Leicestershire Partnership NHS
NHS Trust

Report into the care and treatment given to SW By Leicestershire Partnership NHS Trust

July 2007

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1. INTRODUCTION

1.1 In the early hours of Sunday 24th September 2006, police received a call saying that two people had been stabbed at an address in Beaumont Leys, Leicester. A woman died at the scene; a man was treated in hospital and recovered from the physical injuries sustained.

1.2 The caller identified the person responsible for the attack as SW (SW). The two people stabbed were neighbours of SW and were well known to him. SW was detained and arrested some two hours later, and on 2nd July was convicted of the murder and sentenced to life imprisonment.

1.3 In July 2005, the Department of Health issued guidance which replaced paragraphs 33-36 of Health Service Guidance Note HSG (94)27. This revision allowed local health communities flexibility in deciding the format of independent inquiries into serious and untoward incidents, including homicides, involving people under the care of mental health services. The Leicestershire Partnership NHS Trust (the Trust), with the agreement of East Midlands Strategic Health Authority, commissioned an independent panel to review the care and treatment provided to SW by the Trust. The panel comprised:

- An Independent Chairperson
- A Consultant Psychiatrist from Derbyshire Mental Health Services NHS Trust
- A Specialist Nurse from Learning Disability Services, Leicestershire Partnership Trust

2. Terms of Reference

The following terms of reference were agreed:

i) To review the care and treatment that SW was receiving at the time, including the suitability of that care in view of his history and assessed health and social care needs;
ii) The extent to which the care corresponded with statutory obligations, relevant guidance and local operational policies;
iii) The exercise of professional judgment;
iv) The adequacy of the care plan, its delivery, monitoring and review;
v) The contribution of other agencies involved if relevant;
vi) Any other issues that seem relevant to the panel;
vii) To produce a report containing such recommendations as seem appropriate.

3. Method

3.1 The panel reviewed case notes and policy documents. We also had access to a review of the incident by Leicestershire Constabulary and a report by Leicestershire and Rutland Probation Service into the care and treatment they provided SW.

3.2 In addition, we interviewed a number of people. Those interviewed were offered the opportunity to be accompanied by a friend or representative. Notes of the interviews were taken, typed up and sent to interviewees for their approval, giving them the opportunity to propose clarifications or amendments.

3.3 In accordance with recognised practice, we have anonymised people referred to in this report. Appendix A contains a list of people referred to in the report but not interviewed; and those we interviewed but are not referred to.

3.4 In undertaking this review, our principal concern has been to establish whether this incident was predictable and/or preventable. We have done this by examining the clinical tasks performed by individuals and teams within the Trust; by considering the administrative infrastructure that supports individuals and teams, and by assessing the services provided by the trust to SW.

3.5 At the time of the incident, SW was not under the ongoing care of the Trust. He had been assessed by the Crisis Resolution and Home Treatment Team (CRHT) in April 2006, who had decided he was not suitable for home treatment. He had been referred to Francis Dixon Lodge (FDL), a specialist service for people with personality disorder, in January 2006, but had failed to attend any appointments; and had been referred to the Community Forensic Service in November 2005, but they had declined to assess him as he did not meet their criteria.

3.6 SW had been an in- patient in the Trust on numerous occasions in 2000 and 2003; on one occasion he had been detained under Section 2 of the Mental Health Act 1983. He had also been assessed several times by community teams, usually following self referral to the local Accident and Emergency Department, or following requests by the police following arrest.

3.7 SW is well known to the police, and has been in prison three times. He is known to carry knives and has made numerous threats to harm himself or others. He threatened staff with assault when an in- patient.

3.8 Following his release from prison in October 2005, he was under the care of the Criminal Justice Intervention Team (CJIT), which is managed by Leicestershire and Rutland Probation Service. It was this team which sought advice and help from the Trust in the management of SW's mental health care in 2005.

3.9 He was not referred to the Trust for a mental health assessment by any agency between April 2006 and September 2006, and does not appear to have been seen by anybody from the Trust in that time, and was not under the ongoing care of the Trust. This report focuses on the way the Trust dealt with requests for assessments in late 2005 and April 2006.

3.10 SW was giving concern to CJIT about the risk he posed to others, and he was frequently coming to the attention of Leicestershire Constabulary during this time between April and September 2006.

3.11 After examining the documents in this case, we concluded that this report should focus on the way the Trust responded to requests for help from partner agencies in managing someone who was recognised as a risk to public safety.

4. Personal History

4.1 None of the case notes contain a thorough personal history. From what is available SW is one of 8 children.
[3 lines of text are withheld under the exemption in Section 40 of the Freedom of Information Act – personal data relating to third parties]

4.2 One of SW's brothers died when SW was 8, through choking on a pen top he had swallowed. Two years later, his father died suddenly from a heart attack, apparently in front of SW.

4.3 Details of his schooling and educational attainment are not available in his adult mental health records. It appears that his school attendance record was poor, and it is likely he did not attend at all after 14. CJIT staff describe his educational ability as very poor, with little understanding of how to handle money or follow directions.

4.4 According to a statement provided by his mother in June 2002, he has had 'various problems' for a long time. He is described as being verbally abusive, showing mood swings and making repeated threats to harm people or cause damage.

4.5 There is no comprehensive well documented history of his known substance abuse in the Trust records, although there are frequent references to his misuse of substances, including alcohol, amphetamines, heroin and crack cocaine.

4.6 According to the report by Leicestershire Constabulary his first conviction was in 1999, although he had received earlier cautions. Prior to his arrest for this incident in September 2006, not including sentence breaches, or failing to appear on bail, SW had previous convictions for:

i) driving while disqualified x 4

ii) threatening behaviour x 5

iii) resist arrest x 4

iv) theft/handling x 4

v) dangerous driving x 2

vi) affray, driving with excess alcohol, common assault x 5

vii) possession of cannabis x 2

viii) threats to kill and criminal damage x 5

4.7 At the time of his arrest, the following were pending prosecution:

i) public order x 2

ii) criminal damage, possession of cannabis, resisting arrest, assault x 2

iii) breaches of community orders.

5. Mental Health History

2000

5.1 In June 2000, he was admitted to the in- patient unit under the care of Dr A via the police station, following his arrest for driving whilst disqualified. He complained of feeling agitated in the preceding weeks and said he had attempted to strangle himself. He described heavy use of amphetamines and cannabis over the preceding 3 ½ years and to drinking 2 bottles of cider a day. He also claimed to be using 80mg temazepam (a benzodiazepine hypnotic) per day.

5.2 On the ward he was assessed as euthymic, and discharged with a diagnosis of personality difficulties and drug problems. He does not appear to have been given any follow-up. He was readmitted in July under the care of Dr B. Again, this was a brief admission and he was discharged with the offer of outpatient follow-up.

5.3 In August 2000, he was seen in Glen Parva (a young offenders institution) after being remanded for failure to attend court. The assessment contains reports from his mother and aunt that he had changed over the past 2-3 months, would rock at times and talked of his head going to explode. He had seemed frightened, and spoke of his father (deceased) 'doing things'. He had talked of hurting himself or a member of the public with knives. He expressed other troubling ideas, including a feeling that he was responsible for a friend's relative dying of cancer.

5.4 Dr C, Locum Consultant Forensic Psychiatrist, who saw him, thought he was acutely psychotic. He had been given Clopixol 50 mg (an anti-psychotic) and lorazepam 4 mg (a benzodiazepine sedative) as emergency tranquilisation. Admission was arranged to Knighton Ward, although he did not stay long. As a result of his subjective benefit from Clopixol, he was commenced on Clopixol injections (a long acting anti-psychotic given intra muscularly).

5.5 Following an overdose of zopiclone (a sleeping tablet) he was admitted to hospital complaining of low mood and excessive cannabis use between 28th and 29th September. He was initially extremely agitated and placed in seclusion. He attempted to climb out of a window and was described as 'hostile and aggressive'. He was discharged after the seclusion was terminated with a note that 'his psychotic symptoms [have] resolved'.

5.6 Between 23rd and 25th October he was admitted from the Accident and Emergency department after an overdose of sulpiride (an anti-psychotic) and diazepam(a benzodiazepine sedative). He was initially 'restless, agitated and laughing...responding to hallucinations'. He demanded a depot injection of Clopixol. This episode was described as 'a possible drug-induced psychosis'.

5.7 He was assessed in November by Dr C after making threats to burn his mother's house down. He described voices telling him to do this. The psychiatrist did not feel on this occasion that there was any convincing evidence of psychosis.

2001

5.8 Further arrests and assessments occurred in early 2001. He was charged with breach of the peace after barricading himself in his mother's house. An assessment showed no convincing evidence of psychosis. A letter from Dr B in early January notes he had taken repeated overdoses, and that inpatient admissions had resulted in 'nothing in the way of improvement'.

5.9 In February, he was admitted following an incident in a car park. He was threatening and abusive to staff, and was discharged within a short period of time.

5.10 In May, he was remanded in custody. He was under the care of Dr D and a CPN. He was taking Clopixol, trifluoperazine (an oral anti-psychotic),

citalopram (an anti depressant) and procyclidine (an anti cholinergic, intended to counter the side effects of the anti-psychotic medications).

2002

5.11 In March, he had a short stay on an inpatient ward following release from prison.

5.12 In June, he was assessed in the police cells by Dr E (Consultant Psychiatrist), and a social worker. He had threatened his mother's partner with a knife, and acted as if 'possessed'. He was not thought to be psychotic, despite mentioning that his dead father was speaking to him. No specific recommendation was made.

2003

5.13 Early in the year, he was involved in a number of assaults on his girlfriend and her brother. In November, he was seen by Dr F, Consultant Psychiatrist following a referral by his GP. Towards the end of this assessment, when SW was told he was not being admitted, he became verbally abusive and threatening and assaulted a member of staff.

5.14 Dr F did not find any psychotic symptoms. Towards the end of his letter, he notes 'It appears that the longest period of [*this severity*] has been achieved while on intramuscular Depixol' It is likely that this is a typographical error: the sentence should have read 'It appears likely that his longest period of *stability* has been achieved while on intramuscular Depixol (more likely to be Clopixol)'. Dr F also notes that 'there is no clear documented evidence of satisfactory response to antipsychotics'.

5.15 Dr F was sufficiently concerned about the history and presentation to refer SW to Forensic Mental Health Services on 13th November.

5.16 Following threats to his girlfriend, SW was assessed at the Bradgate Unit by Dr F and a social worker. This assessment reported mood swings, anxiety, aggression and threats to harm himself and others, with explicit details of what he would do, including stabbing named individuals. He was admitted under Section 2 of the Mental Health Act 1983 on the 19th December.

5.17 This admission lasted only 5 days, and on 24th December, the section was rescinded, and he was discharged by Dr G. The discharge letter by Dr G indicates that he settled well in the ward and was calm and relaxed after a few days, and that there were therefore felt to be no grounds to detain him, and he was allowed to take his own discharge, which he had been requesting. On 7th January, Dr H arrived on the ward to undertake the forensic assessment requested by Dr F, unaware that he had been discharged. Dr H offered to see him again, if his address could be established, as it appears that SW was changing addresses frequently.

2004

5.18 There is a note in the file to suggest that SW was 'closed to psychiatric services'. This could mean that his case had been closed-as he had subsequent assessments, we do not think this meaning applies. A more likely explanation is that he was not to be admitted to in patient wards, on the grounds of his aggressive and abusive behaviour. This is supported by a note in the report by Leicestershire Constabulary which quotes an entry made within the CJIT record 'SW was arrested for criminal damage over the weekend and remanded in custody until today for sentencing. Spoke to the ward re referral who explained that they are unwilling to admit him as he has threatened to kill staff previously and is perceived a risk. Client also banned from hostels due to previous violent and threatening behaviour'.

5.19 In June, he was assessed by the CRHT at the A&E Department. He was requesting admission after punching a fellow resident in a hostel where he was staying. He also said he wanted to attack his aunt's boyfriend and slash

him with a knife. Admission was declined, and he was arrested for making threats to kill.

5.20 By the end of 2004 he was using drugs, and was prescribed Methadone by Dr J, at CJIT. In December, the CRHT declined to do an assessment.

2005

5.21 He was offered out patient appointments with Dr K, but did not attend any of these.

5.22 In October, he was released from prison. He engaged well with the CJIT, attending their office regularly until the offence in September 2006. The CJIT team formed a good relationship with him.

5.23 CJIT had numerous concerns regarding his mental health and his potential to harm others through his carrying a knife. These concerns led them to seek help from the Trust.

5.24 In November 2005, they contacted the Forensic Services at Arnold Lodge, and eventually were put in contact with the Community Forensic Service. He was considered at a referral meeting, but it was decided he did not meet the criteria for assessment, a decision communicated by letter on 30th January 2006. No members of staff at CJIT were contacted to provide further information.

5.25 He was referred to Francis Dixon Lodge (FDL), a specialist facility for people with personality disorder. He failed to attend any of the four interviews arranged for him.

5.26 In April, SW had his final contact with staff from the Trust. He was assessed by the CRHT following his arrest for breaking windows. He was showing some pressure of speech, feeling fed up and suicidal, but without active plans. He denied any recent drug misuse, but said he had been feeling angry and

irritable. It was felt that he was not showing any signs of mental illness. He said he had received an appointment at Francis Dixon Lodge and would 'give it a go'. He was not offered any further input from the CRHT. A copy of the handwritten summary of the assessment was sent to FDL, and the forensic medical examiner. As he was unable to register with a GP following threats at various practices, a copy of the note was sent to the patient registration screening service.

5.27 Between April and September, he had numerous arrests and came to the attention of the police many times. He continued to attend CJIT. A report prepared by Leicestershire Probation Service suggests that he was assessed under Section 136 of the Mental Health Act 1983 during this period, but we do not have any records of this, and there is no mention of it in the report by Leicestershire Constabulary.

6. Summary of care.

6.1 The care provided by the Trust to SW comprised some brief in- patient stays, assessments by the CRHT, and referrals to specialist services. The in- patient stays were brief, and included threats to staff, and one actual assault on a member of staff.

6.2 SW does not appear to have had a definitive diagnosis made, but he does appear to have been briefly psychotic at times, to have abused substances, and to have had a personality disorder.

6.3 It is important to state that he had not been under any on-going care of the trust since his last admission in 2003.

6.4 SW presented a risk to the public, and was heavily involved with the police. His longest period of engagement was with CJIT, who were concerned about his mental state, and sought help from the Trust in assessing this.

6.5 All those in recent contact with him were concerned that he would eventually harm someone seriously: none of the people we interviewed were at all surprised at what he had done. He had threatened to harm people with knives on numerous occasions.

6.6 Given that there was no contact between SW and the Trust between April and September, and that he had not been under ongoing care of the Trust since 2003, then it would be unlikely that any action by any members of the Trusts' staff could have prevented the incident. However, it is appropriate for us to consider whether, had he been offered appropriate care and treatment on the two occasions help was sought from the Trust in 2005/2006, the incident might not have happened. It is our role to establish whether the response of the Trust to the requests for help were of a quality that the Trust would expect.

7. Issues arising and discussion

7.1 We consider that there are three issues arising:

i) Was the incident predictable and/or preventable?

ii) How were the referrals to Forensic services handled?

iii) What was the quality of the CRHT assessment in April 2006?

Was the incident predictable and/or preventable?

7.2 Given the extensive history SW had of making threats with knives, and of assaulting others, we conclude that it was predictable that SW would eventually harm someone. There was no doubt in the minds of the CJIT team that he was a risk to others. Those members of staff from the Trust we interviewed were not at all surprised that SW had attacked someone.

7.3 For such individuals as SW, who present as critically unstable individuals, the agencies charged with public safety must work together to limit the likelihood of harm occurring. The Trust participates in the overarching MAPPA (Multi Agency Public Protection Panel) arrangements. These arrangements provide ample opportunity to review the care of individuals that are presenting problems to any of the participating agencies.

7.4 In this case, our role in this inquiry is to assess what the other agencies involved should expect from the Trust in such a case.

7.5 In general terms, the Trust would act by assessing individuals for mental health problems, and determining what level of support (if any) should be offered. Interventions open to the Trust can range from complex packages of care involving teams utilising a range of therapeutic approaches, to ongoing support or regular assessments.

7.6 In determining what can be offered, the Trusts' clinical staff make such assessments as they deem fit, and seek to match clinical symptoms and presentations with treatments of known efficacy.

7.7 If no care or treatment is deemed suitable, it would not be appropriate for the Trust to offer care or treatment to any individual. But the effect of no care being offered is that other agencies may be left uncertain as to how to proceed with an individual. Assessment thus has a crucial role in guiding other agencies in the availability and potential limits of any therapy, and offering suggestions for management plans for such individuals.

7.8 In the case of SW, a lot of his actions were designed to gain admission to hospital. His general level of disturbance was such that when he was admitted, he stayed for only a short period of time, did not engage with the therapy on offer, and on occasion was abusive and assaultative to staff.

7.9 In such circumstances, it is entirely appropriate in our minds that the Trust staff determined that admission would not be the appropriate intervention to offer, and might even have been counterproductive.

7.10 But consequences flow from such a decision for other agencies, and for SW himself. In our view, the Trust should have convened a MAPPA panel to discuss how the agencies should handle requests from SW for admission. Had the agencies discussed this, then the uncertainty that CJIT felt in knowing where to seek help in early 2006 could have been resolved. And the general belief within Leicestershire Constabulary that no help was available from the Trust, and therefore it was pointless to try, might have resulted in an assessment from the Trust, and thus better management of the escalating crisis seizing SW between April and September 2006.

7.11 Given that it seems clear that the attack was predictable, we have considered whether any action by any member of the Trust staff could have prevented it. It seems to us that the distance between his last assessment by the CRHT in April, and the attack in September removes the likelihood that the Trust could

be held directly responsible for preventing it. But we do believe that the requests for help from the CFS in November 2005 and the CRHT assessment in April 2006 could have been better handled, and therefore there is the possibility that this might have influenced the events that unfolded.

Referrals to forensic services

7.12 Firstly, in 2003, whilst SW was an in patient under Section 2 of the Mental Health Act 1983, Dr F was sufficiently concerned to refer him for a forensic assessment. Although someone came to do the assessment, SW had left the ward, having being taken off the Section and discharged. He was changing address frequently at this time, and given his history of non-attendance for appointments, it is debateable whether he would have turned up. However, this was a missed opportunity for a comprehensive assessment of his care needs.

7.13 Secondly, in late 2005, the CJIT were very concerned regarding his behaviour, and approached the Forensic Services for assistance. Unaware of how to refer for such an assessment, they contacted Arnold Lodge, but were then passed on to the Community Forensic Service. The referral was considered at the weekly referral meeting. It was decided that SW did not meet the criteria for the Forensic Mental Health Service. This decision was taken on the basis of the referral letter alone. No attempt was made to contact the referrers, and SW was not seen. The letter back to CJIT merely states that SW did not meet the criteria for the service-it did not state what those criteria were. The letter was copied to Dr G (his general adult area psychiatrist) suggesting that it would be for him to undertake an assessment if one were needed. It did not propose that one should take place, merely that if it were thought desirable, it would be down to general services.

7.14 The consequence of this rejection by the Community Forensic service was that CJIT were left with no advice or guidance in the management of SW, nor were they given any indication of why he was not taken on, nor what they

could do if they believed that help was required, beyond a suggestion that if an assessment was required they should contact general services.

7.15 Mr A, acting manager of the service, told us that it was not practice to see all referrals, but to judge their suitability from the referral letter. Staff in CJIT had no qualifications in mental health, and were seeking help from those that did. To make a judgement about an individual based purely on a referral letter, written by people with no knowledge of the criteria used, appears to us to be unsatisfactory.

7.16 We also think that the failure to speak to CJIT regarding the referral is unsatisfactory. This does not allow further information to be gathered, and denies an opportunity to CJIT to articulate their concerns about SW.

7.17 We also think that the letter to CJIT from the CFS explaining that SW did not meet the criteria is unsatisfactory, on two counts. Firstly, it did not explain what the criteria were that SW did not meet. This does not aid multi agency understanding of what the Trust can-or cannot-offer a person referred. Secondly, the letter was copied to Dr G with the statement that ' who I understand is his last Adult Mental Health responsible medical officer in order that *if*(our italics) a mental health assessment is required then this can be expedited'.

7.18 The meaning of this letter is clear. The CFS did not think that he was worth assessing on their (un-stated) criteria; they sought to pass the responsibility to the local service. They were not suggesting that an assessment should take place, merely that if one was needed, it was not their job to do it.

7.19 It is our view that the CFS failed in its duty to consider this case appropriately. They failed to seek further information, failed to state the criteria which were used to reject SW, and failed to ensure that an assessment would be carried out by the local adult mental health team. Their failures at this point left SW at large and unassessed. It left CJIT without support and guidance.

7.20 We are not suggesting that SW should have been taken on for treatment. It may have been that following assessment, the CFS would have decided that what they had to offer was not suitable for him, and that the way CJIT was handling the case was appropriate. We would have had no criticism of them for acting in that way-previous attempts to engage with SW had failed, and he had never stayed long enough in- patient care to benefit. Our criticism lies in their failure to undertake an assessment which would have made clear what the Trust could contribute by way of a multi agency management plan; and their failure to respond to a partner agency in need of help and advice.

The CRHT assessment April 2006

7.21 This was the last time anyone from the Trust saw SW. He was seen at Beaumont Leys custody suite following his arrest for breaking windows. He was threatening suicide.

7.22 The assessment was carried out by two members of the CRHT team on the standard assessment form used by the team. The front of the assessment form lists his previous contacts with the Trust, and includes the words 'Previous threats to kill CRT staff'.

7.23 We are concerned that the assessment of such a complex and challenging individual with a significant history of risk was carried out by staff who had insufficient seniority and expertise to undertake such a difficult assessment.

7.24 The assessment falls short of the standard required-this is accepted by the team manager and the nurse who summarised the assessment. Several of the sections indicate that his history was unknown-this is untrue. Several sections are not completed, or the information is superficial. The impression is that the assessment was undertaken as an administrative requirement, and that the team undertaking the assessment had already decided that there was no prospect of SW being taken on. Although the summary sheet indicates that a fuller assessment of risk is required, no action was taken to arrange this.

7.25 We conclude that this assessment fell short of the standards expected by the Trust. The form contains insufficient information to make an informed judgement about disposal options for SW. In failing to undertake this assessment properly, an opportunity to assess the risk SW posed and contribute to a multi-agency management plan, was lost.

7.26 It is routine practice for the written summary sheet to be sent to referrers. We believe that this is unacceptable and contributes to the poor recording of information. It removes from CRHT staff the necessity to formulate in a logical way the problems and outcomes for any assessment. We believe that a typewritten letter should be prepared and sent to all referrers when someone is assessed by the team whether they are taken on for treatment or not.

8. Conclusions in relation to terms of reference

8.1 This section follows the Terms of Reference:

i) *To review the care and treatment that SW was receiving at the time, including the suitability of that care in view of his history and assessed health and social care needs.*

SW was not receiving any care or treatment at the time of the incident.

ii) *The extent to which the care corresponded with statutory obligations, relevant guidance, and local operational policies.*

SW was not receiving any care at the time of the incident.

iii) *The exercise of professional judgement.*

We conclude that the Crisis Resolution and Home Treatment assessment in April 2006 fell short of the standard required.

iv) *The adequacy of the care plan, its delivery, monitoring and review.*

No care plan was in operation

v) The contribution of other agencies if relevant.

The Trust did not work with effectively with partner agencies to manage the public risk presented by SW.

vi) Any other issues that seem relevant to the panel.

We consider that the Community Forensic Service failed to deal appropriately with SW's referral

9. Recommendations

We make 8 recommendations:

9.1 The Trust should satisfy itself that systems are in place to effectively manage the boundaries between in-patient services and functional teams. There must be clear and prompt communication between teams about the purpose of admission, and post discharge follow up.

9.2 The role and function of the Community Forensic Service should be reviewed to ensure it plays a full and appropriate role, alongside other agencies, in contributing to the protection of the public.

9.3 Consideration should be given to revising the operational policy of the Community Forensic Service to the effect that all referrals should, if possible, be seen and assessed, and comprehensive reports and guidance sent to referring agencies when people are not taken on for treatment.

9.4 All members of the CRHT should receive training in the assessment and management of people with personality disorder.

9.5 The CRHT should review the way it allocates staff for assessments of the most complex individuals to ensure that staff of sufficient seniority and expertise are available.

9.6 The CRHT should send a typed letter to all referrers indicating the outcome of the assessment, and, if the person is not taken on, what further help or advice is available.

9.7 The Trust should arrange to have this report and its findings made available to the MAPPA strategic committee.

9.8 The Trust should seek a review of SW by the MAPPA strategic committee; such a review should have available the reports by Leicestershire Constabulary, and the Leicestershire and Rutland Probation Service.

Appendix A

People seen:

Staff member, CJIT
Staff member, CJIT
Mr A, Acting manager, Community Forensic Service
Manager, Crisis Resolution and Home Treatment
CRHT team member

People referred to and not seen:

Dr A, Consultant Psychiatrist
Dr B, Consultant Psychiatrist
Dr C, Consultant Psychiatrist
Dr D, Consultant Psychiatrist
Dr E, Consultant Psychiatrist
Dr F, Consultant Psychiatrist
Dr G, Consultant Psychiatrist
Dr H, Consultant Forensic Psychiatrist
Dr J, Associate Specialist, CJIT
Dr K, Consultant Psychiatrist