REPORT OF THE INDEPENDENT INQUIRY

INTO THE CARE AND TREATMENT OF AB

A report commissioned by

Brent & Harrow Health Authority
(succeeded by North West London Strategic Health Authority)

December 2002

CONTENTS

PREFACE

We were commissioned in August 1999 by Brent & Harrow Health Authority to undertake an independent review of the circumstances surrounding the care provided to AB by Health and Social Care Agencies between 16 March 1991 and 3 March 1998, and, in particular the adequacy and appropriateness of such care. Our Terms of Reference appear in Appendix 2 to this report.

We were required to prepare a report and make recommendations to the commissioning authority.

Since the Inquiry was commissioned, there have been a number of changes to the names, geographical area and responsibilities of the organisations mentioned in this report. The recommendations should be read in conjunction with Chapter 2 "Commissioners and Service Providers" which indicates where organisations have changed. The recommendations are addressed to the successor organisation where appropriate.

We regret that it has taken longer to report than anticipated – the large amount of evidence submitted, administrative problems and the death of the Inquiry chair caused some considerable delay.

We now present our report and recommendations in accordance with our Terms of Reference having followed the Procedure agreed and issued to all witnesses and their representatives.

John Sedgman
Solicitor (Chairman)

Bozena Allen
Former Director of Social Services (Panel Member)

Dr Cyril Davies
Consultant Psychiatrist (Panel Member)

Note

During the completion of this inquiry, John Sedgman sadly died. The Health Authority and his panel colleagues were saddened by this news, are grateful for his meticulous work and would like to take this opportunity to pass on their condolences to his family and many friends.

ACKNOWLEDGEMENTS

Our grateful thanks are due to the following:

- Mr Bob McDonald acting on behalf of Brent & Harrow Health Authority for his professional and constructive support throughout the Inquiry.

- Miss Catherine Afolabi of Brent & Harrow Health Authority for her assiduous, skilful and ever cheerful work in connection with all aspects of the Inquiry.

- All witnesses of fact for their attendance, co-operation and frankness during a process that may, for some of them, have been at times stressful and upsetting.

- The legal and other witness representatives for their helpful and professional contribution to the work of the Inquiry.

- The representatives of Brent & Harrow Health Authority and Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust, and of the Prison, Housing, Probation and Social Services who gave of both their time and expertise in providing evidence and background information.

CHAPTER 1

1 INTRODUCTION

1.1 On 2 March 1998, Hugh Patrick McCaffrey died following a stabbing incident. On 19 October 1998 at the Central Criminal Court, his girlfriend, AB then aged twenty-eight, was convicted upon indictment of his manslaughter, and sentenced to three years imprisonment. She was released on Licence on 1 September 1999.

1.2 Between 16 March 1991 and the date of conviction, AB had from time to time, been in receipt of mental health services from Brent, Kensington, Chelsea & Westminster Mental Health NHS Trust and/or its predecessor (hereinafter referred to as "the Trust"). All such mental health services had been purchased by Brent & Harrow Health Authority and/or its predecessors (hereinafter referred to as "the Health Authority").

1.3 On 20 March 1991, AB was held at the Park Royal Centre on the campus of the Central Middlesex Hospital under section 5(2) of the Mental Health Act 1983, and re-graded later the same day to section 2 of the Act. (Hereinafter referred to as the "MHA 1983").

1.4 On 16 March 1995, AB was again admitted to the Park Royal Centre (herein after referred to as PRC) under section 35 of the MHA 1983 for assessment. Following assessment, it was concluded that she was not then suffering from mental disorder and she left hospital on 29 March 1995.

1.5 On a number of occasions between 16 March 1991 and 2 March 1998, AB was admitted as a voluntary patient to various hospitals.

1.6 Between 16 March 1991 and 3 March 1998, AB received help, support and advice from Brent Social Services Department, and/or their predecessors (hereinafter referred to as "the Department") and from Housing agencies.

1.7 Between the 16 March 1991 and 2 March 1998, AB incurred a considerable forensic history as a result of which the prison and probation services became involved over a period of time.

1.8 On 10 May 1994, the NHS Executive issued a circular HSG (94)27 entitled "Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community". Paragraph 33 of that circular stipulates that "if a violent incident occurs, it is important not only to respond to the immediate needs of the patient and others involved, but in serious cases, also to learn lessons for the future. In this event, action by local management must include an immediate investigation to identify and rectify possible shortcomings in operational procedures with particular reference to the Care Programme Approach". Paragraph 34 stipulates that "in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved".

1.9 Following the conviction for manslaughter, an Internal Review took place within the Trust into the care provided for AB prior to the homicide. This Internal Review resulted in a Serious Incident Report, prepared by Mr Peter Raimes, Sector Manager for East Brent. This report was undated. It concluded that AB had a well-documented Personality Disorder which had been comprehensively assessed by Dr Mallett in 1997 when she was in Holloway Prison. It further concluded that "there was no evidence of any psychiatric illness in her contact with psychiatric services", and that "it seemed entirely appropriate that she was offered only outpatient follow-up at various times which she was not compliant with. The report recommended that following the review of the case, there did not appear to be any concerns regarding the provision of care offered to AB, and that therefore, it had no recommendations to make at that time.

1.10 In May 1999, the Health Authority set up an independent inquiry into the care and treatment of AB by Health and Social Care Agencies between 16 March 1991 and 3 March 1998. We as Chairman and Members of the Inquiry were appointed, and the Terms of Reference for the Inquiry were agreed by us thereafter. A Procedure and letter of invitation to potential witnesses were also agreed. The Inquiry's Terms of Reference are included at Appendix 2, Procedure adopted at Appendix 3, and letters to witnesses at Appendix 4 to this Report.

1.11 The first task of the Inquiry was to obtain documentary evidence from a variety of sources including Prison, Probation, Health, Housing and Social Services. Full medical, nursing, probation, housing and social services records were requested. A very considerable quantity of documentation was obtained, circulated and considered. Throughout the period of the Inquiry, and in part as a result of interviews with witnesses and others, it became apparent that further documentation might be material to the Inquiry, and an appreciable further weight of documentation was obtained and considered as appropriate.

1.12 Consideration was also given to the question of witnesses. This proved a considerable task, not least in view of the fact that the Inquiry's Terms of Reference required it to consider the care offered to AB over a period of no less than seven years, and by a multiplicity of agencies, both statutory and voluntary.

1.13 Some witnesses were easier to access than others. The vast majority co-operated fully from the outset, attended before us and gave helpful evidence. Throughout the period of the Inquiry, there have been continuing efforts to locate other witnesses who proved more difficult to locate for a variety of reasons including retirement, change of job, movement away and illness. Such difficulties were inevitable bearing in mind the extended period covered by the Inquiry. Many such potential witnesses were located and some interviewed. It was not felt that any not located and/or interviewed, seriously inhibited the Inquiry's remit.

1.14 The Inquiry Team met formally for the first time on 4 August 1999. On 24 August 1999, it interviewed AB at Holloway prison. On 16 November 1999, it began receiving evidence from witnesses and continued such interviews until 24 March 2000. Prior to commencing the interviewing of witnesses of fact, the Inquiry felt it important to consider whether such interviews should be conducted in public or in private. It was mindful that its brief resulted from a tragic sequence of events resulting in a homicide; that the perpetrator had been treated for mental illness in the past; and that the matters which were to be investigated, with potential witnesses who included doctors, nurses, family members, social services and probation staff, were potentially delicate, difficult and/or distressing. It was considered that the Inquiry was investigatory and inquisitorial rather than adversarial in nature, and that the less confrontational the interviews could be, the more likely the Inquiry was to be in a position to ascertain the true facts of the case which it had been appointed to investigate. Its view was that its function would be assisted by the hearing of evidence in private, and in the absence of press and public, and this it resolved to do.

1.15 The Inquiry was further of the view that it would assist its endeavours if witness evidence was recorded, transcribed into written form, and the transcripts sent to individual witnesses with an invitation to make comment. This was done, and some comments were received and considered.

1.16 Lists of potential witnesses were prepared, and letters enclosing copies of the Terms of Reference and the Procedure to be adopted by the Inquiry, were sent to each of the potential witnesses with an invitation to attend the inquiry and to give oral evidence. The Zito Trust were invited to attend, but it was accepted that it would not be practical for the personal attendance of a representative, and that body was invited to make written representations. This it did, and such were considered by the Inquiry. One unsolicited representation was received and considered. All witnesses invited to attend and give evidence to the Inquiry were informed that they could bring a friend or relative, trade union or other representative, lawyer, member of a defence organisation or other person to accompany them to the hearing, and/or to advise them thereat. Some availed themselves of this invitation, others did not.

1.17 Documentary evidence obtained by the Inquiry was, where appropriate, used as the basis for witness interviews.

1.18 Representatives from both the Trust and Health Authority, were invited to attend and give evidence, and this they did.

1.19 Prior to the preparation of this Report, and before the Inquiry considered its conclusions and decided upon its recommendations, it considered all verbal and documentary testimony received, as well as all relevant documentation. Due and appropriate weight was given to all such.

1.20 A list of witnesses attending and giving evidence appears at Appendix 5. This appendix also lists the dates of witness interviews, those not attending for a variety of reasons and those who could not be located.

1.21 In the course of this Inquiry, some thirty witnesses have been interviewed, and documents running to approximately 6,500 pages considered.

1.22 During the interviewing of witnesses, the Inquiry Team member with the most relevant knowledge and experience led the questioning on behalf of the Inquiry. When all members of the Inquiry team had raised all matters that they considered relevant, the witnesses were each invited to provide any such further evidence as they might deem appropriate. Whilst maintaining an appropriately structured procedure, the Inquiry team's concern throughout the interviewing of witnesses was to conduct such in as informal a manner as possible, and not to adopt too rigid a procedure or to create an intimidating environment.

1.23 The Inquiry would like to express its appreciation to all those who appeared before it for the frankness and honesty with which they gave their evidence in circumstances where, often, the need for them to recall events may have been distressing.

1.24 As stated, one or two witnesses were unable for good and sufficient reason to attend. The Inquiry however, is not of the view that any potential witnesses who were not able to be seen were, in light of all the other evidence available, indispensable.

1.25 The Inquiry would also like to express its thanks to those representatives and others accompanying the witnesses for their individual contributions.

1.26 Finally the Inquiry would like to express its appreciation to the Health Authority which commissioned it. Whilst at no time and in no way seeking to compromise the independence of the Inquiry, it provided a highly efficient support service in every regard including the provision of appropriate accommodation, recording, and secretarial facilities.

CHAPTER 2

2 COMMISSIONERS AND SERVICE PROVIDERS

2.1 During the period covered by this Inquiry, AB, with only brief absences, lived in and around the Willesden area of North West London. Her only semi-permanent base has been her mother's address. During this period, she has been essentially peripatetic, living at a multitude of different addresses. The authorities responsible for her welfare have been for the most part, London Borough of Brent Social Services Department; Holloway Prison; Brent & Harrow Health Authority; Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust; local GP practices and the Middlesex and Inner London Probation Services. Other service providers have included voluntary housing agencies and voluntary agencies involved in supporting individuals with substance abuse problems.

Brent & Harrow Health Authority (and its predecessors): the Purchasing Authority (succeeded by North West London Strategic Health Authority, Brent Primary Care Trust and Harrow Primary Care Trust)

2.2 The Health Authority is responsible for the commissioning of primary, secondary and tertiary health care services in its area.

2.3 The Health Authority commissions health care services from, amongst others, the Trust.

2.4 The socio-economic profile varies to a marked degree over the area covered by the Health Authority. Social deprivation and morbidity were considerably higher in the area in which AB lived during the period considered by the Inquiry, than in other areas covered by the Health Authority.

2.5 The Health Authority purchases the bulk of its psychiatric services from the Trust.

Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust (and its predecessors): the Provider Trust (now called Central & North West London Mental Health NHS Trust)

2.6 The Trust is a dedicated Mental Health Trust providing both hospital and community based services.

2.7 The Trust provides in-patient hospital services at a number of *loci* including the PRC.

2.8 The Trust provides services for amongst others, the Health Authority, and local GP practices.

2.9 The Trust provides within Brent, in-patient services based at the Park Royal Centre. This includes acute and intensive care wards, mother and baby unit, a rehabilitation lodge, and wards for acutely ill patients.

2.10 The Trust also provides day care at the Calcott Centre and at Belvedere House. A map showing the area covered by the Trust is at Appendix 8.

2.11 Resource centres and community mental health team bases are also provided within Brent.

London Borough of Brent Social Services Department (hereinafter referred to as "The Department")

2.12 The Department has a wide range of duties and responsibilities including the provision of various services for individuals and families in the geographical area shown at Appendix 9.

2.13 One of the Department's duties is to facilitate positive mental health to people living in the community.

2.14 The Department is required to provide a "cradle to grave" service, and to deliver such service in the homes of service users, their carers and elsewhere in the community as and when required.

2.15 In addition to the Department's core statutory functions with regard to the provision of services, it has a responsibility to work in partnership with the independent sector, with other statutory agencies, and with other interested parties.

2.16 The Department has a lead role in the purchasing, commissioning and provision of social care services for mentally ill people living in the community.

2.17 The Department's responsibilities in the areas covered by the Inquiry's Terms of Reference include:

- The commissioning, development, delivery and monitoring of Community Care Plans, and other care packages under the Care Programme Approach (CPA)
- The undertaking of assessments of need and risk necessary for the delivery of appropriate care packages
- The provision of social work support for persons in need including those with mental health problems and their carers
- The provision and/or purchasing of a range of personal social services, including day, domicilliary and residential services
- Registration and inspection of residential care homes
- Implementing and monitoring the CPA in collaboration with the Health Authority, Trust, and other statutory and non-statutory organisations.
- The employment of Approved Social Workers in order to provide a seven-day a week assessment and support service under the provisions of the MHA 1983

- Providing, in conjunction with the relevant statutory and non-statutory organisations, a s117 MHA 1983 aftercare service
- Producing, implementing and monitoring policies, procedures and Eligibility Criteria for assessment of those accessing its services.
- Providing and monitoring a Guardianship service under the MHA 1983

Brent Council Housing Department

2.18 The Housing Department of a Local Authority has a key role to play in the effective delivery of community care through the provision, wherever possible, of secure and suitable accommodation to, amongst others, those suffering from mental illness.

2.19 A Housing Department has a duty to contribute to the development of a comprehensive housing strategy in conjunction with the Local Authority Social Services Department, appropriate Trusts, Primary Care Groups and other relevant statutory and non-statutory organisations.

The Inner London Probation Service (now part of National Probation Service for England and Wales, London)

2.20 This service provides support *inter alia* for prisoners serving sentences in Holloway Prison. It operates separately from the prison medical service and the prison administration.

2.21 Its services include liaison with the community probation services, local housing services, prison and community medical services and other support services both within prison, and in the community. Its services also include advice, counselling and other services normally within the remit of the community probation service.

Middlesex Probation Service (now part of National Probation Service for England and Wales, London)

2.22 This agency provides community based probation service covering the areas within which AB was living during the relevant period. It operates from a number of local offices and provides probation cover for *inter alia* the Willesden, Malborough Street, Watford, Brent, Hendon, Marylebone areas and for the Marylebone Magistrates' Court, the Knightsbridge Crown Court and the Central Criminal Court.

2.23 Community Probation services include supervision and support of persons living in the community who are subject to a Probation Order or on licence following prison sentences.

CHAPTER 3

PEN PICTURE OF AB

3.1 AB was born in Lambeth. Soon afterwards, the family moved to Willesden. Both her parents are from Ireland. Her parents divorced in 1988 when AB was eighteen years old. Following the divorce, AB has lived from time to time with both parents. She has a brother two years younger than herself. She went to local schools in Willesden and in the early years of her secondary education she was reported to be doing well. By the age of fourteen however, she was reported to be sniffing glue, inhaling lighter fuel, and exhibiting behaviour which was unacceptable to the school and was expelled. She received no formal education after that.

3.2 She enrolled in the Youth Training Scheme (YTS) undertaking training in painting and decorating, and was later employed in various jobs such as packing and factory work. However, she experienced long periods of unemployment and this has remained the pattern throughout most of her adult life. She is reported as having been a regular drug and alcohol abuser from her middle teens.

3.3 In childhood, and as a teenager, AB was a fairly regular attender at her General Practice surgery. However, her General Practice records indicate that from the age of eighteen she frequently failed to attend medical appointments, reviews and check-ups. She was diagnosed as suffering from schizophrenia in 1991, and this diagnosis persisted to a greater or lesser degree until 1997 at least. There have been other suggested diagnoses from time to time, including personality disorder, drug-induced psychosis and depression. Throughout that period, though not on any regular basis, she received depot anti-psychotic medication. At no time has she shown full compliance with any treatment plan devised for her, nor has she exhibited co-operation on a regular basis with any of the statutory or voluntary agencies.

CHAPTER 4

4 HEALTH SERVICES

Background

4.1 As noted in section 3, AB is reported as being a regular drug abuser from her middle teens and has admitted at various times to using cannabis, crack cocaine, LSD and heroin. Coupled with this drug abuse has been a frequent and heavy intake of alcohol, mainly in the form of spirits, but at times including wine and high-strength beer.

4.2 The first mention of any psychiatric problems is recorded in her General Practice (GP) notes in June 1989 when she complained of feeling weepy and depressed. She also believed that people were "looking at her" when she walked down the street. A diagnosis of depression was made by her GP and an appropriate prescription for an anti-depressant given. There was a further GP consultation in September 1989 with a complaint of depression when a further low dose of anti-depressant was prescribed.

4.3 In September 1990, AB consulted her then GP requesting help with her housing application on medical grounds. She said that she felt depressed, but refused to see a psychiatrist when offered referral by her GP.

4.4 On 27 February 1991, AB again consulted her then GP and was reported to be weepy and depressed, expressing feelings of self-harm. Anti-depressants were again prescribed and she agreed to be referred to a psychiatrist. Her GP, Dr Parkar, wrote a letter to the Park Royal Centre for Mental Health (PRC) on 4 March 1991 with a provisional diagnosis of a depressive illness and requesting psychiatric advice. An appointment was offered but, before that took place, she was taken to the Accident & Emergency Department by her parents on 16 March 1991. After a preliminary assessment at the A&E department, she was referred to the PRC and was assessed by Dr Jeffries, the duty Psychiatric Registrar. Dr Jeffries undertook a full examination, took a full history and admitted her to hospital for observation and assessment. During the initial examination, AB had revealed the extent of her drug taking and alcohol consumption.

4.5 On the day after admission to hospital, she went absent without leave (AWOL) for several hours. On her return to the hospital, she exhibited bizarre behaviour. Over the next few days, AB made it clear that she felt "not herself", she became hostile and angry, and expressed a wish to leave. On 20 March 1991, s5(2) of the MHA 1983 was applied as a holding power, and later that day, she was fully assessed and detained under s2 of the MHA 1983. She appealed against this detention, and a Mental Health Review Tribunal was held on the 9 April 1991. The Tribunal decided not to discharge her from the section. When the twenty-eight day order expired, she agreed to stay in hospital as an informal patient. However, from that day onward, she was

frequently absent from the ward. The pattern of frequently being AWOL continued for the remainder of May. She was technically discharged from hospital on 4 June 1991, although she had been AWOL for several days by then. It is recorded that she was "not psychotic for several weeks – discharge". Before being discharged, she was referred to the Social Work Department at the hospital, and discussed her accommodation needs with them. This resulted in her being seen by Brent MIND and eventually offered accommodation in a group home, though this was not available on the day she was discharged.

4.6 A discharge summary was compiled by Dr R White, Staff Grade Psychiatrist on 11 June 1991. The discharge letter (case summary) contained the following information: "arrangements were made for her to go into a group home run by MIND. The diagnosis is most likely schizophrenia. She will be maintained on Depixol 40mg every month. Her disorganised and sometimes anti-social behaviour may also give rise to further problems with her accommodation." She failed to keep an appointment with Dr White approximately three months following discharge, but was seen by him on 30 October 1991, when he decided to refer her to the Day Hospital.

4.7 The Inquiry has not been able to confirm whether such a referral was actively made and/or whether she attended the Day Hospital at that time.

4.8 AB attended the PRC on 9 January 1992. She reported a recurrence of many of her symptoms adding that she was unhappy at the group home, having being burgled and stated that she was continuing to receive depot medication from her GP, though she had missed some doses. She denied taking any non-prescribed drugs. Dr White discussed the situation with AB's then GP, Dr Thompson, who confirmed that she had received some of the depot injections prescribed, had said she would attend regularly but had not, and would at times attend at the wrong time. She was then referred to the Community Psychiatric Nursing service with the depot injection prescribed to be given every two weeks from 28 January 1992. On the prescription sheet it is recorded "Patient refused treatment".

4.9 No further hospital medical notes were written between 9 January 1992 and 8 December 1992.

4.10 In April 1992, AB's GP wrote to a Community Psychiatric Nurse (CPN) at the PRC informing her that she had difficulty in giving depot medication to AB, and asking if she could be visited at home as soon as possible, and her injection given there. Several attempts were then made by the CPN to see AB but access was only first gained on 21 May 1992. Medication was given and AB agreed to stay at home next time the Depot was due. Further home visits were attempted on 11 and 12 June, and on 1 and 14 July 1992, but AB was absent. The CPN visited again on 16 July 1992, and was able to meet AB who informed her that she did not want the Depot medication. As a result of this conversation, the CPN decided to discharge AB and sent a letter to her GP and social worker confirming this.

4.11 AB was next reviewed on 8 December 1992 when she was seen by Dr White and Nola Slater (social worker). AB stated that she wanted to re-start medication as she was getting violent and into fights. She had ceased living with her husband but still saw him. It was decided to refer her to the Roundwood Day Hospital at Willesden Hospital.

4.12 The first note of any contact in 1993 is on 28 July when she was reviewed, having taken an overdose the previous week, and been admitted to a medical ward. She had taken an overdose as she had felt depressed about her situation. She said that all her belongings had been stolen, and the Housing Association had repossessed her flat. She had been charged with criminal damage and noise which had been caused by her associates, and was being charged legal fees. She was accompanied by a male friend who said that she was much better when she was receiving depot medication. Her friend agreed to ensure that she received her depot medication, but would prefer to take her to her GP's surgery for this.

4.13 She was next seen on 30 September 1993 and reported to be receiving depot medication two-weekly as prescribed. She claimed to have been taking heroin and cocaine every day for the previous two years. There are no further entries in her psychiatric notes for 1993.

4.14 On 31 October 1993, she was seen by Dr Mallett at Holloway Prison at the request of Dr Kharti, Prison Medical Officer. AB had said that she had been experiencing withdrawal symptoms which she attributed to being cut off from heroin, cocaine and alcohol since her admittance to prison. Dr Mallett found no evidence of any overt psychiatric disturbance, or of severe drug withdrawal symptoms. He gave advice about discontinuing some of her medication, and arranged to see her again when she was no longer in custody. There is no evidence that she kept that appointment. She attended the Accident and Emergency department at St. Mary's Hospital on 26.11.93. The reason for this attendance is unclear, but during the time there, AB presented as a drug user and assaulted a medical student in the department. No acute medical problem was found and she was discharged with an appointment to attend the psychiatrist three days later. There is no evidence that this appointment was kept.

4.15 In February 1994, solicitors wrote to Dr Mallett requesting a Psychiatric Report for presenting to the court. In April 1994, Gaynor Keightley, CPN, wrote to AB's GP seeking help in locating her. AB had left her last known accommodation with no forwarding address. She had moved four times in early 1994.

4.16 On 2 August 1994, AB was brought by her mother and uncle to the PRC. She had been living with her mother for the previous two weeks and her mental state had deteriorated significantly. She had taken an overdose of Procyclidene two weeks previously and had been talking about harming herself further. On the day before this admission, she had turned up at the PRC at 7:00am, asked to be admitted, had been refused, and punched the nurse who would not let her in. Following assessment on 2 August, she was

admitted to Napsbury Hospital where she was treated with medication and improved though she continued to inflict superficial cuts on her arm. She remained at Napsbury Hospital for ten days though she would frequently leave the ward without permission, occasionally returning smelling of alcohol. She was verbally abusive to staff and aggressive. After a further period of being absent without leave, she was discharged on 12 August 1994, and provided with a letter recommending re-housing. Her diagnosis on discharge was drug-induced psychosis with the added caveat "her disorganised life, anti-social behaviour and tendency to abuse drugs may give rise to further relapses". There are no further entries in her medical notes for 1994 although Dr Doig saw her on 23 December at Holloway Prison and produced a report stating that she was fit to plead in court. She was again seen by Dr Doig on 7 March 1995, as a result of which he stated that she was fit to attend court.

4.17 AB appeared before the Crown Court on 10 March 1995. The court decided that she should be remanded to the PRC for a report to be made on her mental condition. She had been charged with robbery, theft, assault and criminal damage. At hospital she complained of hallucinatory voices telling her to take an overdose.

4.18 Following assessment, she was found not to be suffering from a mental illness, and was returned to Holloway Prison.

4.19 AB frequently changed her GP during the period covered by the Inquiry. At times, this was at the request of the GP; at other times, it was due to her changing her accommodation. She registered with a new GP on 29 April 1996 following release from prison and was prescribed oral and depot medication.

4.20 On 25 June 1996, the Practice Manager on behalf of her then GP wrote to Dr Mallett requesting information about AB, and asking what medication she was receiving at that time. Dr Mallett was asked to confirm that she was under his care, and that her Lithium levels had been checked.

4.21 Dr Fletcher received a reply from Dr White, a month later saying that he had no recent information about AB.

4.22 On 17 August 1996, AB was seen at St. Mary's Hospital Out-of-Hours Service. As a result of that assessment, she was prescribed anti-psychotic medication and referred to the local Drug Dependency Unit. On 28 August 1996, the Out-of-Hours Service wrote to the sector Consultant Psychiatrist pointing out that AB had not co-operated with the treatment offered.

4.23 On 29 August 1996, AB attended the Central Assessment Team but failed to keep any subsequent appointments.

4.24 On 2 November 1996, AB registered with a new GP, having been removed from the list of her previous GP on 11 September 1996, due to threatening behaviour. She registered with a further GP on 12 March 1997.

4.25 Little has been recorded about AB during 1997. She did however, attend the Clinic run for homeless people and was seen there on three occasions towards the end of 1997 and, again, in February 1998. Dr Edmondson who saw her there reported that she had continued to self-harm, had a drink problem, and was experiencing violent outbursts when drunk. She was markedly depressed and wanting counselling. He wrote to the psychiatric department of the PRC requesting a formal psychiatric input.

4.26 AB was offered an appointment at the PRC on 12 December 1997, but she did not attend that appointment nor a further one offered on 22 December. Further appointments were offered, but none were kept.

PSYCHIATRIC HISTORY

4.27 General Practice records show that AB was a frequent attender at primary care surgeries from 1971. She experienced many of the illnesses and behavioural problems that are common to childhood. None of the GPs consulted during adolescence had recorded that she was a frequent illicit drug user, though one did record that she had been expelled from school at the age of fourteen, accused of starting a fire.

4.28 AB was first diagnosed as having a psychiatric problem in June 1989 when her then GP found her to be clinically depressed and prescribed an anti-depressant. A similar diagnosis was made in September 1989 and further anti-depressants were prescribed. There is no record as to whether she took this medication, and/or whether the prescriptions brought any improvement in her clinical state.

4.29 In September 1990, AB requested help for an application for housing on medical grounds. She again complained of depression, and her GP recommended a referral to a psychiatrist, which she refused.

4.30 In February 1991, she presented to Dr Parkar, her GP, complaining of depression and feelings of self-harm. She was prescribed further anti-depressants and agreed to a referral to a psychiatrist. Dr Parkar wrote a letter to the PRC stating that AB would like to be seen for further advice. As a result of that letter, an appointment was made for her to be seen but before that could take place, her parents took her to the Accident & Emergency department of the hospital on the 16 March 1991 due to her bizarre behaviour, particularly during the preceding week. Dr Jenkins, the duty psychiatric registrar, obtained a history from her parents that AB had been behaving oddly for several weeks, but that her behaviour had become more bizarre during the preceding week. AB was not sleeping and leaving the house at all hours of the night, she had had crying and had laughing fits, she was moving furniture and clothing around the house for no obvious reason, putting plates on top of the wardrobe, walking naked in front of her father, and not making sense when she spoke.

4.31 AB proved difficult to interview and was unable to give a satisfactory history of recent events, mostly answering questions by saying, “I don’t know”.

However, she did disclose that she smoked cannabis daily, had taken LSD and heroin in the past, and was drinking a bottle of spirits everyday. She was admitted to the psychiatric unit.

4.32 She remained an in-patient until 4 June 1991, although she was frequently absent from the ward, and on the day of discharge, she had been absent without leave for several days. The Discharge Summary written on 11 June 1991 states "the diagnosis is most likely schizophrenia, in view of the symptoms and the positive family history. The illness may have been brought on by drug abuse, but during her admission, she developed hallucinations without having previously taken drugs. She will be maintained on Depixol Depot by injection 40mg every month". Arrangements were made for her to go into a group home run by MIND. She attended the ward the day after discharge and agreed to receive a Depot medication on a monthly basis.

4.33 The next recorded contact with AB is in October 1991 when she attended the ward. Following discussion, it was decided to refer her to the local day hospital.

4.34 She again came to the ward in January 1992 when she appeared less well and was apparently experiencing psychotic symptoms. At this time, her depot medication was being given at her GP surgery, although AB was not fully compliant. It is unclear as to what contact she had with the psychiatric services during 1992. There is no entry from January 1992 until December 1992, when she again attended at CMH. During the interview she revealed that she had married a Moroccan man. AB complained of "getting violent" and "still hearing voices". She was referred to Roundwood Day Hospital and a Community Psychiatric Nurse was to administer further depot medication.

4.35 In July 1993, AB was admitted to hospital following an overdose of hypnotics and reviewed a few days later in the psychiatric department. Depot medication was again prescribed and arrangements made for her to continue to receive this at her GP surgery. There is a further note on 30 September 1993, when she is reported to be taking heroin and cocaine, and also a large intake of alcohol. The notes do not indicate whether there was any change to her treatment plan or medication.

4.36 Throughout 1994, her compliance with fortnightly depot injections was poor. On 2 August 1994, her mother took her to see her GP. AB said she was ready to go into hospital and was referred to the PRC. The notes of that visit recorded "…increasing levels of disturbed behaviour over the last two weeks. Past history of possible schizophrenia with drug abuse and disorganised lifestyle since last admission. Relatives can't cope with her. Risk of self-harm. Needs admission for assessment and treatment, but is happy to be admitted informally".

4.37 She was admitted to Napsbury Hospital on 2 August 1994 and remained there until 12 August 1994. On discharge from Napsbury Hospital the following was recorded, "in view of the symptoms, course and response to treatment, the most likely diagnosis is drug-induced psychosis, her disorganised life, anti-

social behaviour and tendency to abuse drugs may give rise to further relapses". She was prescribed oral anti-psychotic medication on discharge. It is not known whether she complied, and there is no record of a discharge plan or CPA meeting.

4.38 In 1995, AB was remanded to Holloway Prison and was seen there by Dr Mallett on 8 March in his role as visiting psychiatrist. As a result of that assessment, and with his previous knowledge of her, Dr Mallett concluded that "the most likely diagnosis is that of severe emotionally unstable Personality Disorder --- it is possible that she has an underlying psychotic illness and in view of this, I would recommend that she be admitted to the CMH [Central Middlesex Hospital] --- for assessment". No evidence of schizophrenia or of a psychotic disorder was found, and on 29 March 1995, she was returned to Holloway Prison. No other medical contacts are recorded for the remainder of 1995.

4.39 During 1996, AB's only medical contacts were with GPs. She registered with a new GP in April 1996 and again with a further new GP in March 1997. During this time she was intermittently receiving psychiatric medication including depot injections. In August 1996, she was seen at the Out-of-Hours Service at St Mary's Hospital, Paddington where she was found to have a recurrence of her psychiatric symptoms with auditory hallucinations and paranoid ideation. She claimed to have been taking crack cocaine for the past three to four years, and to have taken £200 worth of "crack" the previous day. She was prescribed anti-psychotic medication and referred to her local psychiatric team and also to the Drug Dependency Unit. On 29 August 1996, she attended the Central Assessment Team. Further appointments were offered, but she failed to keep any of these.

4.40 In October 1997, she attended the Homeless Persons' Clinic and was seen by Dr Edmondson. When seen, there was evidence of self-mutilation and she was referred again to the PRC psychiatric department. She failed to attend that appointment. She continued to be seen occasionally at the Homeless Persons' Clinic up until 18 February 1998. There were no symptoms of schizophrenia or psychosis noted, but she was clearly alcohol and drug dependent. The Inquiry has not seen any records of medical contacts since 18 February 1998.

Key Messages

Inter-agency working

4.41 There is evidence that during her first hospital admission, hospital-based social workers were involved in the initial assessment which resulted in AB being detained under s2 of the MHA 1983. An Approved Social Worker (ASW) is the applicant when a patient is detained under the MHA 1983. Social workers were also involved when, following detention under the Act, she appealed to the Mental Health Review Tribunal, and a social worker provided a written report for the Tribunal and appeared at the hearing. Social Workers were again involved when questions were raised about where AB should live on

discharge from hospital. The medical notes state that on discharge, arrangements were made for her to go into a group home run by MIND, but there is no information indicating how that decision was arrived at, and whether it was as a result of joint working of the medical team with social services or not.

4.42 Little appears to have resulted from the fact that at the end of April 1991, AB was arrested for shoplifting and criminal damage, though in May there is an entry in the notes stating that the court hearing was adjourned. There is no record of the hospital staff being in contact with the police or the court regarding this offence or action taken specifically as a result of any relevant advice contained in Home Office circular 66/90 on psychiatric services for mentally disordered offenders.

The Care Programme Approach

4.43 HC (90) 23 required Health Authorities to implement the Care Programme Approach. The timetable said that "by 1st April 1991, Health Authorities must have drawn up and implemented, in consultation and agreement with Social Services Authorities, local care programme policies to apply to all in-patients considered for discharge, and all new patients accepted by the specialist psychiatric services they manage from that date". It appears that the North West London Mental Health NHS Trust and its successors did not apply the Care Programme Approach (CPA) at any time to AB. The Inquiry has been informed that the Trust did fully adopt the CPA from some time in 1995. Though AB had many contacts with the psychiatric services from 1995, the CPA was never, it seems, fully applied to her. The CPA mentions some specific issues that all authorities need to address in determining their local arrangements. These are (1) Inter-professional working; (2) Involving patients and carers; (3) Keeping in touch with patients and ensuring agreed services are provided and (4) The role of key-workers. The medical notes do not identify a key-worker at any time. The CPA details the arrangements that should be made for keeping in touch with patients but also states "sometimes patients being treated in the community will decline to co-operate with the agreed care programmes, for example by missing out-patient appointments. An informal patient is free to discharge herself from patient status at any time, but often treatment may be missed due to the effects of the illness itself, and with limited understanding of the likely consequences". The CPA goes on to state "every reasonable effort should be made to maintain contact with the patient, and, where appropriate, her carers, to find out what is happening, to seek to sustain the therapeutic relationship and, if this is not possible, to try to ensure that the patient and carer knows how to make contact with her key-worker or the other professional staff involved". AB was discharged from care by a CPN on two occasions. At that time, there appears not to have been any policy laid down as to how to deal with patients who failed to attend appointments and interviews.

Risk Assessment

4.44 Formalised Risk Assessment is a recent development in mental health services though it has been practised to a greater or lesser degree for many years. A Risk Assessment of AB could have considered the following:

- From 1991, she had a diagnosis of schizophrenia;
- She was a regular drug and alcohol abuser, and had indeed been diagnosed as having a drug-induced psychosis as well as schizophrenia;
- She was prone to self-mutilation, had attempted suicide on more than one occasion and had a significant forensic history;
- When admitted to Napsbury Hospital, she was said to have been carrying a knife in her bag, had damaged property and talked about harming herself;
- She had attacked a nurse at the PRC when she was denied admission to the ward, having arrived early one morning without an appointment.

4.45 A proper assessment cannot be made in the absence of information about the patient's background, present state and social functioning, and also his or her past behaviour". (Paragraph 28a, "Building Bridges"). The teams responsible for AB's medical care from time to time were in possession of information about her past history, were able to observe her mental state, behaviour and symptoms, and had access to information from the family. At no time was she identified as being at high risk of violence to herself or others. Other factors that were available to be considered in risk assessment were her forensic history, inappropriate sexual behaviour and self-mutilation. In addition to and no doubt as a result of such risk assessments as were made, it was not felt that she was in need of any assertive care.

Access to Services

4.46 The information available to the Inquiry indicates that AB was able to access services whenever she felt in the need of those services. Problems usually arose due to her failure to avail herself of services when these were offered. Her failure to attend, whether at the PRC, the Day Hospital, GP surgeries, or at other locations, is often recorded. Her persistent failures to attend did not however appear to have resulted in significant effort being made to follow her up.

4.47 She attended her current GP surgery fairly regularly and was accepted on presentation at hospital. On only one occasion, she may have had difficulty in accessing services, this was when she presented at CMH and was refused admission.

4.48 The continuing pattern throughout the period covered by the Inquiry was not of AB not being able to access services, but of those services being offered and she not availing herself of them.

Mentally Disordered Offenders

4.49 Home Office Circulars 66/90 and 12/95 concerning mentally disordered offenders appearing before the courts advise that, in the case of offenders who are identified as having a mental disorder, treatment and care should take precedence over the criminal justice system, and that they should be diverted from the courts especially if they are in need of hospital care.

4.50 AB merited the description of "mentally disordered offender". It was recorded that she offended whilst an in-patient in 1991 and, in 1995, whilst on remand at Holloway Prison, she was seen by no less that three consultant psychiatrists, Drs Mallett, Browne and Doig. Dr Mallett, though recognising that she had a "severe emotionally unstable personality disorder", felt that it was possible that she had an underlying psychotic illness, and recommended that she be admitted to the PRC for a period of observation. After a two-week assessment, she was returned to prison with the diagnosis of Personality Disorder, and was said not to be suffering from a mental illness. This is the only time that AB appears to have been treated as a mentally disordered offender under the Home Office circulars and DoH guidance.

Comment

4.51 During the time she was in contact with the mental health services, AB received a variety of diagnoses. The first, of schizophrenia, seemed to persist as a diagnosis for most of the period covered by the Inquiry. As a result of that initial diagnosis, she was deemed to be in need of depot anti-psychotic medication, and this treatment was persisted with until at least 1997. There is little evidence that she received this regularly, mainly due to her lack of co-operation and compliance whether she was asked to attend at the hospital, at her GP's surgery, or whether the CPN tried to meet with her for its administration.

4.52 In 1990, the Department of Health issued a joint Health/Social Services circular outlining the Care Programme Approach (CPA) for people with a mental illness referred to the specialist psychiatric services. It required Health Authorities to implement the CPA for people with a mental illness whatever its cause, referred to the specialist psychiatric services. It was intended to commence in April 1991. The Trust did not implement the CPA until some four years later. Had it been implemented as required by the DoH, AB would have had a care programme developed which would have involved her, her family, and the various professionals involved in ensuring that the care plan was delivered. A key worker would have been identified who would have had the role of keeping in close touch with AB and ensuring that the services agreed as part of the care programme were provided. Though the Trust did implement the CPA at some time during 1995, AB never formally became subject to it.

4.53 Had the relevant services fully implemented the CPA as required by the DoH, it is possible that AB would have been subject to a more comprehensive and

coherent provision of care notwithstanding her consistent failure to comply with that in fact offered.

General Practice

4.54 AB was a frequent attender at GP surgeries and saw numerous doctors, but it has not been possible to identify them all. Although most entries had some form of signatures - usually a couple of initials – hardly any of these were legible. The first psychiatric diagnosis made was in June 1989. However, "AGP" recorded in 1986 that she had been expelled from school having allegedly started a fire. A diagnosis of depression was recorded in September 1989, September 1990 and in February 1991, which resulted in a referral being made to the psychiatric unit at the PRC.

4.55 After her discharge from Pond Ward at the PRC, her GPs attempted to ensure that she continued on the medication recommended on her discharge from hospital, mainly depot Depixol 40mg every month. This was sometimes administered by a CPN, and sometimes administered at GP surgeries.

4.56 Notes record that she was at times abusive at the surgery and at other times, she would attend without an appointment. When advised that she could not be seen unless she made an appointment, she would on occasion walk out without making one.

4.57 The admission to Napsbury Hospital in August 1994 does not appear to have had any effect on her GP's view of her condition, neither does the admission in March 1995 under s35 of the MHA 1983 when the conclusion was that there was no evidence of any psychotic disorder.

4.58 AB herself changed her GP on several occasions, and on at least one, she was removed from her then GP's list by the doctor. This was in September 1996. When asked about the reason for the removal, he said that though the exact reason was not recorded, the most likely reason was because AB had been exhibiting disturbed and aggressive behaviour at the surgery premises.

4.59 On one occasion, it was recorded that she was verbally violent at the surgery, shouting and demanding drugs and had raised her arm as if to attack the GP, but then walked out.

4.60 When released from prison in April 1996, she registered with another GP who recorded that as well as receiving depot anti-psychotic medication, she was also receiving an anti-depressant and a mood stabiliser, Lithium.

4.61 In January 1997 she again received depot medication. This is the last note of her receiving this.

4.62 In October 1997, AB attended the Homeless Persons Clinic and was seen by Dr Edmondson. At that time, she was also attending the Cricklewood Day Centre. Dr Edmondson found evidence of self-mutilation – AB had cut her forearms and set fire to her hair. He was aware of her alcohol and drug abuse,

and referred her to the psychiatric unit at the PRC. She received an appointment to attend there, but failed to do so.

4.63 She saw Dr Edmondson again in February 1998 but he found no evidence of a psychotic illness.

4.64 Most of the GPs that AB saw seem to have been content just to endeavour to ensure that she received prescribed medication as recommended after her first admission to the PRC. Most of them knew that she had marked problems with drugs and alcohol.

4.65 It is clear, however, that she was an irregular attender at surgery, frequently failing to keep appointments, but at other times, became angry if not granted an immediate consultation. It was also clear to the GPs that she often failed to comply with any medical treatment regime, although significant efforts were made to gain her compliance.

4.66 Although AB received depot medication, albeit intermittently, for almost six years, the report from Napsbury Hospital in 1994 and that from Dr Mallett at the PRC in 1995 did not substantiate the diagnosis of schizophrenia.

4.67 It has to be said that the records kept on AB in general practice are extremely brief, and, though no mental state assessments are recorded, this does not necessarily mean that none were carried out.

Prison Medical Service

4.68 AB spent significant periods of time in Holloway Prison. She was first assessed at Holloway in May 1994 when she had been remanded on a charge of possession of drugs. Prison medical staff recorded that she was known to suffer from schizophrenia, and had been taking heroin and benzodiazipenes. It was decided to restart her depot injections whilst she was an inmate.

4.69 She was again remanded for a brief period in October 1994 on a charge of theft, and again in December 1994 with a similar charge and a fourth time later in December 1994 when it was recorded that she was thought to have a psychotic illness. Treatment was instituted with an oral anti-psychotic. She suffered a spontaneous miscarriage in February 1995 when in Holloway Prison.

4.70 In March 1995, she was again admitted to the PRC, this time under s35 of the MHA 1983 for a report to be made to the court. After observation and assessment there, she returned to Holloway Prison within two weeks. She then spent the rest of 1995 and part of 1996 in Holloway Prison. It is unclear whether she had any significant treatment during this period, although she was referred to prison psychologists at one stage, as she had made allegations of childhood sexual abuse.

4.71 Few observations can be made about the medical care AB received in prison, as little was recorded. There is no record of her receiving any specific help

with her drug and alcohol problems, and though her allegation of abuse received some attention, there is no record as to whether there was any positive outcome from this. During her time at Holloway, she was seen by three Consultant Psychiatrists, two of whom appeared to limit their role to giving a view as to whether she was fit to plead and to appear in court. Both these psychiatrists functioned independently, and seemed to have little or no links with any agency in the community outside the prison or with any psychiatric service.

4.72 The Inquiry found no evidence that the medical information elicited in prison was formally communicated to any GP or to the community psychiatric services on release into the community.

Evidence of Psychiatrists

4.73 Dr White, who was involved in AB's treatment during the 1991 hospital admission, recalls that there was neither a Care Plan developed during that admission nor any discussion on her diagnosis. He was unable to recall any formal discharge plan, and stated that he had no knowledge of her criminal offences. Dr White was unaware of any system or policy concerning a patient who failed to attend for appointments or for treatment. His diagnosis was that of drug induced psychosis with personality problems. He did however admit that, during her in-patient stay in 1991, a drugs screen did not show the presence of any non-prescribed drugs. He stated that there was a day hospital on site and that some patients were referred to the Roundwood Day Hospital in Willesden but that notes from the PRC were not usually sent to the Day Hospital. The staff at the Day Hospital would inform a patient's GP if that patient had failed to attend.

4.74 Dr Mallett saw AB on several occasions in prison. When AB was seen in 1993, Dr Mallett was aware of her significant multi-drug abuse and high intake of alcohol which AB claimed had been the situation for some two years. He was also aware that she was receiving, intermittently at least, depot Depixol medication. He records that AB had said she was not going to give up drugs for anybody, and that they were her only friend. He also recorded that it had never been really clarified whether the diagnosis during that first admission in 1991 was one of schizophrenia, or of a drug-induced condition. In view of her chronic and severe poly-drug abuse over the ensuing years, he felt that it was impossible to say for certain. A mental state examination revealed no evidence of overt psychiatric disturbance, or severe drug withdrawal symptoms. Dr Mallett offered some advice as to AB's prescribed medication, and offered to send her an out-patient appointment when she was no longer in custody. He had no other recommendations to make to the court concerning her disposal.

4.75 Dr Mallett saw AB again at Holloway Prison on 8 March 1995. He had available her medical file from the PRC and information concerning her admission to Napsbury Hospital in August 1994. He noted that her upper limbs were covered with multiple scars, old and new, where she had mutilated herself, and her face was red because she had scoured it with a brush. She

appeared to be experiencing pseudo-hallucinations, elevated mood and pressure of talk. He felt the most likely diagnosis was that of "severe emotionally unstable personality disorder" which would have accounted for the symptoms that she was experiencing. However, he felt it was possible that she had an underlying psychotic illness and recommended admission to the PRC for observation and assessment, adding that, if at the end of this admission it was clear that she was not suffering from a psychotic illness, he would judge her to be fit to plead in court. When asked about follow-up arrangements, Dr Mallett responded that this often depended on a patient's vulnerability, and the nature of the mental disorder. If a patient was vulnerable, and had a major mental illness, then the follow-up would be more assertive in nature, although he also added that voluntary co-operation by the patient was extremely important. He said that, at the time that he saw AB, there was no formal risk assessment policy in place and that the CPA did not come about until 1995. When patients were discharged from hospital, Dr Mallett said there would be multi-disciplinary meetings, but social services and probation were not necessarily involved, and there were no formal communication systems between the Health Team and Probation Services.

4.76 AB was seen at Holloway Prison by Dr Browne and Dr Doig. Dr Browne had limited recollection of seeing AB although he was able to record that he found no evidence of any mental illness when he saw her. He felt that she was fit to appear in court and made no significant recommendations.

Recommendations

4.77 The Trust should ensure that the CPA is fully applied and complied with, and that each patient seen by the secondary services has a key-worker. No patient should be discharged from the secondary services without the benefit of a multi-disciplinary multi-agency discussion of their needs, and the development of an agreed Care Plan.

4.78 Patients who are unwilling or unable to comply with a care plan should be given special consideration and care. Patients who have, in addition to a mental disorder, problems with drugs or alcohol dependency should be able to access appropriate specialist services, and these should be provided as part of their care plan.

4.79 Risk assessment should be undertaken in respect of all patients seen by the secondary services. Ideally, this should be on a multi-disciplinary basis and reviewed as often as is appropriate.

4.80 Patients seen as unable or unwilling to attend appointments should be afforded greater flexibility and extra efforts should be provided to meet their needs.

4.81 Many patients with psychiatric disorders also have significant problems with drugs and alcohol. Appropriate specialist services should be accessible and provided locally.

4.82 The Trust should consider the development of assertive outreach teams to access those patients who are seriously ill or unwilling/unable to access the conventional services.

4.83 The prison medical services should maintain close links with the rest of the NHS. Appropriate protocols should be negotiated.

4.84 No inmate should leave prison who has healthcare needs without there having being a full assessment of their needs, and a care plan developed providing for those needs.

4.85 The therapeutic role of Consultant Psychiatrists visiting prisons for the purposes of assessment of prisoners for forensic purposes should be developed further.

4.86 Service Agreements should be developed for the role of Consultant Psychiatrists visiting prisons for the purposes of assessment of inmates in order to make reports to courts.

4.87 The Trust, Probation Service and court systems should recognise that mentally disordered offenders may have special needs and require diversion from the criminal justice system and that treatment should be a priority.

4.88 Information concerning any mental health assessment and treatment undertaken whilst an individual is a prison inmate should be communicated to that person's GP and Psychiatrist when that person is discharged from prison.

4.89 No patient should be discharged from care or support by any health worker without full prior consultation with that worker's line manger and/or appropriate senior colleague and under the CPA.

CHAPTER 5

5 SOCIAL SERVICES

Background

5.1 Social Services initial contact with AB was in 1989. This was in response to her then GP's concern about her mental state. She was showing signs of endogenous depression. Medication was prescribed at the time with no further request for Social Services department involvement.

5.2 Over the next two years, very infrequent contact was had between AB and the Social Services Department (SSD). In total, three episodes were recorded in the case file. During one of these episodes, there was a request for the SSD to provide, in writing, support to re-house AB. She had submitted a housing application as a result of being homeless. The report identified her need to find alternative accommodation as she had been staying with her aunt but this placement had been terminated.

5.3 AB's relationship with her mother at that stage was recorded as being fraught. Had AB not stayed with her aunt, she would have become homeless that much earlier. The SSD complied with AB's Housing request, and there was no further contact with the Department until 1991.

5.4 The period from March 1991 started to see greater involvement from the SSD in AB's life. The PRC sought a report to be presented to the Mental Health Review Tribunal. AB had been admitted to the PRC under section 2 of the MHA 1983. The request for a report was as a result of AB appealing against the section. It is well documented in the case file that all professional staff at the PRC were recommending that AB should not be discharged from hospital.

5.5 A key-worker was allocated to the case. The worker was based at the PRC but employed by the SSD. The then Mental Health Team comprised only Approved Social Workers, and was not a multi-disciplinary team. They worked alongside the medical staff/CPNs, but were operating as two separate teams. The Social Services Mental Health Hospital Team was line-managed separately from the medical team at the time.

5.6 The designated social worker attempted to engage AB, but found that she would only engage at a very superficial level, on her terms, and only when she felt there was a need – i.e. when it was in her interest to do so. Case records show that this was a consistent pattern that evolved over the years. AB often came to the SSD when she had decided that she needed some support, predominately in obtaining housing.

5.7 She frequently failed to keep appointments with the Social Worker; the start of a pattern that emerged throughout the Department's contact with her. Appointments for AB to see social workers were arranged either by telephone

or when AB was on the hospital ward. However, these appointments were usually not kept by AB, with no reason given.

5.8 AB did not respond to the conventional way of making appointments. At the time, it was noted that she was living a fairly destructive and chaotic lifestyle, was often under the influence of drink and/or non-prescribed drugs which affected her relationships, not only with her family and boyfriends, but also with the professionals.

5.9 AB had no permanent accommodation during most of the 1990s. She was often found living in bed and breakfast, with her mother, in rented accommodation, or with her boyfriend. It was often the case that AB's whereabouts were not known, and she was not contactable unless she made herself available. Her relationship with her mother was described as being a fairly volatile one. Her mother did provide some stability in terms of short-term accommodation in times of crisis. On one occasion, her mother requested support for her daughter, as she was concerned about her mental health.

5.10 AB's mother was known to the Social Services' Department Sensory Impairment Team. A key-worker was allocated to Mrs B in order to meet her assessed needs. A care package was arranged following this assessment with a note on AB's file that a social worker was involved with her mother.

5.11 From the case records, throughout this early period, the Department's role was at a fairly low level. The health input appeared to be of greater importance. Although AB attended the Cricklewood Day Centre, there was very little recorded on the social work file as to the success and/or appropriateness of this service. Contact with other agencies was limited. It was noted from the file that AB had developed a reasonably good relationship with one of the workers at the Cricklewood Day Centre.

5.12 Overall, Social Services role throughout this period remained very much dictated by AB's request for support to meet her housing needs. AB did not appear to see the Department's role in any other way.

5.13 Throughout this period, AB appeared to be unable and/or unwilling to keep appointments with the Department, unable to hold down any employment, and exhibited frequent mood swings. It was at this stage in AB's contact with the Department that she alleged that she had been abused as a child.

5.14 Case records show that the allocated social worker started to discuss with AB the allegations that she had made. However, during the course of this work, AB once again started to form a pattern of not keeping appointments with her key-worker. Her main concern again reverted to requesting the Department to support her housing applications.

5.15 The key-worker allocated continued to be based in the hospital, and was involved in ward rounds with her medical colleagues. From the records, there appears to have been no formal inter-agency discussions or conferences held

on AB. Case discussions were held informally, within the medical model, and took place on ward rounds. At this point there was no CPA operating and no formal care plan agreed.

5.16 The first time a voluntary sector organisation became involved in the case was following AB's housing application. This was Brent MIND. She had requested support from the SSD that led to her obtaining appropriate accommodation from this voluntary organisation. Staff from this organisation wished to discuss with AB her future housing needs. However, it soon became apparent that although she had been offered a place, she was falling behind with rent payments, and professionals were expressing concern about her ability to manage in the community without appropriate levels of support.

5.17 By this time, there had been a change in social worker, and AB remained on the new social worker's caseload up until January 1994 when the case was closed. There was no clear reason recorded on the file as to why this course of action was taken.

5.18 During her period as key-worker, the hospital social worker, in conjunction with the CPN, had attempted to work with AB on her drug/alcohol problems trying to establish a more stable lifestyle for her.

5.19 Despite attempts to engage AB via the traditional methods – home visits, appointments being offered by letter, unannounced visits to the home or to the last known address – she was not at that time willing to engage in any meaningful work. Reports concerning her chaotic lifestyle, bouts of anger and aggression, and drunken episodes were recorded. This led to the Network Housing Association, another voluntary organisation approached, expressing concerns to the Department as to AB's ability to maintain a reasonably independent but safe lifestyle whilst living in the community.

5.20 There was at this time only limited evidence of professionals communicating with one another and attempting to provide a seamless service. Agencies continued to offer services alongside each other but, from the case records, there appeared to be little contact between the agencies themselves.

5.21 Throughout the years leading up to 1994, the SSD attempted to engage AB in case work but with evidence of only limited formal care planning taking place. However, it should be noted that AB was unwilling to co-operate for the most part with her social worker even though attempts were made to engage her.

5.22 AB's chaotic lifestyle contributed to her inability to retain permanent accommodation. She appeared to view the Department as a means to an end, and felt that through them, she would be able to obtain appropriate housing. A Vulnerability Report was written by the social worker and contact with a voluntary housing association was made on her behalf. Supportive reports were written by the Department via the duty social workers. However, AB was unable to maintain any accommodation offered to her for any length of time due to her inability to pay the rent, control her chaotic lifestyle, keep appointments, and/or ensure that her behaviour was acceptable.

5.23 By January 1994, Social Services middle managers had decided to close the case. AB's needs and her then current situation appeared not to meet the recently introduced Eligibility Criteria, which were being operated at the time by the Department. Her case was not seen as of a high enough priority, in comparison with other competing demands on the service. Throughout this period, it was clear that AB's situation, according to the Department, did not warrant a consistent social work input.

5.24 Towards the end of 1996, the Probation Service had become involved due to AB's criminal convictions. Social Services were re-engaged by the Probation Service in order to complete a needs led assessment which was necessary in order to request appropriate housing. Two separate social workers completed the Vulnerability Report which was to be submitted to the Council's Housing Department for their attention. This report was submitted by AB. The intention of submitting this report was to assist AB in obtaining appropriate accommodation within the community.

5.25 At this time Social Services involvement was secondary to the involvement of the Probation Service and, to a lesser extent, the medical services.

5.26 In October 1996, AB's mother's social worker was expressing concern about AB, and her ability to live in the community unsupported. Mrs B's health was starting to deteriorate.

5.27 It is recorded that Mrs B's social worker felt that the Probation service was not offering AB sufficient support. A joint social services/probation meeting where AB's needs were discussed took place on 31st October 1996.

5.28 In November 1996, Social Services middle managers made a decision to again close the case.

5.29 By 1997, AB had re-contacted the SSD, again for the purpose of having her housing needs met. The duty social worker offered AB an appointment to discuss her current housing situation prior to making a referral to the Housing Department. A number of duty appointments were offered, but were never kept by AB. AB appeared to have no qualms about coming into the office when she felt that she needed support, but otherwise she did not keep appointments made or walked out of them if she did not wish to talk.

5.30 AB was not regarded as being a high-risk mental health case. When comparing this case against the eligibility criteria operated by Brent Council Social Services, and taking into account the demands made on the Department's limited resources by the more severely mentally ill individuals, AB's case was regarded as of low priority. AB failed to keep appointments and was not accepting support. Taking all these factors into account, middle managers again took the decision to close the case.

5.31 Middle management had decided that although the case was officially closed, AB would be offered support, as and when she made herself available via the

duty system. A reactive service from the Department was to continue, until the Department decided to close the case once again in November 1997. During this period, AB's contact with the Department was again very spasmodic.

5.32 The last contact recorded, is when AB contacted the SSD in February 1998. However, although an appointment had been made for AB to come to the office to discuss her housing needs, she failed to keep this.

5.33 The Department had no further contact with AB until middle managers were notified by the Probation Service that AB had been charged with manslaughter.

Care Programme Approach (CPA)

5.34 In 1990, there was national government guidance published stating that the CPA was to be implemented by all Health and Local Authorities from April 1991. From the records, Brent Council Social Services were not involved in implementing the CPA until 1995. It should be noted, however, that nationally the majority of local authorities did not fully implement the guidance until the mid 1990s.

5.35 There is no evidence at any time of any multi-agency formal conference being held relating to AB's case within the CPA. Although ward rounds did take place on a multi-agency basis, communication was not formalised. There were no available records which identified AB's needs, what care packages were necessary, what the outcomes were to be achieved were or what monitoring processes were to be used.

5.36 There was little explanation given, either by the witnesses or by the records, as to why there was such a delay in implementing the CPA.

5.37 There appeared to be no clarity as to whose responsibility it was to implement joint working under CPA nor any indication as to what time-frames they were working to. In fact, no social/key worker was allocated to AB after 1994 under CPA or otherwise.

Recommendations

5.38 Social Services should ensure that the CPA is fully implemented in respect of all cases that meet the Eligibility Criteria.

5.39 Social Services should ensure that each case has a clear Care Plan which reflects the assessed individual's risks and needs, and that the same is reviewed at appropriate intervals by means of multi-agency meetings.

5.40 Social Services should ensure clear lines of inter-disciplinary communication before, during and immediately after closure of any case.

5.41 Social Services should ensure that closure of a case which falls within the CPA should follow agreed policy and directives.

5.42 No agency should unilaterally terminate their contact with any client who is subject to the CPA without a multi-agency meeting having taken place, a joint agreement reached, and the decision fully recorded.

Access to Services

5.43 In line with the eligibility criteria that were being operated by Brent Social Services, witnesses including Ms Jones and her colleagues, stated that the only way that they were able to respond to the increased demand for their services, with limited resources, was to operate such criteria strictly.

5.44 Whilst the eligibility criteria appeared to be implemented quite strictly, AB was nevertheless seen on a duty basis when she presented herself.

5.45 According to records and witness evidence, AB's case, when being compared against the eligibility criteria, was not judged to be of a high priority. The case was regarded as one that did not demand or require a permanent social worker to be allocated to her after 1994.

5.46 AB's demands after 1994 could be met, according to the Social Services staff, on a duty base system. Although they had tried to engage her with a key-worker whilst in hospital, this was not entirely successful. This begs the question as to what happens to vulnerable individuals like AB, who obviously have a need but do not meet the criteria of warranting an allocated social worker.

5.47 A mental health needs-led assessment was completed by two different social workers in 1996 which assessed AB as being "very vulnerable" and stated that "unless she resumes her medication, she may develop severe mental health problems". It also reflected her vulnerability to men. However, social workers involved in AB's care did not always place her in the highest risk category as far as her mental health was concerned.

5.48 The pressure of high risk, high priority cases often created waiting lists for the allocation of a social worker. Those not complying with such criteria nevertheless still, in many cases, need a level of support in the community. This applied to AB, who remained vulnerable. She was offered support if she requested it, via the duty system.

5.49 The limitations on working with AB appear to have been due to limited staff resources, the need to focus work on the most vulnerable and her failure to engage. AB was placed in a lower priority group where there was little social work/therapeutic involvement. The Department's management decided that AB fell within this lower priority group, so no consistent service was offered to her and, latterly, no social worker assigned to her.

Recommendations

5.50 The Eligibility Criteria should be reviewed in line with available resources. There should be an acknowledgement that vulnerable adults may fall outside such criteria and that alternative responses should be offered to meet their needs.

5.51 An Assertive Outreach team should be established available to work with vulnerable people living in the community who are not deemed to be of high enough priority to qualify for an assigned social worker and who yet need support.

Inter-agency Communication

5.52 From the evidence, there appears to have been no multi-agency meetings held between the appropriate agencies i.e. Health, Social Services, Housing, Probation and other agencies that were dealing with AB from time to time. Had the CPA been implemented fully, this would have taken place. There appears to have been a very fragmented and *ad hoc* approach to communication by all agencies.

5.53 More particularly, in relation to the Probation Service's involvement, there was very little communication evident between this service and Social Services, at times when both agencies were involved. Respective officers appeared at times to have a lack of awareness of each others' involvement, the extent of such involvement and action plans being prepared by each.

5.54 From the records, there appears not to have been any great clarity as to the roles to be played by the Probation and Social Services Departments. Although probation officers were clearly responsible for meeting their statutory responsibilities when working with AB, there appeared to be no enthusiasm or desire to work over and above the minimum statutory requirements.

5.55 The understanding from Social Services appears to have been that, when probation officers had prime responsibility, their own role was of a secondary nature. Social Services officers assumed that probation officers would link in with them when they felt it appropriate. Although these assumptions were made, there was no evidence to suggest that these were checked out, that clarity was obtained as to what the two agencies were doing, what their expectations of each other were, and how they could best work together.

5.56 Communication between the health teams, Social Services and the voluntary organisations appears to have been fairly confused, and not particularly focused in terms of their roles, expectations of each other and as to what action plans were being prepared by each. The lack of a CPA for AB did not help.

5.57 There appears to have been no seamless service offered to AB by the key statutory agencies. Each agency appeared to be working very much along

parallel lines with each other, with no integrated service being offered. There were clear demarcations between each organisation, and although there may have been overlaps, this was not fully recognised by officers.

5.58 AB's case appears to have been closed without any communication or consultation with other relevant agencies involved in her care. It could be questioned in fact as to whether all the agencies actually knew of each other's involvement.

Recommendations

5.59 The formation of a joint health/social services mental health team under one line manager should be considered.

5.60 Social Services should ensure that all Care Plans are well documented and monitored.

5.61 There should be clarity of roles established between all agencies involved in a case. Each agency should have a clear understanding of their respective roles, how they work within a multi-agency team, what protocols exist and what arrangements prevail for termination of their involvement.

5.62 Social Services should ensure that individual clients and their carers have written information as to how to contact the key worker under CPA and what can be expected of each agency involved in the Care Plan.

5.63 Social Services should ensure that the CPA is fully applied and complied with and that each service user seen by the secondary service has a key worker. No service user should be discharged from the secondary services without the benefit of a multi-disciplinary, multi-agency discussion of their needs and the development of an agreed Care Plan.

Intra-agency Working

5.64 Brent SSD had a number of separate divisions. There appears to have been poor communication between these different divisions in this case. The social worker for AB's mother and AB's own social worker appear, from the records, to have had only minimal contact with one another, if that.

5.65 There appears to have been no appropriate sharing of information between the above two social workers in order to benefit their individual clients.

Recommendation

5.66 Social Services should have an agreed policy on what information can be shared between different divisional social workers working with different members of the same family and ensure that the database is cross-referenced to identify other divisional workers' involvement in such cases.

Working relationships with the voluntary sector

5.67 Brent MIND, Network Housing Association and Cricklewood Day Centre had all been involved in offering AB a service. The level of their involvement varied but there was very little evidence recorded on social work files as to the purpose, outcomes and contacts that AB had with them.

5.68 More particularly, there is no record on file with regard to the impact that Cricklewood Day Centre had on AB. There was no clarity on the file as to who referred her there, the purpose of this referral and the outcomes. Neither was the frequency of her involvement with the Day Centre clear.

5.69 As there was no consistent formal social work involvement after 1994, *ad hoc* involvement by Social Services seemed to have been the norm. How AB's needs and case were being managed and what work was being undertaken by voluntary organisations and the Day Centre after this date was sometimes difficult to ascertain.

Recommendations

5.70 Social Services should ensure through the use of the CPA that all agencies are aware of each others' contributions to Care Plans.

Housing/Social Service Interface

5.71 AB was constantly moving from bed and breakfast accommodation to her mother's, aunt's, and boyfriends' homes or being homeless. Obtaining supported housing from the Council or other agencies required the completion of Vulnerability Reports prepared by the SSD.

5.72 Some reports written by Social Services appeared to have been "hyped up" with regard to AB's situation. Witnesses stated that this was done in order to give her a higher priority in terms of the points system. These reports, according to the witnesses, did not necessarily reflect AB's true situation at the time.

5.73 On one occasion, the SSD completed and submitted a Vulnerability Report directly to the Housing department via AB. Social Services' staff relied on AB to produce this report when she went to the Homeless Unit. It is interesting to note that no copies were sent to Housing colleagues from Social Services. There was an assumption made by the SSD that AB would produce this report in the appropriate place in order to resolve her homeless problem.

5.74 AB's history suggests that when she needed appropriate housing, she would contact the SSD who would then submit a Vulnerability Report on her behalf. However, Social Services did not, on at least one occasion, feel it appropriate to contact the Homeless Unit to alert them to the fact that AB would be presenting herself with a report and requesting alternative accommodation.

5.75 There appears to have been no recognition of the fact that AB might not turn up at the Housing Department's Homeless Unit to present herself as being homeless.

Recommendations

5.76 Brent Social Services should ensure that when writing a Vulnerability Report, it is an accurate reflection of the situation. Inflation of individuals' problems should not occur.

5.77 When submitting a Vulnerability Report, Social Services should ascertain whether the individual had afterwards presented themselves to the Housing Department's Homeless Unit.

5.78 A copy of the Vulnerability Report should be sent directly to the Homeless Unit to alert it to pending requests for help.

5.79 Through joint planning and the development of the housing resource base, there should be greater clarity as to the accommodation needs of vulnerable adults living in the community.

Diagnosis of AB's medical condition

5.80 From the Social Services case files, the exact diagnosis of AB's medical condition is unclear.

5.81 A clearer and consistent statement of AB's mental health needs would have been helpful in order to accurately identify AB's needs and, in particular, whether these fell within the Eligibility Criteria as agreed by the Local Authority. Joint arrangements between the Health and Social Services for discharging people with mental health problems into the community appear to have lacked co-ordination.

5.82 The Eligibility Criteria operating at the time meant that when AB presented with problems relating primarily to substance misuse, the mental health teams were not engaged fully.

5.83 Multi-agency case conferences under the CPA should have been held. Such would have resulted in an individual care plan being prepared with a clearer statement of AB's mental health needs, an identified risk assessment level established more accurately and a care package agreed to keep AB supported in the community.

Funding for Drug/Alcohol Rehabilitation Services

5.84 From the social services files, there appeared to be a lack of clarity as to whether AB was mentally ill, misusing drugs and alcohol or both. She appeared to have got "lost within the system".

5.85 At one stage, there was discussion about funding arrangements for AB to attend a drug/alcohol rehabilitation unit. However, it was unclear from the records which agency was responsible for securing the placement, how it was to be funded and which agency was to take the lead in following the referral through.

5.86 From the records, it appears that there was little clarity as to exactly what the recommendations were with regard to this placement, whether this was an appropriate use of resources and whether AB would benefit from going into such a unit.

Recommendations

5.87 Care Plans prepared for clients needing to use the drug and alcohol rehabilitation services should clearly identify users' assessed needs and the availability of the services which will need to be accessed and such should be noted on an accessible database available to all relevant agencies.

5.88 Managers of all relevant agencies should be made aware of the rehabilitation services purchased by the Health Authority, their availability, eligibility criteria and how to access the same.

Reactive v. Proactive Outreach Services

5.89 It is evident from the case files that there was a service offered to AB from the Social Services Hospital Team, and also from the Community Health Team. In the initial stages, the hospital-based social worker was working very much within the medical model. This service, strictly speaking, only extended to inpatients and the only forum for inter-agency discussion was the ward round. It is fair to recall that at this time, the CPA, key-worker system, CMHTs and joint agency working had not been developed to the models now accepted. Nevertheless, there was at the time an expectation that agencies would generally communicate with each other.

5.90 The hospital social worker and the CPN did make attempts to contact AB once she was discharged from hospital, but there was little evidence to suggest that there was any pro-active communication between the two respective workers.

5.91 In this case, it might have been possible to adopt a more pro-active approach to keeping in touch with AB given the way that she had previously responded. Perhaps approaches using other agencies might have had some success though, again, it is fair to note that such inter-agency co-operation has improved greatly over the last decade.

5.92 At the time, no assertive outreach team had been established. Outreach, as it now exists, was not developed until much later. Such outreach as then existed for persons who had moved on to supported accommodation was provided by a joint Social Services and MIND team and had AB remained in her initial accommodation she may well have been referred to such team. AB's main

requirement of Social Services over the years was assistance in obtaining accommodation. Other needs were addressed by referrals to Roundwood Day Hospital where CPNs, psychologists and OTs were based and by referral to Jobsearch.

5.93 In attempting to contact AB, traditional approaches by letter and telephone were used. The hospital social worker also informed the Inquiry that she also endeavoured to contact AB by visiting squats where she might have been living, by keeping in touch with her mother, by visiting her first two addresses and by speaking to neighbours. There was no evidence, however, of any formal review having taken place to address the question of whether the methods that had been used to contact AB were, in all the circumstances, the most appropriate and effective and whether any other ways of seeking to engage her might have been possible. The hospital social worker, however, did inform the Inquiry that she had also discussed the case with her line manager and with Dr White.

5.94 Understanding the history of this particular young person, it is no surprise to the Inquiry that appointments were not kept by her. She was living a fairly nomadic lifestyle, with no fixed abode at times and reported bouts of heavy drinking and/or drug abuse. She was also at the time failing to keep appointments with other statutory organisations. She was not at the time in the category of persons who could be compelled to accept services from the department. It is accepted that she was offered support from the duty social workers when she requested it. Formal eligibility criteria for access to social services were introduced later.

5.95 From case records and witness statements, although AB received responses from Social Services when she appeared at the office, there appeared to be no outreach pro-active approach in this case. It was, in the main, very much a reactive service that was offered as and when AB presented herself to the office.

Recommendations

5.96 Senior or middle managers in the Social Service departments should actively monitor the number of failed appointments between services users and relevant agencies in order to evaluate whether the adopted approach is appropriate or should be altered. All decisions taken should be recorded on the case file, signed and dated by the respective worker and line manager.

5.97 All agencies should have a clear understanding with regard to implementing the eligibility criteria for accessing respective services, and for identifying measurable outcomes.

Strategic Planning

5.98 In view of the fact that the NHS & Community Care Act came into force in 1993, there appears to have been a significant delay by the two key agencies in implementing and operating the Act, and the Care Programme Approach.

5.99 The joint Community Care Strategy provided limited information as to how the respective services were going to identify needs and work together.

5.100 There was no proposal or discussion about pooling budgets, thus avoiding duplication of services and maximising resources in the most effective way. There was acknowledgement that resources were scarce, and demand outstripped supply. However, the Community Care Plan should have jointly identified assessed needs, the availability of limited resources, how these were to be targeted and what role each respective agency had in contributing to the whole.

5.101 The lack of joint working between Health and Social Services Mental Health Teams was quite apparent. Although they were both based on hospital premises, there was no formal system of communication identified except the ward rounds. There was no evidence of case-conferencing on a multi-agency basis where formal communication could take place to share information and plan the way forward.

5.102 There was a view clearly expressed by social services witnesses that the eligibility criteria were getting tighter due to increased demand on services with a reducing resource base. The eligibility criteria were apparently so tight that they excluded a significant number of people from gaining access to all the services, including vulnerable individuals such as AB who was effectively only offered a reactive duty worker service after the initial allocation.

5.103 As there were no key-workers allocated to AB whilst she was living in the community, the risk and needs led assessments were less focused. A number of individuals without previous knowledge of AB were involved in her case. The way in which AB presented herself to agencies could be misleading. The only constant figure in AB's case throughout Social Services' involvement was a middle manager.

Recommendations

5.104 Risk assessments should be jointly undertaken between the relevant key agencies with outcomes being formally recorded and shared between these agencies.

5.105 Sharing of this information should be assisted by a multi-agency conference under the CPA pulling together all agencies, identifying information including that of risk and appropriate needs and how the care packages should be delivered via the care plans.

5.106 Risk assessments should lead to the development of Risk Management.

5.107 A joint Community Mental Health Team should be established under one manager, bringing together Health and Social Services workers.

5.108 The team should operate under one Line Manager, with clear, shared eligibility criteria that are well documented and publicised.

5.109 Pooled budgets from Social Services and the Health Authority should be considered in order to provide a seamless service, avoid duplication and offer a service within the Best Value framework.

5.110 The eligibility criteria should be reviewed in line with available resources. There should be an acknowledgement that vulnerable adults may fall outside the service eligibility criteria and that alternative responses may need to be offered to meet their needs.

Housing Involvement

5.111 The main reason for AB's contacts with Social Services was her lack of ability to secure and maintain accommodation. AB required supported housing whilst living in the community. It is recognised that Brent Council is an inner city area where the demand for appropriate supported independent and semi-independent accommodation is very high.

5.112 Brent Council has the characteristics of an inner city area with accommodation at a premium. The completion of the Vulnerability Report was an attempt by social workers to assist AB in obtaining housing from the local council and/or the voluntary sector. Due to her personal circumstances, AB was unable to maintain and secure tenancies for any length of time.

5.113 Social Services witnesses in their evidence stated that vulnerability reports were often exaggerated in order to assist the individual in moving up the tariff scale, giving a higher points score. AB appeared to be relatively successful in obtaining accommodation.

5.114 Due to failure to fully implement the CPA, no multi-agency case conferences were held between the relevant agencies. The role that the independent housing associations could play in supporting AB in the community was perhaps underestimated. Joint close working relationships between Housing, Social Services and the voluntary sector appear not to have taken place as fully as they might.

5.115 Social Services duty workers did complete vulnerability reports and on one occasion, assumed that AB would present herself with a report to the Housing Department Homeless Unit. Bearing in mind AB's unreliability, it should be noted that the report was not faxed or phoned through direct, nor was a hard copy sent to the Homeless Unit. There was no guarantee that AB would present herself to this Homeless Unit.

Recommendations

5.116 All Vulnerability Reports submitted from Social Services to the Housing Department should be followed up formally. This can be done either by a formal letter, fax or e-mail with a hard copy also sent in all cases.

5.117 Brent Social Services should ensure that when writing a Vulnerability Report, it is an accurate reflection of the situation. Inflation of individuals' problems should not occur.

5.118 There should be joint strategies developed to increase housing stock for vulnerable service users living within the Brent geographical area. Such should attempt to co-ordinate all relevant housing needs with an existing/future resources database.

CHAPTER 6

6 FORENSIC SERVICES

Care Provided to AB by The Court System, Probation and Prison Services

Background

6.1 AB's forensic history began on the 2nd February 1988 when she was seventeen. Her earlier life is referred to elsewhere in this report but it appears to have been problematic, including substance abuse, truanting, and exclusion from school. Her first appearance before the courts was when she appeared before the Willesden Magistrates' Court charged with two counts of theft and was placed on probation for twelve months on each charge. Her subsequent forensic history is as follows:

02.88	Willesden Magistrates' Court – Theft x2	Probation Order – 1 year
06.88	Willesden Magistrates' Court – Breach of Probation Order	Order to continue
05.89	Marlborough Street Magistrates' Court – Theft	Fine
06.90	Watford Magistrates' Court – Travelling on the railway without paying fare	Fine
02.91	Brent Magistrates' Court – Assault occasioning actual bodily harm	Compensation Order
02.93	Court appearance (no details available)	
04.93	Hendon Magistrates' Court – Theft	Conditional Discharge (12 months)
07.93	Marylebone Magistrates' Court – Prostitute loitering	Fine
08.93	Marylebone Magistrates' Court – Prostitute loitering	Fine
05.94	Marylebone Magistrates' Court – Failing to surrender to bail Prostitute Loitering x2 Theft Possession of a controlled drug	 Probation Order - 2 years (subsequently varied) As above As above As above
12.94	Marylebone Magistrates' Court – Theft	Imprisonment – 1 day/Fine
03.95	AB at Holloway Prison. Details of sentence not known	N/K
06.95	Knightsbridge Crown Court – Theft Common assault on adult Robbery Theft Criminal damage	Imprisonment – 1 month Imprisonment – 2 months (consecutive) Imprisonment – 2 years (concurrent) Imprisonment – 1 month (concurrent) Imprisonment – 2 months (consecutive)
07.96	Marylebone Magistrates' Court – Prostitute Loitering	Fine
08.96	Marylebone Magistrates' Court – Prostitute Loitering Failing to surrender to bail	 Fine Fine
10.96	AB awaiting sentencing for common assault	
07.97	Marylebone Magistrates' Court – Assault on police	Compensation Order
11.97	Brent Magistrates' Court – Assault on constable x4	Compensation Orders
02.98	Brent Magistrates Court – Criminal damage	Probation Order - 2 years
10.98	Central Criminal Court – Manslaughter	Imprisonment – 3 years
09.99	Released on Licence – Conditional release	

6.2 The Inquiry benefited from the opportunity to interview David Cochrane, Peter Sutlieff and Gerry Lehane, Probation Officers involved from time to time in AB's care between the years 1993 and 1999. The Inquiry were also able to interview Ms Liz Hogarth who provided valuable information on the work of the Inner London Probation Service in Holloway Prison, and Ms Mary Wyman, Assistant Chief Probation Officer with the Inner London Probation Service. Certain other potential witnesses were considered, but were either unable to attend, could not be located, or were considered by the Inquiry not to be relevant to its Terms of Reference. See Appendix 5 for a list of witnesses. Documentary evidence was obtained by the Inquiry from the Probation, Prison and Court Services, and considered.

6.3 AB's forensic history has throughout been contributed to and complicated by the element of substance abuse and, in all probability, by elements of mental disorder. The question of mental disorder, its existence, likely diagnosis, nature, degree and the treatment and support offered in connection therewith are dealt with in more detail elsewhere in this report.

6.4 AB was involved with the court system, and with the Probation and Prison Services, throughout the period covered by the Inquiry's Terms of Reference. She has necessarily been involved, from time to time, with a great number of different people in many and various services, both voluntary and statutory, and with a proliferation of such agencies. The Inquiry has some concern as to whether full information was always conveyed by one service to the next, and by one individual to the next. However, it is probably fair to say that AB's chaotic and peripatetic lifestyle did not make continuity of care any easier particularly when combined with her reluctance and/or inability to keep appointments.

The Probation Services

6.5 AB's first involvement with the Probation Service of which the Inquiry has some detailed information, is that leading up the preparation of the pre-sentence report, and subsequent supplementary pre-sentence reports prepared by Mr Cochrane in late 1993. These are helpful reports which set the scene, although AB failed to attend the subsequent court hearing and the substantive charges were not dealt with until the late Spring of 1994. Shortly after this (the charges having resulted in a two-year Probation Order), the case was passed to another probation officer.

6.6 Whilst there is a fairly consistent element in AB's history of failure to attend interviews and appointments, this refers more to appointments made with the medical, social services and voluntary agencies and only to a lesser extent with the Probation Service, where her history of attendance is somewhat better. This may have some connection with the statutory responsibility placed upon those subject to probation orders to attend interviews. There is an example of this shown in late 1993 where AB attended three interviews with David Cochrane, but failed to attend any of the offered interviews with her Consultant Psychiatrist which had been arranged to enable a full pre-sentence report to be prepared.

6.7 Around this date, the report of the Clunis Inquiry was published, national standards were revised and pre-sentence reports tended to concentrate more after this date on Risk Assessment than had previously been the case. Mr Cochrane commented to the Inquiry that in 1993, there was an issue as to whether he should concentrate more on the substance misuse treatment or on the psychiatric treatment route. Another witness, Mr Sutlieff, commented that it might be said that the Probation Service concentrated too much in and around 1994 on the substance misuse and social issues, and might perhaps have addressed the psychiatric aspect in more depth.

6.8 Referral facilities for drug and substance abuse are more available today than was the case in the early 1990s. Nevertheless, the Inquiry accepted that Mr Cochrane did investigate to some extent the possibility of referring AB to facilities for treatment of substance abuse. It seems not unreasonable to the Inquiry that there was no specific recommendation for a Probation Order with a condition of residence at a drug rehabilitation centre at this time. It also seems to the Inquiry appropriate to have left the matter of a referral until after a Probation Order had been imposed by the court, if such had been the court's disposal. The Inquiry were also able to consider whether it would have been reasonable for there to have been a suggestion in the pre-sentence report for a Probation Order disposal with a condition of psychiatric treatment. However, as AB had failed to attend the consultant psychiatrist's offered appointments on more than one occasion, it is understandable why such a specific recommendation was not made, as no named psychiatrist had agreed to such a condition.

Comment

6.9 The Inquiry was not able to access documents relating specifically to the 1988 Probation Order. The first occasion on which the Probation Service provision was able to be looked at in some detail was at the time of Mr Cochrane's involvement in late 1993 for appearances by AB before the Marylebone Magistrates' Court in 1993/1994. Though, understandably not having any direct recollection of the circumstances of his involvement during this period, Mr Cochrane was nevertheless, able to assist the Inquiry to a considerable extent when informed by the documentary evidence. This involvement was pre-Clunis and the revision of national standards, and therefore the Pre-sentence reports dwelt to a lesser extent on Risk Assessment both to the subject and to the public than was often the case afterwards. Evidence of circumstances pertaining in 1993 give an indication of the difficulty that various agencies were having in locating AB and persuading her to attend interviews – though, as stated, she was rather better motivated to attend probation interviews than medical, social services and others. The Probation Service at that time certainly appeared to consider the appropriate ways of dealing not only with her criminal behaviour, but also with the complicating factors of her possible mental disorder and her substance abuse. Both these matters were considered and it no doubt presented a dilemma for the Probation Service at that time as to which of these complicating factors was the more important and how best they might be dealt with.

6.10 The Inquiry do not criticise the probation pre-sentence reports prepared at that time for not making specific recommendations for a Probation Order with either a condition to accept psychiatric support, or to attend a substance abuse facility. Both aspects might have been addressed after the imposition of a Probation Order, but due to AB's failure to attend the court, the Probation Order was not made until some time later. It is not entirely clear as to why, when the Probation Order was made, these avenues were not then further pursued.

6.11 Prior to the disposal of the charges against AB by the Marylebone Magistrates' Court on 31.05.94, a further pre-sentence report was prepared by Ms Joanne Gallagher. This report was limited by the fact that, again, enough time had not been available to investigate fully either the psychiatric or the substance abuse elements of the case. The fact that AB had been placed in custody for some three weeks already may have been a factor in the recommendation for Probation, rather than remanding her in custody for a period for further assessment. If the court had been so minded, it could have remanded AB further to give the Probation Service an opportunity of investigating in more depth the psychiatric/substance abuse elements. However, it seems to the Inquiry a reasonable recommendation for the Probation Service to have made at that time. As stated, the court decided to impose a straight two-year Probation Order.

6.12 Following this disposal, AB reported to her assigned probation officer on three occasions, but failed to report on a further five and proceedings for breach of the Probation Order were being considered when she was again summoned to appear before the court. Another pre-sentence report was prepared on 23.12.94, this time by Mr Peter Coghill. This report was considered by the court in conjunction with medical evidence from two Consultant Psychiatrists. The report suggested a three-month deferred sentence with a recommendation that if four stated objectives were successful in the meantime, a fresh Probation Order with appropriate conditions would be suitable. The objectives were not to re-offend; to keep in contact; to address her drug and alcohol problems and to investigate the possibility of residential rehabilitation. This recommendation also appeared to the Inquiry to have been eminently sensible, and to have addressed the appropriate concerns in the case at that time. In fact, the court decided, on 29.12.94, to impose a fine or one day's imprisonment.

6.13 AB's lifestyle was as chaotic during this period as at anytime, and she failed on numerous occasions to attend the probation appointments offered. There were sensible and constructive pre-sentence reports prepared by the Probation Service during this period but, beyond that, there was little meaningful contact. The Inquiry can find little to criticise in the care and support offered to AB during this period.

6.14 Efforts were made by the Inquiry to locate and interview the probation officer who took over AB's care on 13 June 1994, but unfortunately this officer has since become ill and was not able to be interviewed, nor to provide written

evidence to the Inquiry. In February 1995, AB's probation officer left the Willesden Office and was replaced by another.

6.15 A further pre-sentence Report was prepared by the Probation Service for the Knightsbridge Crown Court on 31.05.95. This was a factual and competent report, and recites that the Probation Service had contacted Phoenix House Rehabilitation Centre after the court's disposal on 29.12.94 with a view to AB possibly attending there. At that time however, there was apparently no vacancy for her. Funding was commented on as being a possible problem due to AB's lack of a permanent address. A suggestion was made that the hearing fixed for 31.05.95 be adjourned for a month to enable a full assessment of AB's suitability for residential treatment at this facility to be made and for the question of funding to be investigated. However, the court decided to impose a prison sentence.

6.16 Again, appropriate Pre-sentence reports were prepared and, at this time, the possibility of referral to a residential detoxification facility was considered. The Probation Service appeared prepared, given an adjournment of the case, to investigate the availability and suitability for such a placement, and to investigate the question of funding. This investigation was overtaken by the court's decision to impose a sentence of two years' imprisonment upon AB. As a matter of record, this also varied the previous Probation Orders imposed on 31.05.94. The involvement of the community Probation Service ended for the time being at this stage, and AB became the responsibility – in so far as there was a continuing Probation Service responsibility – of the Inner London Probation Service who dealt with prisoners serving a term of imprisonment at Holloway.

6.17 On 2.6.95, Knightsbridge Crown Court imposed terms of imprisonment on AB totalling two years. She was sent to HMP Holloway. The Inquiry had the benefit of interviewing Ms Liz Hogarth of the Inner London Probation Service, which is that arm of the Probation Service that operates at Holloway Prison. It was explained that the Probation Service in HMP Holloway, at that time, undertook a number of functions including Risk Assessment, addressing offending behaviour, sentence planning, group work, parole reports and links with the community. Community links were facilitated by probation officers in Holloway who would liaise with community probation officers, friends, family and community agencies. Ms Hogarth informed the Inquiry that one of the important functions of the prison Probation Service is to link both with the community Probation Service and Social Services when a prisoner's release is imminent, so that such concerns as welfare payments and housing may be addressed in good time. They saw part of their function as encouraging community probation officers to attend prison at the appropriate times, and to fulfil their responsibilities under National Standards.

6.18 The Inquiry was reminded that prisoners serving less than a year no longer have a community probation officer assigned after release and are not released on licence. Automatic Conditional Release prisoners are those serving between twelve months and four years, have a supervising probation officer and go out on licence. It was somewhat surprising to find that though the

prison Probation Service would identify the community probation officer who would be supervising the prisoner whilst on licence after release, they would not necessarily see it as part of their duty to arrange an interview, prior to release on licence, with the community Probation Service.

6.19 Under National Standards, the supervising probation officer from the community should interview the prospective licensee prior to release. This apparently does not always happen, perhaps because of financial restrictions or shortage of staff. It would seem to the Inquiry that such interviews should take place some months prior to release so that matters such as risk assessment, housing and welfare can be addressed by the community probation officer assigned, and/or by other agencies as appropriate. It was made clear to the Inquiry that the responsibility of the prison Probation Service ends immediately upon release of the prisoner on licence.

6.20 Defined responsibility for a prisoner's needs generally prior to release was obscure. There is an activity centre at Holloway where about fifteen outside agencies attend at the prison and offer various services. At some stage in 1996, NACRO became involved in assisting AB to find accommodation, and there appears to have been some liaison with the community Probation Service. It was made clear to the Inquiry that the responsibility of the prison Probation Service ends immediately upon release of the prisoner on licence. However, how all these agencies liaise with each other, with the prison services, and with personal officers at the Prison, was not at all clear to the Inquiry.

6.21 The impression gained by the Inquiry was that Prison regimes have altered and improved since 1996and that it is likely that less rehabilitation and services were provided for prisoners prior to 1996 than is now the case. It was also stated that in view of the large numbers of women passing through Holloway each year - some 6,000 per annum in recent years - the Prison probation service could not be involved with every one.

6.22 Sentence Planning really only became effective from about 1997. Such planning addresses the needs of the prisoner both whilst serving their sentence and upon release. Probation Officers, however, do not have to attend such Boards for prisoners serving less than four years. An initial Sentence Plan is drawn up to address targets for the prisoner during the period of their sentence. The community probation office receives a copy of the plan. The plan will also address what needs to be done on release, as well as during the sentence.

6.23 There is a pre-discharge report on file completed by the Prison Service and received by the Probation Service in March 1996, but this is substantially uncompleted. There is a universally accepted procedure for the prison probation service to pass their records, on release of a prisoner, to the assigned community probation officer. This officer described the concept of Through-Care as ideally a seamless process linking the prison based service, the offender, and the assigned community probation officer and affording links between work undertaken with the prisoner whilst in prison and that available on discharge. He did not however, feel that this ideal concept was working in

1996 when the arrangements were described as then being more "hit and miss".

Comment

6.24 The Inquiry could not find that there was anything specific to criticise in the functions performed by the prison Probation Service during AB's period of imprisonment in 1996, though there is little documentary or primary evidence available. The facilities offered to her during her most recent period of imprisonment and the support received on release are both strictly outwith the Terms of Reference of the inquiry. However, it appears that there has been reasonably regular contact by AB with her community Probation Officer whilst on licence from her last term of imprisonment, and with a counsellor from *Turning Point* (an independent voluntary organisation providing help for those with substance abuse problems). She has been referred to a Consultant Psychiatrist, and registered with a GP. It is hoped that she may be admitted to a rehabilitation facility for alcohol misuse. Temporary housing was arranged, and her future housing needs are being addressed. She has links with the local community mental health team. It seems therefore that *post* discharge in 1999, discharge arrangements have worked reasonably well, and there has been adequate liaison between the various agencies involved.

6.25 Following release from Holloway in April 1996 on licence, AB was assigned a community probation officer. The Inquiry is satisfied that this officer did all in her power to assist AB in her re-integration into the community, including several referrals in connection with housing requirements, welfare benefits, and substance abuse rehabilitation. The service appears to have done everything it could to assist AB at this vulnerable time. Unfortunately, however, AB again failed to co-operate to any significant extent, and this resulted in her being "breached" on her licence. She requested a transfer of assigned Probation Officer and this was arranged in the summer of 1996.

6.26 The "Breach" summons was eventually withdrawn as a result of the unavailability of a witness. A pre-sentence report dated 3.10.96 was prepared. This report stated that, in addition to there being a high risk of re-offending whilst she was under the influence of drugs and alcohol, she was "capable of behaving impulsively and irrationally, and consequently the public remain at risk from her behaviour". In a further pre-sentence report dated 2.1.97, it is stated that "there is also a growing history of violence and whilst there is no specific or identified victim given that such offences are likely to occur when she is at her lowest ebb, the risk of harm to the public is quite great". On 2.1.97, a Risk Assessment was prepared quoting a level of risk assessed at "two". Mr Sutlieff gave evidence to the Inquiry that in 1997, whilst he could not have necessarily anticipated homicide, his view at that time was that there was a risk of further physical violence to others through irresponsible conduct triggered by substance abuse.

6.27 Mr Sutlieff had the benefit of knowing AB from 1994 and of being her assigned probation officer between June 1996 and February 1997. The Risk Assessments undertaken by him appeared to have been adequate and

reasonable in all the circumstances. It seems that all avenues of support were followed up during this period, in so far as was possible, given AB's less than enthusiastic co-operation. A suggestion was made by Mr Sutlieff that perhaps there was a concentration around 1994 on the social and substance misuse issue, to the possible detriment of the mental health issues.

6.28 There appears to have been little involvement by the Probation Service between February 1997 and January 1998 when, following an alleged offence in December 1997, a new probation officer, Gerry Lehane, was requested to prepare a Pre-sentence report. This was prepared following two interviews with AB. This Pre-sentence report was accompanied by a Risk Assessment, again assessing risk at Level "two". The report stated, under the heading "risk to the public of re-offending", that she presented as having "a high risk of re-offending". It went on to state that "incidents of impulsive and irrational behaviour have been aggravated by alcohol abuse and the public remain at potential risk from her behaviour whenever she is under the influence of alcohol". This comment proved to be tragically prophetic only some three weeks later. The disposal recommendation was undeniably problematic in this case, given AB's history, lack of motivation to undergo substance detoxification, and comparative failures in the past to engage with Probation or other agencies. Given her lifestyle, the exclusion of a disposal by way of Community Service Order does not seem unreasonable. A financial penalty recommendation may appear surprising (this being the recommendation in the Pre-sentence report), but little else, apart from another Probation Order or imprisonment may have seemed to have been available. This latter disposal was addressed by the court and effectively discounted. It should be remembered that the index offence was criminal damage to a glass door panel, i.e. an offence not involving injuries to persons, and of a comparatively modest value. If the author of a Pre-sentence report feels uncertain about a disposal recommendation, they should discuss it with their Line Manager. Whether a previous poor track record with probation should in this case have justified a decision not to recommend another Probation Order, is open to argument but does not seem unreasonable. The court thought otherwise. In any event, a Pre-sentence report and its recommendations should be checked in all cases by a senior officer. It is not known if this was done in this case. In fact, the disposal on 16.2.98 was by way of another two-year Probation Order.

6.29 On 20.2.98, Mr Lehane wrote to his colleague at Acton requesting that officer to contact AB with a view to taking over responsibility for the new Order. This followed an interview on 18.2.98 when AB had reported to Mr Lehane (as she was required to do by law) and informed him that she would be living at an address in the Acton area. A transfer of the probation file was promised. Basic documentation was enclosed. The Acton office offered AB three appointments on 27.2.98, 3.3.98 and 5.3.98, none of which were kept. The last, of course, could not be kept because by then AB was again in custody.

6.30 AB did however attend upon Mr Lehane not only on 18.2.98, but also on 25.2.98. Unfortunately, no notes of these interviews were made, contrary to National Standards, although Mr Lehane is satisfied from perusal of his diary that the interviews did take place. A Supervision Plan is required by National

Standards to be prepared within ten days of a Probation Order being imposed. This sets out a programme of work with the subject of the order, and objectives for the ensuing year, and would include a Risk Assessment. It is reviewed after three months. Mr Lehane did not put the preparation of such a plan in hand as he felt that with the imminent transfer to Acton, it would be better prepared by the assigned officer there. A note to this effect should have been made and checked by a senior officer. A provisional Supervision Plan could have been prepared by Mr Lehane in these circumstances but was not. As the Order was *de facto* to start at Acton, he did not feel it appropriate to set up any sort of three-way formal handover involving himself, AB and the new Probation Officer at Acton.

6.31 It was unfortunate however, that no note was made of the two interviews which took place on 18 and 25 February, and it would have been prudent for there to have been prepared at least a Provisional Supervision Plan, with perhaps a provisional Risk Assessment, despite the imminent anticipated transfer. The Inquiry accept that the two interviews did take place, and has no reason to suppose that any indication was given at either of such interviews that there was any particular or imminent risk of the events that were to follow, although notes made would have clarified the situation. The Inquiry also think that it would have been appropriate for Mr Lehane to have set up a three-way transfer meeting between himself, AB and the receiving officer at Acton rather than simply dealing with the transfer by way of correspondence.

6.32 Sadly, before she had engaged with the Acton officer and before a Supervision Plan had been prepared, the homicide on 2.3.98 took place. No indication of any potential problems with AB's partner had been recorded in Probation notes, nor was recalled by Mr Lehane as having been raised by AB at either of their two meetings.

Recommendations

6.33 Concerns and recommendations contained in Probation Service pre-sentence reports should inform the conduct of a subsequent probation order, even if they are not formal conditions.

6.34 Continuity of probation officers preparing pre-sentence Reports and subsequently assigned supervising officers should be maintained, as far as circumstances allow.

6.35 There should be closer monitoring of any failures to attend interviews by those on probation or licence, and early action taken in respect of breaches.

6.36 There should be closer liaison between prison and community probation services, Social Services and Housing Departments in relation to clients' social and housing needs, before release from prison.

6.37 There should be closer liaison between the probation and medical services operating in prison and in the community in relation to a client's health requirements, prior to release from prison.

6.38 All prisoners serving sentences exceeding six months should have an assigned supervising probation officer whilst in prison.

6.39 The prison probation services should arrange for all prisoners serving sentences exceeding six months to have a meeting prior to release involving the assigned community probation officer, social services, and all other relevant agencies. A risk/vulnerability assessment should be undertaken. The prisoner's post-discharge housing, welfare and social needs should be addressed, and suitable arrangements made for their return to the community.

6.40 Protocols should be agreed clearly stating respective responsibilities and methods of liaison between all agencies involved in a prisoner's care whilst serving a sentence and upon release, and clear avenues of access to such agencies provided.

6.41 The assigned probation officer in prison should attend all Sentence Boards considering sentence plans for all prisoners serving sentences exceeding 6 months.

6.42 There should be a post-discharge care plan which should be committed to writing and conveyed to the prisoner and all other agencies concerned with the prisoner's care and welfare.

6.43 The prison probation service should make available to the assigned community probation officer, all prison probation records relating to a prisoner's release.

6.44 All pre-sentence reports and recommendations should be submitted to, and checked by, the author's line manager.

6.45 Probation officers should always make full and appropriate notes of interviews with clients and, in particular, make a comprehensive record of interviews immediately pre and post release from prison, and at the beginning of a new probation order or a period on licence.

6.46 Where for any valid reason, a full supervision plan and risk assessment cannot be prepared under National Standards within the prescribed ten days of a new probation order being imposed, a provisional supervision plan and risk assessment should be prepared, and a full note of the circumstances made. Such arrangements should also be made in cases where a new probation order is to be transferred from a previously assigned probation officer to another.

6.47 Where a transfer of a new or existing probation order is to be made, a three-way meeting should be arranged before the transfer involving the client, the transferor and the transferee probation officers. Such arrangements should not be left merely to an exchange of letters. At such meetings introductions should be made, a full briefing undertaken, a care summary written and records transferred.

6.48 An audit of assigned probation officers' records should be undertaken at appropriate intervals by the probation officer's line manager.

6.49 Risk assessments should be undertaken in respect of all prisoners, probation clients and patients in care of the forensic services on a multi-disciplinary basis and reviewed as often as is appropriate. Subject to legitimate concerns for confidentiality, all risk assessments undertaken should be made available to all relevant authorities and personnel involved in the care of patients, clients and prisoners, and should inform such care.

The Courts

6.50 AB's sundry court disposals do not seem inappropriate in all the circumstances. They did not always follow the recommendations of the Probation Service as contained in the various pre-sentence reports prepared but the Inquiry cannot see that the actual disposals were in contrary to the evidence and background available to the disposing court.

The Prison authorities

6.51 The systems of initial Sentence Planning and Through-care were in their infancy in the mid 1990s when AB first received a substantial prison sentence yet, even then, some effort was being made to bring these systems into effect. The manner of co-ordination of the various services available whilst AB was in prison and upon her release, are not entirely clear. The prison authorities have their part to play in what should be closer liaison between all agencies responsible for prisoners' welfare whilst they are serving a prison sentence.

Recommendations

6.52 The prison authorities should ensure liaison at all times between the prison medical services, relevant voluntary agencies, the probation services, other prison personnel such as personal officers, the community social services and all other relevant agencies involved in the welfare of prisoners before their release from prison.

CHAPTER 7

7 HOUSING

7.1 In 1989, Social Services became involved with AB when she made her initial contact requesting support for re-housing. Her prime reason for contacting Social Services was their ability to assist in finding her appropriate accommodation.

7.2 AB's contact with various Housing Associations stems as far back as 1992. From the limited records available, it is evident that AB was fully aware of how to make contact with the appropriate agencies in order to help her meet her housing needs. This area of her life is one of the key triggers in terms of her keeping appointments with professionals, especially Social Services and Housing Departments.

7.3 In 1992, Network Housing Association became involved with this case. This agency primarily deals with vulnerable tenants who live in independent tenancies in the community. Their referrals come mainly from the Homeless Unit of the Council's Housing Department.

7.4 The Association has a policy of keeping files for only seven years before being archived or destroyed. By 1999, the 1992 files had already been destroyed.

7.5 The officers at the time have no recollection of their contacts with AB. The limited records from SSD files indicate that some contact was made with Network Housing Association in January 1993 when the housing officer expressed concerns about AB's behaviour. Previous correspondence between the two agencies is vague.

7.6 Records show that AB had a tenancy with Network Housing Association from 6 April 1992 to 4 October 1993. At the time, the NHS & Community Care Act 1990 was being introduced with the organisation gearing itself up to working with vulnerable people in the community. The agency was attempting to make appropriate links with other agencies, such as Social Services and Health, where community support was required. This was a completely new way of working for all professionals and it was recognised that workers and managers were going through a steep learning curve at the time. This was not an unusual situation and was happening throughout the country.

7.7 At the time, neither Health nor Social Services was offering assertive outreach work in the local community, and thus many vulnerable individuals tended to be picked up by Network Housing Association or other similar agencies.

7.8 Agencies were not seen as working together in partnership eight years ago. This style of working had not been developed and therefore communication and sharing of information was not the norm. There were no clear boundaries of responsibility or clarity of roles established between agencies.

7.9 No further records were available from Network Housing Association until AB came to the attention of the Housing Department's Homeless Unit in January 1997.

7.10 AB lost her tenancy at this time as a result of her deteriorating health. This was probably contributed to by an increase in her substance misuse. As a result, she was often faced with homelessness, especially when she was no longer able to live with her mother.

7.11 AB was again offered appropriate supported accommodation by Network Housing Association. However, within a short period of time, concerns about AB's behaviour, non-payment of rent and her violent/aggressive outbursts were such that, following a meeting between housing representatives and Social Services, the tenancy was terminated. The Housing Association was considering taking legal action against AB, but this was not pursued.

7.12 AB often lived with her mother, who was herself unwell and unable to offer permanent accommodation to her daughter. It should be noted that AB often abused these facilities, creating additional stress and tension between the two of them.

7.13 By 1997, AB once again found herself in difficulties with regard to accommodation, and presented herself to the duty Social Services office. A Vulnerability Report was completed by two different duty social workers. AB was given this report with the expectation that she would take it to the Homeless Unit that same day.

7.14 This particular report has been referred to in the Social Services section. AB presented herself at the appropriate office with the completed report, and was re-assessed. She met the eligibility criteria and was offered Bed and Breakfast accommodation within her specified locality.

7.15 AB was moved from Bed and Breakfast accommodation to other hotels in response to a number of complaints made by hoteliers with regard to her behaviour including late night visitors and allegations of damage to property.

7.16 The case was transferred from the Homeless Unit to Brent Council's Resettlement Section. They offered her accommodation separate from Mr McCaffrey but when the Housing Department checked, AB had not taken up the offer and had instead remained with Mr McCaffrey.

7.17 During the next two months, two contacts were made with AB as a result of complaints received from hoteliers about inappropriate behaviour.

7.18 In November 1997, the Housing Department was informed that AB had separated from her partner Mr McCaffrey and was requiring separate accommodation. Mr McCaffrey was offered a Housing Association property in January 1998.

7.19 Mr McCaffrey's and AB's housing applications were treated separately following this.

7.20 Brent Council's Housing Department was informed in January 1998 that AB had left her then allocated accommodation. Her whereabouts were unknown and a decision was made to close the case. The Housing Officers assumed that she had found herself alternative accommodation.

7.21 Bearing in mind the volume of homeless individuals that pass through the Housing Department and the transient population of Brent, cases were often closed but could be re-opened within a six-month period should the need arise.

7.22 Contact with Social Services was activated if the Housing Department assessment officer and/or other individuals expressed concerns. The complaints about AB from hoteliers were regarded as fairly "run of the mill", and no different to many other cases that the Housing Department handled on a daily basis. There appear to have been no undue concerns expressed which would have triggered a call to Social Services. However, it should be noted that no communication is recorded between Social Services and the Housing Department when AB presented herself with the Vulnerability Report written by Social Workers.

7.23 According to Brent Council's Housing Department, AB had her housing needs met, and, given the eligibility criteria operated by Social Services at the time, it was not felt that referring AB to the duty service for further support would have resulted in an allocated worker.

7.24 It was generally recognised by housing colleagues that a referral to the Social Services' Dept. would only be made if the client had acute/severe mental health problems.

7.25 The Housing Department knew of the Probation Service's involvement, but there is no evidence that direct contact was made between the two agencies.

7.26 The last recorded contact the Housing Department had with AB was in November 1997. No contact was made by AB from that date onwards, and therefore a management decision to close the case was made in February 1998.

7.27 On 4 March 1998, the Housing Resource Centre was notified that Mr McCaffrey had died in the temporary accommodation in which he had been living since January 1998.

Issues

7.28 AB appeared to have been fairly successful in obtaining temporary accommodation when she presented herself as being homeless. By using the Social Services Vulnerability Reports that had been completed by the duty social workers, she was able to obtain accommodation.

7.29 AB appeared to have met the eligibility criteria as operated by the Homeless Unit in Brent.

7.30 From submitted records and witness statements there was no contact made by the duty social workers in 1997, either by telephone or fax to inform the Homeless Unit that the completed Vulnerability Report had been completed and given to AB to take with her to the unit. There was no evidence that any communication between the two agencies took place in connection with this report.

7.31 There appeared to have been no consistent Social Services' guidance as to the way Vulnerability Reports were to be completed and whether they were to reflect the true situation of the individual service user.

7.32 There was recognition that due to the volume of vulnerable homeless individuals that were coming into Brent Council's Homeless Unit in 1997, there would have been no follow up by Social Services as to whether AB had attended the Homeless Unit, whether had been re-housed nor as to the outcome generated by this particular request. There is evidence that telephone calls made by the Housing Department to Social Services were not returned.

7.33 There appeared to be a lack of clarity between expectations, roles and involvement of Social Services, Probation and Housing respectively as to housing provision. From the evidence collected from case files and witness evidence, it appears that relationships between the respective statutory agencies had significant room for improvement. Until implementation of the Care Programme Approach and multi-agency meetings, the agencies appeared to have worked to a greater extent in isolation from each other.

7.34 During the interviewing of witnesses, it became clear that there was some lack of understanding as to the way the Social Services Community Mental Health Team operated in terms of their eligibility criteria, how referrals were made and how agencies worked together.

7.35 Links between the Probation Service, Local Authority, voluntary agencies, CMHT and Housing Associations appear to have been weak.

Recommendations

7.36 Vulnerability Reports should clearly identify individual agencies' roles, involvement and contact numbers.

7.37 Clear communication and understanding should be established between the Social Services Department and the Homeless Unit of the Council's Housing Department as to how Vulnerability Reports are to be used.

7.38 Following the submission of Vulnerability Reports, the Homeless Unit should ensure that the Social Services are formally informed in writing as to the outcome of the initial referral made by them.

7.39 All communication and contact between agencies should be appropriately documented. Such should include dates of contact, messages left and by whom.

7.40 The housing department should seek wherever possible advice from the appropriate CMHT when placing vulnerable persons with mental health problems.

7.41 Clarity should be established as to the role of the Probation Service in housing cases by means of a multi-agency meeting to be achieved under the CPA and/or good practice.

CHAPTER 8

Since the Inquiry was commissioned, there have been a number of name, geographical and responsibility changes to the organisations mentioned in this report. The summary of recommendations should therefore be read in conjunction with Chapter 2 "Commissioners and Service Providers" which indicates where an organisation has changed.

8 SUMMARY OF RECOMMENDATIONS

CRIMINAL JUSTICE SYSTEM

8.1 Concerns and recommendations contained in Probation Service Pre-sentence reports prepared for the courts should inform the conduct of a subsequent probation order, even if they are not formal conditions.

8.2 Continuity of probation officers preparing Pre-sentence Reports and subsequently assigned supervising officers should be maintained, as far as circumstances allow.

8.3 There should be closer monitoring of any failures to attend interviews by those on probation or licence, and early action should be taken in respect of breaches.

8.4 There should be closer liaison between prison and community probation services, Social Services and Housing Departments in relation to clients' social and housing needs, before release from prison.

8.5 There should be closer liaison between the probation and medical services operating in prison and in the community in relation to a client's health requirements, prior to release from prison.

8.6 All prisoners serving sentences exceeding six months should have an assigned supervising probation officer whilst in prison.

8.7 The prison probation services should arrange for all prisoners serving sentences exceeding six months to have a meeting prior to release involving the assigned community probation officer, social services, and all other relevant agencies. A risk/vulnerability assessment should be undertaken. The prisoner's post-discharge housing, welfare and social needs should be addressed, and suitable arrangements made for their return to the community.

8.8 After such a meeting, a written post-discharge Care Plan should be prepared and forwarded to the assigned community probation officer and all other agencies to be involved in the care and welfare of the prisoner.

8.9 Protocols should be agreed clearly stating the respective responsibilities and methods of liaison between all agencies involved in a prisoner's care whilst serving a sentence and upon release and clear avenues of access to such

agencies provided. The assigned probation officer in prison should attend all Sentence Boards considering sentence plans for all prisoners serving sentences exceeding six months.

8.10 There should be a post-discharge care plan which should be committed to writing and conveyed to the prisoner and all other agencies concerned with the prisoner's care and welfare.

8.11 The prison probation service should make available to the assigned community probation officer, all prison probation records relating to a prisoner's release.

8.12 All pre-sentence reports and recommendations should be submitted to, and checked by the author's line manager.

8.13 Probation officers should always make full and appropriate notes of interviews with clients and, in particular, make a comprehensive record of interviews immediately pre and post release from prison, and at the beginning of a new probation order or a period on licence.

8.14 Where for any valid reason, a full supervision plan and risk assessment cannot be prepared under National Standards within the prescribed ten days of a new probation order being imposed, a provisional supervision plan and risk assessment should be prepared, and a full note of the circumstances made. Such arrangements should also be made in cases where a new probation order is to be transferred from a previously assigned probation officer to another.

8.15 Where a transfer of a new or existing probation order is to be made, where practicable a three-way meeting should be arranged before the transfer involving the client, the transferor and the transferee probation officers. Such arrangements should not be left merely to an exchange of letters. At such meetings introductions should be made, a full briefing undertaken, a care summary written and records transferred.

8.16 An audit of assigned probation officers' records should be undertaken at appropriate intervals by the probation officer's line manager.

8.17 The prison authorities should ensure liaison at all times between the prison medical services, relevant voluntary agencies, the prison probation service, other prison personnel such as personal officers, the community probation service, the community social services and all other relevant agencies involved in the welfare of prisoners before their release from prison.

8.18 Risk assessments should be undertaken in respect of all prisoners, probation clients and patients in care of the forensic services on a multi-disciplinary basis and reviewed as often as is appropriate. Subject to legitimate concerns for confidentiality, all risk assessments undertaken should be made available to all relevant authorities and personnel involved in the care of patients, clients and prisoners, and should inform such care.

MENTAL HEALTH SERVICES

8.19 The Trust should ensure that the CPA is fully applied and complied with, and that each patient seen by the secondary services has a key-worker. No patient should be discharged from the secondary services without the benefit of a multi-disciplinary multi-agency discussion of their needs, and the development of an agreed Care Plan.

8.20 Patients who are unwilling or unable to comply with a Care Plan should be given special consideration and care. Patients who have, in addition to a mental disorder, problems with drugs or alcohol dependency should be able to access appropriate specialist services, and such should be provided as part of their Care Plan.

8.21 Risk assessment should be undertaken in respect of all patients seen by the secondary services. Such should be on a multi-disciplinary basis and reviewed as often as is appropriate.

8.22 Patients seen as unable or unwilling to attend appointments should be afforded greater flexibility and extra efforts should be provided to meet their needs.

8.23 Many patients with psychiatric disorders also have significant problems with drugs and alcohol. Appropriate specialist services should be accessible and provided locally.

8.24 The Trust should consider the development of assertive outreach teams to access those patients who are seriously ill or unwilling/unable to access the conventional services.

8.25 The prison medical services should maintain close links with the rest of the NHS. Appropriate protocols should be negotiated.

8.26 No inmate should leave prison who has healthcare needs without there having being a full assessment of their needs, and a Care Plan developed providing for those needs.

8.27 The therapeutic role of Consultant Psychiatrists visiting prisons for the purposes of assessment of prisoners for forensic purposes should be developed further.

8.28 Service Agreements should be developed for the role of Consultant Psychiatrists visiting prisons for the purposes of assessment of inmates in order to make reports to courts.

8.29 The Trust, Probation Service and court systems should recognise that mentally disordered offenders may have special needs and require diversion from the criminal justice system and that treatment should be a priority.

8.30 Information concerning any assessment and treatment undertaken whilst an individual is a prison inmate should be communicated to that person's GP and Psychiatrist when that person is discharged from prison.

8.31 No patient should be discharged from care or support by any health worker without full prior consultation with that worker's line manger and/or appropriate senior colleague and under the CPA.

SOCIAL SERVICES

8.32 Social Services in conjunction with Health should ensure that that the CPA is fully implemented in respect of all cases that meet the Eligibility Criteria.

8.33 Social Services should ensure that each case has a clear Care Plan which reflects the assessed individual's risks and needs, and that the same is reviewed at appropriate intervals by means of multi-agency meetings.

8.34 Social Services should ensure clear lines of inter-disciplinary communication before, during and immediately after closure of any case.

8.35 Social Services should ensure that closure of a case which falls within the CPA should follow agreed policy and directives.

8.36 No agency should unilaterally terminate their contact with any client who is subject to the CPA without a multi-agency meeting having taken place, a joint agreement reached, and the decision fully recorded.

8.37 The Eligibility Criteria should be reviewed in line with available resources. There should be an acknowledgement that vulnerable adults may fall outside such criteria and that alternative responses should be offered to meet their needs.

8.38 An Assertive Outreach team should be established available to work with vulnerable people living in the community who are not deemed to be of high enough priority to qualify for an assigned social worker and who yet need support.

8.39 The formation of a joint health/social services mental health team under one line manager should be considered.

8.40 Social Services should ensure that all Care Plans are well documented and monitored.

8.41 There should be clarity of roles established between all agencies involved in a case. Each agency should have a clear understanding of their respective roles, how they work within a multi-agency team, what protocols exist and what arrangements prevail for termination of their involvement.

8.42 Social Services should ensure that individual clients and their carers have written information as to how to contact the key worker under CPA and what can be expected of each agency involved in the Care Plan.

8.43 Social Services should ensure that the CPA is fully applied and complied with and that each service user seen by the secondary service has a key worker. No service user should be discharged from the secondary services without the benefit of a multi-disciplinary, multi-agency discussion of their needs and the development of an agreed Care Plan.

8.44 Social Services should have an agreed policy on what information can be shared between different divisional social workers working with different members of the same family and ensure that the database is cross-referenced to identify other divisional workers' involvement in such cases.

8.45 Social Services should ensure through the use of the CPA that all agencies are aware of each others' contributions to Care Plans.

8.46 Brent Social Services should ensure that when writing a Vulnerability Report, it is an accurate reflection of the situation. Inflation of individuals' problems should not occur.

8.47 When submitting a Vulnerability Report, Social Services should ascertain whether the individual had afterwards presented themselves to the Housing Department's Homeless Unit.

8.48 A copy of the Vulnerability Report should be sent directly to the Homeless Unit to alert it to pending requests for help.

8.49 Through joint planning and the development of the housing resource base, there should be greater clarity as to the accommodation needs of vulnerable adults living in the community.

8.50 Care Plans prepared for clients needing to use the drug and alcohol rehabilitation services should clearly identify users' assessed needs and the availability of the services which will need to be accessed and such should be noted on an accessible database available to all relevant agencies.

8.51 Managers of all relevant agencies should be made aware of the rehabilitation services purchased by the Health Authority, their availability, eligibility criteria and how to access the same.

8.52 Senior or middle managers in the Social Service departments should actively monitor the number of failed appointments between services users and relevant agencies in order to evaluate whether the adopted approach is appropriate or should be altered. All decisions taken should be recorded on the case file, signed and dated by the respective worker and line manager.

8.53 All agencies should have a clear understanding with regard to implementing the eligibility criteria for accessing respective services, and for identifying measurable outcomes.

8.54 Risk assessments should be jointly undertaken between the relevant key agencies with outcomes being formally recorded and shared between these agencies.

8.55 Sharing of this information should be assisted by a multi-agency conference under the CPA pulling together all agencies, identifying information including that of risk and appropriate needs and how the care packages should be delivered via the care plans.

8.56 Risk assessments should lead to the development of Risk Management.

8.57 A joint Community Mental Health Team should be established under one manager, bringing together Health and Social Services workers.

8.58 The team should operate under one Line Manager, with clear, shared eligibility criteria that are well documented and publicised.

8.59 Pooled budgets from Social Services and the Health Authority should be considered in order to provide a seamless service, avoid duplication and offer a service within the Best Value framework.

8.60 The eligibility criteria should be reviewed in line with available resources. There should be an acknowledgement that vulnerable adults may fall outside the service eligibility criteria and that alternative responses may need to be offered to meet their needs.

8.61 All Vulnerability Reports submitted from Social Services to the Housing Department should be followed up formally. This can be done either by a formal letter, fax or e-mail with a hard copy also sent in all cases.

8.62 Brent Social Services should ensure that when writing a Vulnerability Report, it is an accurate reflection of the situation. Inflation of individuals' problems should not occur.

8.63 There should be joint strategies developed to increase housing stock for vulnerable service users living within the Brent geographical area. Such should attempt to co-ordinate all relevant housing needs with an existing/future resources database.

HOUSING

8.64 Vulnerability Reports should clearly identify individual agencies' roles, involvement and contact numbers.

8.65 Clear communication and understanding should be established between the Social Services Department and the Homeless Unit of the Council's Housing Department as to how Vulnerability Reports are to be used.

8.66 Following the submission of Vulnerability Reports, the Homeless Unit should ensure that the Social Services are formally informed in writing as to the outcome of the initial referral made by them.

8.67 All communication and contact between agencies should be appropriately documented. Such should include dates of contact, messages left and by whom.

8.68 The housing department should seek wherever possible advice from the appropriate CMHT when placing vulnerable persons with mental health problems.

8.69 Clarity should be established as to the role of the Probation Service in housing cases by means of a multi-agency meeting to be achieved under the CPA and/or good practice.

CHAPTER 9

9 CONCLUSIONS

9.1 AB is a woman who exhibited numerous problems including mental disorder, drug and alcohol abuse, prostitution, imprisonment, coupled with periods of unemployment and accommodation difficulties.

9.2 All agencies who had direct contact with her found it difficult to maintain and sustain their involvement with her. This resulted in a number of agencies offering services and care in a reactive manner.

9.3 AB's contact with health services was numerous including three admissions to hospital, formal and informal. Evidence shows that she frequently failed to comply with recommended medical treatment and failed to keep outpatient appointments on many occasions.

9.4 Medical diagnoses varied throughout her contact with health services. She continued to receive treatment for the original diagnosis for some time, even after a new diagnosis was applied in 1995.

9.5 She was not afforded the full CPA programme which should have provided the necessary support at varying times by appropriate agencies.

9.6 Insufficient focus was given to her drug and alcohol problems.

9.7 The view taken by Social Services workers in the community was that due to her presentation and difficulty in engaging, this did not make her eligible to be allocated a key worker on a consistent basis.

9.8 At times, there were several agencies aware of her problems and needs but there was an absence of inter-agency communication and responses.

9.9 Reports produced and submitted to any agency should accurately reflect the true nature of the situation.

9.10 In dealing with AB, the Probation Service failed in certain areas to comply with National Standards which could have had a bearing on the type of service offered to her.

9.11 The Prison Service acted as a stand-alone institution with little or no liaison with other appropriate agencies throughout the period covered by the Inquiry.

9.12 The Housing agencies involved with AB during this period delivered appropriate type and level of service – even though she proved to be a challenging tenant.

9.13 From the evidence presented, the quality of the Risk Assessment undertaken by agencies was not of the expected standard.

9.14 The homicide did not appear to have resulted from a premeditated intention. The view of the Inquiry team is that it could not have reasonably been foreseen by any agency.

9.15 The Inquiry team's intention is for all the agencies involved to consider the recommendations made as an aid to furthering joint working and in offering improved services to people like AB.

APPENDIX 1

AB's CHRONOLOGY

02.02.88	Willesden Magistrates' Court – Theft x2 Probation Order (12 months)
07.06.88	Willesden Magistrates' Court – Breach of Probation Order Order to continue
26.05.89	Marlborough Street Magistrates' Court – Theft Fine
26.06.89	AB diagnosed as suffering from endogenous depression and prescribed an anti-depressant by GP
13.09.89	AB depressed, attended GP, Dr Thompson. Charmayne Harty (CH) social worker informed.
15.06.90	Watford Magistrates' Court - Travelling on railway without paying fare Fine
20.09.90	AB contacted Social Services Department requesting support for housing on medical grounds. AB living with aunt who refused to have her any longer. AB refused to see a psychiatrist.
05.02.91	Brent Magistrates' Court - Assault, A.B.H. Compensation Order
22.02.91	AB weeping and depressed - threatened to harm herself.
04.03.91	AB referred to PRC by her then GP Dr Parkar with a three-year history of episodes of depression anxiety and feelings of violence. Treatment started with Lofepramine, an anti-depressant by her GP.
16.03.91	AB seen at the PRC by Dr Jeffries having been brought to the A&E Department by her parents who had been concerned about her, particularly with the change in her behaviour over the previous month. Admitted to the psychiatric wing.
20.03.91	Held under s5(2) of MHA 1983. Re-graded to s2 later the same day.
25.03.91	Social work report requested by Mental Health Review Tribunal for Hearing. CH contacted AB who was aggressive and angry towards her. AB explained circumstances of her voluntary admission. CH obtained background history from AB who alleged abuse as a young person.
26.03.91	CH discussed case with another social work colleague with regard to events leading to AB's detention.
27.03.91	CH made contact with AB's mother Mrs B and informed her of Tribunal on 28.3.91.

	Mrs B provided background information as to events leading to AB's hospital admission and AB's angry outburst at the DHSS office. Mrs. B in poor health.
27.03.91	Medical report for Mental Health Review Tribunal prepared by Dr Duckworth.
28.03.91	Mental Health Review Tribunal postponed to 9.4.91 due to unavailability of Dr Duckworth.
01.04.91	Care Programme Approach to be introduced nationally.
08.04.91	CH recorded outcome of interview relating to alleged abuse. AB's solicitor to represent her at the Tribunal on 9.4.91.
09.04.91	CH discussed AB's case with Dr Stonehill. Consideration is given to AB being placed under Section 3 Mental Health Act 1983. Mental Health Review Tribunal Hearing: AB to remain in hospital until section expires. CH informed AB that she is leaving Department. CH concluded AB needs an allocated worker to pursue issues relating to abuse, finding alternative accommodation and long term support due to her mental health.
09.04.91	Case allocated to Nola Slater (NS), Social Worker. AB eager to see NS. (AB due to appear in Court for assault and theft.) AB facing homelessness and needing the Department's support.
18.04.91	Drug screen negative.
01.05.91	AB failed to keep appointment with NS.
07.05.91	NS discussed AB's case at the Ward Round. Court case adjourned for 2 weeks.
09.05.91	AB keen to see NS. Meeting arranged that afternoon. On arrival AB not keen to discuss issues with NS and left soon after.
13.05.91	AB did not keep appointment with NS but seen later and informed of appointment with Brent MIND on 16.5.91.
16.05.91	AB interviewed by Brent MIND about accommodation.
17.05.91	NS contacted Brent MIND for further appointment with AB on 21.5.91. NS informed AB about appointment with Brent MIND.
20.05.91	AB absent without leave from hospital for several days.
21.05.91	NS, AB and Brent MIND worker met. Accommodation offered to AB with AB to meet residents of the Hostel on 28.5.91.
28.05.91	AB failed to keep appointment. Further appointment offered by Brent MIND a week later. AB leaves hospital and fails to return on time.
04.06.91	AB discharged from hospital. - had been absent without leave for one week.
05.06.91	NS tried to contact Brent MIND. AB saw NS. Further appointment made with Brent MIND. AB living with her mother on temporary basis.
11.06.91	AB interview with Brent MIND went well with AB moving to own accommodation on

	the 24th June 1991.
11.06.91	Discharge summary written by Dr White.
26.06.91	NS left message for AB to contact her.
04.07.91	NS visit to AB abortive.
06.07.91	Meeting between AB and Brent MIND did not go well - NS requested to attend in order to resolve issues. NS tried to contact Brent MIND three times - left messages.
14.07.91	NS contacted AB. AB feels she is settling well into new accommodation. NS contacted Brent MIND who view situation differently - AB failed to go to residents' meetings and not paying rent. Further meeting arranged between AB and Brent MIND.
29.07.91	AB failed to keep appointment with NS.
06.09.91	NS wrote to AB. New appointment made by NS with AB for 18 September 1991.
30.10.91	AB's case reviewed at PRC – referred to day hospital.
02.12.91	Letter from NS to AB informing her of her availability during Christmas/New Year period.
06.01.92	NS received telephone call from Acting Area Manager of Network Housing Association Limited wishing to discuss AB's aggressive behaviour towards support staff. Association considering taking out injunction against AB on grounds of alleged violence towards other residents and legal action to evict her. Willesden Police contacted Judith Jones (JJ) Social Services Directorate in late evening. AB assessed under Mental Health Act 1983 but found not to be detainable. AB refused voluntary admission to hospital.
09.01.92	AB attended PRC – said to be receiving depot injections from General Practitioner but not a regular attender.
28.01.92	AB referred to Community Psychiatric Nurse (CPN) by Dr White.
06.04.92	Tenancy offered by Network Housing Association to AB. This tenancy lasted up to 4th October 1993.
07.04.92	Dr Thompson (GP) wrote to CPNs asking them to see AB on a regular basis for the administration of depot medication.
23.04.92	Network Housing Association made a written referral to Brent Social Services expressing concern about AB's vulnerability as AB living alone and made suicidal threats.
23.04.92	Letter from Team Leader, Network Housing Association Limited to NS expressed concern about AB feeling suicidal.

23.04.92	Letter from Dr Thompson stated that AB had not received depot medication.
07.05.92	NS wrote letter to AB offering appointment on 13.5.92 following abortive visit with Dr. White.
13.05.92	NS visited AB at home. AB given CPN Stephanie Yamaguchi's (SY) telephone number. NS to contact SY requesting home visit.
14.05.92	CPN failed to gain access to AB.
18.05.92	AB failed to keep appointment with NS. New appointment made.
18.05.92	JJ completed Assessment of Vulnerability report for Brent Housing Department.
19.05.92	CPN failed to gain access to AB.
21.05.92	Depixol 40mg (medication) given by CPN.
10.06.92	NS telephoned SY who agreed to visit AB the following week. NS sent letter to AB about appointment with her.
11.06.92	CPN failed to gain access to AB.
12.06.92	CPN failed to gain access to AB.
16.06.92	AB failed to keep appointment with NS.
01.07.92	CPN failed to gain access to AB.
14.07.92	CPN failed to gain access to AB.
22.06.92	Further appointment offered to AB by NS. AB telephoned saying she was unable to keep appointment. CPN visited but AB did not hear her knocking. NS contacted SY and left message for her.
24.06.92	AB contacted NS about visiting GP for medication from CPN.
16.07.92	AB refused to accept medication.
05.08.92	Letter from SY to Dr. Thompson. AB noted to be married to Moroccan. SY decided to close case. Copy of letter sent to NS.
26.08.92	NS wrote to AB offering appointment on 3.9.92.
05.10.92	NS wrote to AB who failed to keep appointment on 3.9.92. Further appointment offered on 9.10.92.
06.11.92	NS received telephone call from Mrs. B who was concerned about AB's mental state. AB allegedly in physical fight resulting in broken nose, not taking prescribed medication and running up bills. Appointment made by NS with AB and Mrs. B for 17.11.92.
17.11.92	NS received telephone call from Mrs. B. AB had left last night. NS visited AB at home - abortive visit. NS had telephone conversation with AB. AB failed to keep GP appointment but stated she would attend tomorrow. New appointment made for 19.11.92 with NS.
19.11.92	Telephone call from AB to NS. AB stated unable to attend appointment. New

	appointment made for 10.12.92. NS discussed case with Dr. White. AB offered outpatient appointment with Dr. White and NS.
08.12.92	AB seen by NS and requested medication as she was hearing voices. Dr. White and NS saw AB that day. Medication prescribed and fortnightly visits to Dr. White and NS arranged.
08.12.92	AB attended Community Mental Health centre by appointment but early – referred to the CPN and Roundwood Day Hospital.
21.12.92	NS received telephone call from Network Housing Association Officer about neighbours' complaining about AB and her friends' behaviour. NS visited AB - abortive.
30.12.92	Correspondence between Dr. Patel and Dr. White regarding AB's potential attendance at Roundwood Day Hospital.
04.01.93	AB contacted NS requesting re-housing. Further appointment made with NS for 7.1.93 at Mrs. B's home. AB arrested and taken to Willesden Green Police Station for alleged attempt to set fire to a notice board. Seen by police doctor and Psychiatrist.
07.01.93	NS visited Mrs. B. who had taken out an injunction against AB in October due to her behaviour. Mrs. B agreed that AB could stay with her occasionally. NS visit to AB abortive. Network Housing Association took out injunction against AB preventing her from visiting their offices and accessing her rented flat.
08.01.93	NS contacted Mr B and requested that AB contact her urgently.
12.01.93	AB saw NS and Dr. White. AB's lifestyle said to be chaotic – reported to be taking drugs, not taking prescribed medication and homeless. AB offered bed and breakfast for two days whilst appointments arranged for AB to see Network Housing Association officers.
14.01.93	Meeting between AB, NS and two senior officers from Network Housing Association. Discussion about AB's alleged unsociable behaviour towards other tenants. Injunction served on AB by the Association. Request made to Brent Housing Department for AB to be allocated emergency accommodation. AB met Eligibility Criteria. Supportive letter faxed to Brent Housing Department.
15.01.93	NS received telephone call from Network Housing Association that AB will be evicted from premises under a Court Order. AB failed to contact staff at Brent Housing Department.
18.01.93	AB contacted NS saying she had no money. NS referred her to DHSS. Appointment made for AB to see NS that afternoon. AB failed to attend meeting.
05.02.93	NS received call from Mrs. B. AB arrested in Cricklewood and taken to Police Station. Court appearance that day. NS contacted Network Housing Association.

09.02.93	NS received copy of letter from Dr. White's secretary stating that AB failed to keep appointment with Dr. White. New appointment made for 24.2.93. No record of appointment kept.
13.02.93	Mrs. B. contacted NS concerned that AB had not been seen for 3 weeks. AB collected benefit from Benefits Office.
17.02.93	NS wrote to AB when she failed to keep appointment on 9.2.93. Further appointment offered by NS for 26.2.93.
26.02.93	AB failed to keep appointment with NS.
03.03.93	NS received copy of letter from Dr. Patel's secretary to Dr. White, discharging AB from their caseload as AB had failed to keep appointment.
05.03.93	AB failed to keep appointment with NS.
06.03.93	Mrs. B. contacted NS about AB's latest address. NS asked AB to contact her as support from NS cannot be offered without AB's co-operation. AB failed to keep appointments. NS sent letter to AB c/o Mrs B offering further appointment on 13.5.93.
21.04.93	Hendon Magistrates' Court Theft - Conditional Discharge (12 months)
07.07.93	Marylebone Magistrates' Court: Prostitute Loitering - Fine
22.07.93	AB seen at PRC having taken an overdose the previous week. Housing Association had re-possessed flat and she was likely to be charged with causing damage and noise. Depot medication given 28.07.93. Assessment by Dr White on 28.07.93.
29.07.93	Dr. White wrote to Dr. Thompson about AB receiving her injections fortnightly from the surgery.
03.08.93	Marylebone Magistrates' Court: – Prostitute Loitering - Fine
09.08.93	Letter from Dr Thompson GP to Dr White stated that Practice Nurse could give depot injections to AB.
09.09.93	Letter from Dr White about the dose and frequency of injections.
30.09.93	AB attended somewhere, location unclear from the notes. She reported receiving depot injections fortnightly but also said that she had been taking heroin and cocaine daily for the previous two years plus a significant amount of alcohol each day. Unclear from this entry what action was taken.
01.10.93	Letter from Dr Mallett, Consultant Psychiatrist who had seen AB at Holloway Prison – no recommendation made to the Court re disposal. AB was offered a further appointment on 29.10.93 – no evidence that this appointment was kept.
26.11.93	AB attended A&E Department at St Mary's Hospital, Paddington, where she allegedly

	assaulted a medical student. Appointment made to attend at Park Royal on 29.11.93.
21.01.94	SSD decided to close AB's case. Case summary by left on file.
10.05.94	AB remanded to HMP Holloway on a charge of possession of drugs. Reported to be known to suffer from schizophrenia and to be abusing heroin and Benzodiazapenes. Depixol depot injections re-started.
31.05.94	Marylebone Magistrates' Court: – Failing to surrender to bail - Probation Order (2 years) (subsequently varied) – Prostitute Loitering x 2 - As above – Theft - As above – Possession of a controlled drug - As above
02.08.94	Brought to hospital by her mother and uncle – said to have been referred by her then GP, Dr Desmuch but without any letter. Seen by Dr White who concluded that she needed admission for assessment and treatment, and that she would accept informal admission. She was admitted to Lodge Ward, Napsbury Hospital and discharged on 2.8.94 with a diagnosis of drug-induced psychosis.
29.12.94	Marylebone Magistrates' Court: – Theft Imprisonment (1 day) / Fine
30.12.94	Admitted to Holloway Prison. Treated with Clopromazine.
23.12.94 & 07.03.95	Seen by Dr Doig at Holloway Prison.
08.02.95	Spontaneous abortion at Holloway Prison.
08.03.95	Seen by Dr Mallett at Holloway Prison, who recommended an assessment in hospital under s35 of the Mental Health Act 1983.
16.03.95	Admitted to Pond Ward at PRC under s35 of the Mental Health Act 1983 for assessment by Dr Mallett. After assessment, it was concluded that she did not suffer from mental disorder.
29.03.95	Returned to Holloway Prison.
02.06.95	Knightsbridge Crown Court: – Theft - Imprisonment (1 month) – Common assault on adult - Imprisonment (2 months consecutive) – Robbery - Imprisonment (2 years concurrent) – Theft - Imprisonment (1 month concurrent) – Criminal damage - Imprisonment (2 months consecutive)
28.07.95	Reported to be "paranoid" by prison staff.
29.08.95	Self-inflicted lacerations on her forearm recorded by prison staff.
06.04.96	Self-inflicted lacerations of her wrists recorded by prison staff.

29.04.96	Registered with a new GP who prescribed depot anti-psychotic medication and recorded a diagnosis of schizophrenia. In May and June 1996, AB attended the GP on several occasions and received depot and oral medication.
25.06.96	Letter from GP Dr Fletcher's practice manager requesting information about AB from Dr Mallett.
23.07.96	Marylebone Magistrates' Court: – Prostitute Loitering - Fine
26.07.96	Dr White responds on behalf of Dr Mallet to Dr Fletcher.
17.08.96	AB attended the Out-of-Hours service at St Mary's Hospital, Paddington, and was referred to the Central Assessment team.
20.08.96	Marylebone Magistrates' Court: – Prostitute Loitering - Fine – Failure to surrender to bail - Fine
29.08.96	AB attended the Central Assessment team requesting inpatient admission and rehabilitation. Further appointments were arranged but she did not keep any of these.
11.09.96	AB removed from her current GP's list.
26.09.96	JJ requests duty Social Worker to contact AB's Probation Officer, Mrs. B's social worker, Adele Horner (AH) and Duty Nurse to obtain up-to-date information on AB.
27.09.96	Message left for JJ by Duty Social Worker that AB known to Gerry Lehane (GL), Probation Officer.
03.10.96	Telephone call from Willesden Probation Office. AB known to Probation since 15.9.95. GL reported to have been AB's previous Probation Officer. File record notes "AB does not have a history of willingly accepting appointments with Social Services".
15.10.96	AH contacts JJ about support from AB's Probation Officer.
17.10.96	Duty Social Worker rang Mrs. B. who expressed concerns about AB. Mrs. B. believes she needs support. Duty Social Worker contacts Senior Probation Officer based at Willesden. AB does not keep her appointment with them. Probation Office expects SSD to take lead, but happy to come to meeting called by SSD. SSD to arrange meeting and notify AB by letter.
22.10.96	Joint appointment made for 31.10.96. AB, Duty Social Worker and Peter Sutlieff (PS) Senior Probation Officer, to attend. PS to contact AB regarding these arrangements.
31.10.96	Joint meeting between AB, Linda Wiafe-Ababio (LWA) Social Worker and PS to clarify and resolve medical, housing and finance issues.

	AB awaiting sentencing on Common Assault charge. Community Care Assessment Team from St. Charles' Hospital arrange to visit AB on 6.11.96. Mental Health Needs led Assessment of AB commenced by LWA. AB involved in the assessment with PS. Assessment completed by another social worker, Danny Anschel (DA), on 6.11.96.
02.11.96	Registered with another new GP who recorded a diagnosis of schizophrenia and Personality Disorder.
06.11.96	Abortive home visit by DA. Needs led Assessment report completed by Department and put on file.
07.11.96	JJ requests DA to follow up issues with Brent MIND, and to invite AB to come to office.
08.11.96	DA makes appointment through Mrs. B for AB to attend office on 19.11.96.
09.11.96	AB's brother informs DA that AB will not be keeping appointment.
10.11.96	DA informs PS that he will not work with AB unless she contacts him. Contact made with Community Assessment Team. AB offered four appointments between September and November but fails to keep all.
20.11.96	DA recommends AB's case be closed and this is approved by a senior manager from the SS Department.
07.01.97	LWA offered AB duty appointment for the afternoon. AB claims she is homeless. Vulnerability report is completed and AB presents herself to Brent Homeless Unit with the Report.
14.01.97	Received depot medication of Depixol.
20.01.97	AB and partner Mr. McCaffrey presented themselves as homeless to Brent Housing Resource Centre requesting a joint tenancy. Both were interviewed by Miss Clitheroe (Ms C), Homeless Persons Officer. AB had a completed Vulnerability Report dated 7th January 1997 completed by a social worker from the East Sector, Mental Health Team. The report was counter signed by JJ. AB and Mr. McCaffrey were offered emergency accommodation pending further assessments. Case was allocated to Ms C.
27.01.97	AB and partner present themselves to Duty Officer, LWA. AB requests assistance with completing the Incapacity Benefit form. AB's new address noted.
30.01.97	AB offered Duty appointment on 4.2.97.

06.02.97	Ms C telephoned social worker LWA, who had also completed part of the Vulnerability Report. At the time Social Services had no allocated social worker for AB but JJ was to be contacted if there was a need. On the same day AB was re-accommodated at another hotel as the previous hotelier refused to have her back with her partner due to their previous alleged anti-social behaviour.
10.02.97	AB's boyfriend comes to SSD office and explains that previous appointment not kept by AB as she was unwell. Advised to make contact once recovered.
26.02.97	AB visits Duty Officer who informs AB that James McCaffrey was due to come to the office. AB left stating she would return the next day.
13.03.97	Brent Council's Medical Officer assessed AB and Mr. McCaffrey to be vulnerable and recommended that they be re-housed in a "drug free" environment, if possible.
30.04.97	The Social Assessment Panel considered AB's housing application and the areas that were suitable for them to be re-housed i.e. Cricklewood, Kilburn or Neasden. The decision was based on where AB had her support networks. This decision was supported by the Mental Health Support Team. The Panel's decision was notified in writing to AB with a copy sent to JJ. Case re-allocated to Mr. Waheed, Homeless Person's Officer.
09.07.97	Marylebone Magistrates' Court – Assault on police Compensation Order
12.08.97	AB presents herself at the Housing Resource Centre requesting immediate accommodation claiming that Mr McCaffrey had beaten her up. AB was offered a room at one hotel whilst Mr McCaffrey remained at another.
12.08.97	"One Stop Shop" contacts Duty Officer as AB was requesting a bus pass. Duty Social Worker writes letter to AB offering appointment for 19.8.97.
19.08.97	AB fails to attend duty appointment.
27.08.97	A senior Homeless Person's Officer contacted the hotel where AB was accommodated, to be informed that AB and Mr. McCaffrey were both staying there together.
09.97 & 10.97	AB attended the homeless persons' clinic and was seen by Dr Edmondson who referred her to the psychiatric department of the PRC .
10.10.97	SSD writes to AB via Duty Social Worker asking her make contact with the Department.
29.10.97	Letter from Dr Edmondson to PRC requesting formal psychiatric input. Appointment made for 12.12.97.

07.11.97	AB and Mr. McCaffrey presented themselves to the Housing Resource Centre requesting separate accommodation as their relationship had broken down. Separate housing files were made for AB and Mr. McCaffrey. AB was to remain at present hotel while Mr. McCaffrey was relocated to another.
11.11.97	AB came to office and seen by Duty Social Worker. AB allegedly involved in domestic violence involving Hugh McCaffrey. Willesden Police involved in incident. AB presented with cigarette burns all over her body and black eyes. AB staying with her brother and receiving support from Agapay Project. Duty appointment offered on 24.11.97 to discuss her concerns.
19.11.97	Brent Magistrates' Court – Assault on constable (x4) - Compensation Orders
20.11.97	AB presented herself to Duty Social Worker. Brother evicted her. She is advised to go to Brent Homeless Unit. Message from AB that Agapay Project will be faxing information to the Duty officer with AB collecting the report from the Department to take to Brent Homeless Unit.
26.11.97	JJ closed case as AB did not keep appointment on 24.11.97. Summary and rationale for closing case recorded. Case closed until re-referred.
03.12.97	AB attended the homeless persons' clinic. Failed to keep appointment at PRC.
19.01.98	Mr. McCaffrey offered a tenancy in his own right.
26.01.98	AB referred herself to the Department asking Duty Officer to find her accommodation as she was homeless.
06.02.98	Failed to keep outpatient appointment.
09.02.98	JJ ascertained that AB missed last outpatient appointment on 6.2.98. New appointment offered to AB on 20.2.98. Mrs. B. informed of this appointment and asked to take AB to it. Hospital will discharge AB if she fails to keep this appointment. AB also offered appointment with Duty Social Worker on 13.2.98.
10.02.98	AB's housing file closed and The Housing Resource Centre informed that AB no longer lived at the hotel and had not made herself available to the Resource Centre.
13.02.98	AB failed to keep Duty appointment.
16.02.98	Brent Magistrates Court – Criminal damage – Probation Order - 2 years
18.02.98	AB attendance at homeless persons' clinic. Further appointment arranged at CMH.
19.02.98	AB contacted Duty Social Worker. Requested another appointment as only received letter that day. Duty Officer in process of booking another appointment but AB rang off.

20.02.98	Decision to close case by SSD. AB failed to keep appointment with outpatient department
02.03.98	Mr McCaffrey died.
19.10.98	Central Criminal Court: – Manslaughter - Imprisonment – 3 years
01.09.99	Released on licence - conditional release until 1.6.2000

APPENDIX 2

TERMS OF REFERENCE

The Inquiry's agreed Terms of Reference are as follows:

1. To undertake an independent review of all the circumstances surrounding the care provided to AB by health and social care agencies between 16 March 1991 and 3 March 1998, and in particular the adequacy, scope and appropriateness of such care.

2. To examine the extent to which the 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 light of her 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 supervision and aftercare provided.

6. To examine the adequacy of the collaboration and communication between the agencies and the professionals involved in the care of AB.

7. To make appropriate recommendations.

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

APPENDIX 3

PROCEDURE ADOPTED BY THE AB INQUIRY

1. All sittings of the Inquiry will be held in private.

2. The findings and any recommendations of the Inquiry will be made public.

3. The evidence which is submitted to the Inquiry either orally or in writing will not be made public save as is disclosed in the findings and recommendations within the body of the Inquiry's final report.

4. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

    a. Of the Terms of Reference and Procedure to be adopted by the Inquiry
    b. That when they give oral evidence they may raise any matter they wish and which they feel might be relevant to the Inquiry
    c. That they may bring with them a friend or relative, a member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness
    d. That it will be the witness who will be asked the questions and who will be expected to answer
    e. That their evidence will be recorded and a copy sent to them afterwards for them to sign and date

5. Witnesses of fact will be asked to affirm that their evidence is true.

6. Any points of potential criticism will be put to a witness of fact, either orally when they give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

7. Representations will be received from voluntary and professional organisations and other interested parties, as to present arrangements for persons in similar circumstances to those being considered by the Inquiry, and as to any recommendations they may have for the future. Such organisations and interested parties may be asked to give oral evidence to the Inquiry about their views and recommendations.

8. Anyone else who the Inquiry Panel members feel may have something to contribute to the Inquiry will be invited to make written submissions for the Inquiry's consideration, and/or to give evidence in person to it.

9. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the report and any recommendations will be based on those findings.

APPENDIX 4

LETTER TO WITNESSES

The A B Inquiry
[Address]
[Tel:]
[Fax:]

[Witness name]
[Witness address]

Dear [witness name]

Independent Inquiry into the care of AB
Request for evidence from witnesses

You may be aware that Brent and Harrow Health Authority has set up this Inquiry after discussion with the National Health Services Executive and Social Services Inspectorate. The members of the Inquiry panel are myself as chairperson, Dr Cyril Davies (Consultant Psychiatrist), and Ms Bozena Allen (former Director of Social Services).

I enclose copies of the Terms of Reference set for this Inquiry and of the Procedure adopted by the Inquiry.

From an initial examination of available documents, it appears to the panel that you may be able to provide relevant evidence which would assist the Inquiry, and we would therefore request that you attend a Hearing on *(date)* in order to provide such evidence. If however, this date is not possible, please telephone Catherine Afolabi, Secretary to the Inquiry on (tel. no.) who will endeavour to re-arrange the hearing schedule. Your reasonable travel expenses and subsistence costs arising from your attendance will be reimbursed. The hearing will be held at *(time and place).*

When giving this evidence you may be accompanied by a friend or relative, trade union representative, lawyer or member of a defence organisation, or anyone else, with the exception of another Inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. Your evidence will be recorded and a copy will be sent to you afterwards, which you will be asked to sign, date and return. At the hearing, we shall be happy for you to raise any matter that you feel may be relevant to the Inquiry.

Should you feel that you would like to send in any comments, information or observations about the matters we are considering, prior to our meeting, we would be pleased to hear from you.

I would like to thank you for your co-operation and assistance. If there is any matter on which I can give further explanation, please let me know. I look forward to meeting you.

Yours sincerely

John Sedgman
Chair, AB Inquiry

APPENDIX 5

LIST OF WITNESSES SEEN

WITNESS		DATE SEEN
AB	Subject of inquiry	24 August 1999 (invited again March 2000 but did not attend)
Dr R White	Staff Grade Psychiatrist, CMH	15 November 1999
Dr M Browne	Visiting Consultant Forensic Psychiatrist	15 November 1999
Mr MB	Father	16 November 1999
Dr P Mallett	Medical Director, The Trust	16 November 1999
Dr Kharti-Kesalingam	GP	16 November 1999
Mr P Raimes	Manager, The Trust	17 November 1999
Mr G Lehane	Probation Officer, Middlesex Probation Service	17 November 1999 & 24 March 2000
Dr C Patel	Staff Grade Psychiatrist, Roundwood Resource Centre	29 November 1999
Mr D Cochrane	Former Middlesex Probation officer	29 November 1999
Dr C Edmondson	GP	30 November 1999
Ms H Clitheroe	Housing Resource Centre, Brent Council	30 November 1999
Mr C Moore	Director, Housing Resource Centre, Brent Council	30 November 1999
Ms L Wiafe-Ababio	Care Manager, Brent Social Services	30 November 1999
Dr R Doig	Visiting Consultant Forensic Psychiatrist	30 November 1999
Ms E Hogarth	Inner London Probation Service, Holloway Prison	01 December 1999
Ms N Slater	Senior Social Worker – Forensic, CMH	01 December 1999
Dr G Waldron	Specialist Registrar in Forensic Psychiatry, Three Bridges Secure Unit	01 December 1999
Ms M Wyman	Assistant Chief Probation Officer, Inner London Probation Service	01 December 1999
Ms J Jones	Team Manager, Brent Social Services	20 January 2000
Mr P Sutlieff	Probation Officer, Head of Youth Offending Team	24 January 2000
Mr R Nesbitt	Director of Mental Health Fieldwork, Brent Social Services	24 January 2000
Ms J Gallagher	Probation Officer, Middlesex Probation Service	24 January 2000
Dr P Carter	Chief Executive, The Trust	24 January 2000 & 01 March 2000
Mr R Owens	Housing Support Officer, Network Housing Association	01 March 2000
Mr A Gunn	Manager, Housing Support Work Department, Network Housing Association	01 March 2000
Ms C Harty	Social Worker, Brent Social Services	01 March 2000
Dr J Muthiah	Psychiatrist, North West London Mental Health NHS Trust Out-of-Hours Service, St Mary's Hospital	02 March 2000
Mr D Sheehan	Director of Health Impact, The Health Authority	24 March 2000
Mr R Frak	Mental Health Services Manager, The Health Authority	24 March 2000

APPENDIX 6

DOCUMENTS RECEIVED

Statutory guidance – Policies, Protocols and References

1. LASSL (94)4 incorporating HSG (94)27
2. LASSL (90)11
3. Mental Health Act 1983
4. Carers (Recognition of Services) Act 1995
5. Codes of Practice – the Mental Health Act 1983
6. Memorandum – Mental Health Act 1983
7. The Mental Health Act Commission's Biennial Reports
8. Report of the Expert Committee – "Review of the Mental Health Act" 1999
9. Green Paper – "Reform of the Mental Health Act" 1983
10. Report on NHS Charter – Greg Dyke 1998
11. Modernising Health and Social Services – National Priorities Guidance 1999/2000, 2001/2002
12. Modernising Mental Health Services - "Safe Sound and Supportive" 1998
13. Managing Dangerous People with Severe Personality Disorder – Proposals for Policy Development 1999
14. "A First Class Service – Quality in the New NHS" 1997
15. NHS – The Patients Charter
16. The Confidential Inquiry Annual Report 1999
17. Home Office – Victims Charter 1997
18. The Health of the Nation – Building Bridges 1995
19. NHS and Community Care Act 1990
20. "Still Building Bridges" 1999
21. Home Office Circular 12/95

Trust Documents

22. Risk Assessment and Management Procedure 1999
23. Joint Policy CPA and Care Management 1995
24. Discharge Arrangements1994
25. Admission Policy
26. Serious Incident Report – Mr P. Raimes
27. Consultation Document – The reconfiguration of MH Trusts in inner West London (with updates)
28. Map: "The Provision of MH Care in KCW by Locality & Age, 1993 –1999"
29. Map: "The Provision of MH Care in West London" 1993 -1999
30. North West London Mental Health Services Inquiry Report (February 1994)
31. NWL MH NHS Trust Serious Incidents Procedure 1996
32. Mapping – Adult and Elderly
33. Draft Statement of Strategic Policy
34. Contribution to HON 1996
35. Quality Standards for Mental Health 1996 - 1997

Brent Housing and Social Services Documents

36. *'The Housing Register'* factsheet
37. MHF Risk Management Procedures 1999
38. MHF MDO Policy & Procedures – the role of the supervisor
39. MHF Approved Social Work manual
40. Joint Mental Health Strategy for adults of working age in Brent 1999 – 2002

41. Brent Council & NWLMHT Joint Policy Procedures on supervised aftercare s25 MHA 1983
42. MHF Revised Eligibility Criteria 24.03.97
43. Mental Health Fieldwork (MHF) Policy Document list
44. Housing Resource Centre *'Homelessness'* pack 1997
45. MHF Supervision Code of Practice 1996
46. MHF File Maintenance Policy 1997
47. MHF Code of Practice on Recording 1997
48. Eligibility Criteria (Pre 1997)

Other

49. Crown Court transcript – Proceedings on 2.9.98
50. Crown Court Trial Record Sheet and Certificate of Conviction
51. Press cuttings
52. HM Inspectorate of Probation Report – Probation Order with Requirements for Psychiatric Treatment 1993
53. Probation Circular 41/1995
54. Effective Care – Co-ordination in Mental Health Services 1999
55. Draft Guide to Arrangements for Inter-agency working for the Care and Protection of Severely Mentally Ill People 1995
56. Brent & Harrow Health Authority Draft Service Specification People with Mental Health Problems

Records received

57. Health care records
58. Probation records
59. Social Services records

APPENDIX 7

GLOSSARY

A & E	=	Accident and Emergency department of a hospital
Assertive Outreach Team	=	A pro-active multi-disciplinary team operating in the community
ASW	=	Approved Social Worker trained and undertaking assessments under the Mental Health Act 1983
AWOL	=	Absent without leave
Care Plan	=	Multi-disciplinary plan to meet identified needs
Case File	=	Social work record of contact with client
CMH	=	Central Middlesex Hospital, London
CMHT	=	Community Mental Health Team
CPA	=	Care Programme Approach
CPN	=	Community Psychiatric Nurse
Depot	=	Intra-muscular injection of an anti-psychotic medication
DHSS	=	Department of Health and Social Security
DoH	=	Department of Health
Dual Diagnosis		Dual diagnosis is a term applied when a person with a psychotic illness also presents with evidence of a Personality Disorder often including drug or alcohol dependence.
Eligibility Criteria	=	Criteria used to assess entitlement to a specific service
GP	=	General Medical Practitioner
Medium and/or high risk cases	=	Social Services vulnerability risk assessment
ICD10	=	Tenth edition of the World Health Organisation's "International Classification of Mental & Behavioural Disorder"
Inter-agency working	=	Different agencies working together to a set of agreed objectives
Intra-agency working	=	Different parts of an agency working together to an agenda.
MHA 1983	=	Mental Health Act 1983
MHAC	=	Mental Health Act Commission
MIND	=	Voluntary organisation working with people in the mental health sector
Network Housing Association	=	A voluntary housing organisation
PRC	=	The Park Royal Centre for Mental Health
PSR	=	Pre-Sentence Report for the Court prepared by the probation services
Reactive services	=	A service that responds to identified need
RMO	=	Responsible Medical Officer
SHO	=	Senior House Officer
SSD/The Department	=	Brent Council Social Services Department
The Health Authority	=	Brent & Harrow Health Authority
The Trust	=	Brent, Kensington, Chelsea & Westminster Mental Health NHS Trust
Voluntary Sector	=	Non-statutory bodies
Vulnerability Report	=	Report by Social Services identifying housing needs

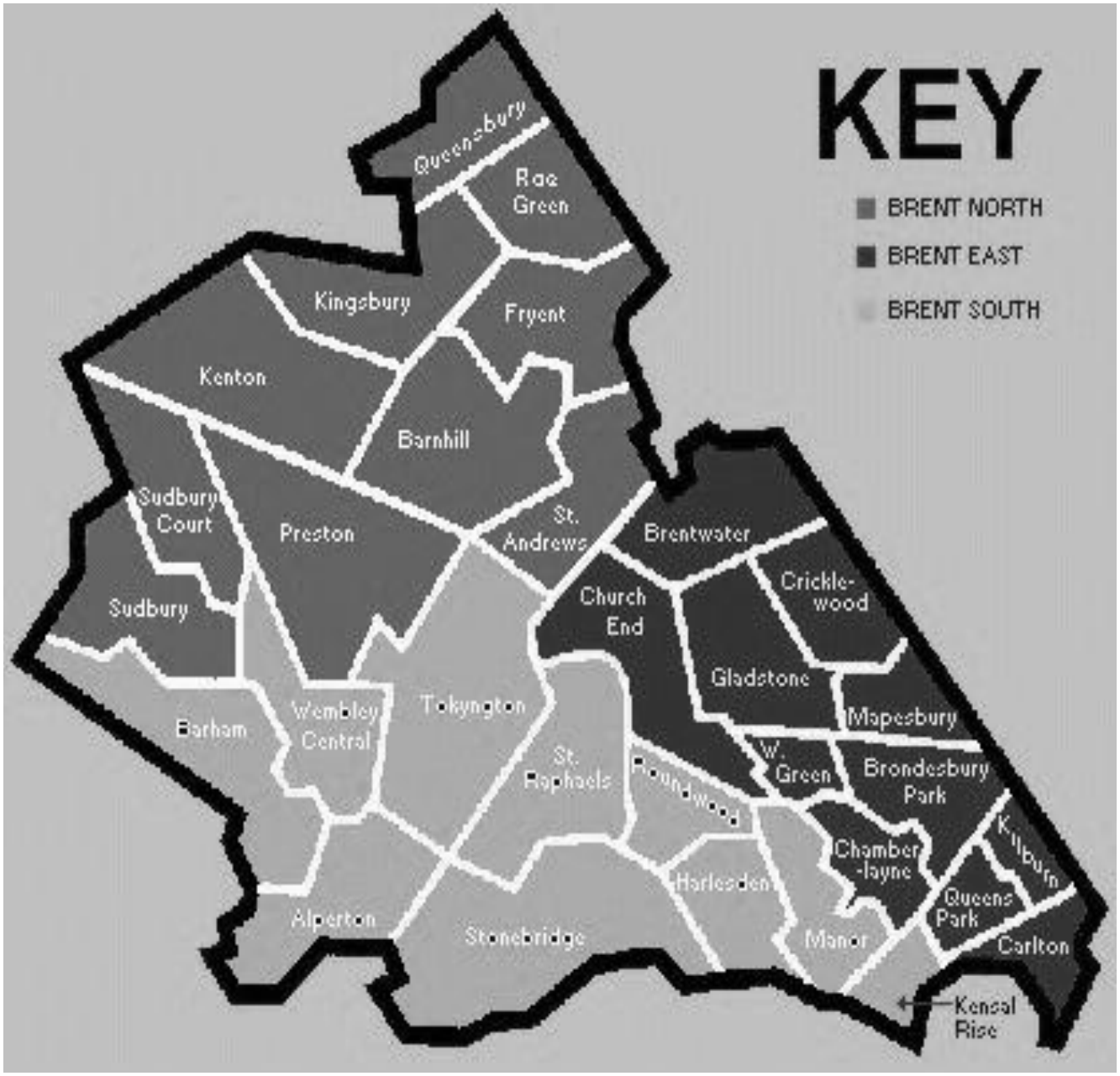
APPENDIX 8

Map of BKCW area

(HARD COPY ONLY - TO BE INSERTED AT PRINTING).

APPENDIX 9

MAP OF BRENT COUNCIL'S GEOGRAPHICAL AREA (PRE MAY 2002)



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