendance by a new patient and then settle down at between three and six months, but there can be no absolute rules nor do we presume to offer any guidance.

5.57 On the other hand we do think that once a decision has been made by a clinician in relation to the timing of a review it ought so far as possible to be implemented.

5.58 On almost every occasion of an attendance by Paul at the Out-patient Clinic the timing of the ensuing review was spelt out, either in the notes or in the letter to Dr Kellermann or both. However, between 1992 and 1994 there was a remarkable lack of correspondence between the intended and the actual intervals. We have drawn attention to these discrepancies in Chapter 3.

5.59 The particular chaos in the latter part of 1993 is partly explained (although not in our view excused) by the requirement for locums, but we have not otherwise been provided with a satisfactory explanation for the discrepancies. We doubt that they can have been due to any difficulty with dates presented by Paul himself, as there was nothing to stand in the way of his availability. We also doubt that clinicians would have specified an interval to the person making the appointment and then

written down something quite different. We can only suppose that there was some practical problem in the administration of the appointments system. Whatever this may have been, it ought to have been ironed out.

5.60 We also consider that Paul's failure to attend in 1994 ought to have been followed up, although this lacuna probably made no difference to the course of events.

Record Keeping and Handover

5.61 On the whole we were satisfied with the quality of the notes, although we have pointed to instances when no entry was made or the entry was out of order.

5.62 We did nonetheless feel that the method of record keeping, which amounted to a chronological compilation of notes and letters, was not ideal for the clinician who came to the case for the first time. That person would have to read through the file in order to obtain the full history. It is true that Paul's file was not very bulky, but the exercise would still have been time consuming and there would also have been other files to read through prior to an Out-patient Clinic, some of which may have been much more extensive.

5.63 For this reason we think that there ought to have been at the front of every file a printed summary sheet containing primary information in relation to the patient and reference to the actions taken. Further reading would still have been required, but it could have been much more selective.

5.64 We were also concerned as to the ability of a new Senior House Officer to embark upon a proper review of the case of an existing out-patient simply on the basis of having shortly beforehand read a file which did not contain a handover note. That

paper exercise would not necessarily provide enlightenment as to the reasoning behind the current Care Plan or the best way of handling the patient at the Out-patient Clinic. We therefore think that at each rotation there should have been a handover of cases by the departing Senior House Officer.

5.65 This evidently was not a routine practice. We understand that sometimes an entry would be made in the notes for the benefit of the new incumbent, but there was never an entry of this kind in Paul's file and in any event we consider that a formal handover procedure should have been laid down and that its observance should have been monitored by the Consultant.

Evaluation of Risk

5.66 The assessment of Paul's needs could not be adequately carried out without taking a history, performing a mental state examination and arriving at a formulation of the presenting problems. These steps were properly undertaken by Dr Witcomb and the clinicians who subsequently reviewed Paul adopted a similar approach.

5.67 The process of assessment also called for a full evaluation of the risk which Paul posed either to himself or to others. This was emphasised in the Guide and it was likewise highlighted in the 1995 Joint Policy, which set out the CPA checklist of risk factors.

5.68 There was nothing in Paul's history or ongoing behaviour to suggest that he might cause harm to his mother or a member of the public. On the other hand he had in the past taken an overdose and on a number of occasions he indicated that he was feeling suicidal. The risk of suicide was low, but it was a factor to be weighed in the scales in the initial construction and later revision of the Care Plan.

5.69 The notes do not conclusively establish that any of the psychiatrists specifically addressed the extent of the risk. It is easy to say that they must have done, that this would have been an automatic response and that in effect there was no need for anything to be spelt out in writing. We can see the logic of that argument and we accept that the risk cannot altogether have been ignored, but we are not convinced that it was necessarily given the importance which was warranted. The material findings ought in our view to have been recorded.

5.70 The absence of recorded risk evaluation is another illustration of the weakness of CPA procedures in Brent during the period with which we are concerned.

5.71 Attention was ultimately drawn to this subject when the 1998 draft Joint Policy was produced. It was then stressed that professionals had to place themselves in a position to demonstrate that decisions were taken after consideration of evidence about the risk a user presented. A detailed risk assessment was to be carried out and the results were to be recorded on the CPA form.

5.72 In February 1999 the Trust and Council laid down detailed risk assessment and management procedures (annexed to our report). They included completion of a risk indicator checklist and an assessment of risk form. This was a substantial step in the right direction and one which could usefully have been taken at an earlier point in time.

The Care Plan

5.73 The formulation of a Care Plan addressing the health and social needs of a patient was from the outset a key feature of the CPA. It was required irrespective of the level on which the patient was placed.

5.74 Accordingly it was Dr Witcomb's responsibility to produce a suitable plan and this had subsequently to be kept under review and revised in the light of developments in Paul's circumstances.

5.75 We do not think that the plan had to be particularly complex, but it had to take account of the fact that Paul's needs extended beyond treatment of his anxiety and depression by medical means; there had to be some mechanism directed towards alleviating his social problems, because they purported to be the root cause rather than the consequence of his symptoms.

5.76 At the end of her detailed note on the 10th April 1992 Dr Witcomb made an entry under the heading of *"plan"*. We doubt that she can have had the CPA in mind as it had not yet been implemented in Brent, but planning was anyway a part of good psychiatric practice prior to the CPA.

5.77 What followed was barely a plan at all. It consisted solely of Paul looking into the Asset scheme. This did not address most of the issues which Dr Kellermann had raised in her referral letter.

5.78 On the 8th May 1992 the plan was revised so as to include the administration of medication and thereafter revisions related solely to that medication until the 26th November 1993 when Dr Laznowski wrote in the notes *"Plan : Ask him to phone Brent Counselling Service"*. There was then the suggestion of a hobby by Dr Sarasola on the 17th December 1993. Paul does not appear to have pursued either of those ideas. It was not until the 18th February 1994 that a reference to the Day Hospital was proposed and that also was not taken up by Paul.

5.79 We have to say that over the two year period as a whole the degree and quality of planning was poor. The objectives were never clearly defined, the options for the

provision of assistance never stated, the structure of such assistance never laid down. What should have been a scheme of action, involving intervention over and above attendance at the Out-patient Clinic, amounted in actuality to a series of ad hoc decisions which in the end led nowhere.

5.80 There are a number of probable explanations for this deficiency. The CPA was not being properly implemented; the clinicians were insufficiently aware of what was required under the CPA and did not have any CPA documentation; they may not have possessed a detailed knowledge of what Brent had to offer and in any event this was limited; they would have been reluctant to pass the case on to the Social Services; and each of them only had a transient involvement in the case.

5.81 When Paul returned in 1996 Dr Mallett did formulate a plan, namely to discharge him, and this was put into effect but frustrated. It was then replaced with a trial of Paroxetine and the possibility of psychological input. On the 14th March 1997 Dr Al-Asadi observed that the Paroxetine had helped and increased the dosage. She also wrote in the notes *"Gave him a Counselling Centre"*. So there was a more planned approach once Paul had come to be seen by a Consultant, although it was still limited in its scope, it did not fully comply with the requirements set out in the 1995 Joint Policy and it likewise ended in failure.

5.82 There is now a much greater appreciation of the necessity for a proper Care Plan and we would expect close compliance with the current Joint Policy.

Key Working

5.83 The responsibilities of Paul's key worker were to develop his Care Plan, keep in regular contact with him and co-ordinate the services provided for him.

5.84 A patient who received his care under Level 2 and who was attending at the Out-patient Clinic would usually, although not invariably, have as his key worker the psychiatrist who saw him there. Paul therefore had a series of key workers, none of whom undertook that function for more than six months.

5.85 We do not think that any of these clinicians could properly be regarded as other than a purely nominal key worker. We have already indicated that there was little in the way of care planning; no other professional was ever involved and therefore no co-ordination was necessary; and personal contact was broken on each occasion that there was a change of personnel.

5.86 This raises the question of whether Senior House Officers on rotation should be key workers at all. If the level of need of a patient is such that stability can be achieved and maintained by means of medication and encouragement alone, then there is no reason to look elsewhere for a key worker. We apprehend that most patients in this category can be discharged to the care of their General Practitioner after a relatively small number of out-patient appointments. If on the other hand the patient has problems, albeit of comparatively low severity, which either call for the intervention of another professional or are likely to take a lengthy period of time to resolve, then we do not think that a clinician on a short term placement ought to be key working the case.

5.87 If following the initial assessment a key worker had been assigned to Paul who was experienced in dealing with patients with social needs, it seems unlikely that he would have continued to be reviewed time after time in the Out-patient Clinic without any effective progress towards solving his particular problems.

5.88 In view of the organisational changes which have taken place since 1995, we see no reason why patients such as Paul should not now have a suitable key worker.

Medication

5.89 Between May 1992 and February 1994 Paul was primarily treated with Stelazine. This was prescribed for the express purpose of controlling his chronic anxiety. It was at that time (although less so today) regularly used for that purpose, but in low dosages of 5mg or less per day. Higher dosages were prescribed to patients for the treatment of psychosis.

5.90 In the first instance Dr Witcomb recommended Stelazine 5mg at night, which was within the appropriate bracket for Paul's condition. However, within a matter of three weeks the dosage was increased by Dr Kellermann to 15mg per day. This is somewhat surprising, as not only was the dosage raised above the level for the treatment of anxiety but it was also done without any discussion with Dr Witcomb. We were led to believe that it is not uncommon for General Practitioners to alter prescriptions recommended in the Out-patient Clinic. That is understandable if there is a lengthy interval between appointments, but it is less justifiable when the next review is (as it was here) to take place in a month's time. We are inclined to think that pressure from Paul was a material factor.

5.91 When Paul next attended at the Out-patient Clinic Dr Witcomb left the dosage as it stood. Thereafter there were attempts to reduce it and at one stage a reduction to 5mg per day was specified, but the prescribing was not always in a downwards direction and in any event while Paul was still attending at the Out-patient Clinic he never actually seems to have brought his consumption down below 10mg per day. Accordingly he was in effect taking antipsychotic medication, largely at his own instigation.

5.92 However, we do not think that any harm was done. Paul did not suffer from any side effects and he appears to have derived benefit from the medication. If he did

not in fact have an underlying psychosis, taking Stelazine in antipsychotic dosages would not have masked a significant disorder which otherwise would have been brought to light.

5.93 The dosages did of course result in the additional prescription of Procyclidine as a precaution against side effects. The use of this particular drug is recognised as involving a risk of complications. Attempts were therefore made by the clinicians to minimise its consumption, but they were not particularly successful as Paul did not co-operate.

5.94 Paroxetine was introduced into Paul's drug treatment in May 1993. Paroxetine is an anti-depressant, but it is also effective in controlling anxiety disorders such as obsessive compulsive disorder and there was good reason to test its effectiveness in Paul's case. However, he did not at that time take it on a consistent basis.

5.95 Between May 1994 and July 1996 Paul received no medication at all. We have concluded that there is likely to have been a consequential deterioration in his condition. But nothing could be done to treat him if he did not choose to attend at the Out-patient Clinic.

5.96 From November 1996 onwards Paul was treated with Paroxetine alone. He did then purportedly take it as prescribed and because he reported to Dr Al-Asadi that it was helping him the dosage was increased. Whether he actually adhered to his prescription and, if he did, whether he derived as much benefit from Paroxetine as from Stelazine are matters of conjecture. The sequence of events inevitably leaves us wondering whether continued administration of Stelazine would have made a difference to the outcome, but we cannot answer that question and in any case the trial of Paroxetine was within the range of reasonable options.

The Day Hospital

5.97 There were at least three occasions on which the possibility of referring Paul to the Day Hospital must have been considered. The first was when he was initially seen by Dr Witcomb, who would have read the letter in which Dr Kellermann raised the matter. The second was when Dr Woodhatch actually made the decision to refer him. The third was when he was seen by Dr Mallett, who wrote in the notes that he should probably not be referred.

5.98 The Day Hospital is a facility which largely caters for patients in the community who suffer from a relatively severe and chronic mental illness. Those patients are usually quite disabled and require a considerable level of assistance.

5.99 Paul fell into a different category, as he was neither seriously ill nor disabled. To have put him into the environment of the Day Hospital would in certain respects have been disadvantageous. Both Dr Harrison-Read and Dr Mallett expressed the view that he would not have mixed well with the other patients. They also thought that he would have been given the message that his mental health problems were severe and that he could have become over-dependent upon the service.

5.100 For these reasons, although the Day Hospital did operate an anxiety management programme from which Paul could have obtained some benefit, this was probably not a sound long term proposition for him. But on the other hand the Day Hospital was a place where he could have been intensively assessed over a period of about a week. A thoroughly informed decision could then have made as to the best way forward.

5.101 It is possible that Paul would have been referred for a more formal assessment for psychotherapy. It is also conceivable, although unlikely, that he would have been

passed on to the Social Services; there would have been a greater prospect of their accepting him from the Day Hospital than from the Out-patient Clinic.

5.102 In any event a detailed assessment would probably have resulted in a decision that there was not much to be gained from a series of out-patient visits at which the principal consideration was medication. The appropriate drug therapy could have been determined and Dr Kellermann given clear instructions to which she would have been more likely to adhere. Paul could then have been discharged.

5.103 We would not necessarily have expected immediate referral to the Day Hospital in 1992, although as a matter of courtesy Dr Kellermann ought to have been told why it was thought to be unsuitable. However, it should not have taken the best part of another two years for action to be taken.

5.104 It is of course singularly unfortunate that when referral did come into the picture in 1994 Paul did not take advantage of that offer. His response might well have been different at an earlier time, although because he always seems to have had an agenda of his own we cannot be certain how he would have reacted. Given how he did respond, Dr Mallett's decision not to refer him in 1996 can perhaps be justified.

The Psychotherapy Services

5.105 There are three routes by which a patient may come to be afforded psychotherapy. At the top end of the scale the patient can be referred to the Willesden Centre for Psychotherapy. This offers a highly sophisticated service for which the demand is great, but there is a limit to the numbers who can be accommodated. We were told that during the period with which we were concerned particular difficulties

were experienced in obtaining access and ultimately the Centre was temporarily closed down, although it was reprieved and the situation is now much better. It therefore seems highly improbable that a patient such as Paul would have qualified for assistance from that quarter.

5.106 Then is next a psychotherapy service at the Central Middlesex Hospital, operated by the Clinical Psychology Department, which specialises in short term focused therapeutic measures such as cognitive behavioural therapy. It does not appear that any of the clinicians who saw Paul considered him to be a suitable candidate for this service. There is a strong likelihood that such was likewise because there was a limitation upon its availability for patients on Level 2, particularly as it was not as well developed in those days as it is now.

5.107 Further services in the form of counselling are provided by the voluntary sector. A broad range of organisations in Brent offer these services. Referral is here not direct; the patient is given the name, address and telephone number of a suitable organisation and advised to make contact. This is not altogether satisfactory, as many patients are likely to be hesitant in making their own arrangements and need a high level of encouragement and assistance.

5.108 We are unclear to what extent the Senior House Officers who were involved in Paul's management possessed a working knowledge of the voluntary bodies to whom he could have been referred. Because they were on a short term placement, this may have been comparatively restricted. In any event, aside of mentioning the Asset scheme, they do not seem to have pointed Paul in the direction of any body which might have provided him with help. On the other hand one of the locums, Dr Laznowski, did suggest to him that he should telephone the Brent Counselling Service. However, Paul does not seem to have referred himself and this was not then followed up at the subsequent out-patient appointments.

5.109 Paul was subsequently given the name of a voluntary organisation by Dr Al-Asadi, but there is nothing to suggest that he took this any further either. We can only conclude that he did not have much motivation for counselling, probably because he did not perceive it as serving his personal aims, although he might conceivably have accepted it if the necessary introduction had been effected for him.

Communication with the Family

5.110 At no time does anyone seem to have thought that it might be a good idea to make contact with Henrietta Leane. This is surprising, since her relationship with Paul was plainly a significant aspect of his problems and she might at least have been a source of useful information. We would therefore have expected an invitation to her to attend at the Out-patient Clinic with Paul on the occasion of a review.

5.111 The fact that this did not happen is probably a reflection on the system rather than a lack of good sense on the part of the clinicians. Out-patient reviews for a Level 2 patient such as Paul inevitably tended to focus upon whether or not his mental state was under control and whether he was receiving the right medication. Issues of a broader nature would be discussed, but not much action taken. Moreover Dr Harrison-Read indicated in his written evidence that family members and carers of patients on Level 2 would usually only be involved in the process of assessment and management if either this was requested by the patient or it was requested by the carer and the patient consented, which did not happen in this instance.

5.112 There would have been a greater likelihood of communication with Paul's mother and perhaps with his aunt if the Social Services had become involved in the case. They would surely have made an effort to see his mother. However, we doubt that she would actually have been very forthcoming or indeed welcomed intervention

by outsiders. She might well have seen them as a threat to her relationship with Paul and become anxious that he would be encouraged to live elsewhere.

The Social Services

5.113 It is a remarkable feature of this case that the clinicians never referred Paul to the Social Services despite his lengthy history of social difficulties and his repeated complaints of isolation, inability to socialise with others, incapacity for work and lack of motivation.

5.114 The reasons for this are not hard to find. There was a poor level of association, communication and co-operation between employees of the Trust and those of the Social Services; they were both overburdened; and there was an in-built resistance to the referral of Level 2 cases.

5.115 In the North West London Mental Health Services Inquiry Report, published in February 1994, the situation as it then stood was described as follows :

"In the part of north west London in question, relations between social services and health staff have long been strained. Tensions have existed at strategic levels - over planning, funding and policies. But the operational level has also seen conflicts. In both Brent and Westminster there has been failure to agree how best to work together on a day-to-day basis. That is not to say that social workers do not relate well to doctors, rather that such collaboration is patchy ... On a day-to-day basis, the absence of multi-disciplinary working in geographical sectors and patchy implementation of the Care Programme Approach do not help either".

5.116 This matter was subsequently addressed by senior management, but with limited

success. A number of problems were identified to us. These were that the Social Services were heavily under-resourced; that the criteria for their involvement in cases were increasingly exclusive and limited; that they did not offer a service to a substantial number of the individuals who were identified by the psychiatrists as being in need of their service; that until sectorisation the two services operated out of different premises; that even when the sectorisation took place and the team system was set up, Social Workers came to the referral meetings with the medical staff but just listened and then had their own meetings; and that there was still no integration of the CPA and Care Management.

5.117 In August 1995 Mr Nesbitt was appointed to the post of Service Director, Mental Health Fieldwork. He told us that his first task was to re-write the policies for day-to-day working. A new comprehensive assessment form was devised and the criteria for eligibility were revised. There were also other initiatives. But it was still clear to Mr Nesbitt that Care Management was not being properly embraced.

5.118 Further action with a view to remedying the situation was then taken. Social Workers were redesignated as care managers and a CPA Development Officer was appointed with the aid of joint funding. One of her duties was to train both health and Social Services staff in the implementation of the CPA. Subsequently she was involved in a research project on the integration of Care Management and the CPA. The basic conclusions of that project were that all care planning needed to be integrated, that the locus of control needed to be moved from the hospital into the community and that structures needed to be created within the Community Mental Health teams which would manage the CPA properly.

5.119 We were told by Mr Matt that agreement has now been reached in principle for integration to take place. That is encouraging, but it does seem to have taken a very long time to reach that objective and it remains to be seen how well any new

system actually works. As matters stand, it looks as though many of the problems to which we have referred are still in existence. There is a considerable turnover in social work staff and a real difficulty in recruitment. While good relations exist at ground level between the health and social work staff, their differing approach to the management of cases is still giving rise to an element of tension. There remains a perception among the psychiatrists that the Social Services will not take on patients without a severe level of disability and that even a sizeable number of those cannot be accommodated.

5.120 It is quite clear that the clinicians who dealt with Paul would not have expected him to have met the eligibility criteria for acceptance by the Social Services. In effect to have referred him (other than perhaps through the Day Hospital) would have created a situation of potential conflict. Thus it was never contemplated as a viable course of action.

5.121 As it happens, Paul did in 1992 come into contact with the Social Services of his own volition. The fact that this did not lead to a full assessment of his needs is a sad reflection upon the approach dictated by limited resources. It must have been fairly apparent that he required help over and above the specific assistance for which he was applying, but the offer of such assistance to someone who was not actually seeking it and who did not come across as suffering from a severe level of disability was outside the contemplation of the Social Worker and Team Leader who dealt with the case. Nor was there any realistic prospect of follow up when there was a failure to attend an appointment.

5.122 We asked Mr Nesbitt to indicate what the Social Services might have had to offer Paul if he had been taken on as a client. He thought that Paul would have been provided with an outreach worker, who would have concentrated upon developing a rapport with him and then introducing him to services such as the Day Centre

and voluntary counselling, getting him involved in various activities so that he had a routine of meaningful occupation during the day and perhaps directing him back to employment. There was also a possibility that he might have been moved into a form of supportive accommodation.

5.123 We cannot say with complete assurance that Paul would actually have co-operated with a plan which came from an external source. It must be borne in mind that he did not take his medication in the dosages prescribed, that he did not always turn up for his appointments and that he did not take advantage of offers of counselling. His actions were essentially dictated by what he himself wanted and not by what others thought might be beneficial for him. However, we do think that he would probably have been willing to engage with a Social Worker and become involved in group activities. It is doubtful that he would have been prepared to countenance a return to work, but he might in due course have been weaned away from his total dependence upon his mother and moved out of his home.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 This case illustrates many of the problems faced by the authorities which have the obligation to provide care in the community for individuals who do not suffer from a severe and enduring mental illness but have a personality disorder which results in social dysfunction.

6.2 It is unlikely that Paul had a serious mental illness. His odd persecutory ideas did not amount to convincing evidence of psychosis; they can be explained in terms of a personality disorder. The experts who have examined him are not agreed as to the precise nature of that disorder, as the overall presentation is unusual, but on any view there would appear to have been no prospect of a cure by medical means.

6.3 Insofar as anxiety and depression were symptoms of Paul's condition, they could be controlled to some extent by medication prescribed by a psychiatrist. On the other hand his underlying problems called for counselling and assistance of a kind which could not be provided by straightforward psychiatric intervention.

6.4 Paul did not pose a risk of harm to other persons; his history did not brand him as someone who might end up in the criminal justice system. Nor was there a very high risk of suicide, but the possibility that he might attempt to harm himself in order to seek attention could not be discounted.

6.5 The management of a patient such as Paul was always going to be difficult, but it is apparent that simply requiring him to attend at intervals at the Out-patient Clinic was not a productive approach. The therapeutic benefit potentially to be derived

from short periodic consultations was insufficient to warrant the use of restricted psychiatric manpower in that way, particularly if the personnel involved in the exercise kept changing.

6.6 Paul therefore needed to be provided with a different kind of service, entailing the involvement of other professionals. But there was a severe shortage of resources for patients requiring that level of input and Paul was just one of a large number of individuals with a personality disorder for whom a more detailed plan of care would have been beneficial.

6.7 Prioritisation between patients in those circumstances calls for a high quality of assessment and planning and efficient use of the available resources. That will not be achieved if the CPA is poorly implemented and if the mental health and social services do not operate in an integrated structure.

6.8 Given the system in which the psychiatrists were working between 1992 and 1995 and the inadequate improvement in that system subsequently, we do not find it at all surprising that Paul was afforded care at a minimal level.

6.9 We consider that the Trust was dilatory in the formation and implementation of suitable policies and procedures and that the service which it provided was not of a particularly high standard. We do however recognise that it was faced with a massive problem and that it was severely handicapped by difficulties in forging a good working relationship with the Social Services and in obtaining a sufficient level of funding.

6.10 We think that the performance of the various psychiatrists and social work staff who had involvement in Paul's case was much as would be expected in an over-stretched and sub-standard service. Some things could have been done in a better

way and these have been identified in Chapter 5, but we do not consider that any of the professionals concerned can be fixed with personal blame or censure.

6.11 The points which we have made are not novel. The Trust and the Social Services have for many years been well aware of the need for improvements in the delivery of mental health services to the local population. We realise that a number of steps have already been taken to that end. This process of evolution and change needs to be continued in the future.

6.12 Our **recommendations** (several of which are similar to those made in the Boland Report in 1995) are as follows :

(i) The Trust should ensure that the case of every new patient referred to the Out-patient Clinic is initially screened by a multi-disciplinary team and that a decision is then taken as to whether the patient is a suitable candidate for mental health or social care and, if so, by whom the assessment of that patient is best to be undertaken.

(ii) The Trust should devise and implement a procedure whereby every patient whose assessment is to be carried out in the Out-patient Clinic is so far as possible seen by a Consultant Psychiatrist or (if this proves impracticable) discussed with the Consultant and the outcome of that discussion recorded in the case notes.

(iii) The Trust should ensure that every assessment includes an evaluation of risk and that this is properly documented.

(iv) The Trust should ensure that following assessment of a patient a Care Plan which complies with the requirements of the CPA is always formulated and recorded and that it includes express reference to the Level on which the patient is to be managed and a review date.

(v) The Trust should encourage a greater input by carers into the information on the basis of which the Care Plan is prepared.

(vi) The Trust should undertake a review of the process of appointment of key workers and should not permit a junior psychiatrist to undertake the role of key worker for a patient unless the Care Plan is straightforward, short term and does not necessitate the involvement of other professionals.

(vii) The Trust should devise and implement a procedure whereby a patient who has attended at the Out-patient Clinic for a period in excess of one year is thereafter invariably seen by a Consultant.

(viii) The Trust should carry out a general review of the functioning of the Out-patient Clinic for the purpose of achieving an equitable distribution of the workload between the senior and junior psychiatrists.

(ix) The Trust should ensure that the case notes of every patient attending at the Out-patient Clinic have a front sheet setting out primary information about the patient and summarising the actions taken.

(x) The Trust should introduce a handover procedure, to be supervised by the Consultants, whereby junior psychiatrists coming to the end of a placement are required to make an entry in the case notes of their patients describing the salient problems and the way in which they are being managed.

(xi) The Trust should carry out a review of the appointments system in the Out-patient Clinic so as to achieve so far as practicable consistency between the recommended and actual intervals and expeditious follow up in the event of non-attendance.

(xii) The Trust should impress upon patients and their General Practitioners the importance of adhering to the regime of medication recommended in the Out-patient Clinic.

(xiii) The Trust should ensure that in any case in which it is suspected that a social problem is significantly contributing to a patient's illness or disorder action is taken with a view to assessing the extent of that problem and that if upon such assessment it is apparent that the patient would benefit from support careful consideration is given to the best method of providing it and in particular to the need for referral to the Social Services.

(xiv) The Trust should carry out a review of the process of referral of patients from the Out-patients Clinic to the Day Hospital, psychotherapy services and voluntary counselling organisations so as to ensure that sufficient and suitable use is made of these facilities.

(xv) The Trust and the Social Services Department should ensure that there are effective channels of communication between the medical teams and the Social Services.

(xvi) The Trust and the Social Services Department should work together to co-ordinate the processes of the CPA and Care Management in order to avoid differences in policy and practice, duplication of effort and inefficient use of resources.

(xvii) The Trust, the Health Authority and the Social Services Department should review the allocation of resources so as to ensure as far as possible that an adequate range of services is available for individuals with a mental illness or personality disorder who require a medium level of support.

(xviii) The Health Authority should monitor the performance by the Trust of its obligations under the CPA.

JOINT POLICY - CARE PROGRAMME APPROACH AND CARE MANAGEMENT

NORTH WEST LONDON MENTAL HEALTH NHS TRUST AND SOCIAL SERVICES

1. Context

This policy has been jointly produced between Health and Social Services as required by the Department of Health and outlined in Circulars LASSL(90)11 HC(90)63 and HSG(94)27.

In the context of the purchaser/provider arrangements in Health and Social Services post-April 1991, this document outlines the local arrangements for multidisciplinary working in relation to Care Programme Approach (CPA) and Assessment and Care Management.

Care Programme Approach - This is a planned process of assessment and co-ordination of the delivery of care services for people being discharged from hospital and for people in the community who have mental health difficulties.

Care Management - This is a parallel process undertaken by the Local Authority with the additional function of purchasing and review of services to meet the client's needs as a result of a social needs assessment.

Because both systems overlap in many cases, this document seeks to clarify roles and responsibilities of each agency in caring and supporting people with significant mental health difficulties and their carers.

This policy document also incorporates by definition S. 1 17 and Supervision Register arrangements. However, refer to additional guidelines for Supervision Register.

2. Who can receive this service?

The CPA applies to all persons (including those with dementia) accepted by the specialist psychiatric services whether they be inpatients or outpatients.

For Health Services, it is appropriate to divide care programmes into two levels.

Level I - a multi-disciplinary assessment and agreed Care Plan are required where a client has a significant level of health need eg. usually has had 2 admissions or more and has reasonably satisfied the CPA Checklist of Risk Factors (as listed in section 15 of this document).

Level 2 - applies to all other patients who have no or only one episode of admission and do not require multidisciplinary assessment and care planning. The assessment and Care Plan of one professional will usually be regarded as adequate (unless the level of need indicates the person should be placed on level 1 irrespective of whether they have been admitted or not).

Social Services, in addition to its role as a partner with Health in the planning and delivering of services under CPA, has the responsibility under Care Management for purchasing and monitoring services required to be arranged by the Local Authority. For people with complex needs requiring a high level of co-ordination, a Care Manager will be appointed. Social Services are required to make initial or comprehensive assessments for services according to level of need. The criteria for these assessments are as follows:

They must be aged 16-64 years and have a recognised psychiatric difficulty, and the following applies:

- a) there is a recent or imminent discharge from Psychiatric Hospital
- b) referrer states there are social care needs which are not being met
- c) assessment under the Mental Health Act 1983 is requested
- d) there is an immediate risk of psychiatric breakdown
- e) the referral is from the Court
- f) statutory Duties require Social Services Department involvement

Clients being discharged from hospital will usually correspond to CPA Level 1 and will probably require a comprehensive multidisciplinary assessment.

It is recognised that not all clients living in the community who are referred to Social Services Sector Teams will need multidisciplinary assessment. These will usually correspond to Level 2 criteria and only require an initial assessment by Social Services.

Key components of CPA and Care Management are:

- a) identification of the members of the multidisciplinary team
- b) an assessment by the multidisciplinary team to consider the needs of the client
- c) formulation of a Care Plan with the multidisciplinary team, taking into account the wishes and needs of the client, and the views of carers and any other relevant agencies
- d) the purchasing and commissioning of care services when appropriate
- e) regular review of the Care Plan
- f) allocation of a Key Worker, and Care Manager as appropriate
- g) a system of monitoring CPA arrangements and a system to seek to prevent clients losing touch with services
- h) identification of any unmet needs

4. Assessment

There are planned arrangements for the assessment and delivery of the health care and the social care needs, where appropriate, of all clients living in the community and those who will be discharged to the community.

The Multidisciplinary Assessment will address the health and social needs of the client with reference to information about psychiatric, social and forensic history.

5. The Care Plan

The Care Plan is based on the assessment of the client's needs and is designed with the patient and carer to support the client in order for them to maintain their mental health in the community.

The Care Plan should include:

- a) identification of services available in the community which best meet the individual needs of the client on discharge, e.g. Day Hospital, Counselling, Outreach support, Drop-In, Day Centre, Carers Group, Supportive Accommodation etc.
- b) the name of the professional with responsibility for providing each component of the Care Plan
- c) the name of the Key Worker
- d) any other professionals involved in the care of the client
- e) a review date
- f) strategy for action, if for any reason the Care Plan breaks down.

6. Procedure for those eligible for CPA while in hospital

All new referrals must be registered in accordance with the Trust's and Social Services' procedures.

An initial assessment must be carried out by the Ward Manager in liaison with one or two mental health workers involved with the client and then referred to the CPA meeting/predischarge meeting for discussion, if considered to be eligible for Level I CPA.

A predischarge meeting of the appropriate personnel will be convened by the Ward Manager to discuss the Care Plan. This should include the client, carer and/or advocate.

All inpatients will have a ward-based named nurse who will be expected to attend all predischarge meetings for Level I clients.

7. People eligible for CPA while in the Community

Existing clients living in the community who have severe mental health difficulties (CPA Level 1) ,will have their needs assessed at a multidisciplinary Care Plan Review meeting of the appropriate Sector.

Clients with less severe mental health problems who correspond to CPA. Level 2 will be able to be assessed for a range of services in the community e.g. Day Centre, Outreach Support, Outpatients etc. Assessment for these services can be arranged through the local Social Services of Health Sector Teams as appropriate.

8. Users and Carers

Users and carers should be fully involved in the process where appropriate. The client should always be given a copy of their Care Plan.

9. Care Plan Review

The Circulars require that reviews of the Care Programme are conducted regularly for clients with significant mental health difficulties (CPA Level 1).

Where there are particular concerns about a client, reviews should be held frequently. In all cases the first post-discharge meeting should be held within 6 weeks of discharge.

The Team Administrator will convene the Care Plan Review meeting in liaison with the Key Worker and as directed by the multidisciplinary team.

They should be attended only by persons who are directly involved in the care of the client.

These will normally be held in the Sector Team, unless another venue may be appropriate, e.g. at a residential hostel.

10. The Multidisciplinary Team

The Team consists primarily of the Consultant, Social Worker, Community Psychiatric Nurse and other Health, Social Services and independent sector staff who are involved in the assessment and planning of the client's care. eg. Housing Officer, Day Centre/Day Hospital staff, etc.

The Team is identified at the CPA Planning meeting.

It is stressed that individual team members are accountable for their own practice as laid down by their professional bodies.

11. Role and Responsibilities of the Responsible Medical Officer

The Consultant will be the RMO and will retain clinical responsibility for all clients on Level 1.

Level 2 clients will be the responsibility of either the GP or the Consultant Psychiatrist. Where a GP referral is dealt with solely by any other health professional, the GP retains responsibility.

The RMO, or in their absence, his/her nominated deputy, will ensure that the CPA meeting is chaired. The chairperson must ensure that:

- a) at or before the pre-discharge and review meetings, a comprehensive risk assessment is carried out as detailed in Section 15 of the policy
- b) the members of the multidisciplinary team are identified
- c) a full discussion takes place about the contribution that each agency is able to make in supporting the client in the community
- d) the community key worker is identified and agrees his/her role and ability and responsibility

The Chairman, in liaison with the Team Administrator, will ensure that decisions and actions as agreed at the CPA meeting are systematically recorded on the proforma and arrangements for communication between members of the care team are clear.

If a client is discharged or transfers to another catchment area, the RMO, in liaison with the Key Worker and Team Administrator and, where appropriate, the Care Manager, must ensure that a thorough handover takes place between the two multidisciplinary teams and recorded in writing.

12. Role and Responsibility of the Key Worker

It is recognised that clients who require coordinated services are best supported by an identified case worker who has an active role and will provide most immediate feedback to the other multidisciplinary team members regarding any concerns or changes in respect of the client.

The Key Worker must be a qualified practitioner from either Health or Social Services.

The Key Worker has the authority to monitor the Care Plan effectively and to highlight areas where individual team members' responsibilities have not been carried out as agreed in the Care Plan.

The Key Worker may not be the main care/treatment provider. However, it is preferable that this is the case.

The Key Worker will be expected to:

Use their professional skills in maintaining regular contact with the client. This includes consultation with carers.

Provide support and care in a positive, creative manner which aims to be as acceptable to the user as possible within their professional guidelines.

Act as a consistent point of reference for users, carers, GPs, Care Managers (if not Key Worker) and other professionals re concerns about client's welfare.

Ensure that the user has registered with a GP.

Encourage the user to maintain contact with appropriate agencies, eg. Probation Services etc.

Closely monitor the agreed care package and documents.

Immediately alert the RMO and any other appropriate agency about any untoward incident, particularly when identified in the Care Plan, which might compromise the health and safety of the user or the public. In this event the Key Worker will convene an early review.

Attend the review meetings as outlined in the Care Plan.

Only discharge Level I clients from caseload following full discussion at the Review Meeting with the RMO and all others involved in the care. The Key Worker will inform all relevant personnel that the client is discharged.

In liaison with the RMO and Team Administrator, arrange review meetings as outlined in the Care Plan.

13. Role and Responsibilities of the Care Manager

- a) completion of a Local Authority Needs-Led Assessment
- b) purchasing of services on behalf of the Local Authority
- c) monitor and review individual services being purchased eg. Care Home. This might take place at a different time to the Care Plan Review.
- d) contribute to the overall assessment and care planning coordination of clients' needs with the multidisciplinary team.

The Care Manager and the Key Worker are not necessarily the same person.

14. Section 117 Arrangements

There is a legal requirement for Health and Social Services to consider and provide aftercare services for clients detained on Section 3, S.37, S.37/41 , S.47 and S.47/49.

For the latter two categories, there are additional considerations to be taken into account (see Code of Practice).

Procedures for S. 117 clients will follow those for the CPA as detailed. There is a legal responsibility to ensure that all aspects of the procedures are followed (see Code of Practice for further guidance).

15. Broad Factors to be Considered in Assessing Risk

Clients with High Risk

Clients with a forensic history or a history of violence, severe self-harm or neglect need special consideration.

A more careful and detailed Risk Assessment should be made of the client's needs with the information available, and a detailed Care Plan formulated which seeks to minimise the risk.

- Patients with longer term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking behaviour, need special consideration, both at the time of discharge and during follow-up in the community. No decision to discharge should be agreed unless those taking the clinical decisions are satisfied that the behaviour can be controlled without serious risk to the patient or to other people. In each case it must be demonstrable that decisions have been taken after full and prompt consideration of any evidence about the risk the patient presents". (HSG(94)27).

Key Factors to be Considered in Assessment of Risk

- -History of severe mental illness and more than one admission to psychiatric hospital
- -History of aggressive behaviour
- -Reported concerns about the patient's behaviour from whatever source
- -Self-reported incidents by the patient at interview
- -Observation of the patient's behaviour and physical and mental state
- -Discrepancies between what is reported and what is observed
- -Previous history of offending
- -History of alcohol and/or drug abuse
- -Lack of family and other social contacts and/or unwillingness to accept help
- -Reluctance to engage in and sustain treatment
- -History of deliberate self-harm including overdosing
- - History of homelessness and drifting
- - History of self-neglect
- - Pregnant clients who have a history of mental health difficulties

Further consideration may be made regarding placing the client on the Supervision Register (see Supervision Register Procedure).

16. Documentation

Individual professionals should complete documentation as required by their agency.

A copy of the CPA Proforma must be held within each agency's case files.

There should be evidence in the Care Plan that the client's and their carer/relatives' views have been taken into account.

Copies of CPA Forms must be kept in the client's case notes of each Case Worker involved in the care delivery.

All new clients who qualify for Level I CPA should have completed by the Trust's Sector Team Administrator.

17. Audit Arrangements

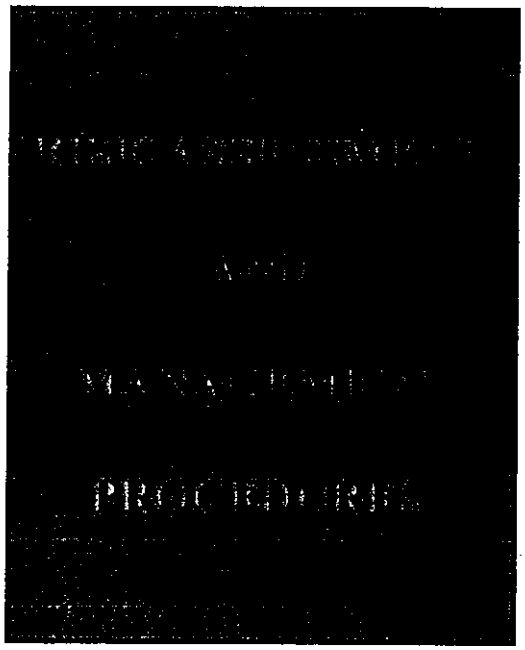
These CPA procedures will be monitored by each agency at 6-monthly intervals to evaluate their effectiveness and outcomes reported to each Commissioning Agency.

A percentage of Care Plans will be sampled regularly by the Trust's Audit Department to ascertain:

- a) the numbers of patients who have recorded Care Plans
- b) evidence of reviews
- c) rates of discharge from care
- d) loss to follow-up

July 1995

ANNEX 2



NORTHWEST LONDON MENTAL HEALTH NHS TRUST &

BRENT COUNCIL MENTAL HEALTH FIELD WORK

February 8TH 1999

ASSESSMENT OF RISK FORM

CONFIDENTIAL

Patient/client name:..... **DOB:**.....

Please tick ✓ to indicate a history of risk behaviour or specific areas of concern:

SELF –HARM ☐ **SELF-NEGLECT** ☐ **RISK TO OTHERS** ☐ **RISK FROM OTHERS** ☐ **FIRE RISK** ☐

1. HISTORY

1.1 Please give details of any previous risk behaviour as identified in the categories above:

1.2 Is there evidence of rootlessness or "social restlessness" (for example few relationships, frequent change of address or employment)	YES ☐	NO ☐

1.3 Is there evidence of poor compliance with treatment or disengagement from psychiatric aftercare/ or discontinuation of medication	YES ☐	NO ☐

1.4 Is there evidence of substance misuse or other potential disinhibiting factors(for example a social background promoting violence)	YES ☐	NO ☐

1.5 Can any precipitants or any changes in mental state or behaviour that have preceded earlier violence/ or other risks (e.g. self –harm, arson, self-neglect) be identified?	YES ☐	NO ☐

Are these risk factors stable or have they changed recently?

1.6 Is there any evidence of recent severe stress?	YES ☐	NO ☐

1.7 Have there been any loss events or any threat of loss	YES ☐	NO ☐

CONFIDENTIAL

BRIEF RISK INDICATOR CHECKLIST – to be completed for all patients

Patient / client name:..... D.O.B. .....

Sector Team:..... Date assessment started.....

RISK ASSESSMENT HISTORY

History of violence (ever)
- None ☐
- One incident ☐
- Two incidents ☐
- Three incidents ☐
- More than three incidents ☐
- Threats of violence ☐
- Not able to assess ☐

Most serious harm caused
- None ☐
- Minor injury ☐
- Serious injury ☐
- Fatality ☐
- Not able to assess ☐

History of arson(ever)
- No ☐
- Yes ☐
- Threats ☐
- Not able to assess ☐

History of suicide attempts (ever)
- None ☐
- One ☐
- Two ☐
- More than two ☐
- Threats of suicide ☐
- Not able to assess ☐

History of severe self-neglect(ever)
- No ☐
- Yes ☐
- Not able to assess ☐

History of harm to children(ever)
- No ☐
- Yes ☐
- Threats of harm ☐
- Unable to assess ☐

History of containment (ever)
- None ☐
- Special hospital ☐
- Secure unit ☐
- Prison ☐
- Locked ward ☐
- Detained under the MHA 1983 ☐
- Detained under section 136 ☐
- Detained at the police station ☐

History of dropping out of contact with mental health services **Yes** ☐ **No** ☐

RISK BEHAVIOURS IN THE PAST YEAR

	Yes	No	Threats
Accidental harm at home (e.g. falling, careless smoking)	☐	☐	
Not able to assess	☐		
Accidental harm outside the home (e.g.) wandering into the road	☐	☐	
Not able to assess	☐		
Lack of awareness of danger	☐	☐	
Not able to assess	☐		
Abuse/exploitation from others	☐	☐	☐
Not able to assess	☐		
Drug abuse	☐	☐	
Not able to assess	☐		
Alcohol abuse	☐	☐	
Not able to assess	☐		
Non-compliance with medication	☐	☐	☐
Not able to assess	☐		
Arson (deliberate fire setting only)	☐	☐	☐
Not able to assess	☐		
Self-injury(e.g. cutting)	☐	☐	☐
Not able to assess	☐		
Overdose	☐	☐	☐
Not able to assess	☐		
Other method of self-harm	☐	☐	☐
Not able to assess	☐		
Harm to children	☐	☐	☐
Not able to assess	☐		
Sexual assault (including touching/exposure)	☐	☐	☐
Not able to assess	☐		
Violence to family	☐	☐	☐
Not able to assess	☐		
Violence to staff	☐	☐	☐
Not able to assess	☐		
Violence to other patients	☐	☐	☐
Not able to assess	☐		
Violence to the general public	☐	☐	☐
Not able to assess	☐		
Incidents involving the police	☐	☐	☐
Not able to assess	☐		

Current mental state: are there any active symptoms that indicate an increased risk of harm to self or others? **No** ☐ **Yes** ☐

Please describe:

Is further risk assessment required?

No ☐ *If necessary please give details in the box below*
Yes ☐ *If yes, please complete "Assessment of Risk Form"*

Does the client meet the criteria for inclusion on the Supervision Register? **No** ☐
Yes ☐ **if yes please complete the "Assessment of Risk Form" and the Supervision Register form.**

Brief summary /action plan (please include reasons for no further assessment)

Main sources of information – please note whether relatives/carers/ significant others and GP have been consulted as part of the assessment

Form completed by: ..... **Designation** .....

Date of completion:.....

RMO Name:..... **Signature** .....

Key worker name: ..... **Signature**.....

Risk assessment and management procedures

1. Completion of the form	The risk indicator checklist should be completed for all patients who are accepted by the specialist mental health services
On the ward	The risk indicator checklist should be started at the point of admission (*as part of the admission process and an immediate risk care plan should be drawn up*). This will be the responsibility of the ward manager and the duty doctor. The assessment should be discussed at the ward round and decisions made on any further action to be taken and whether a more comprehensive assessment is needed. The risk indicator checklist should be completed within 5 days of admission. The risk indicator and/or comprehensive assessment should be repeated prior to consideration of hospital discharge
At Accident and Emergency	The duty psychiatrist and senior nurse should take responsibility for beginning the risk indicator checklist and ensuring that the information gathered is passed to the appropriate team for follow-up and completion.
In the community	The risk indicator checklist should be discussed at the referral meeting. Where it is decided that further action is needed by means of face to face contact the risk indicator should be started at the first contact. A professional identified at the referral meeting should be responsible for ensuring relevant information is available to complete the form (*this does not mean that one person will necessarily be solely responsible for obtaining the information but for co-ordinating the process – this may be the key worker)*. The information should be brought back to the meeting for discussion and a decision on further action. The risk indicator checklist should be completed within 4 weeks of referral.
2.	Teams need to decide in individual cases whether to proceed with the more comprehensive"Assessment of Risk" form. This should be discussed at the clinical review meeting and should involve Mental Health fieldwork .The consultant should make the final decision in consultation with the team.
3.	Teams need to agree local procedures for initiating the comprehensive "Assessment of Risk"form.
4.	All CPA participants who are going to be actively involved in the care plan need to familiarise themselves with the risk assessment and management plan. The teams need to decide how the information in the risk assessment and management plan is shared and how the information can be accessed. It is a matter of clinical judgement whether the complete risk assessment and management plan, or an appropriate part of it is shared. the final decision for this rests with Responsible Medical Officer(RMO)
5.	The risk assessment and management plan should be reviewed at the same time as the rest of the care plan. Teams need to discuss how this should be done, in individual cases, and whether a separate meeting or separate part of the meeting needs to be identified to discuss issues relating to risk.

6.	It should be a matter of clinical judgement whether and how the risk assessment is shared with the user.
7.	For clients who meet the criteria for inclusion on the Supervision Register. The appropriate Supervision Register documentation should be completed.
8.	For both the initial risk indicator checklist and the more comprehensive assessment for risk, the RMO should sign the form to ensure that the information contained in the form and the decision on further action has been agreed.
9.	Where the box "unable to assess" has been marked, an indication of the reasons should be given and the team should follow this up, if appropriate.
10.	It is important that the risk assessment it discussed in a multi-disciplinary team setting, including Mental Health Fieldwork, and that individual team members do not feel that they are solely responsible for completing the risk assessment Consideration should be given to the most appropriate team members to be involved in the assessment for example it may not be appropriate for unqualified members of the team to complete the assessment.
11.	All information contained in the risk assessment should include details of the risk and the context in which the risk behaviour occurred
12.	The risk assessment and management process should be based on anti-discriminatory and anti-racist practice.
13.	The risk assessment should be reviewed as often as required. It should reflect any additional information, which becomes known. Any changes to the risk management plan should also be indicated. This should be reflected on the CPA care plan and circulated as appropriate.
14.	Consideration needs to be given as to how the risk assessment and management plan is integrated with the CPA care plan summary. In some case it may be appropriate to distribute the risk assessment with the CPA care plan and in others it may be sufficient to reflect the plan on the CPA care plan summary.
15.	All risk assessment documentation should be on green paper and should be clearly identified in the clinical notes.

2. ENVIRONMENT

2.1 Does the patient have access to potential victims, particularly individuals the patient has identified in mental state abnormalities e.g elders/children	YES ☐	NO ☐

2.2 are there any features in the environment which may exacerbate the identified risks	YES ☐	NO ☐

3.MENTAL STATE

3.1 Does the patient have firmly held beliefs of persecution by others? (persecutory delusions)	YES ☐	NO ☐

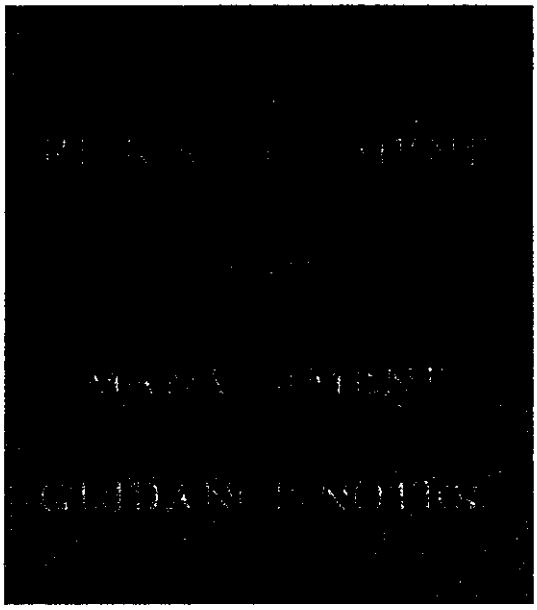
3.2 Does the patient report experiences of mind or body being controlled or interfered with by external forces? (delusions of passivity or command auditory hallucinations)	YES ☐	NO ☐

3.3 Does the patient show any of the emotions related to violence (for example irritability, anger, hostility suspiciousness)?	YES ☐	NO ☐

3.3 1. Does the patient show any of the emotions related to self-harm /suicide (e.g. feelings of hopelessness ,low self-esteem, no hope for the future)	YES ☐	NO ☐

3.4 Are there any specific threats made by the patient?	YES ☐	NO ☐

3.5 Are there particular difficulties in gaining access to the patient's mental state?	YES ☐	NO ☐



NORTH WEST LONDON MENTAL HEALTH NHS TRUST &

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4. INTENTION

4.1 Has the patient expressed any clear intention to harm self or others?	YES ☐	NO ☐

5. PLANNING

5.1 Has the patient made any specific plans in relation to harm to self or others?	YES ☐	NO ☐

6. please use this space to identify any risk factors which have not already been covered

6. SUMMARY

This should be based on these and all other items of history and mental state. It should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it. The formulation should aim to answer the following questions:

SUMMARY OF ASSESSMENT (6.1 – 6.4)

6.1 How serious is the risk of harm	
6.2 is the risk of harm specific or general?	
6.3 How immediate is the risk of harm	
6.4 How likely is the risk of harm	

Risk assessment –harm to others and suicide

	Risk assessment and management of risk of harm to others	Risk assessment and management for suicide
History	An accurate history of violent incidents is very important. This information should be obtained from all possible sources, including the patient themselves Staff should also look for evidence of: • Poor compliance with treatment or disengagement from after-care • Triggers or any changes in mental state which may have occurred prior to the violence or relapse • Recent severe stress, particularly loss events or the threat of loss • Recent discontinuation of medication.	An accurate history of past self-harm incidents and suicide attempts is vital for the risk assessment process. The recency, severity and pattern of these attempts should be examined, as with risk of harm to others. For example when considering severity of attempt, persons who attempt to hand themselves when alone in the house and who take steps to avoid interruptions and are only rescued by chance are at much higher suicide risk than persons who have taken an overdose they know is not lethal and present themselves at casualty
Recency	The more recent the incident of harm to others, the higher the current risk.	
Severity	The more severe an incident, the higher the current risk.	
Frequency	The more frequent the events or incidents, the higher the current risk. Persistent and repeated assaults on others are strong indicators of high risk.	
Pattern	Is there a common pattern to the type of incident or the context in which it occurs?	When considering the pattern of self-harm or suicide attempts, a suicide attempt may typically be made at the ending of a relationship. If that pattern is now repeating itself and the relationship is now ending, this indicates higher risk. Anniversaries and recent traumas and losses may increase risk, usually temporarily, particularly if it leads to a sense of entrapment and hopelessness The patient's view of anticipated events may also increase risk as they approach. It is also important to remember that substance misuse, particularly of alcohol greatly increases risk
Ideation and mental state	What is the person thinking or feeling now.? It is important to assess the patient's mental state and in particular look for evidence of the following. • Evidence of persecutory delusions or delusions of passivity(being controlled by external people or forces) • Emotions related to violence e.g. anger, irritability • Specific threats made by the patient • Command hallucinations	An examination of the person's ideas on suicide can help to assess the risk. • Does the person see suicide as an answer to their problems? • Does the person think or fantasise about suicide? • How frequently does the person think about suicide? • How does he or she respond to these thoughts? The greater the prominence and rigidity of these thoughts in the person's life, the higher the risk of suicide. Fleeting thoughts quickly rejected represent low risk, while persistent, intrusive thoughts and painful thoughts indicate high risk even in the absence of planning. Consider constraints on action e.g. religious beliefs, family obligations

Intent	A statement from an individual that they intend to harm another person is the clearest indication of risk and should never be ignored. Intent, whether declared or not, is the strongest and most powerful predictor of future behaviour.	A statement from an individual that they intend to harm themselves is the clearest indication of risk and should never be ignored. Intent, whether declared or not, is the strongest and most powerful predictor of future behaviour.
Planning	If a person admits to having thoughts of harming others, it is important to establish if they have considered how they might do this. This can be extracted from their own statements or other objective evidence The presence of a plan indicates still higher risk. If the person also has the means to carry the plan out, the degree of risk rises again	If the person admits to suicidal ideas, has he/she taken it a stage further to planning how to do it? How likely in your judgement is the plan to succeed? Plans to avoid detection are of particular significance. For example, if a person has continual thoughts of suicide, has the person determined that he or she will shoot themselves when the rest of the family are away and does the person have the means to do so, for example owning a shotgun- this would indicate very high risk Thoughts of suicide without any plan or without access to the means to do so carry a lower risk
Formulation	Following the assessment a risk management plan should be formulated which should, as far as possible, specify factors which are likely to increase the risk and those likely to decrease it. It should include the factors listed above and how their interaction increases risk. The formulation should seek to answer the following questions • How serious is the risk of harm? • Is the risk of harm specific or general? • How immediate is the risk of harm? • How volatile is the risk of harm? • Are circumstances likely to arise, which will increase it? • What specific treatment and management plan can best reduce the risk of harm?	A formulation should be made as with the risk of violence, including an appreciation of all the risk factors described above and the role of their interaction in increasing risk • How serious is the risk of harm? • Is the risk of harm specific or general? • How immediate is the risk of harm? • Is the risk of harm liable to diminish fairly quickly? • Are circumstances likely to arise, which will increase it? • What specific treatment and management plan can best reduce the risk of harm? **It is important to note that the patient's responses should not always be taken at face value.**

Risk assessment and management guidance

Introduction

Users with long term difficulties and particularly those known to have potential for risk taking behaviour need special attention, both at the time of discharge and during follow-up in the community. Assessment of this group of patients is an important role of all mental health professionals. There are no risk assessment tools that will enable anyone to say with complete accuracy that one patient is at risk and another is not. However there is a considerable body of evidence that indicates which factors are associated with risk and how predication of risk can be made on the basis of assessment information.
In reality all mental health professionals are involved in making judgement on risk, based on assessment information every day.
If is important that a thorough assessment is made and a clear reasoned judgement is made which can show that the best possible practice was followed, this process should be clearly documented.
The decision to discharge a patient form the caseload must be agreed by the RMO.
No decision to discharge a patient from hospital should be agreed unless those taking the clinical decision are satisfied that the behaviour can be controlled without serious risk to the patient or to other people.
Clinicians should pay particular attention to the period immediately following hospital discharge, which is a particularly vulnerable time for patients with mental health problems

Note – it is essential that in respect of all new referrals and patients previously unknown to the service that every effort is made to ascertain any relevant history from other services that have had previous contact with the patient. In consideration of all new referrals an appropriate clinician should be identified to take responsibility for gathering this information.

In relation to recent inquiries it is important that there is evidence of risk assessment and management documentation to demonstrate that risk assessment has been shared and understood by those involved.

This guidance sets out good practice for risk assessment and management, which should be followed for all patients. It is based on the application of the Care Programme Approach, with particular emphasis on the assessment of risk for the Supervision Register.[1]

"Local factors for Risk Management for Brent Residents – applying anti-racist and anti-discriminatory practice"

In Brent we have to be aware that 55% of the population is from an ethnic community and that certain groups of these residents are over and under represented in the local community mental health services. All groups will be subject to racism in their daily lives. Other discriminatory factors will also come into play for other groups, which need to be taken into account as part of the staff members' assessments; including women and elders, lesbians and gay men and people with disabilities.

Looking specifically at race issues, staff have to be especially careful in assessing risk to others to take into account the stereo-typing of some groups such as young black men is common in our society. This can also affect the selectivity of information recorded and presented about black people we work with. It can also affect the way that incidents are emphasised and contextualised. A key part of the service we offer is to make sense of information we are presented with and to analyse it from the point of view of race and culture so that the plan which we develop is balanced, based on evidenced facts and sensitive to that individual's needs.
Equally, for some groups such as Asian women, there can be an under representation with mental health services. There can be a tendency to stereo-type Asian communities as supportive or attribute psychological problems to cultural issues (such as arranged marriages) which leads to a loss of understanding of the individual's needs rather than an increase in understanding.

Under the Risk Assessment and Management Procedures Point 12 states, "the risk assessment and management process should be based on anti-discriminatory and anti-racist practice"

For further information see Brent Council Mental Health Fieldwork's Risk Assessment and Management Policy, and Anti Discriminatory and Anti-racist Policy and NWLMMHT's Equal Opportunity Policy and Code of Practice

Context for Risk Assessment

The nature of the risk assessment will depend on the context in which it is made, such as:

- **Initial and comprehensive assessments** –first contacts and ongoing management of severe mental disorder;
- **Assessments following an untoward incident.**

Initial assessment: first contact

At first contact the psychiatric assessment must always include the proper evaluation of risk of harm to self or others and should consider the following areas:

- Risk factors e.g. age, gender/ethnicity
- History – **this must include history from any previous contact with mental health services, wherever this has taken place.**
- Ideation/mental state
- Intent
- Planning
- Formulation

As far as is possible with the information available, consider the pattern, frequency and severity of any risk factors and how recently they took place (recency)

Management of Severe Mental Disorder

At CPA reviews of a person suffering from severe mental disorder, an assessment of risk should be repeated. The degree of detail should be related to the responsible clinician's judgement of the severity of the disorder, and will be related to the CPA level. Again attention should be paid to the above areas. In addition, consider previous notes, which will provide a fuller picture of the history. It will also be important to consult with other professionals and carers involved in the patient's care. Careful attention to these sources of information will help to reveal any past history of violence and/or self-harm, plus its pattern, frequency, recency and severity

Assessment following a Serious incident

A more detailed risk assessment is required following a suicide attempt or a violent incident. The assessment should generally include the following:

- Detailed reconstruction of the incident based on evidence from the patient,
- witnesses and/or the victim
- Details of the trigger factors e.g. use of alcohol or drugs, events such as contact with relatives, children, contact with authority, refusal of requests for money/services/prescriptions;
- Details of any situational factors e.g. is the person living with vulnerable others or people who they have threatened before?
- Are friends, relatives, or carers available to offer support and monitoring?
- Consideration of the patient's current feelings and attitude to past incidents e.g. acceptance of responsibility and remorse
- Observations by staff of the patient's responses to stressful situations

The clinical management of the risk of violence

	The clinical management of the risk of Violence
General principles	• A clinician, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to ensuring that the risk is reduced and is managed effectively. • The management plan should seek to increase the safety of the patient and the public but should recognise that some risks may have to be taken. • When seeing a patient, who presents a risk of dangerous behaviour, a clinician, having assessed the risk, should then aim to make the patient feel safer and less distressed as a result of the interview.
The management plan	The management plan must be based on an accurate and thorough assessment, and adoption of the principles above. Clinicians should consider the appropriate level of support and containment. The following list is not exhaustive but covers options that clinicians may need to consider in formulating a management plan • Is admission as an inpatient necessary? • Should the patient be detained in hospital • What level of physical security is needed • Should the patient be placed in locked or secure accommodation? • What level of observation and monitoring is required? • How should medication be used? • How would further episodes of violence be managed? • Should the police or security be called? • What has helped to reduce the risk in the past? **If care other than as an inpatient is being considered:** • Has the person been included in the Care Programme Approach? • Is inclusion on the Supervision Register appropriate? • Has the use of legal powers been considered? • What community supports are available? • Do the carers and family have access to the appropriate support and help • Have the carers been adequately informed about the services needed and how they can be accessed?

Risk assessment: severe self-neglect

Risk assessment and management for severe self-neglect	Self-neglect is a common problem with severe and enduring mental illness. In this document we are concerned with severe levels of self-neglect. Assessing the risk of self-neglect is not a straightforward process, except in the most severe situations. It is made more complex by difficulties in relative standards. The areas that should be covered in the assessment process are • Hygiene • Diet • Infestation • Household safety • Warmth.
Management of people who neglect themselves	As for the risk of harm to others and suicide, the principle of negotiating safety should be followed. Although self-neglect can be quite serious it is rare that it should require compulsory admission under the Mental Health Act (1983). Through the CPA and careful liaison between health care agencies the risk of harm from severe self-neglect can be minimised but rarely eliminated. For patients with severe and enduring mental illness the risk of severe self-neglect is often associated with non-compliance with medication, therefore putting effective monitoring mechanisms in place as part of the CPA reduces the risk. For patients being managed in the community under the CPA, the following questions should be considered • Is the patient on the appropriate CPA level? • Has the use of legal powers been considered? • Is inclusion on the Supervision Register appropriate? • What community supports are available? • Do the carers and family have appropriate support and help? • Have the carers and family been adequately informed about services needed and how they can be accessed?(include any independent sector support network) • Are they realistic about their expectations?

Clinical management of the risk of Suicide

Management of the imminently suicidal requires careful judgement of the risk involved balanced against the support and care that can be provided in the community. Although admission to hospital may appear to be the safest course of action, it is not necessarily always the best

Clinical management of the risk of suicide

The management plan

The management plan should consider the same options as those listed for the management of harm to others, following the principle of negotiating safety.

Hospital care under the Mental Health Act should be considered when the suicide risk is high. Risk is high when:

- the person has a history of serious suicide attempts,
- is isolated and without support,
- has clear suicidal ideas and plans,
- is non-compliant with treatment and
- is under stress in the home environment.

If the patient is to be managed in hospital, their safety must be paramount and consideration should be given for the need for the following interventions:

- What level of physical security is needed?
- What level of observation and monitoring is needed?
- Should the patient be placed in locked or secure accommodation?
- Has the patient had their belongings checked for dangerous/sharp objects?
- Is there a system for ensuring that the multi-disciplinary team reviews the management plan?
- How should medication be used?
- Should the patient be detained in hospital if necessary?

If care other than as an inpatient is being considered, once again the same questions should be asked as with risk of harm to others. In addition there are several strategies which can make community care safer.

- Ensure that as a matter of urgency that the community mental health team is involved under the CPA guidelines.
- Increase the frequency of home visits and outpatient appointments.
- Work with the patient to make them feel safer, both by providing emotional support and by putting practical interventions into place.
- Agree a timetable of care and support with relatives and/or friends
- Arrange day hospital or day care attendance on a regular basis, with rapid follow-up for failure to attend.
- Liase with the patients GP to make sure that if anti-depressants are prescribed, relatively non-toxic drugs are chosen, of they are prescribed frequently in small quantities.
- Make sure that the patient and their relatives know how to access help quickly from services, at any time of the day or night.
- Agree a contract with the patient that they will not deliberately harm themselves between appointments.

Longer term management of the risk of suicide

Longer term management of suicide risk	The need for the longer-term management of the potentially suicidal person can arise where someone has made more than one serious suicide attempt over a lengthy period of time, possibly linked to a relapsing depressive condition, an affective psychosis or schizophrenia. It is particularly important in those circumstances to identify any precipitating factors like: • Sudden life changes and losses. • Changes in mood. • Increases in symptomatology or relapses. It may be necessary to keep in fairly close contact so that if any of these circumstances repeat themselves, a further risk assessment can take place and appropriate action can be taken. Carers and relatives can be asked to help in this monitoring process and will need to know where to gain help quickly if a crisis arises. **Note that even where someone has made a series of attempts at self-harm that do not seem intended to end in death, the risk of completed suicide still exist, and accumulates over time.**

Risk management strategies for staff

	Risk management strategies for staff
General	There are definite risks for staff working in mental health services in the day to day course of their work. The following guidance aims to assist clinicians by identifying areas of safe and good practice.
Precautions for home visiting	The most important measure is based upon good risk assessment, communication and therefore prediction. If it can be predicted that there will be a high risk of violence during a visit, workers should visit in pairs or make appointments at the office base. Other strategies to minimise risk include: • Access to mobile phones and personal alarms • Avoiding home visits to high risk areas after dark • Use of a checking in policy – where workers leave details of where they will be etc.
Precautions for offices such as mental health resource centres	All buildings in which people are seen should be equipped with an alarm system. An alarm system is only valuable if people know what to do if the alarm sounds and participate in regular practices. A worker who is alone in the building should not see patients, as backup will not be available. Vigilance needs to be exercised about general building security. Combination locks between patient-accessible and staff areas must be installed. Prior to the building being locked in the evening it must be checked to ensure all patients have left.
Communication	This is a crucial part of the risk assessment process, however there are particular points in the psychiatric care process that commonly trigger communication failures. These failures can have serious consequences. The danger points are all related to transitions in care • **Discharge from hospital** – a full assessment of risk need to take place prior to discharge from hospital. The results of the assessment need to be communicated to the care team in the community. • **Referrals to another care provider** – this can be from one provider trust to another, or from one key worker to another. All referrals should contain information about past history of harm to self or others and a current assessment of risk.
Communication between mental health professionals and other agencies	This usually poses a difficulty because of the desire to maintain confidentiality and not stigmatise the patient in the eyes of others. This issue is raised most frequently in contacts with housing or hostels. Despite the wish to prevent stigmatisation, it is clear that other agencies do need to know what the risks are and how they can best be managed. Occasionally, members of the public who are at specific risk may also need to be informed. In these circumstances the public interest overrides professional confidentiality. Staff may on occasions require advice from their manager or professional organisations on the issue Other agencies may need to be helped to develop procedures whereby information that is passed on remains confidential and protected. The CPA community care plan as formulated by the key worker is the ideal means of communication between the agencies. It contains not just the plan, but the names and contact numbers of those involved, plus information about risks. Copies of the care plan must be sent to all those involved. The communication of risk needs to be considered by the team. **The Consultant and the responsible key worker should consider in individual circumstances whether a full copy of the risk assessment should be attached and circulated with the CPA Care Plan.**
Multi-disciplinary team working	Multi-disciplinary assessment a shared care plan and good interdisciplinary communication are important aspects of risk management by the multi-disciplinary team. In order to promote consistency, multi-disciplinary teams should agree local risk assessment practices, taking into consideration differences in training and levels of expertise.
Clinical supervision	There are many reasons why one to one supervision is recommended for mental health workers. It can provide emotional support in the face of difficult and stressful work. It is the means by which workers can grow and develop in expertise and also managers can ensure that policy is being followed and professional standards maintained. The content of clinical supervision is mostly about patient care. The supervisor can contribute to higher standards of care and safer practice by making sure that risk and its assessment is a regular aspect of the discussions on patient care.

[1] This guidance reflects the requirements set out by t he Department of Health in guidance "Introduction of Supervision Registers for Mentally Ill People" HSG (94) 5 and "Guidance on the Discharge of Mentally Disordered People and their continuing care in the Community" HSG (94) 27.