

**REPORT OF THE INDEPENDENT INQUIRY TEAM
INTO THE CARE AND TREATMENT OF
DANIEL JOSEPH**

Commissioned by:

Merton Sutton and Wandsworth Health Authority
Lambeth Southwark & Lewisham Health Authority

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We would also like to thank all those who provided us with refreshment and sustenance through the long sittings.

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Independent Inquiry into the Care and Treatment of Daniel Joseph

Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of Daniel Joseph, in particular:
 - 1.1 the quality and scope of his health and social care and any assessment of risk.
 - 1.2 the appropriateness of any care plan, treatment or supervision provided, having regard to:
 - (a) the fact that he is deaf
 - (b) his past history
 - (c) any previous psychiatric treatment
 - (d) his assessed health and social care needs
 - (e) the history of his prescribed medication and his compliance with such medication
 - (f) the use of illegal substances and alcohol abuse, if any
 - (g) any later treatment or care provided to him after the index offence of 22 January 1998 in so far as it may be relevant.
 - 1.3 the extent to which his care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health (including the Care Programme Approach HC(90)23/LASSL(90)11 and the Discharge Guidance HSG(94)27 and local operational policies
 - 1.4 the extent to which his care and treatment plans
 - (a) reflected an element of risk
 - (b) were effectively drawn up, communicated, monitored and delivered
 - (c) were complied with by Daniel Joseph
2. To examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care of Daniel Joseph or in the provision of services to him, in particular whether all relevant information was effectively and efficiently passed between the agencies involved and other relevant agencies, and whether such information as communicated was adequately acted upon.
3. To examine the adequacy of the communication and collaboration between the statutory agencies and Daniel Joseph's family.
4. To prepare an independent report and make such recommendations as may be appropriate to Merton Sutton & Wandsworth Health Authority, Lambeth Southwark & Lewisham Health Authority and all other relevant agencies.

Introduction

This particular Inquiry has been extremely complex because we found ourselves having to look at not only the issue of mental illness, but also mental illness in the context of the implications of deafness and the complexities of communication. We consider that it is extremely important in a report like this to address issues relevant to deafness and communication and have tried to cover those which are pertinent to this case.

We have therefore included at Appendix 1 a chapter written by our specialist panel member, Sally Cook, which we hope will illustrate some of the difficulties encountered both by deaf people and those who are involved with their care, and which also explains the need for specialist services.

At the time of the homicide, there were three different Trusts involved in the care of Daniel Joseph – Pathfinder Mental Health Services NHS Trust (of which the National Deaf Service (NDS) was a part), Lambeth Healthcare NHS Trust (which was responsible for St Thomas' Hospital and the Brixton Road Rapid Assessment Team) and The Bethlem & Maudsley NHS Trust (responsible for the Maudsley Hospital and the Brixton Community Team). In April 1999, Lambeth Healthcare Trust, Bethlem & Maudsley Trust and Lewisham & Guy's NHS Trust merged to form the South London & Maudsley NHS Trust. Pathfinder is now part of the South West London and St George's Mental Health NHS Trust.

On 22nd January 1998, Daniel Joseph attacked Carla Thompson and her neighbour, Agnes Erume, in a prolonged and violent assault. Carla Thompson died from her injuries the following day. Agnes Erume, although her injuries were life-threatening, survived.

On 20th July 1998, at the Central Criminal Court in London, Daniel's plea of guilty to the charge of manslaughter of Carla Thompson on the grounds of diminished responsibility was accepted and he was made subject to a Restriction Order under the Mental Health Act 1983 and detained at Broadmoor Hospital. The charge against him of the attempted murder of Agnes Erume was left on the file.

Due to the fact that part of the assault took place in full view of neighbours and the many Police Officers who were called to the scene, and also because of the particularly disturbing nature of the attack, this incident attracted a great deal of media attention at the time.

Because Daniel was known to psychiatric services, the incident was seen as yet another failure of Care in the Community. It seemed a familiar picture - a young man "going berserk" and killing someone in an apparently unprovoked attack. What was not emphasised in the media, and what makes this Inquiry unique amongst the numerous other Independent Inquiries into similar homicides, is that Daniel Joseph is profoundly deaf.

For those of us on the inquiry Panel without specialist knowledge of working with deafness, the Inquiry process has been a real “eye-opener” in terms of learning about the difficulties encountered by deaf people at almost every level of every day living. Things that most of us take for granted – simple things like going to the doctor and explaining how you feel – pose major problems for those who are deaf and use BSL as well as for those trying to care for them.

The problem is most serious in the provision of psychiatric services for deaf people, as communication plays such a pivotal role in the care, management, treatment and monitoring of mental health problems.

We interviewed a G.P., Dr Angela Skuce, who is a partner in the practice where Daniel was registered when he lived at home with his mother. She never saw him after he became mentally ill, but had treated him when he was younger for minor health problems when his mother accompanied him. She told us that Daniel was the only person she had treated who was profoundly deaf.

The week before she came to see us, she had conducted an experiment which had made her realise for the first time how very much more of a problem it was to obtain the services of a sign language interpreter than a foreign language interpreter (which was something she had to do on a regular basis.) She told us:

"I rang the Lambeth interpreting service to see if they could provide sign language interpreters, and they do not. They provide very good interpreters for other languages. We have Portuguese interpreters twice a week, but it is not a service they provide for people who need to sign. They suggested we try the British Deaf Association. We rang them and it would be a four to six week wait to get somebody, and it would cost £50. So it is not an option. Maybe for monitoring a chronic illness you could do that, and most of what we see is people presenting acutely. So realistically we do not have access to somebody who could communicate like that for us.

Just thinking about it, a person would not be able to make an appointment to see us. They would not be able to access our services out of hours, which is all done by telephone. Even if they came to the surgery, they would have to write down that they wanted an appointment, and the appointment would have to be written down for them, so they would have to be literate.

In a case like Daniel's, when he became ill with a psychiatric problem, on his own he would not be able to access our services. If somebody brought him in, I would not be able to help him at all. I would not be able to ask him any questions, and I would not be able to listen to his story. So I would not be able to form any kind of judgement as to whether he was ill and what his problem was.

Again during the week I rang our local psychiatric services to find out, if I had a patient now, what I could do. They referred me to Pathfinders. Well, when I rang up, they told me about Springfield. I rang our local mental health team and said, " What would I do if I had somebody that I thought was psychotic and was deaf and mute?" They said to ring Springfield Hospital. So I rang Springfield Hospital and they gave me another number and I

rang them. They said they will accept routine referrals but not acute... by the time I rang Springfield obviously the woman thought I had an acutely psychotic patient and said, " We are not an acute service". Yet my local mental health team had referred me to them. They obviously did not feel able to handle it...

If Daniel's mother brought him into me... it would have taken me weeks to sort it out, I think, which in an acute situation is not good enough.

I would have ended up sending him up to the acute psychiatric assessment at St. Thomas', or out of hours I would send him to A & E, which would just have been dumping the problem on to somebody else, because they would have had to find a sign language interpreter. I would have been no good to him, basically."

The inability of the specialist service for deaf people who have mental health problems to provide an emergency service is at the heart of this Inquiry. When it is most needed it is unable to be effective and has to rely on local psychiatric services who do not have their specialist skills and knowledge and ability to communicate with deaf people. Proper assessment of the mental state of a deaf person is extremely difficult for the non-specialist, and the fact that non-specialists have to be relied upon in times of crisis is totally unsatisfactory.

Even for those who can communicate with Daniel, it is extremely difficult to know whether some of his more persistent and consistent ambitions, such as to become a famous World Wrestling Federation (WWF) star, are just the unrealistic dreams of an immature and naïve young man whose lack of communication skills have limited his understanding of the world around him, or are delusional. This issue is elaborated upon in Appendix 2, written by Dr Tom Sensky, which looks at Daniel's psychiatric presentation and its relevance to the homicide.

Daniel's childhood was a difficult and fairly isolated one, which was disrupted by moving between London and Trinidad, with his care alternating between his mother and grandmother. Until the age of almost seven when he returned permanently to the U.K., he had little or no education, and had virtually no communication skills. No-one in his large family has ever been encouraged to learn sign language. When he was a young child he was described as boisterous and hyperactive, mostly out of boredom and frustration. Also, when he was eleven years old, it was discovered that he had most probably been sexually abused by a playgroup leader who had befriended him at a playgroup he had attended until about a year before.

Despite him having a loving and caring mother with whom, as a child, he had a close (if not somewhat over-dependent) relationship, it is clear that the only really stable period of Daniel's life was the nine years (from age six to fifteen) he spent at a boarding school in High Wycombe for hearing impaired children. It was here that he learned communication skills, and it was here that he gained great benefit from a structured environment. We interviewed two of his teachers who are clearly extremely fond of him, and have both been regular visitors to him at Broadmoor, despite him having left school nearly six years ago.

Daniel did not have a long involvement with psychiatric services.

Other than some psychotherapy sessions he had at the age of eleven to help him deal with his sexual abuse, the first involvement of psychiatric services was when Daniel was referred to and was seen in January 1994 (when Daniel was fourteen) by Dr Peter Hindley, Consultant in Child and Adolescent Psychiatry with the National Deaf Service ("NDS" - part of Pathfinder Mental Health Services NHS Trust) which runs a special unit for deaf children and adolescents at Springfield Hospital in Tooting. This referral was after a couple of incidents at school which had led to Daniel being temporarily suspended. Apart from counselling sessions with Social Workers to deal with such matters as anger management and social skills, which Daniel regularly attended for a period of time, Daniel did not require any kind of psychiatric care or treatment until the end of November 1996, when he was admitted as an informal patient to St Thomas' Hospital, (following an outburst of aggressive behaviour at home when he felt he was being prevented from going to America to become a WWF wrestler) before being transferred on 27th December, still as an informal patient, to Old Church, the National Deaf Service's in-patient facility in Balham.

Although Daniel remained at Old Church until the middle of August 1997, he was in fact considered well enough to leave hospital by mid-March, but his housing and future education had not yet been sorted out, and therefore he had to remain an inpatient. His mother could not cope with him at home as she only had a two bedroom flat and other children living there, and his extreme naivete and inability to communicate ruled out independent living. In August he was placed on a temporary basis at Ian Collie House, a hostel which provided supported housing for deaf people in Wandsworth. Everyone was working towards a residential placement for Daniel, hopefully in September, at a college in Devon.

Daniel did not pose any management problem in the whole of his stay at St Thomas' and Old Church. Throughout the St Thomas' nursing notes are such comments as "*calm*", "*polite*" and "*socialising well*", although the nurses also reported that at times Daniel appeared frightened and vulnerable.

From September to November 1997 Daniel was seen on a fairly regular basis by members of the NDS team and although there were growing concerns that his mood appeared to be somewhat elated and that his mental health might be deteriorating, there were no signs of aggression or violence.

Daniel left Ian Collie House against advice on 22nd November 1997 and went to live at Carla Thompson's flat in Tulse Hill.

The local and national press, however, portrayed a picture of a young man (Daniel was only eighteen at the time of the incident of 22nd January 1998) with a long-standing history of violent aggression. The following are some of the comments in the Press either immediately after the event, or after the Court hearing in July 1998:

" A deranged man alleged to have brutally murdered a Good Samaritan was a known risk who doctors insisted should be locked up..."

A leading mental health professor assessed care in the community patient Daniel Joseph late last Monday and insisted he posed too much of a risk to remain at large. But action was NOT taken and three days later the 6ft 7in deaf/mute was arrested as he stood over two women who had been severely beaten, partly hanged and dragged naked into the street.”

[No doctor had in fact seen Daniel for some six weeks. That was one of the factors which caused us most concern. He had not at any time been psychiatrically assessed as a risk to others. The women were not ‘partly hanged’, although they were tied together by a rope around their necks, and they were only partially naked.]

“A director of the Zito Trust said that (Daniel) was well-known to psychiatric services as ‘a violent and difficult patient’ ”.

“According to the report, in the last four months before the killing...Joseph absconded from a voluntary care home, refused to take his medication and became extremely aggressive to ‘virtually everyone’.”

Other reports refer to the predictability if not the inevitability of the outcome, sporting headlines such as:

“Nut killed kind pal in horror attack” and “Mallet maniac kills Carla the Caring Angel”.

The worst example in our opinion was a two and a half page article in one of the broadsheet newspapers in July 1998, after the Old Bailey hearing. It carried the headline in big bold print:

“When 18-year-old Daniel Joseph finally went berserk it was hardly a surprise. As long ago as last summer he had been diagnosed as psychotic. And the warning bells rang ever louder, up until the time he killed Carla Thompson.”

The article then at great length and in great detail set out the events of the last two to three months before the killing. Some of the detail was incorrect, but what really concerned us was that many of the significant episodes of those weeks had been chronologically transposed, so that events which had happened only in the last few days and hours before Carla Thompson’s death were reported as having taken place weeks beforehand, thereby creating the wholly misleading impression that a prolonged period of mental illness with escalating violence was being ignored by those responsible for Daniel’s care and treatment. We consider such reporting to be careless and irresponsible, especially when the narrative describing the events is prefaced by such scare-mongering statements as:

“Daniel Joseph’s descent into violence is a familiar story. The best available figures suggest Community Care patients now kill 50 people a year – about one a week – and that they are driven to suicide at the alarming rate of 1,000 a year. The mental health charity, Sane, says almost all of these deaths are preventable....”

As well as being alarmist, these figures are also factually incorrect. There were about 100 homicides by people with mental health problems in the five years prior to this newspaper report. Although one such death is too many, statistics show that the number of such homicides has not increased significantly, if at all, in decades, and certainly not since the Care in the Community programme became the accepted way of caring for most people who required psychiatric care, rather than incarcerating them in secure institutions.

Our assessment of the situation, after careful scrutiny of all the records and interviews with all the professionals involved in Daniel's care, is quite different from the picture portrayed by the media.

Considering Daniel's chaotic childhood and the intense frustration of being profoundly deaf, with few people around him with whom he could communicate on anything other than a very basic level, there are remarkably few episodes of aggressive behaviour in the whole of his background. Almost without exception, those who knew him and had worked with him, spoke of him with considerable affection and had never felt intimidated or threatened by him.

Daniel's Responsible Medical Officer (RMO),¹ Dr Nick Kitson, despite initially considering him to be psychotic, described to us his first – and indeed his lasting impression of Daniel:

"I smile because he was a very personable person even when ill – playful, amusing, extremely large, but in that sense not threatening. The whole flavour of him was not, you know, "Help!". I have seen a few [like that] in my time, but he certainly was not. I must admit I probably thought that the first time I saw him sitting in the waiting area, before I had achieved any response from him – but as soon as you get any response, he was a warm, nice person who was good to have around – would be fun to have around. I did not feel threatened by him and was a little surprised that he was such a warm character, given his background.

I would judge him at that time and, indeed, would have judged him throughout until the final event, as somebody who in our speciality was not a major risk."

On the whole any aggression in Daniel was directed at inanimate objects. From the time that he first became known to psychiatric services at the beginning of 1994 until he left (not absconded from) the hostel two months before the killing, there are only two displays of aggression against people of which we have been made aware. The first was in February 1994 when he turned a fire extinguisher on his headmaster at school, and the second was when he had a fight with his older sister when she visited him at St Thomas' Hospital shortly after his admission there in December 1996.

¹ We recognise that the term 'RMO' is usually applied to the Consultant responsible for a patient's care under the Mental Health Act, however in normal clinical practice, the term is extended to include the Consultant who is responsible for his patient's care, whether the patient is detained under the MHA or not. As many witnesses referred to Dr Kitson as Daniel's RMO - although Daniel was never detained under the MHA - we have used the term as well, although strictly speaking he was not Daniel's 'RMO'.

Even in the weeks leading up to the horrific events of 22nd January 1998, those professionals who did actually see him, saw no signs of aggressive behaviour, indeed they found quite the opposite. Only two incidents of aggression towards others were reported in the nine week period between Daniel leaving the hostel and the attack of 22nd January. The first occurred about a week before the attack and involved a man who had provoked Daniel by 'chatting up' his girlfriend, and the second was on Sunday 18th January and involved Daniel applying a wrestling 'stranglehold' to his 'stepfather' and punching him on the side of his head when he refused to do something that Daniel wanted him to do; but in both cases, Daniel was easily and quickly calmed.

Daniel had been staying at Carla Thompson's for the two months prior to the killing. As far as we can ascertain from what we were told about her, Carla Thompson was a former alcohol and drug abuser (who may have also had mental health problems in the past) who had 'found religion' and opened her doors to young people with drink, drug and mental health problems. She apparently believed in the power of prayer and had dissuaded Daniel from taking his prescribed anti-psychotic medication. At any one time there were likely to be at least three or four young people staying in her one bedroomed council flat.

The two young women who, as well as Daniel, were staying in Carla Thompson's flat in the period immediately prior to her death, said the following in their statements to the Police made immediately after the attack:

"Since I have known Daniel he has never been violent towards me or hit me. The most he did was swear at me. He was very loving towards me." [Kirsty, Daniel's girlfriend.]

"Daniel has always been gentle and affectionate towards me." [A girl who had stayed the night in the flat over the last three weeks before Carla's death]

Carla's son, who did not live with Carla but had last visited her late on Thursday 15th January, a week before she died, also gave a statement to the Police in which he said:

"I had never seen Daniel being violent or aggressive whilst at my mother's."

According to various Police witness statements it also seems as though, for the whole of the week prior to the attack on Thursday 22nd January, including the day before, Daniel was in Brixton during the day, helping friends decorate their flat. He therefore seemed to be capable of a fairly normal existence at that time.

Having said that, there was clearly a sudden deterioration in Daniel's mental state over the weekend of 17th and 18th January. On three occasions Daniel's mother, Mrs Claudette Joseph, contacted the staff at Old Church, expressing her concern at Daniel's state of mind, on the Saturday reporting that Daniel had threatened to kill either himself or an "Indian man" who frequented Carla Thompson's flat (although in a later telephone call on Sunday, she said that the Indian man had left Carla's flat and she felt that Daniel was no longer a risk to himself or others). However even later that day she also reported the assault by Daniel on his 'stepfather'. It is quite clear that Mrs Joseph believed Daniel to be mentally ill at that time, and she expressed her anger that no-one appeared able to facilitate his immediate admission to a local hospital. She had also one month before told

Daniel's Key Worker, the National Deaf Service Community Psychiatric Nurse, Selma Daley, that Daniel had threatened to kill Carla Thompson. However there had not been any reports of violent or aggressive behaviour in the interim.

Mrs Joseph's concerns were taken very seriously. Indeed, those professionals responsible for Daniel's care and treatment had their own considerable concerns about the apparent deterioration in Daniel's mental and general health. The problem was that no-one from the psychiatric services had actually seen Daniel since he had left Ian Collie House on 22nd November 1997. However the National Deaf Service, ('NDS') who were primarily responsible at that time for Daniel's care, do not have a policy or the resources to carry out an urgent assessment in the community themselves nor to offer an emergency bed if required. They are reliant on local services to carry any urgent assessment out, and to provide emergency admission.

On the morning of Monday 19th January, steps were immediately taken to send in a rapid response team to assess Daniel, but there was some confusion as to which Mental Health Community Team should be responsible for carrying it out, given that Daniel had moved from one local catchment area to another, albeit on a temporary basis, and although in moving to Tulse Hill, Daniel had not moved very far geographically (probably less than two miles) from where his mother lived in SW8, which had been his official address prior to going into hospital a year earlier. We were confused ourselves when we began our Inquiry, (and have remained confused at times throughout it) and therefore we have tried to offer some explanation of the catchment areas involved which can be found at Appendix 5.

The NDS approached the issue of the relevant catchment area by reference to the NHS Executive 1993 National Guidelines "Establishing District of Residence", which they argued left Daniel's Mother's address as defining his district of residence. They always considered Lambeth Healthcare Trust as being his local mental health service. This was however not the view of Lambeth Healthcare, who believed that, since Daniel had not lived at his Mother's home for over a year and was now living outside their catchment area, the Bethlem & Maudsley NHS Trust was the appropriate local service.

Although everyone acknowledged that the matter should be dealt with as a matter of urgency, there was no sense of great emergency, and there was also the question of having to have a sign language interpreter present at the assessment. All these matters caused delay, and despite a Mental Health Act assessment being arranged, it was too late to prevent the tragic events of 22nd January.

Unfortunately, the media reporting of this incident (as of others like it) only served to fuel the general public's fear and distrust of Care in the Community. We have been told that Frank Dobson, then the Secretary of State for Health, expressed an interest in the case, and an independently chaired Panel was set up (as far as we know uniquely) to carry out a "Collaborative Review" of the four separate internal inquiries which had been carried out by those services who had had some responsibility for Daniel's care and treatment, namely, Lambeth Healthcare NHS Trust, Pathfinder Mental Health Services NHS Trust, The Bethlem & Maudsley NHS Trust and Lambeth Social Services. The Review Panel consisted of an independent Chairman, Richard Lingham, an independent psychiatrist, Dr Omar Daniels, and an independent administrator, Mr Brian Morden. In addition, the

following sat in turn on the Review Panel whenever an employee of their particular organisation was being interviewed: Mr Christopher Butler, Director of Operations and Nursing at Pathfinder Mental Health Trust; Dr David Roy, Medical Director of Lambeth Healthcare Trust; Dr George Szmukler, Medical Director of Bethlem & Maudsley Trust and Ms Susannah White of Lambeth Social Services, all of whom except for Ms White sat on the internal inquiry panels..

All four internal inquiry panels prepared their own reports with recommendations which were submitted to the Review Panel, who then prepared a further report with recommendations. We read these reports at the very beginning of our Inquiry process when they were all that we had to find out about the background of this matter, before all the records and other documents were collated and released to us. We have deliberately not referred to them again until we had completed our Inquiry and prepared this Report. We felt that this was the only way that we could remain completely independent.

Only Pathfinder Mental Health Services Trust did not interview those members of staff who had been directly involved in some way with Daniel's care (on the understanding that they would be interviewed by the Review Panel). The other three bodies did interview certain members of their staff, who were then further interviewed by the Review Panel.

Therefore, by the time that this Independent Inquiry was established and began its investigations, many of the professionals involved had already been interviewed twice, or had had to submit statements to two inquiry teams.

We can understand the reasoning behind the establishment of the Collaborative Review, and in no way criticise the Panel or its report. However we consider that the very process placed an over-onerous burden on those professionals who were involved in the procedure. By the time we saw them, most had been interviewed in a formal manner by a panel of questioners on at least two occasions. Many of them told us that they found the experience difficult and distressing. At the Collaborative Review interview, one of the top personnel from their employers was part of the Review Panel. This was obviously inhibiting, as many felt that their employment and professional careers were under threat.

In many ways it made our task more difficult, as at times we had to overcome a degree of reluctance and apprehension from witnesses before they realised that we were not a modern day equivalent of the Spanish Inquisition.

We consider that there is no benefit from departing from the normal procedure of holding an internal inquiry followed only by an independent Inquiry, and we hope that the Collaborative Review process is avoided in the future.

We decided that the best way to perform our task was to hold the Inquiry in private, and, although we held structured interviews, as far as possible we adopted an informal atmosphere where the witnesses would feel free to talk to us about their appraisal of what had happened in the context of resources, policies, training and practice issues, as well as answer our questions about their individual roles and responsibilities in Daniel's care. We understand from witnesses' remarks as well as general feedback that this was the right decision, and one welcomed by those we interviewed.

Despite adopting a conversational rather than a confrontational style of interviewing, we were very aware that it was sometimes difficult to establish a dialogue when we had cause to question any individual's actions or judgement. Such dialogue is absolutely essential to achieve the principal purpose of an independent Inquiry, namely to allow lessons to be learnt in order to reduce the risk of further tragedies. When we touched on such sensitive criticisms we noted a tendency to become defensive and a difficulty in perceiving the criticisms as constructive.

We do not think that these observations are unique to this Inquiry. In our opinion they reflect a more general problem, namely the extent to which a culture of blame remains entrenched within health and social services.

Substantial cultural changes will need to be engineered to shift from this position to the 'no blame' and reflective practice which is the cornerstone of professional audit and clinical governance. We can only hope that this can be achieved.

Before we met with anyone else, we wanted to meet with Daniel, so that we could understand better what difficulties there might be in dealing with his care and management. We visited him at Broadmoor at the end of May 1999, and spoke first of all to his RMO, Dr Adrian Paine. Daniel's mother, Mrs Claudette Joseph was there and we spoke to her briefly, but she left the room while we talked to Daniel. (We saw her separately on two further occasions later in the Inquiry process). Daniel's solicitor, Michael Copsey, remained with him as well as Paul Johnson, Senior Social Worker, and Katie Santos, Music Therapist. An RNID sign language interpreter, Byron Campbell, previously unknown to Daniel, interpreted for us. Daniel's own interpreter at Broadmoor (who visited him twice a week) was off sick. We were accompanied on that visit by Dr Paul Davison, Consultant Psychiatrist at the John Denmark Unit in Manchester (one of the three NHS specialist units in England for deaf people with mental health problems).

As had so many other people we interviewed, we found Daniel to be polite and charming and eager to please. He concentrated very hard, and was clearly exhausted by the end of the session, but answered all our questions openly and to the best of his ability.

It was a most enlightening experience for those of us without specialist skills in communicating with a deaf person. Despite Daniel having a very expressive face, we were obviously entirely dependent on the interpreter, and we also had nothing to compare to the experience. It helped us to appreciate the enormous difficulties faced by those professionals attempting to care for Daniel who had never worked with a deaf person before, and we could also see how isolating and frustrating it would be for Daniel when there was no interpreter present to help him 'talk'.

We are troubled to learn of the difficulties encountered nationwide in recruiting, training and retaining specialist staff to work in services for deaf people. Julia Hookway, Social Worker with Lambeth Social Services Sensory Impairment Team, told us that she had had to fund herself to learn BSL and that having specialist skills (such as the ability to sign) was not recognised in either financial or career promotion terms. In some ways having such specialist skills was a disincentive, as career moves and promotions were limited.

We were also saddened to discover that several of the specialist witnesses we interviewed who were involved in caring for Daniel have left their jobs since this incident. It is impossible to know how much, if at all, their decisions were influenced by the tragic outcome of this matter and/or the way it was dealt with.

We saw 40 witnesses in all, ranging from Agnes Erume, (the surviving victim), Daniel's mother and 'stepfather', and two of his former schoolteachers, through to virtually all of the professionals who were involved in his care from 1994 onwards, all of those directly involved in the events of the last week before the attack and those Medical Directors who had conducted the internal inquiries. Unfortunately neither of Carla Thompson's two sons accepted our invitation to meet with us. We tried hard to trace Kirsty, Daniel's girlfriend, but were unsuccessful.

A list of witnesses can be found at Appendix 8.

We are grateful for the frankness and openness with which all of the witnesses gave their evidence to us.

We particularly wish to comment that we were extremely impressed with the high calibre of the professional staff who were involved in caring for Daniel Joseph at every stage of his life. Almost without exception, the professional witnesses displayed qualities of intelligence and compassion as well as skill in their particular field.

If we have had to criticise a few of the actions or failures to act of some of them, such criticism should not detract from the overall impression of dedicated professionalism which struck us all.

We wish to emphasise the fact that no-one except Daniel Joseph was responsible for the death of Carla Thompson. In our opinion the attack on her and Agnes Erume could not have been predicted. There were however several things that we can identify that could and should have been done that may have led to a different outcome. The opportunities were there – indeed there was a clear understanding amongst everyone involved in Daniel's care and management at the time, that Daniel needed to be seen by a doctor and his mental state assessed - but unfortunately time ran out before any plans were put into effect.

Background

Daniel Joseph was born on 12 March 1979 at St Thomas' Hospital in London. His mother, Claudette, already had seven children from her marriage and had been recently divorced in 1977. It is not clear from the records exactly who Daniel's father was. It is sometimes stated that Daniel's father left the family when Daniel was three years old, but at other times it is said that Daniel's father played no part whatsoever in his life. The relationship between Daniel's father and Claudette is unclear. Two further children, Garth and Marijke, were born in Trinidad after Daniel by a different father in 1981 and 1983. The family is Afro-Caribbean. We are pleased to be able to say that ethnicity was not in any way an issue in this Inquiry. We recognise that all of the key agencies involved in Daniel's care reflected the ethnically diverse community of South London.

Daniel is profoundly deaf. He was either born deaf or was noted to be deaf before he acquired speech. None of his family were ever actively encouraged to learn to use British Sign Language (BSL). The family can communicate with Daniel at a fairly basic level using some signs and Daniel can also lip read to a certain extent. His ability to read and write is extremely limited. As a small child he was described as being boisterous and hyperactive.

Sometime in the summer of 1980, when Daniel was one year old, Claudette returned to Trinidad, taking Daniel with her, but after a few months he was sent back to England with a stranger (to him) and thereafter lived with his maternal grandmother. From about September 1981 he attended a school for the partially hearing where he began to make some progress. His grandmother however was in poor health at the time, with failing eyesight, and found Daniel difficult to cope with. Apparently, she would shut Daniel in a darkened room and remove all his toys. In March 1982, when he was just three years old, Daniel was taken into care. Social workers involved with Daniel at the time were sure that part of his hyperactive and boisterous behaviour was due to boredom, lack of stimulation and confusion over all the changes in his life.

Daniel was admitted to Gresham Place, a residential nursery in Surrey, where he remained until Claudette Joseph returned to England in January 1983 and in April of that year took Daniel without permission from the nursery and flew with him to Trinidad. He was then four years old. A report written after his removal from Gresham Place contains the following:

"Daniel would often have outbursts of screaming temper due to the fact he was not always able to be understood or communicate. He often threw shoes off and any heavy toy at the nearest person and pulled his hearing aid out and batteries. His outbursts of temper were soon over and he would always come to be comforted and cuddled. Daniel was capable of showing a great deal of affection. Daniel got on fairly well with other children in the group. On occasions he did tend to be rather spiteful towards other children biting or hitting to get some toy that he wanted to play with. He loved little ones and liked to help with bathing and getting clean nappies etc. However there was an incident when he attacked an 18 month old child when the baby was asleep in his cot, biting and bruising him very badly on his neck and face. The only reason we can think why he should do such a thing, was that M his key worker had come to Gresham on her day off with her five-year-old niece and Daniel

was rather jealous about it. He was totally unaware of what he had done and was perfectly loving to the child the next morning."

The report also reveals that Daniel was extremely resistant to seeing his mother when she returned to England. He treated her like a complete stranger and refused to go with her whenever she visited him. The report ends:

"Daniel had made such good progress in the year he had been at Gresham and was just beginning to trust us and become a more stable and normal little boy. One cannot say what untold damage has been done by this sudden break away from the security he was getting here."

The family remained in Trinidad until April 1985 when they returned to London, initially living with Claudette's mother - Claudette, Daniel, Garth and Marijke all sleeping in one room. One of the main reasons for their return was that there were no educational facilities for deaf children in Trinidad, and Daniel had had little or no schooling whilst he was there. He was now six years old. Daniel was assessed as being '*partially hearing but functioning at the level of a child with severe hearing loss because of lack of stimulation*'. Daniel was referred to Grove House School for Deaf Children and in the meantime he and Garth attended the Charlie Chaplin Playgroup. In June 1985 Daniel was referred to the ENT Department of St. Thomas' Hospital in order to try to diagnose the cause of his deafness. The tests proved difficult to undertake because of Daniel becoming distressed and refusing to co-operate. Daniel began at Grove House School at the beginning of October 1985, but within 10 days the headmaster was recommending that Daniel needed one-to-one attention and therefore would be better off at a boarding school. A report written by the headmaster of Grove House School dated 7th October 1985 states:

"Danny's presence in this School has presented us with a number of problems. He cannot tolerate being with other children in classroom situations and when this was tried his behaviour was very disruptive. He is unable to concentrate or to be guided for any length of time and when attempts are made to give guidance he shrieks loudly and will hurl across the room any apparatus which is in front of him. It is apparent that at present he can only be adequately supervised in a one to one situation..."

In new situations Danny shows evidence of being really disturbed. He has been observed to rock on his chair, to roll on the floor, to bang his head and to bite and punch. In ways his behaviour is more appropriate to a two-year-old and he requires very careful handling..."

By the end of October a council house had been found for the family in South Lambeth and by mid-November Daniel was taken by the Local Education Authority for an interview at the Penn School in High Wycombe, Buckinghamshire, where he started soon afterwards. This is a residential school for hearing impaired children with other handicaps as well. It started off as two separate schools, Pembury Grove (which was for the profoundly deaf, some of whom had additional physical or learning disabilities) and Rayners (which was for the partially hearing with learning difficulties. It was a mainly oral environment.) They were joined together as one school in about the late 1970s, but still functioned in two departments. Daniel started at Pembury Grove because he was profoundly deaf and needed a signing environment. We were told that he did not really have a peer group at Pembury Grove because many of the children were physically

handicapped and Daniel did not have that problem. Again that isolated him to an extent and therefore he began to board at Rayners, while still being educated at Pembury Grove, and he saw this as a "step up". He moved to Rayners fully only in about 1993.

A report from an educational psychologist in April 1986 when he was seven stated:

"Daniel has a profound hearing loss. When I first saw him, when he was just over six years old, he had not had any structured education for the past two years. He was very willful, though at the same time he appeared to be insecure. It was possible to gain a certain amount of co-operation in order to check his abilities. From what he did, it seemed likely that he had non-verbal abilities in the normal range. There was no way of communicating with him other than simple gestures and demonstrations...."

He is a very active boy who has undoubtedly suffered as a result of the many changes he has experienced in his short life. It can only be hoped that once he begins to feel some sense of security his level of activity will lessen. Despite his over-active behaviour he can be polite and show concern for others and one feels that that he has potential to make substantial change and improvement. Daniel is physically large for his age and this in itself may lead to some unrealistic expectations being made often as he presents as being considerably older..."

A further report from another senior educational psychologist a year later in March 1987 (when Daniel was just eight years old) contained the following:

"... the wide variation in the subtest results... again reflect his emotional difficulties rather than intellectual deficits. He showed signs of becoming angry when he felt he could not do something.. From observation of his performance in the testing session there is little doubt that he is of average ability... Daniel is a boy of average ability who had the potential to overcome his handicap and develop speech and language provided he had consistently used appropriate hearing aids and received skilled help. This has not been possible and now in addition he presents as a very disturbed boy who will require psychiatric intervention."

An undated report from Penn School, which appears to have been written about the same time, describes Daniel as having made a great improvement although the School "was very conscious of the fact that this had been due to a huge concerted effort by staff to give Daniel a strong feeling of security by providing a structured day with a variety of activities which lure him away from television and channel his excessive energies wisely." The same report describes Daniel's self image as follows:

"This fluctuates between a strong 'macho' image and that of a small baby or a kitten. He still cannot cope with failure - he has to win, he has to be a success. Although he has a fairly clear idea now of right and wrong he does not seem to be able to stop himself from getting into trouble. When he is in trouble he often hides..."

A sense of security appears to be the key to success in handling Daniel. We are very much aware that the progress made so far is very precarious. It takes very little to tip the balance and we are very much afraid that anything which happens to threaten Daniel's feelings of

security, especially in relation to his home, may have far-reaching consequences. He still requires help to understand himself and the extent of his emotions. It is important to remember that Daniel has temper tantrums that are calculated because he cannot get his own way, and at times he is still very aggressive to children and staff. People admit to being 'very wary of him'. At 8 years this gives concern as every day he grows in strength and stature."

The Penn School did seem to give Daniel the security he needed, and he seemed to respond well to the structured regime that seemed lacking at home, and became much more settled and generally co-operative at school.

He formed a particular attachment to a married couple, Dick and Jenny Freeman, who ran the football team and to all intents and purposes were his "house parents". He stayed with them on several occasions, once when his mother went back to Trinidad, and at other times in the summer holidays.

We interviewed Mrs Freeman as well as another of Daniel's teachers, Mrs Stacey, who both spoke of Daniel with great affection. Indeed both of them visited him regularly every month when he was at Broadmoor. The day before we interviewed her, Mrs Freeman had attended a Review Meeting at Broadmoor as an observer. Mrs Stacey told us:

"I think a lot of people who worked with Daniel have a great affection for him. I was very, very upset when I heard about him. It affected me and I think it affected quite a lot of people at the school. Although Jenny was the one that had maintained contact with him, I did offer to go with her, and it was almost like turning the clock back when I visited him – oh –it's like an old friend. I quite enjoy going to see him actually."

Mrs Freeman said that when Daniel first arrived at the School at the age of six, "*He could only be described as challenging*". She was assigned to him on a one-to-one basis for some intensive input because his signing was poor and his speech was non-existent. He could not lip read and refused to wear his hearing aid. He could not write and it seemed as though he had never used such things as scissors or anything that one would expect a six-year-old to be familiar with. She told us:

"We spent an awful lot of time getting off cupboards and tables...He climbed a lot to escape...He was extremely hyperactive. He was always great fun. We used to spend a lot of time outside because he used to love to run. So we ran and did all sorts of daft things, make him pretend fires and campsites and such, and it was good. I never worried about him running away because I think he was having too much fun to be honest...All credit to his mum, he had good manners. When we took him out he was very well behaved."

She made a very telling remark when she said:

"I think he never really caught up in maturity with his age even though in size he outgrew it".

In the school holidays Daniel continued to attend the Charlie Chaplin Playgroup and indeed one of the male playgroup workers befriended Daniel and used to take him home for weekends. He even had him to stay for one month when Daniel's mother returned to Trinidad for holiday. There was another boy who was also befriended by this man. After about a year, Daniel appeared unsettled about going and by the end of 1989 refused to go any more. In January 1990 the playgroup worker was suspended because of allegations of interfering with the other "special" boy. Suspicions were raised that Daniel had also been interfered with in some way and the school referred the matter to the social workers in Lambeth who had responsibility for the family, and at the end of May 1990 disclosure interviews were carried out. Daniel was eleven years old at the time. He subsequently had regular counselling sessions with a signing social worker/psychotherapist (whose level of competence in sign language skills is unknown to us but she describes Daniel's signing as *"considerably better than my own"*.) In June 1991 she wrote to the Consultant Paediatrician at St. Thomas' Hospital who had referred Daniel for psychotherapy:

"He has never explicitly referred to having been sexually abused, and there is nothing that otherwise makes it patently clear that abuse has occurred. He uses his sessions to try to come to grips with his intense ambivalence: his feelings of deep affection quickly spill over into frustration, anger, and feelings of violence of which he is very frightened..."

The School has been co-operative and supportive to a degree I have not known before; they see that he comes weekly, which means providing an escort for him. The school's commitment to Daniel and his attachment to the school is impressive. Daniel has had a number of changes at significant times in his life, and has not only settled at the school but also worked out very good relationships at Penn, especially with the woman who is his escort. As he proceeds into adolescence, he will need consistency, security and support if his fears about his violent feelings are to be contained. I would hope that he would be able to continue at Penn throughout his secondary school career."

The professionals involved however had little doubt that Daniel had been sexually abused.

Mrs Stacey taught Daniel for three years from the end of 1989, ie. from the ages ten to thirteen. Both she and Mrs Freeman told us about the mood swings he had from the beginning of his time at the school. Mrs Freeman said:

"He used to get very angry. I think a lot of it was misunderstanding, communication, frustration...He was not often angry with me. We hit it off. We had a good relationship. It was usually with other people. I did not actually see him hit anybody. Certainly he did not

hit me. He might have man-handled me a bit I really can't remember. He would throw things around...chairs and tables and things."

Mrs Stacey told us:

"To most people who worked with him at school there was a great affection for him, because he was in many ways a very likeable boy and when he was in one of his charm moods he could charm the pants off anybody. He loved to be able to communicate with people and wanted to be friends with everybody. But of course he had these mood swings and could be a very challenging child.

I think the point I would like to make particularly is that at that time, certainly most of the time that I taught him, he desperately did not want to be seen as a deaf boy. He wanted to be like ordinary boys....He would do anything to be part of a group. Unfortunately he was very naïve. He could so easily be led into things...

...A lot of his anger was directed at himself. He would take something the wrong way. But at that stage – and I can honestly say in the whole of the time I worked with him, I never felt threatened by him. A lot of his anger he took out on himself.

I can remember sitting with him for the whole of one lunch after an incident where he had been disobedient...somebody had misunderstood him. He had come down to school in a bad mood. He did not want to do any work. I got a bit cross with him because he was not doing anything and I said he had to snap out of it. We went out to play. In the meantime he barricaded himself into the classroom...I got the caretaker to unscrew the door lock. So I got in. We carried on. We ignored him, but at lunchtime he clearly did not feel the issue had been finished and he did not want to go to lunch. He stayed in the classroom and I just watched him. I tried to get him to talk to me, but when he did not want to talk, he did not make eye contact with you, so it was very difficult. He just spent the whole time – he would bang his head on the wall or the board and drew all this graphic...this drawing of tomb stones and 'R.I.P.' and Daniel dead and police coming. But he would not look at me and talk about the situation. He gradually calmed down, but he found it very difficult when he got into this mood to express himself. The only way he could do it was by banging his head and doing the graphic drawings."

Mrs Stacey told us that the mood swings seemed to get worse as he went into adolescence. She said that his aggression against other people seemed to start when he went to Rayners full time, which was when he was 13/14 years old. She said:

"It seemed as if suddenly a situation would spark something off and he would get himself into a spiral of aggression – first anger against himself, threatening towards others. He would throw things about and he would put an aggressive stance on but he did not actually thump out at people. He would push people out of the way. That was very often his way. Because he got bigger, that could be equally dangerous."

There were no real concerns until September 1993. (Daniel was by now fourteen and a half.) On the 21st September, one of the teachers went to the headmaster because of concern about Daniel's behaviour. He outlined several minor incidents which had occurred that morning which he said, on their own seemed fairly trivial, but collectively were more concerning, since one of the incidents involved a boy complaining that Daniel had punched him. Mr Jones decided that since there had been several incidents of disruptive behaviour in the last few weeks, he would exclude Daniel from School indefinitely in order to prevent a major incident. He telephoned Jenny Park, Specialist Social Worker for the Sensory Impairment Team in Lambeth, because he felt that Daniel needed outside help. He then spoke to Daniel and asked him to explain his behaviour that morning. Daniel was not prepared to acknowledge anything which would indicate that he was at fault. Mr Jones told him that he would be taken home because he did not like his behaviour towards the children and staff. Daniel appeared quite shocked. Mr Jones and Mrs Freeman drove Daniel home that afternoon. The journey was a difficult one, with Daniel showing increasing concern and reacting aggressively towards Mrs Freeman and Mr Jones. He attempted to get out of the car while it was moving and threatened to break the windows. Mrs Freeman managed to calm him down, although he broke an umbrella which was in the car and threatened to use the handle as a weapon. On arrival at his home he rushed inside, kicking a parked car on the way. At a meeting with Jenny Park on 29 September, Daniel accepted no responsibility for any of his own behaviour. He perceived his exclusion solely in terms of wrong having been done to him at Penn School.

Mr Jones prepared a report in October 1993 in which he wrote:

"He has made considerable progress in many areas bearing in mind his very difficult and unsettling early experiences.

At best he is a charming, sensible and sociable young man with an engaging smile and genuine humour. There are references in his file and school reports to his efforts to succeed and his reliability when given tasks. There are also references to his achievements in sports and in his response to structured teaching situations.

However, throughout this period there is an underlying strand of aggression and violence. It was first recorded by Staff at Grove House School, prior to his admission to Penn. Mrs Joseph indicated his violent reactions to television incidents on his Admission Form.

It was felt that as he learnt to communicate through signing with a wider range of adults and peers, there would be opportunities to help and modify some of his more aggressive behaviour.

Great progress was made and Daniel responded well to the structured environment of Pembury Grove, both in and out of the classroom...

There are comments in his reports indicating his fluctuations between a macho image and his need to act like a young baby.

There are references to his feelings of insecurity and calculated temper tantrums, to get his own way - these often with aggression to children and staff.

There is no doubt in my mind that the constant input of language and the efforts to enhance and improve his self image, have been most successful.

There have been many small improvements in Daniel's behaviour and in what constitutes an acceptable standard. His involvement with Jenny and Dick Freeman and their Football Club Team has been most positive.

He has responded well to good role models in the past. Comments are recorded of his consideration and excellent manners...

Since the early part of the year Daniel has had several confrontations with staff over minor matters which he has magnified. There appeared to be no specific reason why this should be happening, but he was showing a desire to be physically aggressive and provocative...

Since the summer holidays there have been several minor, but important, incidents of pushing and threatening behaviour. An increase in aggressive and abusive behaviour towards staff, particularly when dealing with Daniel's lack of consideration for younger pupils.

Two incidents, early in the term, were particularly significant and indicated a change in behaviour.

In the first he locked himself away, following a minor incident and would not, or could not, discuss any of the reasons for his behaviour.

In the second, he became particularly aggressive and physically violent over money which he wanted, but could not have. He threatened to jump from the second floor window in order to indicate his anger. He was persuaded to discuss his problems, but seemed to be unable to clarify the issues involved.

The particular incidents on the day of the exclusion might appear to be trivial in themselves, but the number was disturbing. Five younger children were either pushed, or punched, for being in the way whilst Daniel was getting ready for breakfast or preparing for School. Requests from staff appeared to have no effect on him. He would not acknowledge that his actions could cause the children pain and/or possible injury.

His general attitude to correction and explanation was dismissive and threatening. Members of staff present were concerned to protect the other children.”

There was a meeting on the 19th October 1993 between the School Governors, a Camden Education Officer, Mr Jones, Jenny Park and Claudette Joseph, following which it was decided that Daniel should return to school on the 31st October, but that he should also receive counselling at Springfield Hospital in Tooting, which has a special clinic for deaf children run by the National Deaf Service (NDS) which is part of Pathfinder Mental Health Services NHS Trust (one of only 3 specialist NHS units in the country for deaf people who need mental health services).

Daniel returned to school, having been referred for counselling, and appeared to be settling down again. However there was a further incident on the 24th November at breakfast when Daniel took two eggs and put them in his pocket and refused put them back when asked. He did eventually return the eggs, and the only time he showed any aggression was when he kicked the kitchen door open when returning them to the kitchen. However when asked not to kick the door, he closed it gently and sat down. The incident was reported to the headmaster Mr Jones who later talked to Daniel about it. Daniel asked for paper and drew several pictures mainly indicating his own death and also a picture of himself in prison. He refused to discuss his drawings with Mr Jones.

We were struck by the contrast of the sinister content of Daniel’s drawings to the trivial nature of the incident which seemed to have precipitated them. These drawings are reproduced at Appendix 3. They show vividly how Daniel tended to accept blame and expected punishment. With the benefit of hindsight they appear remarkably prophetic, but in no way could be seen as predictive of his later behaviour.

On the 17th January 1994, Daniel was seen at Springfield Hospital by Dr Peter Hindley, Consultant in Child and Adolescent Psychiatry at the NDS and Valerie Leach, an NDS Social Worker, who is herself deaf. Daniel told Dr Hindley that communication at home was a problem and he felt very frustrated although he clearly had a high regard for his mother. He talked at length about football and how he believed in keeping fit. It was noted that he seemed proud of his physique and a touch of aggression was detected as he described it.

On the 8th February , there was an incident at school during a game of football. Daniel got upset about a particular boy playing on the opposing team and Daniel initially walked off the field. He then came back and told the boy to leave. When the teacher intervened, Daniel got abusive and the teacher signed to him to get off the pitch. He stormed off and tried to attract attention by throwing small pieces of wood around. He was ignored by the other children who was still very much involved in the football game, which seemed to infuriate Daniel, who became visibly more angry. He went to an area behind some sheds which was out of bounds to the children because it was a dumping ground for items (such as fridges and scrap metal) which were awaiting collection. He began to throw larger items around, but none in the direction of the children playing football who still ignored him. The Deputy Head, Mrs Ford, went out tried to try to talk to Daniel. As she approached him, he picked up a wooden chair and held it above his head, before flinging it to the ground, breaking it. He then it did the same with a large wooden garden bench. There was no eye contact. **[Eye contact is of course essential when one is deaf.]**

He then picked up a brick and threw it to the ground, before climbing over a fence. He began throwing stones at the wall of a shed which contained sheep, and Mrs Ford signed to him not to throw things at the the shed because the sheep would be frightened. He stopped throwing stones and walked away across the field. Other teachers reported that Daniel had then knocked over two Portaloos, broken the pipes on others and was attempting to lift and push over one of the teacher's Campervans. Daniel then climbed a tall tree in the grounds where he remained for the next four hours. He eventually came down and was found in his bedroom at about 7 p.m. and then went to have his supper. Mr Jones went into speak to him in the dining-room. He asked him why he was so upset. Daniel appeared agitated. When Mr Jones asked him if he wanted to go home, he banged his head on the table, then raised a heavy milk jug with both hands, but allowed Mr Jones to remove it from him. Mr Jones told him that he wanted to talk about the problems earlier in the day. At this Daniel jumped up - pushing his chair backwards and stood facing the headmaster in a karate stance. Mr Jones told him he was not staying to argue and he was going to his office. Daniel apparently made a lot of noise as Mr Jones left the dining-room and followed him down the corridor. Mr Jones turned to ask him if he wanted to talk, and Daniel then took a fire extinguisher from the wall and held it above his head as if to throw it towards the headmaster. Mr Jones thought that he was just posturing and would keep his distance, but he then took out the pin and sprayed Mr Jones several times. He then approached him using karate type kicks and chops, still holding the fire extinguisher in one hand. Mr Jones decided that the situation was beyond his control and he called the police. Two Police Officers arrived shortly afterwards. Daniel, who was watching from an upstairs window, saw their car arrive. He went down to the corridor by the General Office and *"assumed the position"* ie. he lay on the floor, face down, with his hands on his head. When the Officers came into the school, he put his arms out as if ready to be handcuffed. The school GP was called who read the notes about Daniel while Mrs Ford talked to Daniel. Daniel told Mrs Ford that he had been treated unfairly in the football game. Mrs Ford comments in her report that *"Football is Daniel's life, it is the only real interest he has"*. Daniel then took a piece of paper and wrote: *"Daniel, jail go now"* above a drawing of a prison cell window. Beneath it he wrote *"Now go, Goodbye"*. When Mrs Ford asked Daniel why he wanted to go to jail, he signed that he was *"bad"*. When Mr Jones went in to speak with him, Daniel appeared much calmer, and it was agreed that the police and the GP need

not stay. Daniel asked to go home. He remained calm and was allowed to go home the following day.

Dr Hindley and Valerie Leach visited Daniel at Penn School two days later on the 10th February (This visit had been pre-arranged the month before) and Val Leach carried out two home visits over the next few weeks.

Valerie Leach told us:

“I felt right at the beginning and right to the end that Daniel’s communication with his mother was only when he wanted something, and it was always on a simple, basic level....

His level of sophistication in the use of sign was not good enough. You could not express an interest in what was happening outside in politics or in the news or outside of the family. He did not seem to want to know either. I do not know whether that was because of lack of interest or he simply did not have enough communication skill...In reality, I think his use of sign language was quite deprived.”

In an assessment report sent by Dr Hindley to Jenny Park, the Specialist Social Worker with the Sensory Impairment Team at Lambeth Social Services, he wrote:

“Daniel is a 15 year-old deaf young man who clearly has a number of strengths but has a number of complex difficulties. In the main Daniel is a pleasant, helpful and sociable person. At school he has good relationships with other children and a number of staff. However in addition he has a number of long-standing problems. Firstly, in his relationship with his mother and other important figures in his life, he needs considerable reassurance, particularly at points of change. In addition Daniel has high levels of activity, poor concentration span and is distractible in unstructured settings. Finally Daniel has episodes of severely verbally and physically aggressive behaviour, primarily following disagreements and confrontations with members of staff.

I believe that three major factors should be taken into account when considering Daniel's difficulties. Firstly, temperamentally Daniel appears to have been overactive and has a poor concentration span since an early stage in his life. Secondly, his need for reassurance in his relationships with important figures in his life, probably reflects the history of early separation that occurred in his first three years of life. Finally, his temperamental attribute and these experiences have further been exacerbated by the sexual abuse that Daniel experienced for at least two years. I would suggest that the moments when Daniel feels particularly angry, he is also preoccupied with feelings of shame, self-disgust and utter isolation and these may stem from his experience of being abused.

I would like to make the following recommendations. At school, that the moment when Daniel becomes particularly angry, I would suggest that it is important that a member of staff, with whom he has good relationship, be available for him when he is ready to communicate. This person should not directly approach Daniel, but remain within his eyesight, responding as and when Daniel makes attempts to communicate with him or her. It would be important that this person has backup from members of staff readily available but not visible to Daniel. I would like to suggest that this arrangement would diminish the sense of isolation that Daniel experiences during his moment of fury and should prevent a massive escalation. Secondly I think it would be appropriate to endeavour to offer Daniel individual counselling if he feels that this is the appropriate time...

Should Daniel's behaviour deteriorate again, I think it would be appropriate to consider an inpatient admission as the next step."

On 19th May 1994 Daniel was on a school trip on a narrow boat near Coventry when he had a disagreement with one of the teachers about keeping the interior of the boat tidy and the ownership of a newspaper. There followed an eyeball to eyeball confrontation and then Daniel indicated that he wanted to get off the boat and walk along the towpath. He was seen to be upset and crying. When spoken to by Mrs Ford, Daniel agreed that the confrontation had been over a newspaper and that it had got out of hand. However he did not want to continue on the trip and agreed to go home to prevent any more difficulties.

On the 1st June 1994 Daniel was at home (for the weekend?) when his mother telephoned Jenny Park to say that Daniel had packed his bags and left home. She said that he was upset and angry with her because she had refused to let him watch a particular film on TV. He did not return until the following day. When Val Leach visited that day, Mrs. Joseph said that she was very worried about Daniel and asked if he could be accommodated in a hostel. For several days Daniel refused to go back to school, but then did return.

There was a further incident on June 23rd. Once again Daniel was playing football, this time at Haslemere Youth Centre, and a mistimed aim at the ball by another boy meant that Daniel was kicked on the ankle. Despite his opponent apologising to him, Daniel became agitated and after the final whistle a few minutes later, he stormed off, got on the school bus and caused damage to the indicator/windscreen wiper stalks and pulled up the hand brake so that it jammed. He then left the bus and refused to get back on it, so that it left for school without him. Later that evening, back at the school, Daniel had not been seen and was reported missing and the police were once again called. Daniel had in fact returned to school unnoticed and was in his room asleep. After the police left, Daniel stripped the bed of the boy who had kicked him and was destructive to various objects in the boy's room. Once again Daniel calmed down quickly, but was still sent home. His mother had gone to Trinidad for a month's break and therefore he had to be looked after by his now blind grandmother.

Daniel's mother made fairly regular trips to the West Indies, and we have noticed that Daniel's behaviour often deteriorated when she was away.

Following this latest incident, the decision was made to permanently exclude Daniel from school. The NDS Team and Lambeth Social Services were informed of the decision.

Shortly after Daniel's exclusion from school, a thirteen year-old girl with cerebral palsy at the school made allegations that Daniel had raped her four times. Daniel was interviewed by the police on 9th August. The girl's evidence was apparently confused and inconsistent, and none of the Staff at the school could believe that Daniel was involved in such behaviour. The alleged incidents were said to have taken place during the time when Daniel was in fact at home having been suspended from school the first time. The notes record that both Daniel and his mother were shocked and upset at the allegations although Daniel remained calm. He thought that he might have to go to prison although he denied that the incidents had taken place. Mrs Joseph was anxious to keep the matter "a secret". On 17th August Mrs Joseph told Jenny Park that one of Daniel's half-sisters had said that he had sexually abused her before she was received into care, but she had subsequently withdrawn the accusation. No charges were ever brought against Daniel. However it was decided that Daniel should be offered a counselling programme dealing with social skills, anger management and (with care) sex education. This was undertaken both by Val Leach and a male social worker from Lambeth Social Services Sensory Impairment Team, Alex Cranwell, who is himself deaf. He attended these counselling sessions regularly and was congratulated on his excellent attendance rate.

Val Leach told us:

"I think I did 10 or 12 weekly sessions with Daniel at one time and part of that work was about making himself more clearly understood by other people. For example, I would give him ideas about how he could say how he felt about things in a more effective way without giving in to his feelings. For example, if he could not have what he wanted, previously he would shout, he would lose his temper. I was trying to give him options about how to ask for things he wanted, how to explain how he felt. He made some progress in that respect.

He knew he had lots of powerful feelings inside him and sometimes he found it difficult to manage those powerful feelings. He was thinking about his early life experiences and things that had happened to him which affected him greatly, and it was very difficult for him to contain his feelings. There were lots of things he had not worked through. But the improvement in his language was not sufficient for him to understand the world around him...

I think after he left Penn School he became increasingly isolated. He was not communicating with anybody within or outside of the family and so his world became very

restricted. He became focused on himself. His inner world was the only world that he had. There was no-one to challenge the way he was. People knew that he would quickly get into a temper, so I think they indulged him and let him get on with his life. Really he had never been challenged or helped or people had not given him options in his life, and so he was left to his own devices. He became very obsessed with wrestling, he liked watching it and it was linked into his obsessions with his physical strength. I suppose it was part of his fantasy of developing his own physicality and his own strength.

I think it was a way of defending himself against bad people because he had been sexually abused, he had been let down by people and he valued trust. He felt it was important to trust and believe in someone, but there was no-one, apart from his mother, who he really trusted.

His world just became smaller and smaller and smaller, focused very much on himself. I was an outsider who did visit him and also the Lambeth Social worker was another outsider who would just visit...His world became focused on his own physical strength and television and there was an unreality about his life in general. He simply was not interested in anything outside of that."

In the meantime Daniel was not receiving any education, and plans were made for him to attend the 16+ department at Oak Lodge, a school in Wandsworth for the hearing-impaired, in September 1995. (The school had said that they were full when attempts had been made to send Daniel there in September 1994). Daniel was keen to go and was very upset in April 1995 when the school said that they could not take him. The Headteacher wrote to Mrs. Joseph:

"I am not able to offer Daniel a place in our 16+ department this year. His needs, both in terms of learning and in the social and emotional support he will require, are very different from the other students in the department. He would, in my opinion, need a significant amount of individual help, and our resources are such that we are not able to offer him that level of support."

In the meantime Daniel was referred to the Lambeth Tuition Centre, but they were unable to take him as they had no teacher who was trained to teach deaf children. Although there was some talk about arranging special tuition for Daniel with the support of a sign language communicator, that never in fact took place, as far as we are aware.

A suggestion was made about Court Grange, a college near Newton Abbot in Devon, but Daniel was so keen to remain in London that that was not pursued. In September 1995, he began a special pre-vocational course for deaf students at Southwark College. For the next year he attended the college and seems to have done quite well, establishing a good rapport with his tutor. The college was willing for him to continue for a second year. His

mother reported that he was quite good at home, but that he tended to spend hours locked in his bedroom on his own.

In May 1996, Mrs Joseph telephoned Jenny Park and expressed concern about Daniel because some ten days previously he had been out locally with his brother Garth when some white youths in a car had mounted the pavement and tried to run Garth over. Since then, Daniel had been very upset and had locked himself in his room. By the end of June, Daniel was still very anxious and "quite paranoid" about people outside. He was staying in a lot, shutting himself in his room and going to college very little. Mrs. Joseph told Jenny Park that when Daniel was eighteen (he was then seventeen) she would like him to live in his own flat. Jenny Park referred Daniel to Val Leach for counselling about the incident, and after she had seen him, Val Leach wrote to Jenny Park on the 12th August:

" Daniel was able to talk through his feelings following the incident. He admitted feeling very upset and not wanting to communicate with anyone. He described his feelings of shock, numbness and his powerlessness to retaliate. He perceived the boys as having got away with it when he felt they should have been dealt with appropriately by the police... As there were apparently no witnesses, the police were unable to deal with the matter further. Although he had felt terrible about this at the time, he is now philosophical but still feeling some disappointment. Daniel was praised for trying to put this behind him. He admits to wanting to protect Garth and feels very vulnerable for him.

Daniel then talked about his developing social life and his attendance at Southwark College in a positive manner. He is forming relationships with his peer groups and he is aware of his sexual attractiveness to the young ladies! He remains very protective of his mother and cares for her deeply.

It is pleasing to see how Daniel is learning to cope with life outside his home and developing insight into how other people might be feeling in certain situations. He explained he is eager to promote his understanding of some BSL signs which appear ambiguous to him and his literary skills. He recognised that improved/meaningful communication skills can be positive elements in developing relationships with other people.

I have offered Daniel another appointment but he did not attend. I wrote to him about his visit here but as he is now obviously wanting to get on with his life, I am not planning to see him again. We have therefore discharged him from our service."

However on 21st August, Jenny Park had cause to write again to Val Leach:

" Further to my letter to you a few days ago I now have to write and let you know that we spoke too soon!

Yesterday I received a telephone call from Daniel's mother saying that there had been a family argument over the weekend when one of the older children came and started an argument. Eventually Miss Joseph had to call the police which of course distressed Daniel considerably. He is now feeling very anti that sibling and very protective towards his mother. There has been more head banging, shutting himself in his room and general anti-social behaviour.

Miss Joseph is again asking if he could see you. It seems that whenever there is some relatively minor incident that Daniel reacts very badly and does not know how to handle his thoughts and feelings. This is of course understandable as there is no-one in the home whom he can discuss his feelings with.

I'm very much wondering if you think there is any way whereby we can set him up with a regular arrangement so that he can meet someone on a regular basis and learn to use that opportunity to talk over any incidents or feelings which are troubling him. I fear that unless we can make such an arrangement we're going to have a regular series of referrals. It does also seem to me that Daniel can make good use of such opportunities."

On 12th September Val Leach wrote to Daniel offering him an appointment on 2nd October at High Trees, the Child and Adolescent Unit at Springfield Hospital. He did not keep that appointment. On 23rd October Val Leach spoke with Mrs. Joseph who said that things were not good at home " *because Daniel is getting very high*". He was insisting on going to the USA and his mother felt unable to handle the situation. Daniel had apparently come down that day and had thrown all the supper dishes on to the floor, slammed the door and walked out. His attendance at college fluctuated, depending on his mood.

The next day Dr Peter Hindley and Val Leach made a home visit to see Daniel. Following this meeting, Dr Hindley wrote to Daniel's GP:

" Mrs. Joseph gave a history of Daniel becoming increasingly active and irritable, leading to episodes of physical aggression towards her and objects at home. This has coincided with Daniel becoming markedly preoccupied with the World Wrestling Federation (WWF) and developing a belief that he should go to America and ask one of the wrestlers, Shaun Michaels, to teach him how to wrestle. Over the same period of time Daniel's sleep pattern has diminished. Over the last three years he has had a persistent pattern of sleeping during the day and waking at night. However over the past one-two weeks he has slept less during the day.

Daniel appeared restless and highly irritable, repeatedly telling people to shut up if they tried to interrupt him and telling people he did not like to leave the room. Daniel communicates in British Sign Language and he appeared unable to talk about anything

apart from WWF. Both Mrs. Leach and myself repeatedly tried to talk through with Daniel the reality of his plan to meet Shaun Michaels. Daniel refused to relinquish this belief and became increasingly irritated with us as we tried to show him that it was based on false premises. Daniel's sign was pressured and it was markedly faster than on the last occasion when Mrs. Leach met Daniel.

I came to the conclusion that Daniel was experiencing an episode of hypo-mania and suggested to him that he might benefit from drugs to help him calm down. In particular I was planning to prescribe haloperidol. I was frankly not surprised when he refused my suggestion, point blank.

It appeared to us that Mrs Joseph was under considerable pressure but that her irritable response to Daniel, was resulting in an escalation in Daniel's irritability. I advised Mrs. Joseph to respond in a non-confrontational way and as far as possible to try to keep calm when Daniel was provoking her. We have arranged to visit Daniel again on Monday evening in order to reassess him and again attempt to encourage him to accept medication. In the meantime I will discuss Daniel's management with my colleagues in the Adult Service to see whether or not they believe that his presentation warrants admission."

[Daniel was at this time seventeen and a half and was therefore borderline between the adolescent and adult services. There is no record of a further assessment having been carried out the following Monday]

On 1st November Dick Freeman, the teacher at Penn School of whom Daniel had been particularly fond, died suddenly. Daniel was badly affected by the death of this man whom he had regarded as a father figure. He attended his funeral. His mother told us that he was very solemn and did not speak at all at the funeral, which was very unlike him. He was usually a joker.

On 27th November 1996 Mrs. Joseph told Val Leach on the telephone that Daniel had packed up all his belongings and left home at seven o'clock that morning to go to the London Arena to meet the wrestlers from America, believing that this would be an opportunity for them to take him to America with them. He had been preparing to go for the past four nights and could not be persuaded to stay at home. He had been taken by Matthew Gillett, his "stepfather", in an attempt to pacify him as he was "*in such a state*"-noisy, belligerent and unreasonable. Mrs. Joseph said that Daniel had a "*hold*" on Matthew who was "*afraid of him*". She was concerned as to what Daniel's reaction might be when he realised that he could not go to America.

On the evening of 27th November Daniel and Matthew went to a WWF event at the London Arena. Daniel had gone with all his bags packed and his passport (which was in fact out of date), believing that he would be able to go to America with the wrestlers after the show.

No-one at home appears to have tried to dissuade him from this belief. At the end of the event Matthew try to approach a referee in order to gain introduction to one of the wrestlers with whom he wanted to discuss the possibility of going to America with them. There was an altercation between Daniel and Matthew who tried to prevent him. Matthew then left Daniel at the Arena and went home.

Daniel was returned home at about midnight by one of the Security Guards from the London Arena. When Daniel arrived home he became extremely angry with his mother, Matthew and his brother Garth, accusing them of preventing him from going to America. It is not clear whether or not he physically attacked them, (there are no reports of any of them being injured in any way) but he did pick up a kerb stone and threw it through the front window of the house. The police were called by Mrs Joseph and Daniel was arrested.

The following day Mrs. Joseph and Matthew went to High Trees to tell Val Leach what had happened. Val Leach then contacted Jim Heron, the Manager of the Sensory Impairment Team at Lambeth Social Services Department, to advise him that Mrs. Joseph would be coming to see him to discuss accommodation for Daniel, as she had decided that she could not have him back at home as her other children were at risk from further physical aggression.

Dr Hindley saw Daniel in Kennington Police Station on 28th November, following a telephone call from Mrs. Joseph. In a letter to Daniel's GP, Dr Hindley described how Daniel had told him what had happened the night before and said that the family were deliberately preventing him from moving to America and that he intended to take them to Court because they had hurt him in the past, repeatedly having beaten him, causing him brain damage. He said that Daniel remains convinced that he would be able to move to America in order to train with the WWF, and interpreted a travel club document that the WWF had sent to him in response to a letter asking for training, as an invitation to work and train with them. Daniel said that he hated his family and felt they were all against him. He initially talked about beating them up when he saw them, but then went on to talk about stabbing them and shooting them and killing them. Dr Hindley concluded the letter:

"I have found it difficult to assess Daniel's mental state over the last month. At first I wondered whether Daniel's belief that he could move to the WWF was a reflection of his naivety and lack of understanding of the world, as a consequence of limited communication arising from his deafness. However, my interview with him yesterday suggested to me that he is now starting to show signs of a first episode of mania, with pressure of sign, suggestion of flight of ideas with a strong paranoid flavour to his thoughts about his family. It appears to me that his beliefs about the WWF and his family's plot against him have delusional qualities."

Daniel agreed to be referred for in patient assessment and treatment at the South Western Hospital. Dr Hindley had felt that Daniel might refuse admission, but he accepted it willingly

and was transferred to the Nelson Ward at the hospital that night and remained there until he was transferred to the Lloyd-Still Ward at St. Thomas' Hospital on 3rd December, St. Thomas' being in his local catchment area. Although very angry at his family when he was first admitted, the nursing notes throughout his stay at South Western Hospital show him to be calm, pleasant and no management problem.

At St. Thomas' he was under the care of Dr Teifion Davies, Consultant Psychiatrist. For the first couple of days on the Lloyd -Still Ward Daniel there were no reported problems, but the hospital staff could communicate with him only by using written notes. On 5th December a sign interpreter accompanied the Doctor on the Community Ward Round and they spent about an hour with Daniel. He was still preoccupied with wanting to go to the USA and most of his conversation was about his anger against his family. Fairly late that evening Daniel was visited by his older sister, Marion. She told the nursing staff that she had been asked to talk to them about Daniel's background. She explained that Daniel and the rest of the family was dysfunctional and that the children would often fight each other. She said that none of the family had ever learned signing and that his mother had sent Daniel off to boarding school where he had " surrogate parents" whom he adored. The " surrogate father" had recently died suddenly, since when Daniel had become aggressive and badly behaved. She said that Daniel often had an " acidy smell" coming from him and that he had been suffering from headaches. His sister said that Daniel gets fixed on ideas and finds it difficult to let go of them. He had also been watching WWF wrestling and had decided to go to America with the WWF team. When he found he couldn't go with them he blamed his mother. During this conversation, there was a disagreement between Daniel and his sister and they started fighting each other, having to be separated by the ward staff. Security was called and they were kept apart until Marion left the ward. Both of them suffered bruises during the altercation. The following morning Marion phoned the ward and stated that she was going to press charges against Daniel for assault. **[As far as we are aware she never did.]** She also telephoned the Social Workers and told them about the incident, and said that she believed that Daniel was "not mad but frustrated." She believed that the problem lay in the fact that Daniel was never punished at home because of his disability and had grown up spoilt. She said that the fight had arisen because she had not accepted Daniel's argument that he should take his family to Court. He had ultimately got so frustrated with her that he physically attacked her. She felt he was being a bully because he could not get his own way. She felt he needed to be punished because he has not been punished for his previous bad behaviour, and he needed to see the consequence of his actions. She did however say that Daniel had never hit her before.

Again throughout the nursing notes, Daniel was described as calm, polite and pleasant. He said that he did not want to see any of his family at present. The SHO made following note on 10th December:

"Over weekend confrontations with family, who have " thrown him out". His sister tells me he had an appalling childhood - virtually no emotional input - none of family signs so he can't communicate. I suspect much of his behaviour can be understood in this context."

One of the nursing entries also describes that Daniel found it " *frustrating about communication skills... thinks that everyone wants to know his business and finds it difficult to trust others.*" The note goes on to recall that when talking Daniel jumped from one subject to another and got upset when he couldn't have his own way in a conversation. Daniel was however still having to communicate without being able to use BSL. The plan was therefore to transfer him to Old Church, the National Deaf Service (which is part of Pathfinder Trust) hospital in Balham as soon as possible, but there were no emergency beds available for another 3-4 weeks. On 13th December Dr Angus, Senior Registrar to Dr Teifion Davies, wrote to Dr Nick Kitson, at that time the only Consultant Psychiatrist on NDS's Adult Team:

"We have found it extremely difficult to formulate Daniel's case. We initially believed that he was suffering from hypo- mania. This was in part based on the history that his mother gave us of Daniel becoming more irritable and aggressive over the past few weeks and on some fixed ideas that Daniel still holds about going to America, which seemed very unrealistic, verging on the delusional. He was signing very fast, possibly with flight of ideas and punning, e.g. " the old man had a heart problem. Do you know Brett Hart, he is very famous?" He was, and remains, preoccupied with taking his family to court as they are stopping him going to America.

Since being on the ward he has been no management problem and is not on any regular medication...

Our concerns are that we are missing a hypomanic episode which is being contained by the ward environment rather than medication. We have arranged for a drug screen to rule out a steroid psychosis. [It was negative]

Daniel is experiencing his inability to communicate with staff and other patients on the ward as very frustrating, and we share these frustrations. We do not feel that we have the additional expertise required to give Daniel the quality of care that we would wish to."

Val Leach saw Daniel in St Thomas' on 18th December. Daniel was adamant that he did not want to return home to the family. Indeed he wanted no contact with them at all. As well as describing past events which had upset him, Daniel told her about his frustration and irritation at the difficulties of communication, and felt that his needs were not always fully understood. He spoke about taking them to Court (he said as a pretence) as if he wanted to teach them all a lesson "that Daniel should not be teased, ignored or abused in any way." He felt hurt and disappointed with them and wanted to strike out on his own and become famous. He wanted to tell them that he must not be treated as they had treated him in the past. He also told Val that the death of Dick Freeman had left him devastated and that he had cried for nine hours non-stop. He said that his mother was not sympathetic and had in fact laughed at him and he was deeply affronted by her attitude. He said that he felt isolated on the ward as no staff had signing skills, but he also felt calm apart from being

unable to communicate. He did not consider himself to be mentally ill but he liked having a "nest" on Lloyd- Still Ward. He was still hoping to go to America to become a famous wrestler and always to be strong. He was unable to be realistic about his chances of going to the USA and believed it to be a real possibility.

On 23rd December Daniel wanted to leave the hospital and it took Dr Angus an hour to persuade him to stay to see Dr Kitson who had been asked to see him the following day.

Dr Angus wrote in the notes to Dr Kitson:

"Thank you for seeing Daniel. From his behaviour on the ward for the last three weeks it is unclear if he has a psychotic illness. Seems to have a lower than average IQ, coupled with an underdeveloped personality, younger than years, and emotionally deprived childhood - perhaps this explains his current mental state.

Would you let us know if you feel he is detainable if he wishes to go. I would not have detained him today if I had been unable to persuade him to stay"

On 24th December Dr Nick Kitson saw Daniel as an outpatient at Old Church.

Following his assessment, Dr Kitson wrote to Dr Angus:

"Today Mr Joseph presented to me in a very similar fashion to his presentation to Dr Hindley. It was not possible to gain an accurate history from him in an ordered fashion due to his communication style. He was able to sit quietly for 5-10 minutes while I read his notes etc. At that time he sat still maintaining an emphatic bored expression and posture. As soon as I started an attempt at dialogue, he launched into a monologue, with progressively increasing arousal. He was very controlling, by use of gaze avoidance, continued talk and determined halting signs to me. It was rarely effective to interrupt him. There was poor reciprocal communication, including attention to my communication needs. He signed in fluent rapid BSL with little attention to context, making the content difficult to follow in detail. His prolonged utterances did not follow a logical sequence though his sentences were grammatical and complete. There were loose associations, around the themes with which he was grossly preoccupied i.e. being famous in the World & American Wrestling field and his nuclear and wider family having physically abused him and ignored his needs. He grandiosely expected to become a famous wrestler with all the acclaim and trappings of a rich American, but similarly complained that his family were preventing him. He fleetingly acted angrily and threateningly towards me as if I and St. Thomas's were party to preventing his ambitions, then equally quickly reverted to a grateful co-operative stance as if we were assisting him with his family problems.

At one point he referred to SM and other famous American wrestlers that he was watching on TV inviting him to America to join them. It was difficult to confirm this utterance due to

his aforementioned communication style, though he clearly gave affirmatives to my restating his account, that the TV was talking about him and had invited him specifically to America.

I am almost certain that Mr Joseph is suffering a psychotic illness. I am uncertain as to the precise diagnosis and believe that admission to a signing ward for observation will assist. My experience of similar patients suggests a schizophrenic rather than manic illness, but time will tell. It appeared the stimulus of a communicating environment wound him up. It is likely that he has been relatively settled in St. Thomas' because it is non-communicating. This would also fit his graphic descriptions of family life winding him up and of St. Thomas's as a peaceful haven away from them.

In view of his aggressive response to me, the aggression to his visiting sister and earlier to his family and others I believe he is currently detainable under the Mental Health Act, if he refuses voluntary treatment. He was accepting of voluntary hospitalisation at my assessment and after a brief adamant refusal to be admitted he importuned as to when he could be transferred. He was consistently adamant in his refusal of any drug treatment, believing that would harm his body and his fitness to wrestle."

Daniel was transferred from St Thomas' to Old Church and to the care of NDS on 27th December 1996. St. Thomas' Discharge Summary gave a provisional differential diagnosis of manic episode or adjustment reaction. He was still a voluntary patient.

On review on 2nd January 1997, his thought processes seemed more coherent and appropriate. He said that he wanted to go to Court Grange (the college near Newton Abbot in Devon to which he had not wanted to go in early 1996 because he wanted to stay in London with his family) for two years to obtain a certificate - he wanted to learn woodwork and tiling - and then he wanted to go to America. When asked why he wanted to America he answered because his "other mother" and grandmother were there and he had not seen his grandmother since he was a baby. He had also written to Shaun Michaels the American wrestler and he wanted to see him when he got to America. It was considered that these were possibly grandiose ideas. He also said that he wanted to distance himself from his family and did not want the hospital staff to tell his mother where he was. When asked if he heard voices, he described hearing J. K. (another patient) shouting, the door slamming etc. **[It was highly likely that he in fact did]**. He denied having a mental illness.

When seen on the Community Ward Round by Dr Kitson on 3rd January, Daniel described having parallel families - one mother and one sister - in both England and America. When questioned more closely by Dr Kitson, he became agitated with exaggerated signing and posturing. He was felt to be psychotic. In a subsequent interview on 6th January, he again talked about having two mothers and wanting to go to America. His signing became increasingly rapid and difficult to follow with very "jerky" hand signs and he gave minimal

eye contact. Topics merged into one long story with no clear boundaries of and no sense of time scale.

He was started on sulpiride (an anti-psychotic drug) as medication. There were no problems with compliance and he caused no difficulties on the unit.

On the 28th January Daniel began to talk about leaving the unit and going to college. He wanted to pass his "certificate" and then go to the USA. It was noted that he had a simplistic and very unrealistic view of things which was also slightly grandiose. He went home and collected his TV and video, and whilst there had an argument with his sister and caused damage to her car. It was noted that the nursing staff were concerned that he was not taking his oral medication and that he was more suspicious than before. On the 31st January of his medication was changed to risperidone (another anti-psychotic drug) but he soon developed side-effects, and his medication was changed again, this time to add procyclidine (normally given to reduce side-effects).

Dr Kitson saw Daniel on 12 March when Daniel again expressed himself to be keen to go to Court Grange to gain a certificate and then go to America. He said that he was getting on better with his mother but still wanted to move away from home. He appeared reasonably calm and friendly with no evidence of grandiose ideas about America or wrestlers. Dr Kitson noted that he was much improved and that he probably no longer needed inpatient care other than to enable his future social care.

On 13th March there was a Key Worker meeting when it was felt that Daniel was now well enough to leave hospital, but his housing and future education means needed to be clarified. Daniel was still saying that he did not want to move back into his mother's home and would like an independent flat, preferably in London, and he said that he would like to learn English, Maths and Computer Skills. Following the meeting, Toby Robinson, NDS Social Work Team Manager, wrote to Jim Heron Team Leader of Lambeth Social Services Sensory Impairment Team, informing him that Daniel was now well enough to be discharged, and that they needed to discuss as soon as possible the issue of a placement for him and whether or not Lambeth would be funding any such placement. Also at the Key Worker meeting an intellectual assessment was requested because there were concerns that Daniel often did not appear to understand relatively simple conversations. The assessment was carried out on 19th March and the subsequent report concluded:

"Daniel's performance on this test does not suggest that he has a learning disability. Indeed, his scores may slightly underestimate his ability because of his lack of motivation to be quick on the timed subtests. The digit symbol is particularly sensitive to this. Excluding the digit symbol would lead to a pro-rated performance IQ of 87, compared to the figure of 83 still within the low average range. Because only the performance scale of the WAIS-R was used, this result does not rule out specific language or communication

difficulties. Further investigation by the Speech & Language Therapist could clarify this point."

On 17th April Dr Kitson saw Daniel at Daniel's request. On this occasion he said that he wanted to go to Court Grange and that when he had passed a certificate he wanted a job in the hotel trade, cleaning, cooking or general repair work. When he had earned enough money then he wanted to go to the USA. He realised that this could take a few years.

On 2nd May Dr Kitson wrote to Jim Heron setting out the background to Daniel's admission to hospital and his treatment and progress. He ended the report:

"Due to his improved mental state he is ready for discharge, but his home situation and extreme naivete makes it essential that he is discharged to a residential setting with opportunities for habilitation. He is particularly suited to placement that would offer vocational opportunities as well as domestic habilitation such as RNID Court Grange College. He is now highly motivated to improve himself, is motivated to manual or semi-skilled employment."

At the same time Toby Robinson wrote to Jim Heron enclosing some information about Court Grange and saying that he would like as soon as possible the decision about whether Court Grange could be pursued with an initial visit by Daniel. The letter concluded:

"There will obviously be pressure on us to discharge Daniel if there is no good reason for him to remain and if Daniel himself does not see some movement in response to his improved mental health there is always the danger of him deteriorating."

At an appointment with Dr Kitson on 22nd May Daniel said that he wanted to leave Old Church to get a flat. Dr Kitson told him that he was free to leave at any time though they were happy to help him if he stayed at present. He wanted to know when he could go to Court Grange, move to a flat and or visit his Aunt Victoria in America. After clarifying the somewhat complicated family tree with Dr Kitson, Daniel confirmed that he did not have another mother in America. Dr Kitson noted that he was clearly using words or signs for relatives loosely. He was still interested in the links with WWF and becoming a wrestler himself but he talked realistically about entry requirements to the USA. Dr Kitson's notes refer to Daniel being "*calm, motivated, appropriate but naive. Dealing sensibly with his situation..*"

On 17th June 1997 there was a Case Conference attended (amongst others) by Dr Kitson, Grant Payne (a Care Assistant at Old Church who was deaf himself), Toby Robinson, Mrs. Joseph and Daniel.

No-one from St Thomas' Hospital (ie. the referring service, Lambeth Healthcare NHS Trust was invited to the Case Conference so that Daniel's future aftercare in the community could be jointly planned. There was also no-one present from Lambeth Social Services, although we understand that they were invited, and it is fair to say that at that time they did not have a specialist Social Worker with signing skills on the Sensory Impairment Team. Jenny Park had left in the previous September and her replacement had not yet been found.

It was felt that it was rather early to be sure of a diagnosis, however mania, acute stress reaction or a more severe psychotic illness were considered as likely diagnoses. It was felt that given time and the reduction of medication in the future, the likely diagnosis would be revealed. It was agreed to continue Daniel's medication for the present (Risperidone 5mg/day). It was felt that Daniel needed a more settled environment with structure in which he could obtain general training and education. His current interest in football was addressed and it was acknowledged that his pursuance of football exclusively might lead to discouragement and relapse if he found the lifestyle too hard. It was suggested that Daniel returned home in one month, but Mrs. Joseph was quick to inform the Conference that her flat was small and that Daniel tended to stress his younger brother who suffered from an anxiety disorder. Dr Kitson accepted the desire for a calm environment to reduce the risk of relapse. It was felt unjustified to place Daniel in a medium-term rehabilitation environment given his level of functioning and his aspirations for a better environment for continued learning and training. Other options were discussed, including Daniel having his own flat and attending Old Church, or attending the City Lit. (a college in Holborn with specialist courses for both the deaf and the hearing) for specific courses. It was agreed that the best option was for Daniel to go to Court Grange where his stay would be stable, structured and focused on training to prepare him for independence in the future. Lambeth Social Services had agreed to part-fund his placement and were hoping that the Further Education Funding Council (FEFC) would also part-fund the rest. He would obviously still need a home in the holidays to return to if he did start at Court Grange in September or later in mid-term. The Case Conference decisions were:

- Discharge in one month's time
- Follow-up in outpatients by Dr Kitson
- Day care at Old Church and involvement in the Clubhouse (run on a 'user-led' model by a charity called SIGN)
- Social Services to follow-up funding for Court Grange
- To continue on Risperidone 5mg/day

The day after the Case Conference Toby Robinson wrote to Jim Heron informing him that the proposed discharge date was 21st July and asking him to find Daniel accommodation that could offer him support that he would need, always bearing in mind that Daniel would need have somewhere to go during breaks from Court Grange.

In July 1997 Lambeth Social Services employed Julia Hookway as a Specialist Social Worker for the Sensory Impairment Team. She would be Daniel's new Social Worker.

They had not had such a Specialist Social Worker since Jenny Park had left the department in September 1996 and therefore Daniel had been without a Social Worker for almost a year. We were alarmed to find that it is often the case that when specialist staff leave, it is extremely difficult to find replacements, especially one with sign language skills.

On 7th August Jim Heron wrote to request that the FEFC jointly fund, together with Lambeth Social Services, Daniel's placement at Court Grange. The Old Church clinical notes show that at that time Daniel was on a self-medication trial in preparation for his discharge.

On 14th August Daniel was discharged from Old Church and became a resident of Ian Collie House, a hostel for the deaf in Wandsworth run by Harding Housing Association, which runs a residential care service for deaf people with mental health problems. All of the staff use BSL, and the Association has a policy of 50:50 deaf to hearing staff. Daniel's placement at Ian Collie House was funded by Lambeth Social Services under the Community Care legislation. This was intended to be only a temporary placement of a few weeks, since the plan was for Daniel to start at Court Grange in September if the funding could be sorted out in time. Ian Collie House was also about to be closed down for renovation, and would not have been available for Daniel if his stay was likely to be anything other than short-term.

The Discharge Summary from Old Church recommended:

"His home situation and extreme naivete makes it essential that he is discharged to a residential setting with opportunities for habilitation.

Court Grange offers vocational opportunities as well as domestic habilitation and this is considered appropriate for him. He is highly motivated to improve himself and is motivated to manual or semi skilled employment."

The Care Plan was that

- he was to continue on Risperidone 2mg am and 3mg pm and Procyclidine 5mg pm;
- his CPN would be Selma Daley who was to see Daniel on a two weekly basis, and
- he would be followed up at Court Grange by Dr Louise Hamblin, Associate Specialist with NDS.

No diagnosis was given in the Discharge Summary.

There was no detailed CPA (Care Programme Approach) Plan upon discharge, and none had been drawn up at any stage of Daniel's care at Old Church.

The Discharge Summary was not copied to Dr Teifion Davies or anyone else at St Thomas' Hospital.

The Discharge Summary was copied to Jenny Park although she had not been Daniel's Social Worker for over a year, and Julia Hookway had been in place for over a month and had been to Old Church and had been co-ordinating his placement at Ian Collie House with the NDS.

The Care Plan sent by Lambeth Social Services to Terry Stanley, the Deaf Services Manager of Harding Housing Association, stated the following:

"Mr Joseph is a vulnerable young person. He is deaf, and is currently an inpatient at Pathfinders the specialist facility for deaf people who have mental health problems. He has no history of living independently and cannot return to his mother's household. He requires a residential placement where he can be cared for and monitored until the end of September when it is hoped he can go to Court Grange College."

Following his move to Ian Collie House, Daniel was seen by both Selma Daley and Julia Hookway, both of whom were concerned that his mood appeared to be slightly elated. As a result a review was arranged for 18th September, but Daniel said that he intended to go to a WWF competition in Birmingham on that date.

On 4th September, Julia Hookway telephoned Selma Daley to report that, because of funding complications, Daniel would not be able to go to Court Grange before December. She also told Selma of her concerns about Daniel's mental state and also that his mother was expressing some concern about the amount of time he was spending at home.

On 8th September Dr Kitson saw Daniel at Old Church at Daniel's request. Daniel asked if he and two Old Church in-patients could go camping for the weekend in Birmingham for a WWF contest. Dr Kitson told Daniel that his friends should seek their leave via the nursing staff and noted that Daniel accepted this with tolerance. Dr Kitson recorded that Daniel's signing was a little expansive, but that he had no grandiose ideas and was easy to interrupt, was reasonable but a little naïve, but with no bizarre preoccupations or ideas.

Daniel was seen two days later at the clinic at Old Church by Selma Daley and another CPN, Clare Campbell, who recorded in the notes:

"Appeared mildly elated, smiling and laughing often and signing quite quickly. Also jumping from topic to topic without break. States he doesn't sleep at hostel any more because they are too strict and they don't let him have a girlfriend to stay. Stays at parents where his mother is teaching him to cook and clean and manage his money. Stepfather came to clinic to speak with Selma. Said that he is happy with Daniel at home, although they have encouraged him to return to hostel. Stated that he sleeps eight hours each night and he eats meals with the family. His only worry is that Daniel talks a lot about going to USA and about being famous. He is very preoccupied with a wrestler named Sean Michael. His stepfather is taking him to see wrestling in 2 weeks and after that he will return to clinic to give us feedback as he feels that if there are any problems it will become evident then. Also Selma informed Daniel that (the) move to Court Grange College may be delayed. Daniel said he was not disappointed and was willing to wait."

Selma Daley wrote a report for the review meeting which contained the following:

"I have seen Daniel on 2 occasions and he appeared pleasant and friendly, however there was some evidence of mood elevation such as rapid signing, excitability and some inappropriate laughter. He also expressed some grandiose ideas, saying he felt he was "a little famous". He continues to express a wish to go and live in America once his course at Court Grange has ended...."

He appears to be complying with his medication and denies side effects. However he was reluctant to discuss administration of same in depth. A mental state assessment will be undertaken by a member of the medical team.

Ian Collie House staff initially reported that Daniel appeared to have settled well, however they expressed their concerns at the increasingly limited amount of time Daniel has spent there despite being advised against this.

Daniel has expressed a strong dislike of the hostel and is adamant he won't return. He says he would prefer a flat of his own and feels he has developed some independent living skills such as self care and cooking. He doesn't like the strict rules at the hostel, i.e.

inability to have a girlfriend there or drink alcohol and is unhappy that he is not allowed to have Sky TV.

[Daniel did not have a girlfriend at the time and he apparently never drank alcohol]

At present he spends his time at his mother's home, who he reports has been teaching him cooking skills. He also appears to spend a lot of time helping a neighbour with his home or just meeting friends nearby. Daniel also frequently visits Old Church to socialise with other clients...

To date, Daniel has complied with his CPN appointments and treatment, however it is proving difficult for the care home staff to monitor his progress and contribute to the development of social skills necessary for independent living.

I feel it may be helpful if we suggest his parents encourage him to sleep at the hostel during the week and return to the hostel by 9 pm on weekdays, to relieve some of the pressures his family may feel and allow some (although limited) contact with the hostel staff. I don't think Daniel would participate in a full OT (Occupational Therapy) programme however hostel staff could work on identifying some of Daniel's interests and facilitate participation in same if possible.

CPN to continue to see Daniel on a 2 weekly basis to educate and reinforce the importance of compliance with medication."

At the weekly Community Ward Round (a multi-disciplinary meeting to discuss any concerns about any patient) on 11th September, concern was expressed that Daniel's mood appeared to be elevated. On 15th September, Jane Finn (NDS CPN) took a telephone call from a member of staff at Ian Collie House. The staff were apparently worried about Daniel's non-compliance with certain ground rules. He said that Daniel had been encouraged to stay at Ian Collie House during the week but had been staying at his mother's instead. Mrs. Joseph and Matthew had reported that he spent a great deal of time at home watching TV and that he told them that he dislikes the hostel. The staff felt that he was wasting time and needed to be learning literary skills. The staff apparently spent hours of their time with Daniel trying to explain this to him. Daniel had asked if the review planned for 18th September could be rearranged so that he could go to Birmingham. Jane Finn (NDS CPN) spoke to Julia Hookway who agreed that the review meeting should not be rearranged. Julia had spoken to her manager who felt that Daniel was unwell at the moment and he wanted Dr Kitson's advice about a psychiatric assessment prior to him going to Birmingham, and Julia had therefore faxed a memo to Dr Kitson because she was concerned that Daniel's previous mental health episode had been precipitated by a visit to a WWF contest. The same day Terry Stanley, Deaf Services Manager of Harding House

Association, telephoned Julia Hookway and in the course of the conversation highlighted his concern at the lack of people who knew Daniel well.

Daniel was seen in outpatients at Old Church by Dr Louise Hamblin on 16th September. She noted that he appeared irritable and slightly suspicious and felt that the woman in the house next door to Old Church was causing trouble and therefore he decided to stay away from her. He continued to take Risperidone daily but refused to consider an increase in the dosage or to change to more sedative medication. Dr. Hamblin concluded her note:

"Need to discuss in CWR if he is sectionable".

The same day the matter was discussed in the Community Ward Round and it was agreed that Daniel was not sectionable at present but that the team would need to monitor him closely. Selma was to talk with his mother. The same day Selma Daley recorded in the notes that the inpatient nursing staff at Old Church had reported that Daniel had displayed aggressive behaviour on two occasions and that they were finding it increasingly difficult to ask him to leave the unit in the evenings. They reported an incident where he was kicking a fence and annoying a neighbour's dog, and then later became threatening and accused the dog of biting him although he had later admitted that this was not so. Riet Saward, the Assistant Care Manager of Ian Collie House, also reported that Daniel was now sleeping there during the week and agreeing to staff monitoring his medication. However she also reported that Daniel was showing some uncooperative behaviour i.e. refusing a meal offered to him and then later taking from the freezer frozen chicken, beef and sausages, and defrosting them under the hot tap and attempting to cook them. He had however accepted staff intervention without any aggressive behaviour.

On 17th September Jane Finn recorded a further call from Julia Hookway to say that the review meeting for the following day had been cancelled as Daniel was going to Birmingham with his mother. She said that she may have been *"panicking"* a little when she had called previously, as Daniel had been at the hostel all week and seemed a little calmer.

Mrs. Joseph told us about the trip to Birmingham. She and Daniel went together and Matthew Gillett was to join them later. They went to the National Exhibition Centre and they joined the crowd waiting to see Shaun Michaels, as Daniel wanted to get his autograph. Shaun Michaels only appeared for a few minutes and didn't even notice Daniel. Apparently as Shaun Michaels drove off in his car, Daniel chased after the car and disappeared from sight. This was at about 21.00. Mrs. Joseph contacted the Police who said that if he hadn't appeared at the place they were staying in Birmingham by 22.30, they would start looking for him. Mrs. Joseph went back to where they were staying and apparently Daniel turned up at about 22.00. Mrs. Joseph told us that she did not know how he had found his way there, but that he was good at reading road signs.

The next day Daniel apparently bought all the "Shaun Michaels gear"-his jersey, his leather hat and ear-rings, and dressed up just like him. The fight didn't start until 2000, yet by 13.30 Daniel was waiting at the Arena. He made friends with all the security guards, apparently buying them drinks, because he wanted to be at the front. He thought that he would get to see Shaun Michaels personally at the end of the show. However despite standing there like "*Mr Cock in his hat*", Shaun Michaels didn't take any notice of him. So Daniel asked the security guards to put him in the front line, but still he didn't get the attention of Shaun Michaels. This really upset Daniel who was very moody for the rest of the night, but the next day he woke up and said to his mother "*Future*", which she interpreted as meaning that he would wait until the future when he was older.

Daniel did not attend a CPN appointment on 1st October but was present the following day at a review meeting at Ian Collie House. Also present were Mrs. Joseph, Selma Daley (the NDS CPN), Riet Saward (Assistant Manager at Ian Collie House), Bron White (Daniel's Key Worker at Ian Collie House), Jenny Towland (sign language interpreter with Lambeth Social Services Sensory Impairment Team) and Julia Hookway (Social Worker). Daniel expressed a strong dislike of Ian Collie House, saying that it had too many rules and regulations. He said that he would like to live by himself somewhere in Norwich and felt that he was ready to live independently. Mrs. Joseph was fairly happy with Daniel living at Ian Collie House. She did not mind him coming home at weekends although there was really not enough room and she was also concerned at the cost of feeding him. The hostel staff reported that Daniel seemed more settled and over the last two weeks had agreed to sleep at the hostel during the week and go to his mothers at the weekend. They felt that Daniel avoided talking about issues concerning his future or improving his social skills. It was suggested to Daniel that he used the daytime facilities at Old Church but he said that although he visited occasionally he would not like to use Old Church everyday. He did not like visiting Old Church because he was afraid of the barking dogs around there and the old people sitting outside drinking. Selma Daley felt that Daniel was not complying with the structured day and Julia Hookway felt that Daniel needed to get balance in his life. Daniel agreed to talk to Bron White to work out a plan to occupy his days and to do his fair share around the house as part of improving his living skills. He agreed that the hostel staff should keep his medication and he would come and asked them for it. He would also inform them of his daily whereabouts.

Julia Hookway recorded in her notes that Selma Daley had not had regular contact with Daniel (she had only seen him twice) although the agreement was that he should see a CPN fortnightly. Selma had stated that she believed Daniel to be complying with his medication. Daniel agreed to visit Court Grange on 13th October and Mrs. Joseph and Bron White said they would like to attend as well. Bron White stated that he had worked at Court Grange previously. Daniel said that he was worried about another move and anxious about another change. He said that his long-term plans were to visit America to see his cousin whom he had not met since he was a small child. However he realised the importance of a "good education" and felt that getting qualifications was just as important.

Selma Daley recorded in her notes that Daniel's mental state was fairly stable at the time of her visit although she was made aware for the first time at the meeting that a few evenings earlier there had been an "aggressive incident". Daniel had apparently not been taking his medication as prescribed and had become angry "when asked to review" but had eventually agreed to the staff keeping his medication and Daniel administering it himself. **[There is no record of any such incident in the Ian Collie House records]**

The plan recorded in Selma's notes was:

- for Daniel to visit Court Grange on 13th October to look around
- 2 day assessment visit to follow to review an appropriate course
- to maintain 2 weekly CPN contact at Ian Collie House
- Daniel to agree to spend Monday to Friday at Ian Collie House and go home at weekends
- to continue to encourage Daniel to attend Old Church and the Clubhouse although Daniel was reluctant to do so
- staff at Ian Collie House to engage Daniel in daytime activities
- for Selma Daley to see Daniel at Ian Collie House on 14 October
- out patient appointment with Dr. Hamblin on 16th October

Julia Hookway felt that it was possible that Daniel would be able to start at Court Grange in January 1998.

On 7th October Bron White, one of the staff at Ian Collie House, telephoned the CPNs to say that Daniel had run out of his tablets. Daniel had apparently given back the empty boxes saying they were finished and denying having any left. However Selma had given Daniel 14 days supply at the review meeting on 2nd October. Bron White reported that he had ordered more tablets from Daniel's GP from whom Daniel would now collect his tablets. From then on the hostel staff would give Daniel his tablets on a daily basis.

Although anxious about the visit to Court Grange, Daniel did go on 13th October and agreed to "think about" a return visit for an assessment.

It is not known whether Selma Daley saw Daniel at Ian Collie House on 14th October as planned at the review, but she did see him at Old Church for his 2 weekly appointment on 22nd October. She recorded:

"looked well, mood pleasant, conversation fairly appropriate i.e. discussing plans to go to Court Grange, his concerns and daily activities. A little preoccupied with finding a piece of paper about " American football" from start to end of session. Also admitted people sometimes look at him in the street which made him feel uncomfortable. Denied feelings of excitement or suspicion. No inappropriate laughter or behaviour displayed. Admits the tablets help him keep calm and happy to continue with them. Staff supervise administration. Denied side-effects, not observed. Denied sleep disturbance or eating problems-weight 16 stone reportedly-wants to get bigger. Requested attendance to physio for weights and some American football training/practice...."

Plan:

- *see in 2 weeks for mental state assessment*
- *to be seen by Dr. Hamblin on 18 Dec for review*
- *to be seen by Dr Kitson on 30th Nov 97 for assessment*
- *(illegible) Ian Collie House staff*
- *contact mother re progress*

Although there is no entry in NDS records of her notes of the appointment, we can tell from Julia Hookway's notes that Dr. Hamblin saw Daniel at Old Church on 16th October. Dr Hamblin told us that Daniel came on his own. On 24th October Dr Hamblin wrote to Daniel's GP:

"I reviewed Daniel in out-patients. He appeared irritable and slightly suspicious. He talked at length about the dog in the house next door to Old Church trying to bite him and seemed quite upset about this. He denied any disturbance of sleep or appetite and he said he would continue with this (sic) but absolutely refused to take any increase in medication or to change to alternative medication.

He has not been taking medication as prescribed but has now agreed to have medication supervised by his Care Home staff.

We will continue to attempt to persuade him to increase Risperidone further and will monitor him closely. If he should deteriorate further we will need to consider a section of the Mental Health Act."

On 16th October Bron White telephoned Julia Hookway and told her that Daniel was now requesting an assessment at Court Grange, and Julia advised that Court Grange should be contacted and an overnight stay should be booked for the assessment to take place. Mrs.

Joseph was wishing to accompany Daniel to Court Grange as well, but Daniel apparently was saying that he would prefer Bron White to go rather than his mother.

On 24th October a letter was sent by Dr. Hamblin to Daniel at Ian Collie House informing him of an appointment to see her on 18th December. On 27th October a further letter was sent to Daniel at Ian Collie House by Dr Kitson's secretary, informing him of an appointment with Dr Kitson on 25th November.

Dr Hamblin told us that, unless the situation was urgent, an eight week gap between out-patient appointments was normal at that time, because the service was so overstretched. However because of her concerns about Daniel, she had asked Dr Kitson to see him in the meantime, as Dr Kitson knew him better than she did.

On 27th October Selma Daley telephoned Mrs. Joseph who expressed her concern at the amount of time Daniel was spending at home and at the expense incurred as a result of this. Mrs. Joseph felt that Daniel was "*over happy*" and constantly made requests for her to go with him to discuss wrestling with various organisations. She reported that he was generally cautious towards others "*due to negative experiences with the police and the general public*", therefore he relied heavily on his mother and other family members to escort him to unknown places. As a result, he was quite demanding of his mother's time and this often became quite wearing. It was difficult to deny his requests. She said that he generally kept his medication himself when on home visits, but she was unaware if he took it. Selma said that she would discuss these matters with Daniel and the staff at Ian Collie House. On 30th October Selma spoke to Riet Seward who said that he was still at his mother's house and the staff were concerned about whether he was taking his medication. Selma planned to visit Ian Collie House the following Monday and she tried to contact Mrs. Joseph, but she was not in. Selma informed those taking part in the Community Ward Round that day of her discussions with Mrs. Joseph and Riet Seward. The question was raised as to whether the planned trip to Court Grange for an assessment on 13th November should be postponed due to the deterioration in Daniel's mental state. It was noted that there was a high risk of further deterioration if Daniel was not complying with his medication.

On 1st November Selma Daley telephoned Julia Hookway to ask if the assessment at Court Grange could be postponed to prevent the possibility of Daniel not being accepted for a placement due to his unstable mental state at the present time. Julia informed her that this would delay funding further and would necessitate further funding for the placement at Ian Collie House. She would however make enquiries. Julia also expressed her concern about the limited amount of time Daniel had been spending at Ian Collie House. Selma advised her that this was Daniel's usual behaviour and that the issue was being addressed with Daniel, his mother and the staff at Ian Collie House. The same day Selma Daley spoke to Riet Seward at Ian Collie House who reported that Daniel was keen to go on the visit to Court Grange. Selma informed Julia Hookway of this, and therefore they decided that the visit on the 13th November should go ahead as planned. It was noted that Daniel's

mother was away for five weeks and therefore he was likely to spend more time at Ian Collie House and would hopefully receive his medication.

Although not recorded in Selma Daley's notes, Julia Hookway records a telephone call from Selma Daley on 3rd November expressing her concern about Daniel's mental health. Selma had said that Daniel had not been staying at Ian Collie House and therefore was without medication and that she had been unable to contact his mother and was unable to visit him at his home. She requested that Julia visit the family and that she should cancel the Court Grange appointment as his present behaviour may be "inappropriate" and might make it difficult for Court Grange to complete their assessment. Julia stressed the need for Ian Collie House to keep her up to date with Daniel's care as the hostel was responsible for ensuring that he had appropriate aftercare. Julia made a telephone call to the Joseph house and spoke to one of Mrs. Joseph's daughters who told her that Claudette was on holiday and unable to be contacted. Julia gave her name and telephone number and stressed the importance of Daniel remaining at Ian Collie House during the week and receiving medication. Julia then had a telephone conversation with Selma Daley who stated that since their earlier conversation, she had been in contact with Riet Saward and Daniel was now at Ian Collie House and she would visit him that day. It seems as though Daniel only remained at Ian Collie House when Bron White was on duty.

Although she made no entry in the clinical notes, it is clear from a letter that she wrote to Julia Hookway dated 14th November, that Selma Daley saw Daniel on 5th November. In the letter she wrote:

"I saw Daniel on 5th November 1997. His mental state was fairly stable throughout the interview however he continues to experience frequent fluctuations characterised by suspicious ideas towards others, mood elation and rapid signing. He expressed ambivalence towards attending Court Grange saying he would only go if we could get details about an American wrestling course. He reported to be complying with medication, (confirmed by Care Home staff) however his mother is unaware of his compliance when at home.

She expressed some concern about the amount of time Daniel spends at home and reports him as being over happy, preoccupied with thoughts and visits to wrestling organisations (which she has to accompany him on) and general caution towards others - as result of previous bad experiences.

She would be happy for Daniel to visit home from 4 p.m. on Fridays until 4 p.m. on Sundays and the occasional short visit during the week but would find it difficult to reinforce this.

I have discussed the above with Daniel who is reluctant to comply however I will continue to reinforce these boundaries and advised Care Home staff of the same.

Daniel has an outpatient appointment to be seen by a Psychiatrist for mental state assessment and review of treatment. I will keep you informed of any changes."

It is recorded in the Ian Collie House notes that on 7th November Daniel returned after being at home and told a member of staff that he was sad because he was living on his own. He didn't have any supper and crossed his name and room number off the tag in the hallway and returned a yale key.

On 10th November Bron White reported to Julia Hookway that Daniel had had a disagreement with his sister on Sunday evening and had not met Bron at Paddington Station to go to Court Grange. Bron went to back to Ian Collie House and found Daniel very upset and not wanting to continue with the assessment. It was agreed that the assessment should be cancelled and another one arranged and Court Grange offered 17th and 18th November.

Julia Hookway visited Daniel at Ian Collie House on 11th November and saw him together with Bron White and Riet Saward. They discussed his reasons for not meeting Bron and his future aims for his education. Daniel said that the argument he had had with his sister on Sunday evening was because she had requested his Giro as payment for feeding him and he had refused. He said that his sister then threatened to "stab" him and he did not want any further contact with her. The incident upset him greatly and he returned to Ian Collie House. Daniel also said that he was not sure about Court Grange as he now had a hearing "girlfriend" called Kirsty. **We believe that Daniel met Kirsty in about November at a church he was taken to by Matthew Gillett.** He wanted her to attend the City Lit to learn BSL and he could attend as well to encourage her. He also stated that he could move to Norwich as he had been there before. Julia noted that Daniel appeared to be slightly elated during the meeting, sometimes refusing eye contact.

On 13th November Julia Hookway discussed the matter on the telephone with Riet Saward. Daniel had apparently been extremely distressed on 11th November and it had taken some time for Riet and Bron to "comfort" him.

Riet Saward told us that Julia had told Daniel off for not turning up at the station to go to Court Grange and tried to explain to him that she had arranged funding for him to go and that he could not just ignore that. After this conversation, Riet noticed that Daniel was in fact crying. She said that he was really upset. He apparently said to her

"I hate being deaf."

Daniel had then asked Bron to contact Matthew Gillett and a meeting was arranged. However Daniel had not returned to Ian Collie House and he did not have any medication. Riet had tried to contact the family and Daniel's girlfriend Kirsty, and had spoken to Kirsty's mother who said that she understood that Daniel was a refugee and only a friend as at present Kirsty was living with another man. The mother was reluctant to be contacted further.

The same day Julia Hookway telephoned Selma Daley but the call was taken by Jane Finn who told her that Selma was on sick leave. She explained the latest developments to Jane Finn who said that she would attempt to find out what Daniel's mental state was from the most recent letters and get back to her. Jane telephoned Julia back a couple of hours later and read her Selma's and Dr. Hamblin's most recent reports. Julia expressed her concern that Daniel was deteriorating mentally and wondered whether it was realistic to pursue Court Grange. By the time of the return call, Riet Saward had informed Julia that Daniel had returned to Ian Collie House with Matthew. Julia therefore said that she would contact Selma the following week and Jane Finn agreed to fax Julia Dr. Hamblin's report of 24th October as she had not been sent a copy.

On 13th November it was reported by one of the Ian Collie House staff that Daniel had had a woman in his bedroom overnight. He was spoken to about it and appeared rather moody and went out late and did not take his medication. The following morning he took his medication but would not allow staff to check his room to see if there was a woman in it. On 15th November it was explained to Daniel that he was not allowed to have a woman staying overnight and he was apparently very calm and understanding about it. He said that he was worried that if he went Court Grange he would miss his friends and girlfriend. He seemed confused about this and was therefore advised to talk to Bron White about it. On 16th November Daniel returned to Ian Collie House late in the evening in a very bad mood but acknowledged the fact that he was going to Court Grange in the morning.

Daniel did attend the two day assessment at Court Grange on 17th on 18th November. He was accompanied to Devon by Bron White. They returned to Ian Collie House on 18th November and Daniel then went out and was not seen again until about 20.00 on 20th November when he returned with Matthew Gillett. The note made at the time records that Daniel was stubborn and demanding about his benefit money. He was described as "high" and talking about three different subjects at the same time. He was given his evening tablets and Matthew apparently told the Care Home staff that Daniel would return to Ian Collie House on Sunday after his visit to church. Daniel was therefore given his weekend medication and he then ran to his room and then left the building with two big bags of clothes and (according to the note) wearing "*a big straw hat!*"

At about 12.15 on Saturday 22nd November Daniel arrived back at Ian Collie House with Matthew Gillett. He was apparently in very bad mood and immediately went up to his room and proceeded to take all of his possessions and piled them outside the door. One of the staff, Coral Ward, asked Daniel what was wrong and he said that he was fed up with his

family and his sister and also Ian Collie House. He wanted to move out and have his own flat. He began to load his belongings into Matthew's van. Coral Ward tried to persuade Daniel to stay at Ian Collie House until he moved to Court Grange but Daniel refused to listen. She described him as rather angry but he showed no aggressive behaviour. She tried to contact Bron White by pager, but when there was no response, she telephoned Terry Stanley who called the Police. Bron White arrived about 14.00 and the Police arrived shortly afterwards. Bron and the Police managed to calm Daniel down but he was still insistent that he wanted to leave and refused to go to Court Grange, stating that he wanted to live in a flat independently. Terry Stanley also telephoned Old Church to find out if Daniel could be admitted. The call was taken by one of the nursing staff who explained that he could only be admitted if he was detainable under the Mental Health Act. Neither the Police nor the Ian Collie House staff thought that Daniel showed any sign of mental disorder, so that he could not be sectioned. They tried to persuade him to go to Old Church for counselling, but he refused. Daniel told them that he was going to stay with Matthew and Matthew agreed to sign a statement saying that he would be responsible for Daniel's welfare and medication. A statement was drawn up by Bron White and signed by him and Matthew Gillett.

The statement said:

"This is to say Mr Matthew Gillett has taken responsibility of Mr Dan Joseph as Daniel has a wish to leave ICH 70, Northside until further notice.

ICH staff will contact Julia Hookway @ Lambeth social services in Clapham, on week of Monday 24/11/97. Medication has been taken with him. Old Church has been informed."

There was therefore no signed "undertaking" that Matthew would ensure that Daniel actually took his medication. However, even if such an undertaking had been given, it is unlikely that it could or would have been effective.

Daniel left with Matthew and all his belongings at about 15.00. According to the note recorded by Julia Hookway following a telephone conversation with Bron White on 24th November, Daniel left as his forwarding address the address of Carla Thompson in Tulse Hill, and Matthew's address was given as The Gospel Church at an address in Streatham together with a telephone number. Rather strangely, Jane Finn was given different address by Ian Collie House, that of a Junior School in SW4, although the telephone number was the same.

Julia Hookway discussed the situation with her Team Manager, Jim Heron, following which it was decided that she should contact NDS CPNs and request an assessment of Daniel's mental health, and that she should contact Matthew Gillett concerning Daniel's health and welfare. She therefore telephoned NDS and spoke to Jane Finn as Selma Daley was not available. **[NDS records show that Clare Campbell (another CPN) noted the call]** Julia

recorded that there was conflicting information from Ian Collie House about the contact address for Daniel, and it was agreed that NDS would check to establish when Daniel was to be seen again and would arrange an assessment with Dr Kitson. She also telephoned Matthew Gillett at the Gospel Church and left a message for him on the answering machine to contact her as soon as possible. She then telephoned Old Church and was told that Daniel had not kept recent outpatient appointments although he had had regular appointments with the CPN.

As far as we can tell from the records, Daniel had in fact kept his outpatient appointments up until the time he left Ian Collie House. He was in fact due to see Dr Kitson the following day, 25th November, but Julia Hookway does not seem to have been informed of this fact.

She was also told that Dr Kitson would be on leave from 3rd December and that Dr. Hamblin was due to assess Daniel on 18th December. Julia asked that accurate details of his whereabouts should be taken if Daniel should attend Old Church.

Carla Thompson telephoned Julia Hookway on the 25th November. Carla told her that Daniel was now living with her family and she would like him to "sort out" his benefits and contribute towards the cost of living with her. She said that he was teaching her family to sign and taking them to the City Lit. Julia informed Carla of Daniel's mental health status and stressed the importance of communicating with him in his first language i.e. BSL. Carla agreed to contact Old Church to find out when Daniel had future appointments and to ensure that he attended.

Daniel did in fact have an appointment to see Dr Kitson that very day, 25th November. He did not attend that appointment.

Julia Hookway's note of the telephone conversation continues:

"When asked about Miss Joseph, Daniel's mother's, whereabouts Ms Thompson did not know and stated "she has known family for nearly a year" - I expressed difficulty contacting Matthew. Ms Thompson informed me that Matthew sometimes stays with her family and she would "pass a message on". Ms Thompson went on to state that "Daniel is very happy living with her. We should not worry about him" and in the future "she would like to build a home for disabled people and perhaps Daniel could live there."

I feel Ms Thompson did not accept the seriousness of the concern surrounding Daniel's present mental health state - she was vague about family contacts given that Matthew has agreed to support Daniel. In terms of future educational needs Ms Thompson did not feel this was a "priority at the moment" and I am concerned that Daniel has not have the opportunity to discuss this matter. Ms Thompson and family do not have sign language skills making it impossible to relay my concerns to Daniel.

I am concerned that Daniel does not have opportunity to discuss his plans, future wishes and views. During his stay at Ian Collie House and prior to this Daniel has not let it be known that he has significant friendship/relationship/support networks and in particular Ms Thompson -

Action - to discuss Daniel's future wishes and views

-to identify support networks and clarify contact names, address etc.

-contact CPN

-write to Daniel informing him of recent discussions"

When asked by us what impression she got of Carla Thompson during that telephone conversation, Julia Hookway told us:

"I was anxious that he had discharged himself from Ian Collie House - from a place that was safe, and to this unknown person who was trying to tell me that everything was fine. She was listening to what I was saying and acknowledging things, but I did not have any feedback that reassured me."

In our opinion, a multi-agency Case Conference should have been held as soon as possible after Daniel left Ian Collie House, and a detailed CPA plan drawn up and implemented. It is not correct to use the term "discharged himself" as Ian Collie House was a hostel which provided support, not a hospital of any kind, and Daniel was free to go whenever he wanted to.

On 27th November Daniel's case was discussed in the weekly Community Ward Round at Old Church and Dr. Hamblin agreed to send a further letter concerning the appointment that she had made with Daniel for 18th December to Daniel at Carla Thompson's address. She telephoned Julia Hookway that day to confirm Daniel's current address and Julia told her that Daniel was not in contact with either herself or others but that Carla Thompson had agreed to bring Daniel to appointments and to supervise his medication. Louise Hamblin informed Julia of the appointment she had made for Daniel to see her on 18th December. On 28th November Louise Hamblin discussed the matter with Dr Kitson in a referral team meeting and it was agreed that NDS should inform the referrers i.e. St. Thomas' Hospital (Lambeth Healthcare NHS Trust) of the current situation and advise them that NDS may not be able to admit Daniel in an emergency.

Dr. Hamblin wrote to Dr Teifion Davies at St. Thomas' on 28th November:

"I am writing to up-date you on the current situation regarding Daniel. Since his discharge from our inpatient unit Daniel was temporarily placed at Ian Collie House a residential care home. His mental state started to deteriorate over the last month and his family moved him out of the residential care home on 22nd November 1997. Since this time staff from our Service have been unable to see Daniel, but we remain concerned about his mental state. We will attempt to remain in contact with Daniel and his family but as we are a National service we may not be able to provide emergency assessment or admission. We will do our best to support local services in the event of an urgent assessment or admission being necessary."

Although the letter says that NDS staff had been unable to see Daniel since he had left Ian Collie House, in fact no attempt had been made to contact Daniel by NDS staff. We were concerned at the use of the phrase "may not be able to provide emergency assessment or admission" as the NDS does not provide either. To use such a phrase was therefore potentially misleading.

Also on 28th November Julia Hookway telephoned Selma Daley. They discussed Daniel's placement at Court Grange and Julia said that if Daniel's mental state deteriorated, she would try to see if the placement could be postponed. It was confirmed that Daniel had been completely discharged from Ian Collie House. Julia said that she would contact Selma if she saw Daniel, and Selma said that she would send Daniel an appointment to meet with him at Old Church within the next two weeks, but if he did not attend she would arrange a home visit at Carla Thompson's house. Julia informed Selma of her recent conversation with Carla Thompson. Julia Hookway wrote that day to Daniel at Carla Thompson's address and said:

"I was sorry to be told that you were not happy living at Ian Collie House and wish to move out without making the appropriate arrangements. As I am sure you are aware people usually plan their move from this residential accommodation to make sure all the necessary arrangements can be made to support you living independently.

Over the last few months Bron and myself have tried to help you gain a place at Court Grange College and I am pleased the interview went well on the 18/19 November.

I am happy for you to make an appointment to see me and talk about your future plans if you so wish.

Carla Thompson telephoned me on 26/11/97 and informed me that you will be living with her family and you want to sort out your welfare benefits to enable you to pay towards your living costs.

Unfortunately you did not attend your appointment with Dr Kitson on 25/11/97, Carla Thompson has informed me that she will arrange further appointments at Old Church with Dr Kitson and Selma Daley your Community Psychiatric Nurse and be responsible for ensuring you are aware of future appointments.

I must stress the importance of ensuring you are registered with a doctor to make sure you are able to receive your medication on a regular basis.

As I am sure you are aware Bron was helping sort out your welfare benefit claims, as you have now decided to take responsibility for sorting this out yourself I would advise you to contact the local welfare rights worker. I have enclosed the address of your local advice centre.

If you require an interpreter for these appointments please contact this office to arrange a time to meet.

If you would like to talk to me about any of the information in this letter please contact me to arrange a time to meet.

I hope you are well and I look forward to meeting you again soon."

Lambeth Social Services had been funding Daniel's placement at Ian Collie House. He was now in an unknown situation, staying with somebody not previously known to Julia Hookway. When asked by us that why she did not go to assess the situation for herself as soon as possible, Julia told us that it was discussed with her Team Manager as part of her supervision and she reached an agreement with him not to go at that time. Jim Heron, the Team Manager, told us that this decision was based on the following factors:

- **Julia was the only Social Worker in the team working with deaf people**
- **She had only been in post for a few months, and there had been no such specialist Social Worker since Jenny Park had left almost a year before**
- **Because of the above factors, there was a considerable backlog of cases and he was trying to ensure that she was not overwhelmed with work**
- **After Daniel left Ian Collie House, efforts were being made to arrange a mental health assessment**

On 2nd December Carla Thompson telephoned Julia Hookway asking for the telephone number of Ian Collie House. **It is not known why.**

Also on 2nd December an urgent fax was sent by Dr Teifion Davies at St. Thomas' Hospital to Dr Louise Hamblin:

"Thank you for your letter (and fax) of 28 November 1997 which I received at my clinic today.

I am very sorry that Daniel's mental state has deteriorated since being placed in a residential care home. I shall, of course, do my best to support Daniel if his mental disorder relapses.

However, I must express my exasperation to find that the only communication I have received from your team comes at a time when Daniel may be in crisis. I have received no updates, and I was not even included on the circulation list for the discharge summary after his admission to your unit. Finally, I was not consulted at the time decisions were made about placement (which leaves my responsibility for his further care in doubt).

This lack of liaison places me at a grave disadvantage in dealing with Daniel and his family. I have no up-to-date knowledge of him, and he does not know me. I am likely to be viewed with suspicion as only arriving on the scene when he requires formal admission.

Since your letter is not specific as to what action you wish me to take, nor whether his family have been informed of your communication with me, I shall await further information. If an urgent assessment is required in the meantime, I suggest you communicate full details to the Rapid Assessment Team based at Brixton Road Community Mental Health Centre.."

Dr Davies told us that he had no idea at that time that there was any sense of urgency, and had only mentioned the Rapid Assessment Team "as a matter of course". It was not his intention to 'refer' the NDS to the Team, but merely to 'make reference' to it.

On 2nd December a letter was sent to Daniel at Carla Thompson's informing him that Selma Daley would like to visit him at that address at 10.00 on Tuesday 9th December. The same day a letter was sent to Daniel at Carla Thompson's reminding him of his appointment to see Dr. Hamblin at Old Church at 11.00 on 18th December.

On 3rd December Dr Nick Kitson went on leave for one month. Dr Peter Hindley of the Child and Adolescent Unit covered for him in his absence.

On 4th December Julia Hookway wrote to Selma Daley informing her that Court Grange had offered Daniel a full-time place to start in January 1998. She continued:

"Unfortunately Daniel has not responded to my request to arrange a meeting to discuss his future options.

As we have previously discussed I remain concerned about Daniel's mental health and his compliance with his medication. I have left messages for Matthew ? who took responsibility for Daniel's health and well-being on leaving Ian Collie House and to date have had no response.

I am aware that Dr. Hamblin is due to carry out a mental health assessment on 18 December and I would be grateful if you could inform me of the outcome."

On 5th December Louise Hamblin responded to Teifion Davies:

"Thank you for your letter of 2nd December. I fully accept your criticisms that you have not been kept up to date on Daniel's progress. This was clearly an error on our part and I shall raise the situation with our team to attempt to ensure such errors do not occur in the future.

I do not think there is specific action you can take at present but wish belatedly to keep you informed of the situation. We are continuing to attempt to remain in contact with Daniel but may not be able to offer emergency admission. I will as you suggest communicate details to the Rapid Assessment Team."

Dr. Hamblin wrote that day to the Rapid Assessment Team at Brixton Road Community Mental Health Centre (CMHC), enclosing a copy of Daniel's Discharge Summary, his outpatient letters and her letter to Teifion Davies.

The Rapid Assessment Team had only come into existence about one month before on about 10th November 1997. It was set up to deal with crises for patients who were not formerly patients of the established community teams. The consultant responsible for the Rapid Assessment Team was Dr Nadia Davies.

On 8th December a member of the Brixton Road CMHC contacted Selma Daley and recorded that she told them that she was concerned about Daniel who had a habit of poor compliance with medication and moving around without any definite address. She said that she was planning to visit Daniel the following day and that she would contact Dr Wong of the Rapid Assessment Team after the visit. She also said that Julia Hookway could be contacted for further information about Daniel and gave Julia's telephone number who was

then contacted by the CMHC. Julia gave them an account of Daniel's behaviour on the occasion when he left Ian Collie House, telling them how he had become excitable and threatening in his behaviour. She also informed them that Daniel had not been seen by any professional since he had left the hostel.

Julia Hookway and Selma Daley spoke to each other on the telephone that day and Selma informed Julia that Dr. Hamblin had referred Daniel to the Brixton Rapid Assessment Team and that she (Selma) had arranged a home visit to see Daniel the following day, 9th December. Julia informed Selma that Daniel had been accepted for a place at Court Grange in January.

On 9th December Selma Daley went to Carla Thompson's home to see Daniel.

Neither Daniel nor Carla was at home.

Although there is no record of any such letter or call in her notes, Selma told us that she was sure that she had sent Carla Thompson a letter about the home visit on 9th December, asking if she could see Daniel at her house, and that Carla had telephoned her to confirm that it was convenient. We just do not know if Daniel's absence that day was a deliberate attempt to avoid Selma Daley's visit.

Later that day she telephoned Dr Wong of the Rapid Assessment Team and told him that she had been unable to see Daniel and requested an assessment to be arranged. Dr Wong told her that he had arranged for Daniel to be assessed at 11 o'clock on Thursday 11th December. However when he attempted later that afternoon to book Jenny Towland, Lambeth Social Services Sensory Impairment Team's sign language interpreter, he was told that she was fully booked and would be unable to make the appointment on the 11th December, and it was therefore cancelled and rearranged for Friday the 12th.

There is an undated note from Louise Hamblin on NDS's file which reads:

"Selma

Re Daniel

2nd opinion for MH Act

I think the best thing is if they contact me when they need second opinion and if I can I will help out depending on situation here"

We have assumed that this note was made around this time, but we are not sure.

The following day Selma wrote an account of her visit to Julia Hookway and sent copies to Dr Wong, Dr. Hamblin and Daniel's GP:

"I visited Daniel at the home of his friend Carla Thompson on 9th December 1997.

Daniel and his friend Carla were not at home at the time of the visit and the other occupants seemed unaware of their whereabouts.

The general condition of the property was poor. There were several broken panes of glass in various doors and windows. There were a number of Biblical scriptures that had been written on A4 paper and stuck on to the walls as well as scriptures scribbled on the kitchen cabinet.

The living-room contained a sofa, a sofa bed, a mattress on the floor and a small divan. These all contained some form of bedding and two of them were occupied at the time of my visit.

I have spoken to Dr Wong from the rapid response assessment team who will try to arrange a visit as soon as possible.

I have advised them to contact Lambeth Social Services for assistance from interpreters and we will try to provide as much support as possible once they have made contact.

I will inform you if Daniel attends his outpatient appointment on 18 December 1997."

Selma told us that there were about four young people in the property at the time of the visit, most of them in bed or lying on mattresses on the floor.

Selma reported the outcome of the visit at a Community Ward Round on 11th December.

Early on the morning of 12th December, Julia Hookway received a telephone call from a Dr Simon Edgar of the Rapid Assessment Team who said that it was now his turn on the duty rota and that he would therefore be carrying out the assessment and not Dr Wong. He said that neither of the addresses that he had been given for Daniel was on the Rapid Assessment Team's patch and that Carla Thompson's address was in the Bethlem and Maudsley patch, and that it was therefore not an appropriate referral for the Brixton Road CMHC's Rapid Assessment Team. However he agreed to assess Daniel that morning and to liaise with Dr. Hamblin and Selma Daley regarding any further action. Julia informed him that Dr. Hamblin was due to assess Daniel on 18th December. Julia then telephoned Selma requesting to be given any further information following the Rapid Assessment

Team's assessment, and they agreed to continue to encourage Daniel to attend his NDS appointment with Dr Hamblin.

On the morning of 12th December, Dr Simon Edgar, Senior Registrar to Dr Teifion Davies, and trainee GP, Dr Claire Bonner went to Carla Thompson's house to carry out an assessment of Daniel's mental state.

Dr Edgar told us that he did not consider this to be a formal Mental Health Act assessment. For this reason there was no Approved Social Worker with them. He also told us that this was the first time that he had had to assess a patient who was deaf.

They arrived just before 10.30. Jenny Towland the interpreter was meant to meet them there. They waited for her until about 10.40 when two people went into the flat and closed the door behind them. Dr Edgar believes that one of them was Carla Thompson. They decided not to wait any longer for Jenny Towland and knocked on the door which was opened by Carla. Dr Edgar recalled that although she would not have been expecting them, Carla seemed pleasant, friendly and cooperative when they said who they were. Matthew Gillett was also there.

Simon Edgar described the room they were shown into and remembered the ceiling being quite low which gave a slightly claustrophobic feeling to the place. Claire Bonner remembered that it seemed dark and that there was an unpleasant smell which seemed to be coming from the fridge which was in the room. They told us that there were several people 'strewn about' in various positions, one asleep on a sofa, and a young girl sitting on a mattress on the floor. At some point during the interview two girls and two dogs came to the room, although the dogs were shut out when they began to upset Daniel. Also one of the men in the room went into the bedroom at the back of the flat at one stage and began to play the guitar, and the two girls who had come in went into the bedroom and started singing. Apart from Carla and Matthew, all the other people were young – in their late teens or early twenties. Daniel was asleep on the only bed in the room which was in the far right-hand corner.

The doctors were invited to sit on another sofa. Carla Thompson offered everyone a cup of tea, and two of the occupants of the flat who were in some state of awareness responded in the affirmative. Carla opened the fridge which was right next to where Dr Edgar was sitting, and Dr Edgar remembers the *"disgusting, very distinctive waft of rancid milk"* as she took out a bottle of milk and passed with it in front of him and Dr Bonner. They both refused the offer of tea, but Carla poured the milk into the four cups of tea she made for herself and the others, and Dr Edgar described seeing *'lumps of milk'* going into the cups. He told us that that was the first very slight question mark that he had about Carla Thompson, since she seemed oblivious of the state of the milk. However everyone else drank it!

They began the interview by asking Carla Thompson and Matthew Gillett questions about Daniel's daily routine. They described him going out to the local shops and to use local facilities, in particular the gym. There appeared to be no concerns about his sleeping or eating habits or his mental health. They discussed Daniel with Carla and Matthew for about 20 or 30 minutes and there was still no sign of the interpreter, and so Dr Edgar asked Carla to wake Daniel up as he was still fast asleep. Daniel was apparently quite calm and unruffled despite being woken from a deep sleep, and went to the bathroom to freshen himself up, and then returned to the room. Dr Edgar took it as a good sign that Daniel had gone to the bathroom to spruce himself up and make himself presentable. Dr Edgar was also struck by his muscular definition. He told us:

"I remember thinking his biceps were probably more or less as big as my legs! He was a very large person, even though not thick boned and thickset. He was incredibly tall..."

And again I think one would make a certain assumption, seeing somebody who is six foot 7 tall, he was exceptionally tall, perhaps one's gut reaction would be apprehension if not fear. The fact is that those emotions seemed to be sort of allayed almost immediately because he seemed quite pleased to see us. He seemed quite pleasant, cooperative..."

Myself and Dr Bonner were sort of pointed to by either Carla or Matthew, and I recall that we actually stood up and he shook both of our hands in turn. He was quite cordial. He had a smile on his face. He extended his hand, and had a sort of firm, but no more than firm, hand. He seemed quite enthusiastic, quite buoyant really, quite non-threatening really."

We have no idea whether Daniel understood who his visitors were or why they were there. Carla and Matthew appeared to be pointing towards them and gesticulating. We just do not know how either Carla or Matthew would have been able to communicate this to Daniel and we were told that nothing was written down for or by Daniel throughout the whole of the interview. Daniel had only been at Carla's for just under three weeks, and, as far as we are aware, Carla had no knowledge of sign language skills. We know that Daniel and Matthew were able to communicate on a fairly basic level with some signs and gestures, but it is difficult to see how it could have been communicated to Daniel in a way that he would understand that Simon Edgar and Claire Bonner were doctors who were there to assess his mental state.

The doctors asked Carla and Matthew whether they could interpret for Daniel if they talked to him, and they said they would do their best. Dr Edgar got the impression that although they were trying very hard, it was extremely difficult for them. He admitted that he really had no way of knowing whether his questions and Daniel's answers were being faithfully interpreted. He told us that this was the first time in his career as a doctor that he had had to deal with a deaf patient. The assessment continued for some 20 minutes like this.

Jenny Towland the interpreter finally arrived at nearly 11.30. She had been given the wrong address. She told us that her first impression on going inside was that it was "very dark. Very very malodourous." Daniel apparently recognised Jenny Towland straight away and seemed extremely pleased to see her.

They had first met each other in 1994 when there was the meeting with members of Camden Education Authority to look into the circumstances of Daniel's exclusion from school, and Jenny was there as the interpreter. She told us that on that occasion he seemed to be very dependent on his mother and had no intention of interacting with Jenny - he totally excluded her. However they met again on a couple of sessions with Jenny Park and also with a home tutor who visited him, and on those occasions he co-operated fully, delighted in having everyone's undivided attention. She had also been called as interpreter to Kennington Police Station when Daniel had been arrested in November 1996 following the trip to London Arena to see the WWF contest.

Jenny Towland told us how there was nowhere for her to sit and how Daniel had moved one of the young people lying on the floor or on the divan so that she could sit down. Jenny was very much aware that the doctors had already been there for nearly an hour and would have to go very soon. From the moment she arrived, Daniel was in full flow. She told us:

".. I am assuming that if I had not arrived at all.. he might not necessarily have started expressing his ideas and thoughts the way he was going when I was there, because there would not necessarily have been somebody that he knew could understand him. So he might think, well, why bother? When somebody arrived who could understand him, that was his moment... He was intent on telling a story, it seemed to me, getting his ideas across, what he was going to do."

According to Jenny Towland, almost from the moment that she arrived, Daniel talked about America and wrestling. It was apparently very difficult for the doctors to get a word in edgeways. Daniel was also signing extremely fast. Jenny Towland told us:

"This 'whoosh' - having gone from nothing at all virtually to this sudden, you know, really very high velocity, high voltage conversation, I think they seemed a bit wrong-footed and maybe did not know quite how to get in or stop (him)."

Claire Bonner told us that she did not feel that this was a sign that Daniel was delusional or had particularly grandiose ideas – they were more unrealistic than grandiose. She said:

" He was I think pleased that Jenny was there, because then he was able to tell us. He wanted to tell us all this and there it was, spilling out. Then allowing him to talk, as it were, it was interesting that it was not just American Football, but then Hollywood. It seemed a

little grandiose, I suppose. Carla was then trying to say that he is ambitious and, I think, trying to normalise it.... I think as well that at 18 it is not so unusual either that 18 year-olds want to be film stars and American football players, and people say "you can do it". A lot of 18 year-olds are like that."

When asked about Jenny Towland's comments about Daniel signing extremely quickly, Dr Bonner said:

"That is perhaps why I said 'grandiose' - maybe that is not fair. I was wondering if she was suggesting that he was a bit hypomaniac. He looked animated and pleased. I am not used to watching people sign, but he came to life and was very excited."

We were also told that Jenny remembered Carla being anxious to involve Social Services to assist her to get larger and better accommodation to house Daniel and the other people she 'looked after'. Claire Bonner remembered Daniel taking them to see where all his belongings were stored in the flat. She also recalled how Carla had seemed anxious that Daniel should not be discouraged from his aspirations to be a famous sportsman in the USA. Jenny Towland also told us that Carla was encouraging Daniel to go to America and told us that it made her quite angry. She said:

" She was saying that this is something that could absolutely happen for him. He was a young man with a splendid physique and was no reason in the world why he could not be accepted for training and this could happen."

Jenny Towland described Daniel as being " *in free-fall*". Yet when Dr Edgar brought an end to the interview after almost another hour, Daniel was apparently quite appropriate in his response to his flow being interrupted and did not get upset or angry.

Before they left, Dr Edgar stressed to Carla Thompson and Matthew Gillett the importance of Daniel keeping his appointment with Dr. Hamblin on 18th December and asked them to ensure that he took his medication. They reassured him that they would try their best to get him to co-operate. When we asked him whether that made any difference to the assessment, he said:

"Yes it made a difference, not necessarily because he would either have gone or not gone, but in a more general sense because obviously one is assessing risk, which is what we were doing all the way along the whole assessment. It is such things as, you know, one is always thinking what are the worst things that could happen? What major alarm bells might be ringing here? And the overall fact that here are seen to be two people who had his best interests in mind, who were concerned about his welfare, who seemed to be reasonably switched on to what was happening with him, I felt... what I did feel confident about was that if things had got worse, they would have flagged it up. Somebody would have heard about it. So I was reassured in that one often does these assessments where you get no

such reassurance and you think "how on earth is anybody going to get flagged up? How is anyone going to know if anything goes wrong?" I felt there seemed to be quite a clear route through which concerns could be communicated and I felt that they could be relied upon to do this. So that reassured me quite a lot actually."

When asked whether he thought that it would have been appropriate to admit Daniel on the day of the assessment, had Daniel volunteered to come into hospital, Dr Edgar told us:

"... he may have benefited from coming into hospital, but I certainly did not feel this chap must be in hospital. I was not getting that feeling at all... I would not have said to him "yes, of course, come with us into hospital". No, because my feeling would have been that I know how precious beds are and ... do not think I would have been thinking "this guy needs to be in a bed today, now"..."

I would say that the pressure for beds is so intense in the Service... that people almost do not get a bed unless you consider they are in really imminent danger of either harming themselves the harming someone else.... I felt there was virtually - one can never say no risk of anything - but I felt that the risk was very low that he was going to significantly harm anyone; and there had been no talk whatsoever of any self-harm. I had never read anything, and nothing from what we had talked about at the interview said that he should be a danger to himself in any way, other than perhaps by, what shall we say... he perhaps was a bit prone to being reckless, but it would have been purely by misadventure rather than anything intentional."

Jenny Towland offered the doctors a lift in her car, but they did not ask for her opinion about Daniel and she did not volunteer any opinion to them. She felt it would have been inappropriate and against the letter of her professional code to proffer any information or opinion without being asked. She was not sure whether they realised that she had known Daniel for some time. She told us however that she felt that Daniel was "unwell".

All three told us about one of the other occupants of Carla Thompson's flat that day – the young girl who was sitting on a mattress on the floor. They all described her as being 'completely in her own world', totally unaware that they were there. She apparently spent the whole time 'plucking at the air' around her. Dr Bonner told us that she was fascinated by this young girl throughout the interview and remembered thinking "She's the one who needs some help". [This young girl was in fact admitted to the psychiatric unit at St. Thomas' from Carla Thompson's address about a month later. She absconded the same day and returned to Carla's from where she was picked up again by the Police on 20.1.98 (two days before Daniel attacked Carla) and returned to hospital.]

Dr Bonner told us how shocked she was when she heard what Daniel had done to Carla Thompson and Agnes Erume. She said:

"It struck me...that of all the patients that I have met who have been disturbed and frightening, he was not one... I liked him. Of the people we go to see, some are less likeable than others, some are unpleasant and some are quite frightening, but he was not. I thought that he was very likeable."

On 15th December Simon Edgar wrote to Dr Hamblin to report to her on his assessment. He sent copies of his letter to Selma Daley, Julia Hookway and Daniel's GP. He reported as follows:

"Mr Joseph was assessed on 12 December 1997... by our Rapid Assessment Team, on that day consisting of myself, and GP Trainee Dr Clare Bonner.

There was some considerable confusion about which Catchment Area he came under, given that the hostel he left in late November 1997 was in Wandsworth, the proposed permanent address from 1998 will be in Devon, and the mother's... he has not frequented since 1996. As it turned out, the Tulse Hill address comes under the Maudsley hospital catchment area rather than ours, and therefore our Team provided the current assessment out of good clinical practice.

The past history of paranoid psychosis in 1996 was noted, including the apparent response to Risperidone 5mg/day.

The assessment was extremely difficult owing to the following:

- 1. Presence of six people and two dogs in one small room.*
- 2. Mr Joseph was asleep for the first 30 minutes or so.*
- 3. Absence of sign language interpreter for the first hour, because she had an incorrect address.*

The house in which he is staying was in a mess, with two sleeping persons initially; rancid milk in the fridge; clothing scattered everywhere; and two rather mangy looking dogs running around. Two of the inhabitants, Carla Thompson and Matthew were helpful and provided the following information.

In general, they did not seem particularly concerned about Mr Joseph. He was managing to get out, visiting friends and going to a local gymnasium. He was eating, sleeping, and maintaining self-care. There had been no overt psychotic symptoms, and no outbursts or aggression or self-harm. No mention was made of taking illicit drugs or drinking alcohol.

When Mr Joseph got up, and the interpreter arrived, further assessment was possible. In general he appeared well kempt, well nourished, and was quite affable and with good social skills. He complained frequently of excessive noise, and of the dogs running around (of which he seemed quite wary), this was quite appropriate. Initially, there appeared to be no abnormalities in his Mental State. However, he began to exhibit grandiose ideas about being a famous person, particularly an American football player, and of wanting to live in Hollywood in the United States of America. He was signing very fast according to the interpreter. There was no evidence of other delusions, or hallucinations in any modality.

His plans for the future were very unrealistic. He did not want to stay at the current address, because it was too noisy. However, he wished to move out to another house, with the two above-mentioned friends. He was very negative about a further involvement with Mental Health Services (keeping medical appointments, taking medication, or seeing his CPN) and only wanted Social Services involved because they could help with accommodation.

Impression

This 18 year-old man, with low average IQ, congenital deafness and past history of psychosis is clearly grandiose in his beliefs, and lacks insight into what may be best for him. He is also non-compliant with medication, and living in inappropriate accommodation and surroundings.

Plan

1. *Whilst Mr Joseph is probably psychotic, and gradually relapsing, it was not of a degree or nature warranting urgent admission to hospital under the Mental Health Act, given that he demonstrated good social skills, and was not endangering himself or others.*

2. *As he has had no connection with our catchment area for over a year now, our service will not provide further follow-up. He was advised to keep his appointment with Dr. Hamblin on December 18th 1997."*

On 15th December, Julia Hookway tried to contact Carla Thompson (who was not on the telephone) through her neighbour, Agnes Erume. She made several calls but there was no response. The same happened the following day.

On the 16th December, Julia Hookway gave Selma Daley feedback on Dr Edgar's visit.

Since the NDS was the referrer to the Brixton Road CMHC Team, we are somewhat surprised that Selma Daley, who was of course Daniel's Key Worker, did not seem to have followed up Dr Edgar's visit herself before now.

Selma Daley's note for that day reads:

" Initially his stepfather interpreted and they found no cause for concern. However when the interpreter arrived it became evident he was expressing grandiose ideas such as going to train for the World Wrestling Federation and requesting the social worker to provide him with a three-bedroom flat with toilets because he had lots of friends visiting who wouldn't be able to queue. He reports he won't return to Ian Collie House and happy to stay at his present address... Apparently doesn't want anything to do with his family.

The Rapid Response Team say he is not in their catchment area as current address not his mother's address and will refer to appropriate catchment area or Maudsley. We are unaware of the outcome of the assessment apart from fact that Daniel was not sectionable.

Plan. Social Worker to phone neighbour and encourage attendance to OPA with Dr. Hamblin on 18.12.97.

To be seen in OPA by Dr. Hamblin on 19.12.97(sic)

CPN to contact GP re medication

S/W to postpone placement at Court Grange for Jan.

GP... reports no prescription picked up for Daniel, has not seen him for some time.

Last medication from Deaf Services given 24.9.97"

In fact we believe that Daniel was receiving medication until he left Ian Collie House and Matthew Gillett took Daniel's medication with him when he left. Therefore as far as we are aware, Daniel was taking medication up until about 20.11.97.

On 17th December Selma Daley received a telephone call from Simon Edgar. She recorded that he reported to her that:

"The assessment revealed evidence of "?manic depressive type psychosis" and that he expressed lots of unrealistic ideas about joining a national American football team on a scholarship and training for the Wrestling Federation.

He reported there were no florid signs of mania and Daniel displayed good social skills i.e. removing the dogs and offering them the best chairs.

Daniel was keen for help from his Social Worker to get a new flat however he strongly refused any further services, especially deaf services. Would not be attending his OPA with Dr. Hamblin. Refused to accept need for medication.

Currently attending the gym regularly and physically looked well. Reported eating and sleeping well.

Stepfather and his friend Carla admitted some concerns about Daniel (not sure what concerns)

Apparently mother in the Caribbean - due back today, but Daniel doesn't want any contact with his family.

He queried whose responsibility to provide care ??

I explained that the Health Authority was still responsible, despite Daniel not being there for some time. He will discuss the above with his consultant re maintaining further contact and possibly referring him to the Assessment and Treatment team - Brixton Road mental health team."

Julia Hookway spoke to Selma Daley later that day and said she would attempt to contact and find out more information about Daniel's mother. She also once again made several calls to Agnes Erume, Carla Thompson's neighbour, but still got no response.

On 18th December Julia Hookway telephoned Mrs. Joseph and informed her of the present position. Mrs. Joseph agreed to attempt to encourage Daniel and to get his friends to encourage him to comply with his treatment and to consider his further education at Court Grange. Julia agreed with Mrs. Joseph that she would contact Selma Daley to discuss the mental health issues. She recorded that Mrs. Joseph felt that:

"Daniel may be being financially abused and she would like to be appointee for Daniel as she states " he is not able to care for his own money". Need to discuss his vulnerability in relation to finances.

Action – T/C CPN → T/C Mother.

T/C Miss Joseph. 19/12/97 for update"

Julia Hookway duly telephoned Selma Daley that day who said that she would contact Daniel's mother about the issues raised, but that his mother may not be an appropriate appointee due to her own difficulties caring for Daniel. Julia Hookway's note of that conversation goes on to record:

"Selma stated Dr Edgar's visit highlighted that Daniel did not want any further contact with Pathfinders and is refusing further appointments.

Selma stated due to present address Maudsley Hospital may be more appropriate referral although as registered Lambeth H.A. it is possible he will remain at Pathfinders. Selma to discuss this further and contact."

Selma Daley's note records:

"Daniel's mother has returned and is requesting appointeeship for his finances as she feels he is being exploited at his present address and has been spending large amounts of money on a girlfriend (who has another boyfriend). Julia will try to maintain contact via mother."

Selma Daley telephoned Mrs. Joseph and recorded the following conversation:

"Returned from break in the countryside - report above - advised I would discuss with team. Asked to contact me if she manages to see Daniel or persuade him to go home.

Mother reports he has allegedly been threatening to Carla - threatening to kill her. She says Carla has a history of mental health problems and feels she has influence over others, so invites down and outs to her house to stay and read the Bible.

Mother fears Daniel may start using drugs, as the others who stay there do. She also reports Matthew (Daniel's stepfather) has a history of mental health problems.

Advised we would continue to offer appointments and liaise with Brixton/Maudsley mental health teams."

We are not sure where Mrs. Joseph got her information from about Daniel having been threatening towards Carla, nor do we know when these threats had actually been made. As far as we are aware, Mrs. Joseph had not seen Daniel at this stage. There is also some confusion as to where Mrs. Joseph had been for the past few weeks.

Daniel did not attend his out patient appointment with Dr. Hamblin on 18th December.

No further appointment was offered to him at this time. No plans were made to visit him. The plan apparently was to seek Dr Kitson's advice on his return from leave in anticipation that Daniel would be seen in the New Year.

Again on 18th December Simon Edgar faxed a copy of his assessment of Daniel to Selma Daley with a covering letter which said:

"To clarify the situation regarding ongoing care, I have discussed with Dr Teifion Davies, my Consultant, and he confirms that he does not feel obliged to provide follow-up.

I suggest the matter is referred directly to himself should you regard this is as unsatisfactory."

Julia Hookway's note seems to say that Selma thought that the Maudsley Team was the more appropriate referral for Daniel, given his present address. She told us that she understood that Selma was going to take the matter up with somebody more senior at NDS to clarify which was the appropriate referral route for Daniel. Selma's own note states that she would liaise with both the Brixton and the Maudsley mental health teams. The very day she made the note, she received the fax from Simon Edgar, stating that the Brixton Road CMHC Team did not consider that they should have any further involvement in that Daniel's care. Selma did not however contact the Maudsley team at this stage, nor did she take the matter up with Dr Teifion Davies as suggested by Dr Edgar. She told us that she was sure that she had several telephone conversations with Dr Edgar and perhaps with Dr Teifion Davies at this time, but none are recorded in any of the notes. However we know from other people's notes of conversations with Selma that do not appear in her notes, that not all of her calls were recorded by her.

What is confusing is that both the St Thomas' and the Maudesley Community Mental Health Teams are situated at different buildings in Brixton Road. That is how close the two different catchment area community teams were.

However on 18th December Selma Daley faxed to Simon Edgar a copy of her letter dated 10th December to Julia Hookway describing her visit to Carla Thompson's home on 9th December.

On 19th December Julia Hookway contacted the FEFC concerning the funding for Daniel's education and the person she spoke to agreed to discuss it further with her manager " as Daniel's history in relation to education was quite unique".

Julia Hookway then went on her Christmas leave until 5th January 1998.

Selma Daley's next entry in the notes is dated 30th December 1997.

Selma told us that the CPNs work 9 to 5, Mondays to Fridays and that there is no community cover over the Christmas and New Year holidays. The inpatient staff do, of course, work over the holiday period.

On 30th December Selma Daley was contacted by Mrs. Joseph who reported that Daniel was refusing to see her or communicate with her and had thrown away her Christmas presents. Her note continues:

He remains at Carla's and has apparently begun smoking illicit drugs. He is threatening and aggressive to all, who all obey his commands, and has taken his mother's car keys from his stepfather whom he wishes to chauffeur him around. He believes or has been told that Carla's son will take him to America.

Mother advised I would contact local Social Services and get back to her.

Otherwise - no bed is available here and may not be sectionable."

Selma then tried to contact Julia Hookway, to be told that she was on holiday, but that the Duty Social Worker for the Deaf would be available on Friday. Selma noted that the plan was to call on Friday and she notified Mrs Joseph of her intention.

There is no note which shows that any call was made on the Friday.

According to the notes, it was another two weeks before anyone from NDS contacted Daniel's mother again.

Dr Nick Kitson returned from his month's leave on 5th January.

Dr Kitson told us that within two days or so of his return on 5th January he received a slip in his in-tray, saying words to the effect

"Help. We cannot get Lambeth Health Care to take responsibility for Daniel Joseph".

There is an undated (but probably written on 5th January) hand written note from Louise Hamblin in NDS file which says:

"Nick

Please see letter. Daniel DNA'd his appointment with me. What do you think we should do next?

His mother says she would try to bring him to further appointments - I am fully booked in Jan. Do you have any spaces?"

Dr Kitson has written on the same page:

"Send appointment for Tuesday 11:00 a.m. 20/1/98

Let CPN and Louise know"

No-one mentioned to us that an appointment had been made for Daniel for 20th January. There is no letter on the file to Daniel informing him of this fact.

Dr Kitson said that he had also spoken with both Dr. Hamblin and Selma Daley and was aware of what he described as *"the impasse"* regarding the St Thomas' team. He disagreed with the view that Daniel now came under the Maudsley catchment area. His view was that Daniel's catchment area address was that of his original address at his mother's and that address came under Lambeth HealthCare Trust. He told us he accepted responsibility for resolving the impasse between the NDS and Dr Davies' team as he was of the view that this needed to be dealt with jointly by the Consultants concerned. Dr Kitson said that he recognised that Dr Hamblin and Selma Daley were very concerned about the situation, and he felt they were relieved that he had returned and that he would now try to resolve it. In terms of priorities, Dr Kitson said that he did not regard the situation as urgent, but thought that it was important and needed to be dealt with.

Dr Kitson also told us that, having read Dr Edgar's report of his assessment of Daniel on 12th December, he believed that it would have been possible to section Daniel at that time. However he could also see how Dr Edgar's decision that Daniel was not sectionable was justifiable.

Dr Kitson told us that he had dictated a letter to Dr Teifion Davies by 6th January but that it was not sent until 16th January, 10 days later. He told us that the draft letter needed considerable correction, and that he had a temporary secretary at the time, and he had had to correct the letter and that was the reason for the delay. We are concerned that an important letter, dictated at time of potential crisis for Daniel, was not sent promptly. We also find it hard to understand why Dr Kitson, despite his expressed concern, did not pick up the telephone to speak to Dr Davies. Dr Kitson told us that the reason he did not do so was that he felt that relations were somewhat strained between his team and the St Thomas' team and he was therefore

reluctant to pick up the telephone because he feared that it might further inflame the situation and would not lead to a constructive outcome.

The letter which was eventually sent said:

"Re; Daniel Joseph: DOB 12.03.79

(Daniel's mothers address in SW8 was then given)

I am concerned that Mr Joseph is deteriorating in the community, having refused our offers of help and follow-up. As a tertiary service, we are unable to provide the emergency local mental health service Mr Joseph now requires. I was pleased to note your intention (letter to Dr. Hamblin, 2nd December 1997) to do your "best to support Daniel if his mental disorder relapses", but disturbed to receive Dr Edgar's fax to Ms Daley, our CPN, of 18th December 1997, stating that you confirm that you do not feel obliged to provide follow-up. This appears in contradiction to your previous (and fully justified complaint), that the only communication you have received was in crisis. We are now trying to involve you and your team, and it is apparently being refused, despite a clear need by Mr Joseph. It is evident from Dr Edgar's assessment and our CPN, Selma Daley's observations, that Mr Joseph is gradually relapsing.

We are not a local service and are not funded to provide such a service, nor emergency catchment area responsibility. In addition, Mr Joseph is no longer co-operating with our follow-up due, in my opinion, to his mental state. I regret that we had not worked closer with your team in Mr Joseph's interest, and for this I apologise. In mitigation, Mr Joseph was doing well and appeared to have a well-planned future (to go to an RNID residential college in Devon), which he was then eager to pursue. We had appeared to have a good relationship with him, both when ill and well. It did not appear likely he would need local Mental Health Act services, and our general, though not exclusive experience has been one of disinterest from such services over our very wide catchment area. It is refreshing to have a service that wishes to be involved and I hope we will be able to work together for Mr Joseph. I can only suggest that I ask Selma Daley, our CPN and Key worker to arrange a fairly urgent joint meeting to plan a joint CPA approach between our teams, so that Mr Joseph's future can be maximised. I will ask Selma Daley to communicate with the Rapid Assessment Team at Brixton Road Community Health Centre if she perceives a more urgent assessment than we can provide is required."

Dr Kitson did not in fact ask Selma to arrange this joint meeting. He told us that he did not intend doing so until he knew with whom he was going to be setting it up.

Julia Hookway returned from her Christmas break on 5th January. The next day she telephoned Mrs. Joseph who said that although she had seen Daniel over Christmas he was not taking his medication and was "not too pleased to see his mother". Mrs. Joseph

was not able to discuss this matter further as she was on her way out. Julia agreed to visit Daniel at Carla Thompson's and telephone her again the following day.

The same day, 6th January, at about 16.00, Julia Hookway visited Daniel at Carla Thompson's together with Jenny Towland, the interpreter. She told us that she wanted the interpreter there for two reasons, despite the fact that she herself was proficient in BSL. Firstly because if Daniel was starting to deteriorate his signing would be 'rapid and manic' and Julia would be more likely to miss any key points; and secondly she wanted to observe him closely.

Daniel and Carla were both there, as were two other unknown men. Julia was never introduced to these two men and therefore never found out who they were. She assumed they were 'residents'. They were both slumped on the sofa, and the only one who attempted to speak appeared to slur his words and could not focus or stand up. The two dogs were also running around.

Despite the time of the afternoon, Daniel was lying fully clothed on his bed, fast asleep.

When Julia introduced herself and reminded Carla that they had previously spoken on the telephone, Carla proceeded to tell Julia how everything was perfectly all right and she seemed very keen to get that point across. However Julia described how Carla had her own "agenda" of things she wanted talk about, such as getting money for Daniel and how his money had been stolen. Julia had to keep bringing her back to the reason why she was there, which was that Daniel had been in Ian Collie House because he had mental health problems, and that Court Grange was somewhere he was supposed to be going to help him. Yet Carla would go off at a tangent again, coming up with something that was completely unrelated. Julia told us that the conversation was very disjointed and Carla was not really listening to what Julia was saying. She seemed keen to reassure Julia that she was perfectly able to look after Daniel, and that Daniel was making an informed choice to live there, and that if Julia could just help out with the financial side of things, then everything would be fine.

Carla then woke Daniel and Julia asked him if she could sit down on the end of the bed to talk to him, to which he agreed. Julia attempted to explain to him that she was going to use the interpreter, but she could not get him to engage with her. She then attempted to get Jenny Towland to engage with him, but that didn't work either. She allowed him time to come around, to give him an opportunity to speak. Once she got his attention, Daniel went off to make a cup of tea. Eventually he came and sat down and Julia tried to get through to Daniel to find out what had been happening, and what he wanted to do about Court Grange.

Daniel told her that he did not want to engage with Social Services or with anybody. He said:

" When I want a flat I will come and let you know. Leave me alone. I just want peace and quiet."

Jenny Towland told us that she remembers Daniel complaining about Carla's housekeeping, pointing out that there wasn't even any milk in the fridge - implying that she could not even organise that. She also said that they did not stay for anything like the length of time that they had planned to be there because:

"He just was not interested. He was not going to go to Pathfinders, he said. He was not going to go. He was very dismissive - contemptuous and dismissive - he really was."

Julia tried to explain to Carla how important it was that Daniel attended appointments and took his medication, and that it seemed as though his mental health might be deteriorating. Carla said that she understood, but Julia was not reassured. She felt that Carla was putting herself in the position of an advocate for Daniel, but her views conflicted with his, or at least his views as they had been when she had last spoken to him, which was when he was still at Ian Collie House. She said:

"Suddenly this was a different person. What she was giving me was the information that Daniel was not interested in Court Grange any more and did not want to do these things... that was not what our last conversation was. So what I had was this person coming in saying " right, he wants to do this now"...

Julia told us that Carla seemed to have no real comprehension of sign language. Any signing that she did was no more than we all do when we talk with our hands.

Julia told us that she came away from that meeting feeling quite distressed. The distress was more at Daniel's overall appearance than at any specific behaviour. She told us he was not aggressive in his tone or in the content of his signing. Although he did not want to engage with her, he was not threatening in any way. He was not elated. He was not signing rapidly. If anything he was subdued.

This was the 'Summary' in the note that Julia Hookway made following the visit to Daniel:

"It is clear that Daniel's mental health has deteriorated impacting on his ability to care for himself given his weight loss and general appearance.

Living conditions are poor and Daniel is unable to communicate with anyone in the house as he is the only sign language (user)

It is not clear from the discussion with Carla who lives at the property and I feel that it would not be safe to visit as a lone worker based on the visit and discussion with CPN."

The following day, 7th January, Julia phoned Selma Daley to report on her visit. Julia informed Selma of her concerns for Daniel's health and safety and that there was a strong possibility that Daniel had not been taking his medication. Selma told Julia that Dr Kitson was going to hold a case conference in relation to the care and treatment of Daniel and would contact her with the outcome.

No case conference was in fact held. As we have stated above, Dr Kitson had not asked Selma to organise one, and as Daniel's Key Worker, she would have expected to have to co-ordinate such a meeting. We are concerned that Selma told Julia that she would inform her of the outcome. Julia should have been invited to attend any Case Conference, especially such an important one.

Ironically, on the 7th January, the education programmes officer of the FEFC, wrote to Daniel at Ian Collie House informing him that the Council had agreed to fund a place for him at Court Grange from 5th January 1998 to 31st January 2000, to enable him to follow a Vocational, Further Education and Social and Life Skills course.

On 8th January Daniel's situation was discussed at the Community Ward Round. Dr. Hamblin was present, as was Selma Daley. There were other members of the community team present as well. Following the discussion a Care Programme form was filled in by Selma, although we understand that due to subsequent events, it was not circulated outside the team. The main details of the Care Plan were:

"MEDICAL

- *Objectives: to stabilise Daniel's mental state*
- *Action: to offer 2 weekly CPN contact for assessment of mental state and response to treatment. Attempts to arrange joint assessment with local services for the purposes of the Mental Health Act*
- *Anticipated problems: refusal to make contact with our services*
- *Staff Involved: Selma Daley/Dr Kitson/Julia Hookway*

OCCUPATION

- *Objectives: provide structured activity to help maintain stability*
- *to help facilitate placement at Court Grange Residential College once mental state stable*
- *Action: liaise with college via S/W J. Hookway*
- *Anticipated problems: placement postponed due to deterioration in mental state*

HOUSING

- *currently living in inappropriate accommodation*
- *Objectives: unable to address needs until suitable placement found*
- *Action: liaise with Daniel's mother and S/W J. Hookway, re: current placement*
- *Anticipated problems: Daniel refuses to meet with our services*
- *Staff involved: Selma Daley/Julia Hookway/Dr Kitson"*

The date of the next Care Review was given as March 1998. Daniel's likely involvement with NDS was given as *"long-term involvement with inpatient admission when required"*. In the section dealing with the Supervision Register, Selma answered in the negative all of the questions: *Is this patient at risk of (a) serious violence (b) suicide (c) self neglect.*

It causes us some concern that the NDS made no attempt themselves, after Selma Daley's abortive visit of 9th December, to make contact with Daniel. They repeatedly stated in notes and letters that Daniel was refusing to engage with their service, but no one from NDS had actually heard that from Daniel himself. After all, their team had been working with him the longest and they were the people who knew him best. Yet after he left Ian Collie House on 22nd November 1997, no-one from the NDS actually saw him, either to assess him or to find out what he really felt about continuing involvement with their service.

On 12th January Julia Hookway spoke with Mrs Joseph on the telephone and was told by her that people at Carla's house were stealing Daniel's benefit money. Mrs Joseph remained concerned about his care. Julia telephoned Selma Daley to be told by Jane Finn (another CPN with the NDS team) that Selma was on leave until 16th January. Jane Finn agreed to send Julia a couple of documents that might assist and she faxed those through the same day.

What is strange is that one of the documents faxed by Jane Finn on 12th January to Julia Hookway was Dr Kitson's letter to Dr Teifion Davies, which for some reason was not sent for another four days to Dr Davies. The other document faxed was Simon Edgar's report to Dr. Hamblin of his assessment of Daniel.

On 13th January Julia Hookway wrote to Court Grange to confirm that Daniel would be unable to start his course in January because of mental health problems. She wrote:

" The mental health team within Pathfinders, National Deaf Services, are providing appropriate care and support and it is anticipated that Daniel will be able to negotiate a start date for college when his mental issues have been addressed.

Therefore, I am requesting that his start date be reviewed March 1998 to allow time for Daniel to receive care services. If you wish to discuss the matter further please do not hesitate to contact myself or Dr Kitson."

Following professional supervision by her team manager, Julia agreed to write to Selma informing her of her role and future aims. She told us that she wanted to be clear about her role, what she was doing, and to make sure that she was responding in the appropriate way that that time. She described to us the concerns she raised in that supervision session:

"He had moved from this place to that. There were services being set up and I was not really completely able to record accurately who was the worker - who was doing this, who was doing that. Equally, was I giving the [proper] information? Was I making it clear to other agencies what I was doing, what my responsibility was that I was pursuing? I was aware that I was not having regular social work contact with an allocated client. What I was doing was pursuing a task which involved a client. So you could make the assumption that I was going to be doing lots of engaging with the client, but that would not have been accurate."

Julia told us that she felt that there should be something on record that said that "Social Worker Julia Hookway is involved", given that that there were going to be case conferences and the likelihood of another assessment by another team at some point. She was also concerned that tasks were getting diffused:

"I was asking: How does this organisation work? Because we were working with Pathfinders, which is an NHS Trust, and we also had Lambeth local resources; we also had Lambeth, Lewisham and Southwark Health Authority. So there were lots of people having lots of different roles and responsibilities. So I was thinking: How does that work, especially with the patch issue? Is it about boundaries and borders, because if that was the case, his GP was over in Wandsworth, he had been over in Harding House which was Wandsworth, his mum's address was Lambeth, and if he had his mum's details from there

that would be Lambeth. He was living in a Lambeth property that did not belong to him - it was somebody else's - and also he was a deaf person. So a lot of people would say "it is not appropriate for me to go and assess him because I cannot get an interpreter" or " he is not known to us", or whatever."

Julia told us that she intended to put all this in writing to Selma Daley, but the computers in the office crashed for two days and she was therefore not able to do so.

On 13th January Jane Finn telephoned Mrs Joseph (Selma Daley was on leave until 16th). Her note states that she was telephoning Daniel's mother " *to update her on current situation re: letter from Dr Kitson etc.*"

Again this appears to be a reference to Dr Kitson's letter to Dr Teifion Davies which still had not been sent, and was not to be sent for yet another three days.

The CPN's note continues:

"Mrs Joseph is understandably extremely worried about Daniel's mental state and living accommodation. She believes that he is taking illicit drugs and worries that he may harm someone as he is such a " large man".

Ventilated her feelings regarding the situation and I reassured her that the team here are liaising with his local catchment area team and the possibility of sectioning him under the M. H. A. in the near future should his mental state warrant it."

At that particular time, there was no actual contact between the NDS and the Brixton Road team.

On 16th January Selma Daley received a telephone call from Mrs Joseph reporting that

"She was unhappy with Daniel's current placement and felt he was using illicit drugs (cannabis). She was also concerned that he was vulnerable to a young lady - Kirsty 18/19 yrs - abusing him financially - and fears that this lady's boyfriend – 40 year old man - may attack Daniel.

Mother felt Daniel was becoming more irritable but denied he was threatening to harm others or himself.

Advised she could contact the Police if concerned.

Also explained that letter had been sent to catchment area consultant advising him of Daniel's condition and our inability as a service to provide emergency services.

Advised I would contact the rapid response team again on Monday to see if they would do a repeat assessment as before but advised that Daniel may present well - as before - and not meet criteria for section.

Advised we would admit him if bed available -and Daniel sectioned - however he is avoiding all contact with our services at present.

Invited to contact the nursing staff on the ward if any further concerns over weekend.

Plan. Call Brixton rapid response team on Monday.

Call mother Monday

Liaise with S/W J. Hookway on Monday

Discuss with Dr Kitson"

At 13.00 on Saturday 17th January Mrs Joseph turned up at Old Church and spoke to one of the nurses, Ruth Woolhouse, who was on duty that weekend. Ruth made the following note:

"Daniel's mother came in at 1300, reporting that she had seen Daniel two hours previously. He has been living at "Carla's" - a woman in Tulse Hill who has mental health problems and brings in drug users and homeless to heal them. He has a girlfriend there who his mother fears is seeing another man and only using Daniel for his DLA money and continually argues with an "Indian" drug user. This morning Daniel had come to her place "very mental", seeming high and impulsive, paranoid about the "Indian" man and threatening to kill either him for himself. Mother tells this is a very real threat but doesn't want Brixton police involved as they are known to be racist. Explained no emergency service here - advised the only route of admission would be via Police or A+E. reassured mother will maintain contact over weekend and inform community team on Monday. Duty senior nurse informed."

Ruth Woolhouse told us that Mrs Joseph conveyed genuine concern on this occasion

"very calmly and very clearly and very articulately. She went to great lengths to explain how concerned she was. You have got to remember as well that she has come from South Lambeth down to Balham. That would have cost her the ticket or a cab or whatever..."

She said to me one thing that I did not document, because it was not really relevant, but I really remember that she said " A lot of people think that us Caribbean people are very highly strung and easily excitable, but I am trying to tell you I am seriously concerned about my son". I reassured her that I took that very, very seriously.... The main thing I took away was that she was coming with a deliberate purpose to give me a very clear message."

Sometime shortly after she came on duty on Sunday afternoon (probably about 14.00) Ruth Woolhouse telephoned Mrs Joseph and was told by her that she had seen Daniel earlier that morning. Ruth noted the conversation:

"She felt he was very animated and elated, talking fixedly about meeting an American football team yesterday and wanting to buy hundreds of pounds worth of equipment. However, the "Indian" man had left Carla's house and Mrs Joseph felt Daniel was no longer at risk of violence against others or himself. She wishes the community team to contact her 19-1-98 a.m. Duty senior nurse informed."

Ruth Woolhouse has no clear recollection of this telephone call, and therefore believes that it must have been " less anxiety-ridden". Obviously Mrs Joseph was not sufficiently concerned after seeing Daniel that morning to telephone Old Church herself. The reference to Daniel no longer being a risk to himself or others is also noteworthy.

However later that same day, Sunday 18th January, at 18.20 Mrs Joseph telephoned Old Church again and told Ruth Woolhouse that she had heard that Daniel had "*beaten up her partner Matthew Gillett*". Mrs Joseph apparently wanted to go round to Carla's house immediately, but Ruth advised her for her own safety to go with friends or the Police. Ruth noted that she seemed to accept this but expressed "*anger that the system could not facilitate immediate admission to local hospital*"

As far as we are aware, Mrs Joseph did not go round to Carla's house that day.

Ruth Woolhouse had got to know Daniel well in the eight months or so that he was an inpatient at Old Church. She told us that she was very shocked to hear these descriptions of Daniel being aggressive. She had earlier told us that her lasting impression of Daniel was that "*he was immediately very warm and friendly, and very large and clumsy*". She said that she was not aware of any other member of staff or patient at Old Church who felt either intimidated or threatened by him in all that time.

Matthew Gillett told us that all that happened on that Sunday was that Daniel had got upset when Matthew had refused to drive him somewhere, and had grabbed Matthew in a 'wrestling hold'. His Police witness statement does describe Daniel as punching Matthew twice on the side of his head whilst he was captive in the wrestling hold,

but apparently Daniel was easily calmed down, and apologised to Matthew for hitting him.

At about 03.00 in the morning of Monday 19th January, the Police turned up at Carla Thompson's flat, saying that somebody had tipped them off that someone (in her statement to the Police, Kirsty said that it was said to be Daniel) had a gun in the flat. They apparently searched the flat, found nothing, and left. It was thought to be Suleman ("the Indian man") who had informed the Police.

We assume that Daniel must have been acting fairly normally on this occasion, otherwise the Police would have taken some action.

When Selma Daley arrived at work on Monday 19th January, she was immediately made aware of the events of the weekend and 'went into action'. Her first call was to Dr Simon Edgar seeking to refer Daniel to the Brixton Road Community Mental Health Team for a further assessment. Presumably in the light of his earlier correspondence, Dr Edgar advised Selma to discuss the matter with Dr Teifion Davies first. Selma then faxed to Dr Edgar a copy of her letter to Julia Hookway of 10 December 1997 which reported on her abortive visit to see Daniel at Carla's, and also faxed the following letter to Dr Teifion Davies:

"I have not had contact with Daniel since he discharged himself from his temporary placement at Ian Collie House residential care home on 24 September (sic) 1997. Daniel has been refusing to interact with anyone from our services and has failed to attend any appointments offered. I visited him at his present address...in Tulse Hill on the 9th December 1997 and found the placement quite unsuitable. Please see previous report attached.

I have also had frequent telephone contact with his mother who has reported that her previously good relationship with Daniel has deteriorated to the point where he is reluctant to communicate with her, harbours suspicious ideas about her and threw away a gift she bought him.

Mrs. Joseph is keen for Daniel to return home, because she suspects he is using illicit drugs (cannabis) at his present placement because a number of occupants are known to be drug users. She also fears he is at risk of financial abuse from a young lady who visits him whenever he receives his benefits.

Mother has described his behaviour as threatening saying he intimidates the others around him into meeting his inappropriate demands. She reports that he stole the keys to her car to enable his stepfather to drive him around and crashed it into a post when he attempted to drive himself.

He remains suspicious and continues to express grandiose ideas about his future.

He also has expressed self-harm thoughts on several occasions, although no attempts have been made.

His Social Worker Julia Hookway who has had contact with him on one occasion since his discharge reports he is quite dishevelled and appears to have lost weight. He also had difficulty maintaining eye contact and continues to express grandiose ideas.

In view of the level of deterioration in his mental state and overall level of functioning, I am concerned that some urgent interventions take place.

I look forward to your response".

There is no mention in this letter of the events of the weekend, in particular Daniel's 'attack' on Matthew Gillett.

The letter says at the bottom that it was copied to Dr Kitson, Daniel's GP, Julia Hookway and Dr Edgar.

Selma then telephoned Julia Hookway and her note of that conversation records that Julia reported that Daniel had lost weight and appeared dishevelled, however Julia was unable to provide any more input until he had been treated (?). She also said that she had contacted Court Grange and had postponed his placement until March when it would be reviewed.

Selma then telephoned the Maudsley Emergency Clinic to refer Daniel to their service for an assessment. The call was taken at approximately 11.00. The Charge Nurse who took the call contacted Mohammed Hussenbocus, a CPN with the Brixton Community Team, who then telephoned Selma Daley.

This was not the same Team as the Brixton Road CMHC, which covered St. Thomas' catchment area, although in fact both teams operate from different buildings in Brixton Road.

Mohammed Hussenbocus made a note that Selma told him that Daniel was deaf and had a diagnosis of hypomania, and that she was concerned about his mental state since he had left his placement at Ian Collie House "on 9.12.97", that he might have stopped taking his medication and might be using cannabis. She told him about Daniel crashing his mother's car, and that he had "assaulted his mother's partner the previous week". She said she was

concerned that Daniel may be becoming increasingly paranoid and manic; he was demonstrating threatening and abusive behaviour, and had threatened self-harm on a couple of occasions. Selma also told him that Dr Nick Kitson was the psychiatrist responsible for Daniel care, but that he was away until the next day and in any event had not seen Daniel since he left Ian Collie House. She also mentioned Dr Hamblin and that there was a Social Worker, Julia Hookway, involved. She advised him to contact Julia Hookway to arrange for Jenny Towland, the signing interpreter, to attend any assessment. The assessment by the Lambeth Rapid Assessment Team was also mentioned, but Mr Hussenbocus recalls that he was told that that had been only some two weeks previously (it was in fact six weeks previously) and that the Team had not found Daniel to be detainable under Mental Health Act.

Mohammed Hussenbocus told Selma Daley that he would need to talk to Dr Kitson to obtain more information regarding Daniel, but that he would present Daniel's case to the weekly clinical forum which was meeting the next day, with a view to carrying out a Mental Health Act assessment later that day, i.e. Tuesday 20th January. He asked Selma to fax 'any further information' to the Brixton Community Team. He told us that he did not specify what information they required, but would expect to receive all the relevant latest information about the patient. He said that he never received any fax from Selma, although Selma is fairly sure that she did fax through one of the reports.

We asked Mohammed Hussenbocus whether or not a sense of urgency was conveyed in Selma Daley's telephone call. He told us:

"She actually asked to speak to a manager and I explained to her that there was a duty system and she really needed to talk to a duty person, which was me. She was happy with that afterwards. I think what transpired from her account was that there was perhaps some degree of urgency but also a degree of not actually knowing what was going on. I thought that because she is perhaps not quite clear how he is, she is asking for somebody else to intervene."

When asked whether it was fair comment that she may not have conveyed any great sense of urgency, Selma very frankly said:

"In my mind it was urgent. He needed to be seen. He needed to be in hospital..."

I saw it as urgent, but it is a fair comment that maybe I did not convey the urgency."

To be fair to Selma Daley, no-one could really know at that stage just how urgent the situation was. No medical professional had seen Daniel since Dr Edgar and Dr Bonner on 12th December. The only reports had come from Daniel's mother, and it was only over that last weekend that she had indicated any real concerns about his mental state, and Selma told us that at times there was an 'ambivalence' in Mrs Joseph's reports. She did however take them very seriously.

After he had spoken to Selma Daley, Mohammed Hussenbocus telephoned Julia Hookway who also expressed her concern about Daniel's mental health, but at the same time emphasised her concerns about Carla Thompson's involvement in Daniel's welfare, saying that Jenny Towland had warned her that Carla's interpretation of signing between herself and Daniel did not correspond to her own interpretation. Mr Hussenbocus told Julia that he would be presenting Daniel's case at the weekly clinical forum the following day, and that Julia and Jenny Towland would be required to take part in any assessment for communication and interpretation purposes. Julia checked with Jenny Towland who confirmed she was able to assist on Tuesday 20th January.

After she had spoken to Mohammed Hussenbocus, Selma Daley received a telephone call from Dr Teifion Davies. He had received her fax. He told her that he had previously been unable to provide follow-up care because he had not received any correspondence from the NDS, and was not aware of Daniel's treatment plans, care plans, CPA etc. and Selma agreed to send him copies of relevant reports. Dr Davies agreed to ask the Brixton Road CMHC Rapid Assessment Team to carry out a Mental Health Act assessment, despite the fact that Daniel's present address was outside their catchment area, and to provide emergency admission if necessary. He felt that the Maudsley would only refer Daniel back to St. Thomas'. The plan was for Selma to discuss those matters with Dr Edgar.

Not long afterwards, Selma received a telephone call from Dr Edgar which she recorded as informing her that Dr Nadia Davies, the consultant responsible for the Brixton Road Rapid Assessment Team, "*was not prepared to assess a patient from another catchment area*" and that she should therefore refer Daniel to the Maudsley.

Dr Edgar also faxed Selma a letter that day stating:

"On discussion with both Dr Teifion Davies, and the Community Adult Consultant Dr Nadia Davies, further assessment by way of home visits should be provided by the Maudsley hospital community catchment area team because Mr Joseph resides outside West Lambeth.

The issue of inpatient care would be between yourselves and Dr Teifion Davies at St. Thomas' hospital.

I hope this clarifies the situation."

Dr Nadia Davies told us that she believed that the Collaborative Review Panel appeared to have formed the impression that Dr Teifion Davies made one decision

which was then countermanded by her. We are of the view that there was some genuine confusion and “crossed wires”, and have therefore set out the evidence on this matter in some detail.

Dr Edgar told us that when he went back to his room at around lunchtime, he found a piece of paper on his desk saying something about “*Dr Teifion Davies and Daniel Joseph assessment*”. He couldn’t understand the message so he picked up a telephone and rang Dr Teifion Davies who mentioned that he had had a conversation with Selma Daley who was expressing concern about Daniel. He said that Dr Teifion Davies was a bit exasperated at the situation because ultimately they had to have the patient’s best interests at heart, and he felt that if he did not offer a bed as a last resort, then Daniel might not get any kind of care. Therefore he said that rather reluctantly he had agreed, as a last resort, that one of his beds could be used to admit Daniel should it become necessary. However, Dr Edgar said that Dr Teifion Davies was ‘*completely equivocal*’ about whether the Rapid Assessment Team should be involved or not. He told Simon Edgar that he had better discuss that with Dr Nadia Davies because she was the lead clinician responsible for the Rapid Assessment Team. Dr Edgar told us:

“The way I understood the service working was that any consultant could request the use of the Rapid Assessment Team, and that although Nadia Davies oversaw the team and felt she had overall responsibility for it, that did not mean that all the other consultants did not have autonomous rights to the services of that team. So, as such, my expectation was not that he would feel that he had to go through her. That was my understanding of how the team was supposed to work. If Teif had said to me, “Yes... never mind, let us go and make the assessment”, we would have just simply deployed this - I do not think I would have even discussed it with Nadia. We would have gone and done the assessment”.

Dr Edgar then had to get Dr Nadia Davies out of a meeting. She knew something about Daniel because his name kept cropping up, and the team had assessed him previously. When she discovered that nothing had changed as far as Daniel’s present address was concerned, and that he was therefore not in their catchment area, Dr Edgar told us:

“Once she had established that nothing had changed, her view was, “Teif made the decision, on or before the 18th December, about the appropriate community service, so therefore, because nothing has changed, why should our Rapid Assessment Team be involved now?” I have to say that I rather agreed with her on that...”

Dr Nadia Davies told us:

“Obviously, in terms of the service, this has been the crux of the issue for us. Teif communicated with Dr Edgar, who then communicated with me - which was probably a mistake - rather than communicating with each other. He was in a clinic and was really

busy, and I was in a meeting and was called out of the meeting. So it was between patients, you know, the usual sort of everybody rushing around. My understanding is that he said to Dr Edgar that he did not think that we should do it. That is my understanding. But that if the Maudsley would not provide a bed for him, he would provide a bed. Because I had worked at the Maudsley, with their crisis service, I knew that they would act as quickly as we would, and they had a very similar system...

I was not aware of how urgent it was. I do not think anybody anticipated that he was going to behave violently. I knew that he was relapsing... With the information that we had, he would not have been a priority that day. We have a lot of other patients who we would consider to be higher risk of violence towards other people...

Had we been the people who arranged the crisis assessment, as opposed to it being a Maudsley service, it still would have involved referring to the Approved Social Work Team actually looking for a Mental Health Act assessment. It still would have required a sign language interpreter; it still would have required getting the Police, the ambulance and other doctor together... there was no indication that a four-day delay was unacceptable in the context. I mean it is unacceptable always, but in the context of the services and resources that we have...

It would not have made any difference to me if I had said, "Just get him into the bed and then let the arguments happen afterwards". But it just seemed to me that we had been through this process before. He had not been provided with a service in the meantime and it was important that he got linked in to a service that would provide a comprehensive service for him. Because in December we had identified that he was living in appalling circumstances, he was becoming unwell, he was living with people who possibly used drugs. It seemed to me that just using emergency services was inappropriate for him. He needed something more co-ordinated...

My decision hinged entirely on what I thought Dr Teifion Davies was saying."

Dr Teifion Davies told us:

"The closeness, the fact that he had moved temporarily in an unplanned way into an area which was quite close to his original catchment area, actually caused difficulties, because we were constrained by catchment area boundaries to some extent. I suspect that a national unit, which is not familiar with catchment area boundaries, was not quite aware of our difficulty and so could not quite see what the problem was, in the sense that there was a problem which would have, in my view, been very easily circumvented by informing the local services of his existence and of concerns. Then, as we have done on many occasions, we could have planned jointly with the Maudsley services who was doing what".

Dr Davies told us that the telephone conversation with Selma Daley was the first time that he had spoken to any member of the NDS team. He said that the telephone call did impress him that Selma was "very very concerned". For that reason he agreed to ask the Rapid Assessment Team to carry out another assessment. He was not, however, the consultant responsible for the team. He admitted to us:

"I spoke out of turn. I suggested that I would ask the team that I do not work in to perform a task and, quite rightly, that was outside my remit..."

I suspect that I made some assumptions about what was being asked and what was available elsewhere, and perhaps certainly it might have helped the National Deaf Unit if I had been clearer at an earlier stage that, in fact, either I was going to be very much involved or I was not going to be involved at all. At the time, and in fact still, I tend to want to be flexible on these things. The cold light of hindsight suggests that, in fact, if I had been harsher, then the situation might have been clarified more quickly".

After speaking to Dr Edgar, Selma Daley telephoned Mrs Joseph to update her. Mrs Joseph told her that she had asked Daniel's older brother to try to escort him to St. Thomas' Emergency Clinic. **(We are not sure if his name is Charles or Kevin – we have heard him referred to by both names!)** Selma advised her that this was a good idea and to inform her if this proved successful. Mrs Joseph also stated that she was going to write a letter of complaint to the Minister of Health about the services in general.

We did not hear from Daniel's brother (who is apparently a paramedic), but we did hear about his visit to Carla Thompson that Monday evening from Mr Jim Kiltie, who told us that he had accompanied him.

Jim Kiltie told us that he has known Daniel since he was a child. He is a Biker and used to live with one of Daniel's half-sisters, Marion. Daniel used to spend quite a lot of time with them, apparently spending two or three nights a month at their flat. Jim let Daniel ride his bikes around the estate. They always had a good relationship. Jim is a 'colourful character', but was able to give us some vital information about Daniel in those last few days before he killed Carla.

He told us that Claudette Joseph had asked Kevin to go to see Daniel at Carla's and that he had gone with him. It was early evening when they arrived. There were about six or seven people there, including Daniel, Carla Thompson and Matthew Gillett. Jim described the flat as filthy, "a pigsty", with mattresses all over the floor. Daniel was sitting on a chair, but when he saw his brother, he got agitated and just "wanted him out". Jim told us:

“If I was on my own he would have let me in. But when he realised Kevin was there, he sees his brother – big guy – I reckon he thought we were there to take him, because Kevin still had his uniform on. He thought we was there to take him.”

Jim told us that Daniel had lost some weight and was not looking his usual smart self.

He and Kevin were at the flat for about 20 minutes. He told Daniel that he could come and stay with him or at Kevin’s, but Daniel told him that he wanted to stay with Kirsty who was also living with Carla.

The most important piece of information that Jim Kiltie gave us was that there was nothing that he saw that evening, even though it was only three days before Carla’s death, that made him think that Daniel was about to injure anyone or himself.

However we must make it clear that, according to the Police witness statements of a couple of the ‘residents’ living at Carla Thompson’s, Daniel’s brother Charles had come to Carla’s on the Monday at a time when Daniel was not there as he was working in Brixton, helping to decorate the flat belonging to family friends, and that his brother had therefore gone to see Daniel there (Daniel was apparently carrying out this decorating work for the week leading up to the events of 22nd January – in fact right up until the day before). As we were unable to interview any of these witnesses, we cannot be sure which version of events is true.

According to a note made by Julia Hookway on 22nd January, Mrs Joseph told her that on the afternoon of Monday 19th January, Carla Thompson had telephoned her and told her that Kirsty was pregnant and Daniel was the father.

The next day, Tuesday 20th January, Mohammed Hussenbocus presented Daniel’s case to the clinical forum. Following the multi-disciplinary meeting, the matter was taken over by Claire Squire, Team Leader of the Brixton CMHT. The decision was made that more information was needed from Dr Kitson and therefore she telephoned him to ascertain the NDS’s role in urgent assessments. According to Claire Squire, Dr Kitson informed her that NDS was not able to provide urgent assessments for patients in crisis and that it was therefore necessary for local services to carry these out. Dr Kitson gave her a brief history of Daniel’s situation since leaving Ian Collie House and said that in his opinion, Daniel was relapsing and would need a Mental Health Act assessment with a view to hospital admission. He said that Daniel had been discharged two to three months ago to outpatient follow-up and residential care, but had discharged himself in December. He told her that Daniel had been assessed 2-3 weeks previously by a Senior Registrar to Dr Teifion Davies. **[It was in fact six weeks since Dr Edgar had assessed Daniel.]** Dr Kitson also told her that he felt that Daniel was psychotic and probably using cannabis which also affected his mental state.

It was agreed that Claire Squire would refer Daniel to the Approved Social Work (ASW) Team at Mary Seacole House for a Mental Health Act assessment, with a view to admitting him to the Maudsley if necessary, with subsequent transfer to the Springfield Deaf Unit when a bed was available . Claire Squire told us that the request for a Mental Health Act assessment would mean that a joint assessment involving a psychiatrist and an ASW would take place. The other factor in referring Daniel for an ASW assessment, was that proper back-up could be arranged if required. She said:

“That would happen because , obviously, if somebody needs a mental health assessment there is a level of risk or complexity to that situation and therefore it is better that everybody who needs to be involved in the assessment should be there to make the proper judgement, and if the person is not sectionable, proper plans need to be put in place and that is why you need a multi-disciplinary approach.”

The paradox is that someone from the NDS was the obvious choice to become involved in the assessment, but the specialist team does not provide such a service in an emergency.

Selma Daley telephoned Claire Squire on Tuesday morning who told her what had been discussed, and that she was referring Daniel to the ASWs for a Mental Health Act assessment and that he would most likely be admitted to the Maudsley Hospital.

At about 14.00 Claire Squire contacted the ASW Team and spoke to Lorraine Roofe-Spence and told her that she had two people whom she wished to refer to the ASWs, one of whom was Daniel Joseph. She told Lorraine that Daniel was known to the NDS Team and had been placed in a residential home by them but he had absconded in December.

Mohammed Hussenbocus’ note of what he was told by Selma Daley was that Daniel had discharged himself from the residential home. There is a subtle difference between ‘discharged himself’ and ‘absconded’. In fact as we have already commented, Daniel did not need to be discharged from Ian Collie House at all. It was merely a hostel run by a Housing Association that provided supported housing for deaf people with mental health problems. What actually happened was that Daniel left the hostel against advice.

Claire Squire said that Dr Kitson from Springfield had made the referral to the Brixton team and that Daniel was currently staying with a friend, was hypomanic and paranoid. He had crashed his mother’s car last week and threatened her partner.

Selma Daley had told Mohammed Hussenbocus that Daniel had ‘assaulted’ his mother's partner, and he had noted it has as such. There was therefore some dilution in the passing on of this piece of information.

He was threatening and abusive and threatening self harm, and was abusing cannabis. Claire Squire told the ASW that she was waiting for further information from Springfield (ie. the NDS), and Lorraine Roofe-Spence recorded that the plan was to:

- *Get further background info from Springfield - Dr Kitson and CPN*
- *negotiate with Springfield their responsibility for this man*
- *establish outcome and background of residential placement*
- *if appropriate co-ordinate assessment with Springfield*

We are somewhat confused about this plan, as Claire Squire had already spoken to Dr Kitson, who had presumably given her sufficient and relevant information. Dr Kitson was not under the impression that anything more was required from him or his team following the conversation with Claire Squire. He believed that the assessment would now be arranged. He had also made it quite clear that the NDS team would not be carrying out the assessment themselves, and would be relying on the local psychiatric services to do so. (The ASW Team covers the whole area, ie. the catchment areas of both the St Thomas' team and the Maudsley team). We are aware that this in effect left the ASW team to work out which local team to approach since the NDS had not previously negotiated who should be responsible for Daniel if an emergency arose when he was living in the community.

There has to be a psychiatrist (in fact the recommendations of two doctors are required in order to detain under the Mental Health Act) as well as an ASW in order to carry out the assessment. Lorraine Roofe-Spence told us that she asked Claire Squire who the duty psychiatrist was, and had been told that no-one was sure who was going to be carrying out the assessment and that she was going to wait until she had got the information from Dr Kitson. Lorraine got the impression that there was some confusion as to which of the local psychiatric services was actually going to carry out the assessment.

Claire Squire then told Lorraine Roof-Spence about the other patient she was referring to the ASW Team. They knew something about this other patient because he had already been referred to the ASW team the previous week, because he was in temporary accommodation and the Team was in fact the Homeless Single Person's Team. This man had a forensic history, with a long list of previous convictions, many of which were related to violence, and his last offence had been an unprovoked knife attack on a member of the public. Claire Squire made it clear that this other referral must be given a high priority.

Lorraine Roofe-Spence took the two referrals to the Senior Practitioner of the Team, and the decision was made to deal with the other referral first, mainly because it was more

urgent, but also because they were still waiting for more information about Daniel's referral, especially who the psychiatrist carrying out the assessment was going to be. Lorraine told us:

"We did not have all the relevant information and we did not have a psychiatrist."

Lorraine told us that Claire Squire did not mention to her that the referral had actually been made the day before by Selma Daley contacting the emergency clinic. She also did not know that, on the form that Mohammed Hussenbocus had filled in the day before, he had ticked the box for an assessment to be carried out within 'next 24 hours' **[The other choices were 'today' or 'over next week']**. She was surprised when we told her that in the 'follow-up' section on the CMHT referral form completed that day i.e. 20th January by Mohammed Hussenbocus and Claire Squire, they had ringed 'Yes' next to the choice: *"Urgent Assessment still required"*. She told us that no great sense of urgency had been conveyed to her, otherwise her team would have insisted that they should forget about waiting on Dr Kitson, and that the duty psychiatrist would have to have gone out with the team.

At 16.45 on Tuesday 20th January, Selma Daley telephoned Mrs Joseph. According to Selma's note in the records, Mrs Joseph told her that Daniel was no longer at Carla's address and that he might be staying with friends on the Landor Road although she did not know which number. Mrs Joseph said that she would try to clarify his whereabouts and that she would let Selma know. She told Selma that Daniel had been informed by Matthew Gillett that "they" were planning to take him away and therefore he had been advised to hide.

When we interviewed her, Mrs Joseph was most insistent that she had not told Selma Daley on 20th January that Daniel was no longer staying at Carla's. She said that she had merely told Selma that he was decorating with friends at a flat on the Landor Road during the day. She told us that Selma must have misunderstood what she said and that she had not known that he was going to move away from Carla's until after the 22nd January.

Daniel had in fact been moved out of Carla's flat on, we believe, Tuesday 20th January. His girlfriend Kirsty had gone with him.

Selma advised Mrs Joseph that the fact that Daniel had moved might delay the process and he may need to be referred back to the West Lambeth (Brixton Road) Mental Health Team.

The following day Selma Daley telephoned Dr Edgar to inform him that Daniel's address may have changed (Landor Road would be back in St. Thomas's patch.) and that she

would update him as appropriate. She also noted that she was unable to contact Mrs Joseph.

There was clearly some confusion at this somewhat critical time as to which team was the appropriate one to carry out the assessment. The fact that Daniel appeared to have changed address again only added to the indecision.

Also on 21st January, another member of the ASW Team, Tricia Wright, came into the office at about 09.00 and found Daniel's file on the desk awaiting attention. She noted that they were waiting for more information either from Dr Kitson or from Claire Squire, and she therefore telephoned Claire Squire to find out whether she had got any further information. She said that she had not, and advised her to contact NDS.

Tricia Wright telephoned NDS at about 10.00 and asked to speak to either Dr Kitson or Selma Daley. She was told they were both in a meeting and she left a message for one of them to telephone her back. Tricia told us that Selma telephoned at about 13.00 (neither Tricia nor Selma made a note of the conversation). Tricia Wright told us that when she explained that they had very little information about Daniel, Selma told her that Daniel had been placed in a Lambeth home, which confused Tricia because she was aware that NDS was in Wandsworth. Selma said that they did not have any acute beds at NDS and could not provide any emergency cover, and Tricia remembers wondering where the doctor was going to come from. Selma said that she would send a fax with background information which she then did, not long after the telephone conversation. Tricia remembers it being a 'medical report' and being fairly long, and that Selma telephoned again and said that she was also going to fax a letter, which she did. We are not sure exactly what she sent, as there are no copies on the NDS file, but we believe it may have included the Discharge Summary and Dr Kitson's letter to Dr Teifion Davies .

At no time was Julia Hookway's name mentioned to the ASWs as someone involved in Daniel's care, despite her name having been given by Selma Daley to Mohammed Hussenbocus. Selma did not mention Julia's name to Tricia Wright on 21st January. To our surprise, we found out from the ASWs that in fact Julia Hookway's office –the office of the Sensory Impairment Team of Lambeth Social Services - was in the same building as the ASW's, four floors below them. Had they known of her involvement, they could have reached her on an internal telephone system to ask her for further information about Daniel. They did not actually know her, or even her name beforehand, but had they been given her name and status, they would have had an additional source of information.

Once the information had been faxed through by Selma, Tricia Wright gave it to the Senior Practitioner. At about 15.00, Tricia Wright was sent out to see someone else as a priority, and therefore cannot be entirely clear as to what happened with Daniel's case thereafter. However she told us that she knew that the Senior Practitioner had just given it to

somebody to deal with the following morning, 22nd January, when the message came through to the office about Daniel's attack on Carla Thompson and Agnes Erume.

There is a letter dated 22nd January (the day of the attack) from Dr Teifion Davies written in response to Dr Kitson's letter of 16 January to him. The letter said:

"Your letter raises a number of issues, which I shall deal with in order.

Firstly, my intention (stated in my letter of 2 December 1997) to provide support for Daniel was based on the information provided by your team that he had returned to an address within my catchment area. This was not the case. To the best of my knowledge Daniel has not lived within my catchment area since he came under the care of your team approximately one year ago.

Secondly, my view expressed in Dr Edgar's fax of 18 December 1997, that I do not feel obliged to provide follow-up, is based on the assumption that follow-up implies that I know something about what I am following. Since I have received no communication from your team for almost a year, I have not been included in any aspect of care planning, I have been given no indication of Daniel's medical treatment nor his physical nor mental health, and I was given an incorrect address for him, I am very unclear as to what "follow-up" is intended to mean. This lack of communication is at best discourteous, and at worst potentially dangerous. Since your team has the recent experience of Daniel's treatment, and the special expertise to provide it, it is extraordinary that you should wish us to go blundering forth unsupported at a time of emergency.

Thirdly, following from the above, I should be most grateful to receive both a Discharge summary and details of the care programme which your team had planned for Daniel. When I spoke to your CPN, Ms Selma Daley, she told me that the lack of communication was because "there were so many people involved!" When many professionals and other carers are involved, it is surely important to prioritise communication to those who are likely to be required to act in emergency.

Fifthly, (there was no fourthly) you note in your letter that you are "not a local service". The service my team provides is a local service for the residents of the Lambeth Healthcare district. As I noted above, Daniel does not appear to have held an address within that district for many months. His current (albeit temporary) address is within the Maudsley Hospital catchment area.

Finally, it is not my intention that Daniel should suffer because of the difficulties between the clinical teams managing his care. Therefore, I have prevailed upon the Rapid Assessment Team based at Brixton Road Community Mental Health Centre to make a further assessment of Daniel's mental state, and to arrange his admission to a bed under

my care should that be necessary. The Rapid Assessment Team are naturally reluctant to provide this service, for the reasons stated above, but they will do so in Daniel's best interests. However any further intervention by the Rapid assessment Team is likely to require negotiation with my colleague, Dr Nadia Davies, Consultant Community Psychiatrist at Brixton Rd CMH Centre.

I hope we can minimise the untoward consequences of this unfortunate incident for all concerned, especially for Daniel. I also hope that any future dealings between our teams will be both more efficient and amicable."

The tragic events of Thursday 22nd January are still not clear. We have tried to piece them together from our interview with Daniel at Broadmoor last May, and from the statements given to the Police by witnesses to the incident. We were unable to trace and therefore to interview any of the 'residents' who were at Carla Thompson's flat at the time of the incident, (we made considerable efforts to trace Kirsty) and therefore do not know how reliable their accounts are, as detailed in the Police statements. They are not altogether consistent with each other, but they are the only eye witness accounts of what happened inside the flat. There were four people staying that night at Carla's – two men and two young women, one of whom was Kirsty. The rest of the account is taken from the Police statements of neighbours who witnessed the attack after Carla Thompson and Agnes Erume had been dragged outside their flats, and Police Officers who attended the scene.

Daniel told us that he and Kirsty had been staying at a flat in Streatham since Tuesday 20th January. On Wednesday night Kirsty had left following an argument and returned to Carla's flat. Kirsty had apparently become concerned about Daniel's behaviour. He said he was banging his head against a wall. He told us that "*feelings in his head exploded*" and that he heard voices in his head – Suleman's voice - the man at Carla's whom he hated. He wanted to beat Suleman up.

In the statement that she gave to the Police on 22nd January 1998, Kirsty made no mention of staying in another flat with Daniel immediately prior to the killing. However she made a second statement on 13th February 1998, and she said she remembered that there had been an argument between Daniel and his brother, following which he was worried about being taken away and put in hospital. Kirsty said that she felt it would be a good idea if he got out of Carla's flat for a while and therefore borrowed the keys to a flat in Streatham from one of the other inhabitants of Carla's flat, and she and Daniel went there, arriving quite late at night. Kirsty said that Daniel was "hyper", doing Kung Fu kicks in the air and kicking the wall. He also hit the wall with a stick. She described how he put a hammer, a piece of wood and a knife on the mattress in the sitting room indicating that it was for protection because he knew that drunks and junkies had been known to break into the flat when it was empty. Daniel's activities went on until 02.00. But he must have calmed down as Kirsty said that she managed to get to sleep and was not disturbed again until the morning. The following morning Kirsty had a go at Daniel who was annoyed and told her to

pack her bags and get out. Kirsty puts these events as the Monday night and Tuesday morning, but from the evidence of others, it seems as though it was Tuesday that they left Carla's and therefore Wednesday when she returned. Kirsty's statement continues:

"I was upset, and I went back to Carla's and told her what happened. It was later that day at about 21.00, when Daniel came to the flat and took his television and video recorder. It was then that Carla said to me that she was going to tell Daniel that I was pregnant by him.... Carla said I should wait for the right time to tell him, but on that Tuesday, she was annoyed with him and wrote a note on a piece of paper saying "Kirsty is going to have your baby" or something like that. She gave him the piece of paper and he looked at it and threw it on the floor before going off with his television and video."

If this account can be believed, this was the last thing that happened between Carla Thompson and Daniel before he killed her.

As far as we know, Daniel spent the Wednesday night on his own in the flat in Streatham. No-one could tell us of another time that Daniel had ever been on his own throughout a night. We heard from various witnesses that Daniel had to go through a ritual at night, locking all the doors, as he was afraid that he would not be able to hear if anyone broke in. We can only speculate as to the effect being alone that night might have had on Daniel, as well as wondering why he had been 'put out' of Carla's flat. We cannot imagine how anyone could have adequately explained to him, given the lack of communication skills in Carla's household, what was happening and why he was being moved to another flat.

According to the various Police statements, at about 07.45 on Thursday 22nd January Daniel walked into Carla's flat and went straight into Carla's bedroom and dragged her out of the room by her hair, banged her head on the doorframe, shook her by the hair and then threw her to the floor and began hitting and then kicking her in the head and then stamped on her. According to two of the accounts, he then tried unsuccessfully to set fire to her hair. He then put some kind of rope round her neck and dragged her outside the flat. He took a piece of wood and smashed several car windows and then picked up and threw a brick at the kitchen window of Agnes Erume's flat, smashing it. He then went up to Agnes' flat and dragged her out and down the steps, laid her down next to Carla and tied the two women together by the neck. He continued to hit Agnes with a piece of wood and kicked her despite the fact that both women were unconscious.

By this time several Police Officers had arrived on the scene and reinforcements were called. Daniel took up a Kung Fu type stance in front of the women. The Officers used CS gas spray but it seemed to have no effect on Daniel. He kicked Carla several times in the region of the head. As the Police Officers advanced, he climbed onto the bonnet of a car and beat his chest 'like Tarzan', then jumped down and began throwing objects at the Police. He then went back to the two women and aimed more kicks and blows at them.

It has struck all of us on the Inquiry Panel that nearly of Daniel's violent actions that day as described in the various Police witness statements, bear a striking similarity to those seen in WWF contests on television. We are aware that there is growing concern at the effect that this violent 'pantomime' has on children who watch it. [See Appendix 4] Contestants drag each other round the ring by their hair, slam each other's heads against posts or on the floor, and appear to jump on each other's heads and chests, and then often beat their chests in triumph. Although to an intelligent adult the actions are obviously carefully choreographed stunts, to a child - or a naïve and immature young man such as Daniel - they must seem all too real.

We obviously cannot say how much of what happened that day was in part Daniel, whilst clearly mentally disturbed, acting out his fantasy of becoming a famous WWF Wrestler, but we feel that the ferocious brutality of his attack on Carla Thompson and Agnes Erume must be looked at in some perspective and context. Without the knowledge of his obsession about WWF Wrestling, the savagery and imagery of that attack would be completely inexplicable. Knowing what we do about his obsession does, in our opinion, put a different light on things.

Daniel was eventually overcome by Officers with shields and batons and was handcuffed and ankle restraints were used as well. He was taken to Brixton Police Station and placed in a cell. He was observed at 09.30 through the wicket of his cell by a doctor called by the Police, Dr Robert Brucechwatt, (who had been advised not to enter the cell itself), who noticed no obvious injuries or active bleeding. He advised that a sign language interpreter should be requested to attend as soon as possible and gave his opinion that Daniel was 'fit to be detained', but not to be interviewed. Dr Brucechwatt asked for him to be subject to 15 minute checks and that the handcuffs should be removed as soon as was practicable with a signer present to explain matters. The doctor entered Daniel's cell at 10.25 with the interpreter and examined Daniel with his consent. He found a band of bruises and scuffed skin on both wrists from the handcuffs, a small cut 1cm in length on the right middle finger, and three superficial scratches under the right forearm. The only treatment required was wet bandages for his wrists. Dr Brucechwatt found him to be anxious and excitable, but able to communicate well through the interpreter. The doctor considered him to be fit to be detained and interviewed with an appropriate adult and a sign language interpreter present.

We would like to comment how impressed we are that, given the usual allegations of the way the police handle suspects, especially young black men, and given the difficulties they had in arresting Daniel after what was a particularly savage attack, Daniel appears to have been handled with considerable sensitivity and restraint. His injuries were minor and everyone appears to have behaved appropriately and thoughtfully throughout his stay at the Police Station.

Julia Hookway received a telephone call from Brixton prison shortly after Daniel was arrested, informing her of the fact that the Police had in custody a "*young, black, deaf male*" refusing to give his name and requesting an interpreter. Jenny Towland was

contacted and agreed to help and arrived fairly early in the morning and remained at the Police Station for most of the day. She described it as "*probably one of the worst days of my professional career.*"

Julia Hookway then spoke to Selma Daley and Claire Squire and then spoke to the duty ASW and arranged for an ASW to attend the Police Station as a matter of urgency to assist with any interview.

Jenny Towland told us that some stage during the morning at the Police Station, Daniel said that he did not like staying at Carla's: that it was filthy; that he hated the prayers on the walls and all the praying; that there was far too much coming and going; that he needed to be calm. She also told us that Daniel said that he "*did not want sex with Carla*", but that that particular comment was never elaborated on.

She told us that the Police were very sympathetic to Daniel and handled him extremely well.

Detective Chief Inspector Sue Hill was called in to deal with the situation, and she immediately realised that, despite the seriousness of what he had done, Daniel was a vulnerable young man who needed help. At times he showed signs of considerable disturbance whilst at the Police Station. However DCI Hill described him to us as seeming extremely frightened and she decided not to interview or charge him, but to try to get him to hospital as soon as possible.

This however did not prove to be easy and DCI Hill told us that she spent most of the afternoon and evening ringing around trying to find a psychiatrist who would come to the Police Station and arrange for Daniel to be admitted to hospital. Eventually, about 21.00 she contacted a Senior Registrar from the Maudsley Hospital on his mobile phone who was on his way to work, but who went instead straight to the Police Station. Daniel was then seen by both this doctor and by a Forensic Medical Examiner and it was decided that Daniel should be admitted to the Maudsley Hospital for assessment under Section 2 of the Mental Health Act. He left the Police Station at about 0300 and was admitted in the early hours of 23rd January under police escort to the locked ward at the Maudsley and placed in seclusion.

We were very concerned to hear of the difficulties encountered by the Police in finding an appropriate secure facility for Daniel. We understand that the junior doctor who agreed to admit him to the psychiatric acute ward at the Maudsley received some criticism for doing so.

Many hospitals would not have a locked ward or even seclusion facilities and would be staffed by mainly female staff (as in fact was the Maudsley ward the night Daniel

was admitted). It is clearly inappropriate and potentially dangerous for staff and other patients to admit someone in a state such as Daniel was in that night to a non-secure facility, but at present - even when required immediately - there is no way to access an appropriate range of secure facilities directly from a Police Station.

The only other option is to keep the person being held overnight at the Police Station and to bring them before a Court in the morning so that a Hospital Order can be made.

DCI Hill and the Officers at Brixton Police Station had very properly assessed that it would be inappropriate to keep Daniel in a cell overnight because of the severity of the attack on the two women, because he was obviously mentally unwell and also because he could not communicate. We consider that the decision they made was absolutely right, although a difficult one for them to make and implement.

We consider that the Maudsley should be commended for taking him in and for their subsequent action in getting him to Broadmoor without a Court Order.

In the afternoon of 24th January he was transferred to the Denis Hill Unit (a medium secure unit.)

However Daniel proved to be too much of a dangerous problem to manage, and as soon as it could be arranged (on 26th January) he was transferred under Police escort to Broadmoor Hospital. The diagnosis on discharge from the Denis Hill Unit was paranoid schizophrenia.

Carla Thompson died of her injuries the day after the attack. Agnes Erume, despite the fact that she was not initially expected to survive, made a remarkable recovery, although she still suffers from her injuries. She gave evidence to us, but mercifully for her, can remember nothing clearly about the attack after Daniel burst into her flat in the early morning of 22nd January 1998.

On 3rd February, Daniel was interviewed by the Police, charged with murder and attempted murder, and brought before a specially convened sitting of Camberwell Magistrates Court which was held in Broadmoor. He was remanded in custody to HMP Belmarsh and transferred to Broadmoor (an administrative procedure) under sections 48 and 49 of the Mental Health Act 1983 on the basis of mental illness.

On 20th July 1998, at the Central Criminal Court, Daniel Joseph's plea of guilty to the manslaughter of Carla Thompson on the grounds of diminished responsibility was accepted. The Charge of the attempted murder of Agnes Erume was left on the file. He

was made subject to a Restriction Order and detained at Broadmoor Hospital under Sections 37 and 41 of the Mental Health Act 1983 where he remained until he was transferred to Rampton at the beginning of this year. We are told that the working diagnosis at Broadmoor was one of bipolar affective disorder, but that in addition to that diagnosis it was noted that Daniel had profound communication problems which considerably complicated his management.

He was the only deaf person out of 450 patients detained at Broadmoor throughout the two years he spent there. This made things particularly difficult both for Daniel and the staff. A sign language interpreter was assigned to him who visited him twice a week, and interpreters were brought in to assist at any interviews, but otherwise communication was extremely limited and made mental state assessment particularly difficult. Apparently even with a fully qualified sign language interpreter, Daniel had great difficulty understanding much of what was said, particularly anything abstract, or involving complicated concepts. Rampton has a level one signer who is also a forensic clinical psychologist and it is hoped that a thorough psychological assessment may now be able to be carried out. They also have a range of staff and patients who are able to communicate in sign language and it may therefore be possible to clarify the exact nature of Daniel's difficulties in order to help him in the process of rehabilitation.

Dr Adrian Paine, Daniel's RMO (Responsible Medical Officer) at Broadmoor, told us that Daniel's case had highlighted the deficiencies in the system as far as deaf people are concerned. We can only hope that lessons can be learned.

Commentary and Analysis

We have deliberately included considerable detail in the Background section of this report, in order that the events leading up to the killing of Carla Thompson can be seen and analysed in their proper context. This Commentary and Analysis cannot and should not be looked at on its own without reference to the Background. Any comments that we make in this section are made on the assumption that anyone reading them has already fully acquainted themselves with the historical facts, and that to read this Commentary without having done so would mean that our comments could not be properly understood, and that would not be just to either Daniel Joseph or those who cared for and treated him.

There is no doubt that Daniel Joseph was severely mentally unwell at the time of his attack on Carla Thompson and Agnes Erume on 22nd January 1998. It is also clear that there was a fairly sudden deterioration in his mental health over the previous weekend. What is not clear is how he would have presented had any mental health assessment actually been carried out in the two or three weeks leading up to the incident.

We wish to make it clear, that although we have had to be critical of the actions of certain individuals, there is really no way of knowing whether the outcome would have been any different, had they done what we have suggested should have been done.

It is easy to say, with the benefit of hindsight, that certain steps should have been taken which might have prevented the tragic outcome, but when assessing the decisions made by those involved in Daniel's care, we have tried, as far as possible, to put ourselves in their position, based upon what they knew (or ought to have known) about him at any material time.

Lessons clearly have been learned as a result of this case, and changes have been made in an attempt to address obvious failures in the system. These changes are to be commended as is the speed with which they were implemented.

The care and treatment of someone like Daniel Joseph will always be complex, when seen in the context of his background of deafness and mental health problems. The National Deaf Service as part of the Pathfinder Trust, provides a service for those deaf people who have mental health problems predominantly in the South of England, but because it covers such a wide area providing a service for relatively few people, it does not provide an emergency service. For that it has to rely upon local services, who may know nothing at all about the patient they are asked to assess, and most likely do not have the communication skills, knowledge or experience to deal with deaf people. When we asked him whether there was anything that could be done by the NDS in an emergency, Dr Nick Kitson, at the time of the incident the only NDS Consultant Psychiatrist for the South of England, told us:

"Of course there is something we could have done, but that is not what the service is there for. It is not what we're contracted to do. It is not our job to do that and it never has been, and that has been understood historically by catchment areas over the years..."

It comes down to priorities. What is the priority for our service? Is it the emergency service or is it the ongoing work that we are doing? If you concentrate on the emergency service, it is to the detriment of the ongoing work... it is my view and my... lead as clinical director, rightly or wrongly, would be - and has been - and it may reflect on the issues - that what we do day-to-day constructively, proactively, is far more valuable than what we might do in an emergency..."

Dr Kitson also described the NDS as

"A community within a community".

However, in order to work well alongside and with local services, those local services need to be aware of how the NDS works and what its limitations are. We were alarmed to discover that most of the professionals working in the local secondary services knew very little about the NDS - indeed some were unaware of its existence on their doorstep. In addition, the NDS did not seem to have a great deal of knowledge about the workings of local services. Dr Teifion Davies who was Daniel's consultant at St Thomas' told us:

"We were relatively unaware of the existence of local [specialist] services until Daniel came under our care. We were very grateful to the service, who may not even have known that we existed, for coming in and helping us.... What I mean by 'we were not particularly aware of them' is that we had not shared any patients. So I was not aware of this particular service that they organised and they probably were not aware of the internal organisation of our service. That, I think, is a feature of the segmentation of the whole of the Health Service.

Dr Kitson acknowledged to us that confusion could be caused by the fact that the NDS provided most of the services that a Community Mental Health Team (CMHT) would provide, as this could lead to an expectation that the NDS would provide all the services that would be expected of a CMHT, which is not the case. He said that the NDS could perhaps have made it clearer at the beginning what it does and does not do. He also said that local services should perhaps have better understood the role and nature of the NDS as a specialist service.

The NDS may be a national service, but the local health authorities have very clearly defined catchment areas. Daniel was in the catchment area of the Lambeth Healthcare Trust whilst he was living at his mother's house in SW8. Therefore when he needed to be admitted to hospital in November 1996, he was admitted to St. Thomas' Hospital (via the South Western Hospital). As far as the NDS was concerned, Daniel's official address remained that of his mother, since his stay at Carla Thompson's flat was only ever intended to be temporary. There was very little distance between Carla Thompson's flat in Tulse Hill and Mrs Joseph's home – probably less than two miles - and yet Tulse Hill fell within the catchment area of the Bethlem & Maudsley Trust.

When Daniel's mental health appeared to be deteriorating after he left Ian Collie House, and it seemed as though it would be necessary for the NDS to involve local services to carry out an urgent assessment, it soon became evident that there was confusion over who would assume responsibility for taking on the referral from the NDS. The fact that Daniel

was deaf further complicated matters as arrangements had to be made for a sign language interpreter to be present, and it was also unclear as to which Doctor would be carrying out the assessment. Some of this confusion could have been avoided by better co-ordination and co-operation between the NDS and local services at a much earlier stage.

We have carefully considered every significant event from the time that Daniel was first admitted to hospital at the end of November 1996 until the date of the fatal attack on 22nd January 1998, and now set out our conclusions and findings.

The incident which led to Daniel first being admitted to hospital at the end of November 1996 was not in itself all that remarkable from a psychiatric perspective. We should also not forget that Daniel at that time was a fairly bored and frustrated teenager of seventeen. For some considerable time he had been allowed to reverse his sleeping habits, staying awake in his room at night watching videos and WWF wrestling on Sky television. We were told that he began serious weight training and insisted on large meals, spending his benefit money on hamburgers to increase his strength. His obsession with becoming a world famous wrestler must have begun this way, and it is clear that his family did not discourage him from his ambition. Indeed Matthew Gillett, his 'stepfather', had even talked to Daniel about a WWF training school in Boston, and had discussed the possibility of accompanying Daniel to America to allow him to attend the training school, if they could get enough money together. Matthew Gillett even drove Daniel to watch the WWF wrestling at the London Arena with Daniel taking his (out of date) passport and having his bags packed, believing that he would be able to join the wrestlers. Matthew Gillett told us:

"He believed he was going to join them and he was going to be the boy wrestler, partner to Shaun Michaels. He had it all planned. It is laughable, but it was terribly serious...."

"That was his first breakdown on that night, when he realised - because he thought I was like an angel and could persuade anybody.... He took all his bags in the car.... I did not say he could do it. I just said no, but I could not talk to him. But that was his plan...."

"He believes that he can live in the hearing world and that he does not need to live with the deaf people. That is another of his beliefs and it is quite a strong belief, stronger than people think."

Matthew Gillett told us that he left Daniel at the London Arena

"Because I thought he would find out for himself that he could not go, and it was not just me telling him he cannot go. He would find out when they just left him."

When Daniel was brought home by the security guard at around midnight, he was (perhaps understandably) very angry with his mother and Matthew. Matthew described the incident that led to Mrs Joseph calling the Police, and Daniel ending up being admitted to hospital:

"He picked up this kerbstone, a big kerbstone. He threw it - I don't know, I thought he threw it at me. We were out in front of the house welcoming him home sort of thing, but he was

really ratted that he had had to come home. He did not want to come home. That is when he blamed me and then his mother argued - somebody else argued with him - and the security guy was wonderful really, because he actually held Daniel back in his temper. It had accumulated, you see, from us saying 'no' on numerous occasions about going to America, and then finding he could not go. That brought his temper out the most."

Although Matthew Gillett described Daniel as having 'an underlying anger', the incident with the kerbstone came as a shock. He had not seen such aggression in Daniel before.

Dr Peter Hindley, the Child and Adolescent Psychiatrist with the NDS, was contacted by Mrs Joseph and went to see Daniel at the Police Station. Dr Hindley told us:

"There would be two things that were striking when I saw him in the Police Station. One was that the speed of his sign language was markedly increased and was extremely fast, and you know that language rates increase when people are anxious; but normally what you would expect is that with engagement and trust that it will go down, and their speed of production would go down. With Daniel, it did not. I mean, it was extremely hard work keeping track of what he was saying and what he was communicating to me."

The other thing that was striking, which I suppose is not to do with thought disorder but to do with the content of his thought, was that he was very preoccupied with World-wide Federation wrestling to an even greater extent than he had been when I saw him at home."

So those were the two things that made me believe that he had a mental illness, and I suppose his behaviour. He was very aroused and very active. In my assessment, I thought this was his first episode of mania... he was pacing and walking up and down on and gesticulating and could not sit down. To me, it was quite similar to people I have seen with mania in the past."

This was the episode that precipitated Daniel's first admission to hospital. Although Daniel's reaction might well be described as nothing more than a teenage outburst, Dr Hindley told us that Daniel was 'undoubtedly' sectionable at that stage but that to his surprise, Daniel willingly agreed to be admitted informally. The Child and Adolescent Unit of which Dr Hindley was the consultant, did not have an inpatient facility at that time, and therefore Daniel was referred to the South Western Hospital, from which he was transferred to St. Thomas'.

Daniel's preoccupation with becoming a famous WWF wrestler was thought to have a delusional content at that time, but there are several people who have been involved in his care who believe that his preoccupation was not delusional, it was just that no-one had ever disillusioned him in his belief that he could achieve fame that way. It was therefore a very real – although totally unrealistic – dream of a naïve teenager. This issue is discussed in Dr Tom Sensky's contribution on Daniel's psychiatric presentation to be found at Appendix 2.

We found it interesting that both specialist psychiatrists, Dr Hindley and a month later Dr Kitson, considered that Daniel was detainable under the Mental Health Act, whilst those non-specialist doctors at St. Thomas' hospital who were responsible for his care in the

interim, were unsure whether or not Daniel's inability to communicate, and his whole personal history, had caused this episode, rather than any mental illness. Dr Teifion Davies told us:

We thought it was very important to involve specialist services, there being specialist services around very fortunately, and Daniel having been previously assessed by members of the National Deaf Service as a child. So we thought it was particularly important to involve them. There is always a fear with people with communication difficulties that we may get the medical side of things, the diagnostic aspects and the treatment, wrong simply because we do not understand something that they are trying to communicate. We thought that was important early on."

A letter dated 13th December 1996 sent to Dr Kitson by Dr Angus, Senior Registrar to Dr Davies, described Daniel's frustration arising out of his inability to communicate with staff and other patients, and concluded:

"We would be grateful if Daniel could be transferred as soon as possible, and perhaps in the meantime a member of your team could see him and advise us",

Despite this request, it was a whole month before Daniel was seen by anyone from the clinical team of the NDS, and the appointment with Dr Kitson was only arranged on one day's notice because Daniel had been saying that he wanted to leave St. Thomas'. He was taken by a nurse to see Dr Kitson as an outpatient on 24th December 1996. We are concerned at the length of time that Daniel remained an inpatient in a hospital without any facilities for caring for deaf people, and without any involvement of the specialist service. When we expressed our concern to him, Dr Kitson explained:

"In one sense, of course, it is not acceptable because there you have a person who communicates in sign language virtually exclusively who is being assessed and treated on an acute psychiatric ward that does not have the capacity to communicate with him, which is pretty essential in psychiatric assessments, care etc., and that is the reason why we exist as a service, of course.

However the reality is that people have to wait six weeks for outpatient appointments. We deliberately do not do urgent outpatient appointments as a policy. We do in practice as and when we can, but we do not say we provide an emergency service because we just could not. We could not drop everything. A tertiary service covering the south of England cannot do that.

What we did as a practice at that time (and still do) is that where somebody is an inpatient and we know of them, we will try and send someone as soon as possible - even though it is not the formal assessment - to assist, do a brief preliminary assessment, provide a bit of help to the local service, and also let us know what the case is and whether we ought to be changing our thinking in terms of urgency."

We believe that Daniel could - and should - have been seen sooner by Dr Kitson or his Associate Specialist, Dr Louise Hamblin or, at the very least another member of staff of the NDS. We are aware that at that time Dr Kitson was the only consultant psychiatrist for deaf

adults in the whole of the south of England, (he was joined in June 1999 by Dr Helen Miller, although she is at present only at stage 1 in sign language skills), but since his colleague, Dr Hindley, considered that Daniel was sectionable on 28th November and had referred him for assessment and treatment to Lambeth Healthcare Trust, we feel that it was not acceptable that Daniel was left that long without any contact, let alone assessment, from any of the medical staff at the NDS. (He was visited on 18th December by Val Leach, the NDS Social Worker, who had been involved with Daniel since January 1994.) Had Daniel not been expressing the wish to discharge himself from St. Thomas', the period of time until he saw someone from the specialist service would have been even longer.

We have already commented in the Introduction that Daniel was calm and co-operative throughout his stay at St. Thomas', and this was despite not being on any regular medication. Even though when he saw him on 24th December, Dr Kitson was of the opinion that Daniel was still currently detainable under the Mental Health Act and was most probably suffering from a psychotic illness, it is interesting to note his impression of Daniel. Because this is such a crucial observation, given that it was made at a time when Daniel was the most acutely ill that he had ever been, and made by a specialist consultant psychiatrist for deaf people, we feel it is appropriate to repeat Dr Kitson's description of his first – and lasting – impression of Daniel:

"I smile because he was a very personable person even when ill - playful, amusing, extremely large, but in that sense not threatening. The whole flavour of him was not, you know, 'help!'. I have seen a few in my time (who were), but he certainly was not. I must admit I probably thought that the first time I saw him sitting in the waiting area, before I had achieved any response from him, but as soon as you get any response, he was a warm, nice person who was good to have around, would be fun to have around. I did not feel threatened by him and was a little surprised that he was such a warm character, given his background..

I would judge him at that time and, indeed, would have judged him throughout until the final event, as somebody who in our speciality was not a major risk."

We believe that it is important to bear this description of Daniel, even when he was ill, in mind when analysing the various responses of those caring for Daniel over the following year.

Daniel was referred by Lambeth Healthcare NHS Trust to Pathfinder Mental Health Services NHS Trust (the Trust responsible for the National Deaf Service) and transferred to Old Church, the NDS inpatient facility in Balham, on 27th December 1996. He was still an informal patient, having agreed to remain an inpatient.

There was no negotiation between Lambeth Healthcare Trust and the NDS as to any future responsibility for Daniel's care in the community once he was discharged from Old Church.

We consider that Dr Kitson should have made it clear at that stage – if not from the outset - to Dr Teifion Davies and his team at St. Thomas', that the NDS were not able to provide an emergency service - either to carry out urgent mental health assessments in the community, or to offer an emergency admission. A contingency plan should have been

drawn up between the secondary and tertiary services at the time of transfer to cover such an eventuality.

Daniel remained an inpatient at Old Church for some eight months, despite being well enough to be discharged in March 1997. (An admission of this length is not uncommon amongst patients of the specialist services for deaf people. They often have to stay for longer than their clinical state requires because of the difficulty in arranging appropriate aftercare placements.) We are mindful that Daniel's mother did not wish him to return on a permanent basis to her home, (nor did Daniel want to live at home), that it would not be appropriate for Daniel to live independently, and that from about May 1997 everyone was working towards Daniel going to Court Grange College in Devon to improve his skills. Nevertheless we are still concerned that plans for his future were not considered earlier, and that he had to remain in hospital for such a long time, although allowed to go home at weekends. Despite Toby Robinson, NDS Social Worker Team Manager, writing to Jim Heron, Team Leader of Lambeth Social Services Sensory Impairment Team, following a Key Worker meeting on 13th March seeking to discuss the issue of the placement for Daniel as soon as possible, it was not really until after the Case Conference on 17th June that any definite steps were taken to try to secure a place for Daniel at Court Grange or to find him accommodation in the interim.

What is important to bear in mind, is that throughout his stay at Old Church, Daniel co-operated with the staff, and apart from a few occasions early on his stay when he refused to take his medication (although he would take it in the end) he was compliant with his treatment. There were several occasions when he went home to his mother's and then wished to stay over the weekend without it having previously been arranged. Had it been arranged he would have been given his medication to take with him. When he called to ask if he could stay, he would be told to return the next day to collect his medication. He always did (and then would turn round and go home again), and he nearly always returned to Old Church when he said he was going to.

No-one from Lambeth Healthcare Trust was invited to the Case Conference on 17th June, despite the fact that they had been the referring service to the NDS. There was also no member of Lambeth Social Services present, (although we understand they had been invited to attend) despite the fact that they were being relied upon to secure a place for Daniel at Court Grange and to arrange the funding of that placement. The NDS had however been in contact with Lambeth Social Services since March 1997, whereas they had had no communication whatsoever with the St. Thomas' team.

Since it was inevitable (given what we have learned of NDS policies) that, once Daniel was discharged into the community, local psychiatric (secondary services) would need to become involved again at some stage, Dr Davies's team should have been kept informed of Daniel's progress and should have been invited to participate in the Case Conference, so that Daniel's discharge could be jointly planned.

Dr Kitson told the Inquiry Panel that, in the main, the practice of all referrers to the NDS was not to have a detailed negotiation about the division of responsibilities. He was of the view, on the basis of his own past experience of being a catchment area consultant, that

catchment area services would assume that they had a continuing responsibility. However he agreed that the catchment area team would expect to be kept informed and invited to case conferences. He accepted that on this occasion the NDS did not do this. He added that the majority of consultant psychiatrists and GPs do not attend case conferences or send a representative even when invited.

There seemed to be no recognition of the fact that the NDS was not a Community Mental Health Team, not only because they provided the services a CMHT would, but also because the NDS themselves failed to involve the secondary services in any care planning and acted as if they were retaining full responsibility for Daniel, when in fact as far as they themselves were concerned they were not. This was not however in the least bit clear to the secondary services, and only served to add to the confusion.

There was no Care Programme Approach (CPA) plan when Daniel was discharged from Old Church to Ian Collie House in August 1997. There should have been. There was just a minimal care plan contained in the Discharge Summary which stated that Daniel should continue with his daily medication, that he was to be seen on 2 weekly basis by his CPN who would be Selma Daley, and that he should be followed up by Dr. Hamblin once he was at Court Grange. This plan implies that the NDS was retaining responsibility for his aftercare. No diagnosis was given in the Discharge Summary. A diagnostic formulation should at least have been attempted. The Discharge Summary was not copied to Dr Teifion Davies or anyone else at St Thomas' Hospital. If any document should have been copied to Dr Davies, the Discharge Summary should have been. It was copied to the Sensory Impairment Team at Lambeth Social Services, but was sent to Jenny Park, despite the fact that she had not been Daniel's Social Worker for over a year, and Julia Hookway had been in place for over a month and had been to Old Church and had been co-ordinating his placement at Ian Collie House with the NDS. Although this should only be regarded as minor carelessness, it does highlight the fact that there was no real co-ordination of Daniel's care at that time.

There should have been a comprehensive and multidisciplinary CPA plan, devised in conjunction with Lambeth Healthcare Trust and Lambeth Social Services, which provided for both Daniel's short-term and long-term aftercare in the community. (Dr Kitson told us that they have only one level of CPA and that effectively all NDS patients are on the comprehensive, multi-agency CPA.) In particular, there should have been clarity as to who would accept responsibility for Daniel if urgent intervention should be required, especially as the NDS would not provide this.

We know that it was anticipated that Daniel would only remain in the local area for a very short time before going to his residential placement in Devon, but we feel that that is no excuse for failing to put in place a clear and detailed aftercare plan. Even if he had gone to Devon, Daniel would no doubt have returned to South London in the holidays as all his family and friends were there, and it should have been considered as his permanent base or 'ordinary residence'.

The care plan sent by Lambeth Social Services to Terry Stanley, the Deaf Services Manager of Harding House Association, when Daniel was about to be discharged to Ian Collie House, correctly identified him as *"A vulnerable young person"*. He was a deaf teenager with mental health problems, and as such, required a carefully documented strategy for his future care, including what should happen if the plan to send him to Court Grange did not succeed for any reason.

Ian Collie House, which provided supported housing, was only ever intended to be a temporary placement for Daniel, since at the time he was discharged from Old Church on 14th August, it was anticipated that he would be starting at Court Grange in September. Ian Collie House would not otherwise have been suggested, as it was about to close for renovation. Most of the residents were long-term and on the whole very much older than Daniel. He never really liked being there, and complained about what he saw as over-strict rules. He tended to come and go as he pleased, and the staff found it difficult to stop him going home. However in the end he accepted their suggestion that he stayed at Ian Collie House during the week and went to his mother at the weekend.

Shortly after his discharge from Old Church, both Selma Daley and Julia Hookway were concerned that Daniel's mood appeared to be slightly elated and therefore a review meeting was arranged for 18th September. It was cancelled when Dr Kitson gave Daniel permission to go to Birmingham to watch a WWF contest. However it should be noted that Daniel turned up at an out patient appointment with Dr. Hamblin on 16th September. He also attended a review meeting at Ian Collie House on 2nd October and a further out patient appointment with Dr. Hamblin on 16th October. Dr. Hamblin recorded on this occasion that he *"appeared irritable and slightly suspicious"* and wrote to his GP that the NDS would monitor him closely and would need to consider whether he should be admitted to hospital under Mental Health Act should he deteriorate further. Because of her concerns, she very properly considered that Dr Kitson should review Daniel's mental state, and asked Dr Kitson to see him. An appointment was made for 25th November.

Selma Daley saw Daniel at Old Church when he turned up for his 2 weekly appointment on 22nd October. She also saw him a fortnight later on 5th November. On this occasion she recorded that although his mental state was fairly stable throughout the interview, he was expressing suspicious ideas towards others, appeared to be elated and was using rapid signing.

This was the last time that anyone from the National Deaf Service saw Daniel before he killed Carla Thompson.

As Dr Kitson acknowledged to us:

"From the 22nd November...we had lost the ability to effectively manage his care."

By the time that Daniel made his unplanned departure from Ian Collie House on 22nd November 1997, there were already concerns that his mental health was deteriorating. His mother was away - probably in Trinidad - until mid-December, no-one at the NDS knew anything about Carla Thompson or her household, and there were no guarantees at all that Daniel would continue to take his medication.

This was clearly a breakdown of the previous care plan and therefore a multidisciplinary CPA meeting should have been called at the earliest opportunity and the following care plan drawn up and put into effect:

- an immediate assessment of Daniel's mental state should be carried out
- an immediate assessment of the appropriateness of Daniel's present accommodation should be carried out
- following the above, the level of risk both to Daniel and others should be assessed
- staff should be satisfied that Daniel will continue to take his medication
- steps should be taken to ensure that Daniel attends his appointment with Dr Kitson on 25th November
- CPN visits should continue on a 2 weekly basis
- the question of whether Court Grange was still an appropriate placement should be reviewed
- it should be decided which would be the appropriate Community Mental Health Team (CMHT) to contact, given Daniel's change of address
- once the appropriate CMHT had been identified, contact should be made and all relevant information about Daniel given
- a contingency plan should be devised to deal with the predicted outcomes of any of the above

When Julia Hookway telephoned Old Church on 24th November, she was wrongly informed that Daniel had not kept his outpatient appointments (up until that time Daniel had co-operated fully with the care plan) and more importantly, she appears not to have been informed that Daniel was due to see Dr Kitson the following day, 25th November. Had she known that, she could have told Carla Thompson when she telephoned on 25th November, and perhaps Daniel might have attended the appointment.

There was enough concern by 28th November for Dr. Hamblin to write for the first time to Dr Teifion Davies at St Thomas' Hospital, to inform him of the deterioration in Daniel's mental state and to 'put down a marker' that it may be necessary to involve Lambeth Healthcare Trust in the event of an emergency. We have already commented that Dr Davies should have been kept informed of Daniel's progress throughout the year.

Despite this considerable concern, no attempt was made to go to see Daniel at Carla Thompson's until Selma Daley made her visit on the 9th December, only to find that Daniel was not there. By this time he had also failed to attend his appointment with Dr Kitson. Selma was fully aware from her visit just how inappropriate Carla Thompson's flat was for such a vulnerable young man as Daniel, especially if he were unwell.

From then on, an assumption appears to have been made that Daniel was refusing to have any contact with the NDS, and no further attempts were made by Selma Daley or anyone

else at the NDS to visit him. Even if that assumption was correct, we strongly believe that that should have provoked even more of an effort to see Daniel and to find out why. In the past Daniel had always responded well to the involvement of the NDS and had been persuaded to be admitted to hospital when ill, and to remain at Old Church for some eight months even long after he was well enough to leave. Whilst at Ian Collie House, he often returned to spend time with the staff at Old Church, and he also visited the clubhouse there.

We believe that if someone he knew well and trusted, and who could communicate well with him, had gone to see Daniel at Carla Thompson's flat, he may well have been persuaded to leave there and to go to Old Church, or at least to a more appropriate environment than Carla Thompson's. Unfortunately, nobody even tried, and we find that most regrettable.

When we put this theory to him Dr Kitson accepted that there was pretty clear evidence from Daniel's mental state as an inpatient and as an outpatient before he finally left Ian Collie House, that his plans and actions could be modified. This included persuading him to take his medication and to attend appointments, thereby maintaining the status quo reasonably well. He went on to say:

"So had it been possible to have face-to-face contact with a member of our staff whom he knew and could communicate reasonably well with, and [with whom he] had a decent rapport - whatever that meant for him - it might have worked, because it had done [before]."

We also find it somewhat difficult to understand why a decision was made by Julia Hookway's Team Manager not to go in and assess the situation for themselves, once Daniel had left Ian Collie House and moved into a totally unknown environment. Lambeth Social Services had been funding Daniel's placement at Ian Collie House (at a cost of £450 per week) and were also responsible for securing and jointly funding his placement at Court Grange College. Once Daniel had decided to leave Ian Collie House unexpectedly, we consider that somebody from Social Services should have tried to find out why he had done so, and should have visited Carla Thompson's in order to assess whether it was an appropriate placement for Daniel. Having said that, we acknowledge that Jim Heron, Julia's Team Manager, told us that he was anxious not to overburden her as she was new in the post as Specialist Social Worker and there was a heavy backlog of cases for her to deal with, given that there had been no such Specialist Social Worker since Jenny Park had left the previous year. We have also not forgotten that Julia Hookway did go to see Daniel almost immediately following her return from her Christmas break. We understand that the decision not to visit was reversed because there was no indication that Daniel's condition was improving or that the health professionals had made any progress, but we consider that a co-ordinated plan of action with input from all the professionals involved with Daniel, could have extricated him from an environment that was clearly unhealthy for such a vulnerable young man.

We take into account the fact that Daniel had recently met Kirsty, who clearly meant a great deal to Daniel and was also staying at Carla Thompson's, and that this may well have influenced him to want to stay there. However we also know from the report by Dr Edgar of

his visit of 12th December, that Daniel told him that he did not want to stay at Carla Thompson's, because it was too noisy. Daniel appears to have made no mention of Kirsty during the time that the doctors and Jenny Towland were there. Daniel was apparently very negative during that assessment about further involvement with the NDS, but we wonder whether he would actually have refused to see them if they had turned up. Based on his past responses, we think not.

The ideal time for someone from the NDS to go to see Daniel was the 12th December when the Rapid Assessment Team went to see him. It would have been helpful for the doctors who had never met Daniel to have somebody along who knew him and could recognise any changes in him. The NDS still had overall responsibility for Daniel's care, and no-one from their service had seen him for over five weeks. We feel that every effort should have been made to accompany Drs Edgar and Bonner that day. It was inappropriate and potentially dangerous for them to have to rely on Matthew Gillett and Carla Thompson to interpret for them when Jenny Towland did not initially turn up.

In the light of Dr Edgar's report following his assessment of Daniel on 12th December, and from his and Dr Bonner's detailed description to us of how Daniel presented that day, we have no doubt that their assessment that he was not detainable under the Mental Health Act was fully justifiable.

Once Dr Edgar had reported back to the NDS that, although Daniel was not unwell enough to be detained, he was not taking his medication and would not be attending his outpatient appointment with Dr. Hamblin on 18th December, some plan of action should have been implemented. Dr Edgar had made it clear in his letter of 15th December that Lambeth Healthcare Trust would not be providing further follow-up, as Daniel had not been living in their catchment area for over a year. On 18th December, Selma Daley told Julia Hookway that referral to the Maudsley Hospital might be more appropriate, given that he was now living in Tulse Hill. In a telephone call also on 18th December Daniel's mother told Selma Daley that Daniel had allegedly been threatening to kill Carla Thompson and that Daniel may be influenced to try drugs by others who stay at Carla's flat. Selma assured Mrs Joseph that the NDS would continue to offer Daniel appointments and would liaise with both the Brixton Road and the Maudsley Community Mental Health Teams. In a letter faxed later the same day, Dr Edgar confirmed that Dr Teifion Davies did not feel obliged to provide any further follow-up.

Despite Mrs Joseph's somewhat alarming report, and despite realising that Daniel was now living in the Maudsley catchment area and that the St. Thomas' team was saying that they did not consider that they had any further responsibility for Daniel, Selma Daley did not contact the Maudsley team. In fact nothing was done at all at that time, or indeed until the New Year. This was yet another missed opportunity to contact the appropriate community mental health team and to advise them of a potential future urgent referral, and to supply them with any information they might require to facilitate a speedy response in the event of an emergency. Having said that, we have no doubt that Selma Daley was very concerned about Daniel's mental state. She told us that she mentioned Daniel at every Community Ward Round and also discussed his situation individually with almost every member of the team, and raised his case at every clinical supervision session. She also told us that she had prepared a CPA report for Daniel to be agreed by the team, and had taken it herself to

four community ward rounds, and asked the other CPNs to take it to those community ward rounds she was unable to attend, but that unfortunately there was never enough time to deal with it, as other clinical matters were given precedence.

Mrs Joseph contacted Selma Daley again on 30th December reporting that Daniel was refusing to see her or communicate with her, and had thrown away her Christmas presents. What was more worrying was her report that he had apparently begun smoking illicit drugs and was “*threatening and aggressive to all*”.

Dr Nick Kitson returned from a month’s leave on 5th January. Perhaps this was what everyone was waiting for. As soon as he was back, he was informed of the latest developments and was made aware of what he called the ‘impasse’ with Lambeth Healthcare Trust. He told us that almost immediately upon his return, he dictated a letter to Dr Teifion Davies suggesting that he asked Selma Daley to arrange a fairly urgent joint meeting to plan a joint CPA approach between the two services.

Selma Daley cannot remember being told by Dr Kitson to arrange such a meeting. In fact Dr Kitson told us that he never asked her to do so. He said that he was waiting until he knew whom he would be holding it with. The letter was not sent to Dr Davies until 16th January. We have remarked upon this letter and the delay in sending it in the Background section of the report. This letter should have been sent promptly and we repeat our concern that such an important letter was not sent until ten days after it was apparently dictated, especially since a copy of it appears to have been readily available to the CPNs from at least 12th January.

Having told us that, having read Dr Edgar's report, he believed that it would have been possible to section Daniel at that stage i.e. 12th December, we find it extraordinary that Dr Kitson did not take more urgent steps to have Daniel assessed again, given that a further four weeks had passed since Dr Edgar's visit and there were several reports that indicated that Daniel's mental health had deteriorated even further. We are aware that the relationship between the NDS and the St Thomas's team was not at its best at that time, but we feel that the best way to clear the air was for Dr Kitson to pick up the telephone and talk to Dr Davies and to personally arrange the joint meeting. Nothing had been achieved during his absence in terms of getting in to see Daniel, and in our opinion, as Daniel's Responsible Medical Officer (RMO) he should have taken control of the situation and ensured (i) that a mental state assessment was carried out as a matter of some urgency and (ii) depending on the outcome of the assessment, either that Daniel was admitted to hospital, or that the joint meeting was set up as soon as possible to plan a joint CPA approach.

At the very least, Dr Kitson should have held a Case Conference to make sure that he was completely up-to-date with everything that had been happening to Daniel in his absence, and to plan what should be done next. Selma Daley appeared to be under the impression that such a Case Conference was going to take place, but it never did.

In all, there were six separate occasions when the NDS team had the opportunity to review the situation and formulate a contingency plan - which would include how they and local services would collaborate in Daniel's care - and did not. These were:

- At the beginning of January 1997 when Daniel was transferred from St Thomas' to Old Church
- At the 17th June 1997 Case Conference
- In August 1997 when Daniel was discharged from Old Church to Ian Collie House
- At the end of November 1997 when Daniel left Ian Collie House and went to Carla Thompson's
- In mid-December 1997 after Dr Edgar's assessment concluded that Daniel was not detainable under the Mental Health Act but his mental health was deteriorating
- At the beginning of January 1998 when Dr Kitson returned from leave to discover that no-one from his team had seen Daniel in two months and that the St Thomas' team were saying that they did not consider that they were obliged to provide any follow-up

In our opinion it is difficult to defend six such missed opportunities.

Dr. Hamblin and Selma Daley did however discuss Daniel's situation at the weekly Community Ward Round on 8th January. Selma completed a Care Programme Approach form indicating that the NDS team did not consider there to be any risk at that time of serious violence, suicide or self neglect. From the information available to us, as at 8th January they were probably right, but we just cannot see how they could assert that there were no such risks, when no-one from the NDS team had seen Daniel in two months. Despite a Care Plan being drawn up on the form, it was not at that time circulated outside the team, despite the fact that Julia Hookway was recorded on the form as being one of the professionals involved in implementing the care plan. As far as we are aware, she was not consulted about the proposed plans, and never received a copy of the care plan. Dr Teifion Davies told us that he remembered receiving it on 23rd January, the day after Daniel attacked Carla Thompson and Agnes Erume.

Julia Hookway visited Daniel with the sign language interpreter, Jenny Towland, on her return from leave on 6th January. She had not seen him since before he had left Ian Collie House in November. He was asleep when they arrived, and after he had been woken, she found him unwilling to engage properly with either her or Jenny Towland and he was generally subdued. She was distressed by his appearance, since she thought that he had lost weight and no longer seemed to be taking pride in what he looked like, and seemed to have lost interest in most things. But Jenny Towland told us that, other than looking more dishevelled, she did not notice any great change in him since she had seen him with Dr Edgar on 12th December. She did however remember him complaining about Carla Thompson's housekeeping, pointing out that there wasn't even any milk in the fridge.

This was an important visit, since it was the first visit by a professional since Drs Edgar and Bonner on 12th December, and the last visit by any professional before Carla Thompson was killed.

Julia Hookway told us that Daniel was not aggressive or threatening in any way. He was not elated, nor was he signing rapidly.

We have asked ourselves the question:

"If a Mental Health Act assessment had been carried out that stage, or at any time before the weekend of 17th and 18th January, would Daniel have been considered to be detainable under the Mental Health Act?"

We have found it an exceptionally difficult question to answer.

Nothing of any real concern had been reported by Mrs Joseph or anyone else since 30th December. What Julia Hookway had found was not consistent with Mrs Joseph's account of Daniel being threatening and aggressive to everyone. Jenny Towland also told us that he was much calmer than when she had seen him a month before.

Assuming that any doctor who went in to assess Daniel did not previously know him, they may well not have considered him - on that day - to be a risk to others or to himself, although they might have considered that there was an element of self neglect. They would assess him as a young man who had fairly recently been discharged from Old Church, who was vulnerable and clearly in grossly inappropriate accommodation. We believe that it is perfectly possible that, even if a mental state assessment had been undertaken then, Daniel would have been judged – once again – not to be detainable under the Mental Health Act.

Having said that, we have little doubt that Dr Kitson would have made a medical recommendation under the Mental Health act for Daniel to be admitted to hospital under section if he had not agreed to an informal admission. We are aware that he himself had no bed available for him. His view of Dr Edgar's assessment six weeks earlier on December 12th was:

"I certainly do not agree with the Collaborative Review that it was not possible to section him. In my view, it was possible to section him at that point in the interests of his mental health. Whether it was necessary or appropriate is another matter and that is debatable...."

Dr Kitson told us that he did not think that Dr Edgar's decision that Daniel was not detainable was unjustified.

The events reported by Mrs Joseph over the weekend of 17th and 18th January stepped matters up a gear. As Dr Kitson put it to us:

"By the 19th it was evident it was not urgent - it was an emergency - full stop".

There is no doubt that the moment she arrived at work on the morning of Monday the 19th January and learned of the events reported over the weekend, Selma Daley was galvanised into action. She immediately called Dr Edgar seeking to refer Daniel to the

Brixton Road Community Mental Health Team for a further assessment. Understandably, in the light of his earlier correspondence, Dr Edgar felt that he should discuss the matter with Dr Teifion Davies first. Selma very properly faxed a couple of documents, one of them a letter to Dr Davies updating him on recent events, but there was no mention in this letter of the events reported by Mrs Joseph over the weekend, in particular Daniel's assault on Matthew Gillett. The assault should of course have been mentioned, since it was a significant new development.

Dr Kitson was not in London on 19th January . He was assessing patients in Bath, but was available on a 'bleep'. We are not aware that anyone did in fact try to contact him on that Monday.

Selma then telephoned Julia Hookway, following which she contacted the Maudsley Emergency Clinic to refer Daniel to their service for an assessment. She had not yet heard back from the St Thomas' Hospital team, so she was clearly making sure that she was keeping all options open.

When she was contacted by Mohammed Hussenbocus, the CPN with the Brixton Community Team, (this was the team from the Maudsley catchment area) Selma gave him a detailed description of recent events, including Daniel crashing his mother's car, the fact that he might have stopped taking his medication and might be using cannabis, and the fact that he had assaulted his mother's partner - although Mohammed Hussenbocus noted that the assault was *"the previous week"*, when in fact it had occurred the previous day. She also gave him the names of Dr Kitson, Dr Hamblin, and Julia Hookway. She also advised him to contact Julia Hookway to arrange for Jenny Towland, the sign language interpreter, to attend any assessment. She also mentioned that the Brixton Road Rapid Assessment Team had carried out an assessment, but for some reason Mohammed Hussenbocus understood it to have taken place only some two weeks previously, when in fact it had been six weeks.

We would like to comment that Selma Daley's actions on the morning of 19th January were entirely correct and appropriate, and that the information she gave to Mohammed Hussenbocus contained the relevant and necessary details.

We are aware that Mohammed Hussenbocus decided to present Daniel's case at the weekly clinical forum the following day, and that he gave the Selma Daley and Julia Hookway (whom he called on Monday morning) the impression that an assessment would be carried out the following day, i.e. Tuesday 20th January. Julia Hookway even checked with Jenny Towland who confirmed she was able to assist as interpreter on the 20th.

Selma Daley received two telephone calls from St Thomas' later on that Monday morning. The first was from Dr Teifion Davies who agreed to ask the Brixton Road Rapid Assessment Team to carry out a Mental Health Act assessment, despite the fact that Daniel's present address was outside their catchment area, and to provide emergency admission if necessary. The second was from Dr Edgar who informed her that Dr Nadia Davies, the Lead Consultant of the Rapid Assessment Team *"was not prepared to assess a patient from another catchment area"* and that Selma should therefore refer Daniel to the Maudsley CMHT. Dr Edgar also confirmed this by fax. Dr Nadia Davies told us that her

decision was based on Dr Teifion Davies's earlier decision that the St Thomas' team should no longer be responsible for Daniel's care.

We have already stated that the issue of which catchment area team would be responsible for carrying out an assessment in Tulse Hill should have been addressed at a much earlier stage. Had the issue been clarified in advance, there would not have been confusion at a time of urgency.

Having said that, we accept that there was some genuine confusion and misunderstanding which allowed wires to be crossed between Dr Teifion Davies and Dr Nadia Davies. In the Background section, we have set out in some detail the evidence given to us by both doctors as to the thinking behind their respective actions that day.

Although it is perfectly understandable why they did not, with the benefit of hindsight we can say that it is a pity that the two Dr Davies did not consult each other directly on this matter, but instead used Dr Edgar as a "go between". Dr Teifion Davies told us that his telephone conversation with Selma Daley did impress him that she was " *very very concerned*". Dr Nadia Davies told us that she was not aware of how urgent the situation was. Had the Brixton Road Rapid Assessment Team been clear on that Monday morning about the urgency of the situation and agreed to carry out the assessment, it would almost certainly have been carried out by or on Tuesday the 20th, assuming the availability of Jenny Towland (and we know she was available on the Tuesday).

Although Selma Daley had already set in train her request for an assessment to be carried out by the Maudsley team, Daniel was completely unknown to them, whereas he had been an inpatient at St. Thomas' a year previously, and had been assessed some six weeks previously by the Brixton Road Rapid Assessment Team. Lambeth Healthcare Trust had been after all the referring body to the NDS. Although we realise that there was no guarantee that it would be Dr Edgar who would have carried out any assessment, there was clearly an advantage in the St Thomas' team becoming involved again, rather than a hospital who knew nothing at all about Daniel.

It was the very fact that Daniel was unknown to the Maudsley services that further delayed any assessment being carried out.

On the morning of Tuesday 20th January, Mohammed Hussencocus presented Daniel's case to the Maudsley clinical forum, following which the matter was taken over by Claire Squire, Team Leader of the Brixton CMHT. She telephoned Dr Kitson to ascertain the role of NDS in urgent assessments and to obtain further information about Daniel. Dr Kitson told her that in his opinion, Daniel was relapsing, was probably psychotic and using cannabis, and would need a Mental Health Act assessment with a view to hospital admission. He told us that he was sure that he said that in his opinion Daniel was 'sectionable.' He also told her that the NDS were unable to carry out an urgent assessment and that it was therefore necessary for local services to carry it out. Following this conversation, it was agreed that Daniel would be referred to the Lambeth Approved Social Work (ASW) Team for a Mental Health Act assessment, with a view to admitting him to the Maudsley if necessary, with subsequent transfer to the NDS when a bed was available.

Early on Tuesday afternoon, Claire Squire contacted the ASW team and spoke to Lorraine Roofe-Spence and referred both Daniel and another person to the team. Claire Squire passed on the information that Daniel was currently staying with a friend, was hypomanic and paranoid. He had crashed his mother's car last week and threatened her partner. He was threatening and abusive and threatening self harm, and was abusing cannabis. This report is not entirely accurate, since Selma Daley had clearly told Mohammed Hussenbocus (who had recorded it as such) that Daniel had "*assaulted*" his mother's partner. Lorraine Roofe-Spence told us that had she known that Daniel had very recently assaulted somebody, it would have heightened the sense of urgency.

Claire Squire told Lorraine Roofe-Spence that she was waiting for further information from Springfield Hospital (ie. the NDS) and Dr Kitson, and there appears to have been some confusion as to which psychiatrist was going to carry out the assessment. It is normally the responsibility of the ASWs to arrange for a psychiatrist to attend MHA assessments. This would usually be the patient's RMO, if known, or a doctor from the same team, or the duty psychiatrist. Ideally, the person's own GP would also attend.

As we have stated in the Background section, Lorraine Roofe-Spence told us that she was unaware (i) that the referral had actually been made the day before by Selma Daley contacting the emergency clinic (ii) that the form filled out the day before by Mohammed Hussenbocus had indicated that an assessment should be carried out within the "*next 24 hours*" or (iii) that on the CMHT referral form completed that day i.e. 20th January by Mohammed Hussenbocus and Claire Squire, they had indicated that an "*Urgent Assessment still required*". She told us that no great sense of urgency had been conveyed to her, otherwise her team would have insisted that they should forget about waiting on Dr Kitson, and that the duty psychiatrist would have gone out with the team. (An assessment could not be carried out without a psychiatrist.)

The Lambeth ASWs were also not told about Julia Hookway's involvement, despite her name having been given by Selma Daley to Mohammed Hussenbocus. Given that Julia Hookway's office was in the same building as that of the ASW's and she could be reached by an internal telephone system, she may well have been able to provide additional information to the ASW team.

There is however no doubt that the other person referred by Claire Squire at the same time as Daniel should have been given higher priority than Daniel (as indeed he was). He had a forensic history, with a long list of previous convictions, many related to violence, and his last offence had been an unprovoked knife attack on a member of the public. However we are concerned that the sense of urgency conveyed in the initial referral got diluted in subsequent exchanges, and as a result Daniel appears to have been given too low a priority.

On the morning of Wednesday 21st January, another member of the ASW team, Tricia Wright, came into the office and found Daniel's file on the desk awaiting attention. She noted that they were still waiting for more information either from Dr Kitson or from Claire Squire, and she therefore telephoned Claire Squire to find out whether she had got any further information. When she was told that she had not, Tricia Wright contacted the NDS and spoke to Selma Daley. There is no record of this conversation but we believe that

Selma repeated that the NDS would not be able to carry out the assessment themselves, gave Jenny Towland's number and she faxed through some background information which Tricia Wright handed to the Senior Practitioner on the team. Apparently the Senior Practitioner had just given Daniel's file to somebody to deal with the following morning when news came through to the office about Daniel's attack on Carla Thompson and Agnes Erume.

Everyone at the NDS had been expecting and assuming that an assessment would be carried out on Tuesday 20th January. We feel that it should have been, and that it was unacceptable that an urgent Mental Health Act assessment took at least four days to be implemented. Given that, as far as we are aware, there were no further attempts to sort out the confusion as to which psychiatrist would be carrying out the assessment, and no further inquiries had been made concerning Jenny Towland's availability after the 20th January, we cannot be satisfied that the assessment would have been carried out, even on Thursday 22nd January. We are not clear exactly what information from Dr Kitson the ASW team was still waiting for. Both Selma Daley and Dr Kitson had given quite detailed information about Daniel's background to Mohammed Hussenbocus and Claire Squire, and Dr Kitson had made it quite clear that no Doctor from the NDS would be able to carry out any urgent assessment in the community. He told us:

"I had to my satisfaction passed on the need for an urgent assessment to the Maudsley services on Tuesday 20th. I knew that it had already been done on my behalf by Selma Daley in any case, but I had confirmed to my satisfaction that they were going to pursue an assessment under the Mental Health Act..."

I was relying on their judgment of the priority, and I had every expectation that that would mean by the information I had got across to Claire Squire that it would be done that day. That is as far as it goes. I did not say 'Tell me if it's not done that day'. I did not say 'It must be done today'. I do not recall saying that. I doubt if I would have said it anyway...What I did clearly [say] is 'This person needs to be sectioned'.

Claire Squire herself rang me... she wanted information relevant to the assessment which I gave. As I understood it, we were in agreement that a Mental Health Act assessment needed to occur."

We know that until at least some time on Tuesday 20th January, Daniel had remained at Carla Thompson's flat, although during the daytime it seems as though he was helping friends to decorate their flat in Landor Road. After that he had been 'spirited away' to a flat in Streatham. That clearly further complicated the matter, but if either the Brixton Road Rapid Assessment Team or the ASW team had responded promptly to the urgency of the situation and gone to Carla's flat to carry out the assessment, there is every possibility that Daniel may have been seen that day. Whether or not he would have been admitted to hospital, we cannot say with any certainty. It may well be that he would have presented as relatively normal until immediately before the tragedy of 22nd January, but that is something that no-one will ever know for sure. After the 20th, there is every likelihood that Daniel would not have been found, even if one or other of the teams had gone to carry out the assessment.

As we have said before, from what Dr Kitson told the Inquiry it is clear that he would have made every attempt to ensure that Daniel was admitted to hospital – including the use of the Mental Health Act if necessary - or at least to extricate Daniel from Carla Thompson’s flat - if he had gone to assess him for himself. In our opinion, he should have done, the moment he got back from Bath on the morning of Tuesday 20th January and found that the St Thomas’ team had refused to be further involved. In his own words, as from the 19th, the situation was not just urgent, it was an emergency.

When we suggested to him that the obvious people to carry out the assessment were the NDS team he replied:

“Obviously – and the obvious people to go and do the assessment on the 12th December was us. The obvious people to go in and do assessments on any deaf person requiring it was us. That is the point. There comes a point where you have to say – any professional has to say – ‘Sod it. I’ve got to do it my self.’

When we asked him if this was not one of those situations when he should have done just that, he said:

“I do not agree that that is one of those situations. I did not, and I would still, under the circumstances, probably not. But there is a threshold at which I do say ‘Sod it. I am going to do it myself’. I cannot really define what that is.”

[The Panel makes no apology for quoting the phrase “Sod it”, because we feel that it graphically reflects the frustration felt by Dr Kitson in being unable at times to act upon his own instincts because of a lack of resources. We fully acknowledge that his use of the phrase was in no way intended to convey any degree of flippancy on his part.]

Dr Kitson’s view is that in most situations a lack of resources would make emergency assessments impossible and that the NDS has to set a boundary on what it will and will not do.

Given that there had been no multi-agency CPA plan on Daniel’s discharge from Old Church, the only way that this complicated situation could have been resolved was if Dr Kitson had gone in and carried out the assessment himself. We accept that he believed that he had made appropriate arrangements on Tuesday 20th January when he spoke to Claire Squire, but he had left her and the ASWs to whom she referred Daniel, and whose responsibility it was to arrange for a psychiatrist to do the assessment, with the dilemma of deciding who was an appropriate psychiatrist. Because this was not clear, and because a sense of real urgency had somehow not been conveyed to the ASWs on the 20th, the matter was not dealt with on that day because there was a second more urgent case referred to the ASWs that day at the same time as Daniel which was dealt with first. Therefore, even if there were no complications or confusion as to who should carry out the assessment and no further information was required, it may still have been too late to find Daniel, even if the assessment had been given the highest priority after the case referred at the same time, since it was unlikely that Daniel’s case could have been dealt with by the ASWs before the morning of Wednesday 21st January, by which time he was in hiding.

But there were complications as to who should carry out the assessment. The obvious choice of psychiatrist was Dr Kitson. He was Daniel's RMO¹ and he was the only psychiatrist with the appropriate skills and knowledge – and he knew Daniel. Now, in an emergency, when he was most needed, he was effectively saying that he could not take RMO responsibility in such an emergency. This left the ASWs in a quandary as to which psychiatrist should assess Daniel. Dr Kitson had not negotiated who should take responsibility in an emergency; Dr Teifion Davies and Dr Nadia Davies had declined to take responsibility because Daniel was no longer on their patch; no-one at the Maudsley knew anything about Daniel; and to throw the whole matter into further confusion Daniel might now be staying at an address in the Landor Road (which was back on St Thomas' patch!).

Once responsibility was passed to the ASW team in the early afternoon of 20th January, there was probably no way that Daniel would have been assessed that day, given the other urgent referral which was very properly given priority over Daniel's case in the light of what was then known about each of them. The real problem after the 20th was that Daniel was persuaded to go into hiding that day. Even if there had been no further delay by the ASW team, he was unlikely to have been traced before the morning of the 22nd, and therefore the tragedy which occurred that day could not have been prevented.

The only way that the events of the 22nd could possibly have been prevented was if Dr Kitson had gone to assess Daniel himself on the 20th – or indeed at any time between his return from leave on 5th January and the 20th, although we accept that there was no real urgency until the weekend of 17th/18th January, when Mrs Joseph reported the sudden escalation in Daniel's aggressive behaviour.

Although we are aware of, and sympathetic to, the fact that it is not a whim of Dr Kitson's but a policy decision of the NDS and its commissioning authorities not to provide emergency cover, we consider that, having failed to put in place a contingency plan to clarify who was to take responsibility for Daniel in an emergency, and having held on to *de facto* RMO responsibility himself, Dr Kitson should have told himself that this was one of those rare situations when he was going to “*go in and do it himself*”.

Nevertheless, the Inquiry has found no evidence to indicate that the homicide could have been reliably predicted, even the day before it happened. There is no consistent indication from his behaviour, as reported by others, that Daniel was very disturbed until very shortly before the homicide.

We understand that, as a result of this case, a disclaimer was printed on all the NDS's headed notepaper and CPA forms, purporting to clarify the NDS position that it does not provide an emergency service. However even this new disclaimer left room for doubt. It read (the underlining is ours):

¹ We recognise that the term 'RMO' is usually applied to the Consultant responsible for a patient's care under the Mental Health Act, however in normal clinical practice, the term is extended to include the Consultant who is responsible for his patient's care, whether the patient is detained under the MHA or not. As many witnesses referred to Dr Kitson as Daniel's RMO - although Daniel was never detained under the MHA - we have used the term as well, although strictly speaking he was not Daniel's 'RMO'.

“National Deaf Services, as a tertiary service covering one third of the UK, cannot necessarily provide on-going care, urgent or emergency assessment, admission or other management beyond that outlined in its internal Care Programmes. Those programmes do not imply any responsibility for care beyond that included in them. Any care additional to this programme should be sought from the client’s local area health service, whose responsibilities remain, as if the client was not on our caseload. Please inform us of any additional healthcare provided.”

The disclaimer was subsequently redrafted to read:

“We serve one-third of the UK as comprehensively as possible. We may not be able to provide urgent assessment or admission. We cannot take responsibility for care outside of our care plans. The responsibility of client’s local health services remain, as if the client were not on our caseload.”

No doubt these disclaimer was intended to make the situation clearer, but in our opinion do not. If it wants to remove any residual uncertainty and ambiguity it should state unequivocally that the NDS does not provide any kind of emergency service. But in fact it can be seen that we have recommended that such disclaimers should be abandoned altogether in favour of an information pack.

Of course, if the NDS is able to provide such a service in any particular case, this is to be welcomed, but it should be recognised as exceptional to current normal practice.

The disclaimer also does not resolve the unacceptable paradox that here is a specialist service unable to be effective when it is needed most. Something has to be done to address and redress this regrettable state of affairs. Otherwise we can foresee a similar tragedy happening again.

We have also been disturbed to realise that the Police do not have direct access to a secure unit in a situation where they find themselves having to decide what to do with someone they are holding who is clearly mentally disturbed and a risk to himself and others, and who should not – for his own safety and the safety of the Police Officers - be kept in a police cell overnight.

At present, if there is not a local forensic psychiatrist available who can arrange admission to a secure unit, the only alternative to keeping the person in a police cell until the morning when they can be brought before a court and a Hospital Order made, is to admit the person to a local acute psychiatric ward, which puts the other patients and the hospital staff at considerable risk.

Another issue which has caused us some considerable concern was that of lack of support after the event for those who had been involved in Daniel’s care. As we have stated earlier in this Report, several highly skilled and dedicated professionals have left their previous posts since January 1998, and we are fairly convinced that the incident itself and the way that the matter was handled within their various organisations had something to do with their decision to leave.

We asked most of those we interviewed who were part (but not head) of a team with responsibility for Daniel, to tell us how they regarded the support that they had received in the aftermath of the incident. From what we heard, we believe that the impact of such an event on those involved – even those involved in a very peripheral capacity – is grossly underestimated and therefore not adequately or appropriately dealt with. Some of those we interviewed were visibly distressed when recalling events, even though nearly two years had passed since they occurred. Some were talking about the incident for the first time to someone other than close colleagues and friends. Only the “key players” had been approached to be questioned and offered some kind of ‘debriefing’ after the killing. The others were left to deal with their feelings about what had happened by themselves.

We feel that we can not describe the effect that that might have on the individuals concerned as well as one of the witnesses did, and therefore we rely on her words which we wholly and unreservedly endorse:

“I think that the quality of support could have been improved in the following ways:

- 1. A liaison person from management...to meet with all the concerned staff regularly to update them on progress in the various stages of inquiries and to keep them informed about what was likely to happen next. I often found out about things at the last minute and found this distressing.*
- 2. Debriefing and support for the team as a whole. This did not happen, and would have been very helpful. I frequently felt very isolated from the rest of the team. Other colleagues have since told me that they felt there was no forum to express their own distress and sorrow and that all the attention was on the key individuals. It would have been helpful for the whole team to have received help in the initial stages. Following the incident a large number of experienced staff left what had previously been a very stable staff group. This, I am sure, was linked to the difficulties all staff experienced in coming to terms with what had happened.*
- 3. Individual debriefing and ongoing support from a service which was not linked to our trust. It was difficult to confide in and receive support from people one had previously known as colleagues.*
- 4. I was concerned about the support that would be offered to the lady who survived the attack, Daniel and his family and to the family of his victim. Whilst it is not appropriate for myself or other staff to know the details of this support it would have been reassuring to know that some form of support was being offered to them.*
- 5. My experience of appearing before the inquiries was that the actions of staff were examined in some detail but that the context in which staff were working did not receive the same attention. Of course I may be mistaken about this. It is very disheartening to feel that the limitations placed on us, particularly the lack of social and educational support, which is after all crucial to the successful care of our patients, is perhaps seen to be of lesser importance.*

6. *It is my opinion that the management of services, both at local and national level, has a great part to play in the ability of staff to provide an effective service. Unless difficulties at this level are addressed then there may be a tendency to scapegoat the least powerful staff who have borne the brunt of attempting to provide a service in extremely difficult circumstances.*
7. *There is no easy way to go through such a difficult experience, however I think that improvements could be made in the support following such an event."*

It should not be forgotten that there are many victims in the aftermath of an incident such as this – the victims of the attack and their families, Daniel and his family, and also those who were responsible for his care and treatment. All suffer in some respect and to some degree following such a traumatic event. All should receive appropriate support as soon as possible and for as long as is individually required.

As well as expressing our concerns, we would also like to recognise the positive impressions we have gained of many aspects of this Inquiry, although we still have some comments to make about other less favourable aspects of each organisation.

Social Services are often criticised for failing to recognise the strengths of Afro-Caribbean family patterns and therefore failing to provide adequate support. It is clear from the records we have seen that Lambeth Social Services made a number of interventions over the years with Mrs Joseph and her family, not just in response to Daniel. Those interventions appeared appropriate and sensitive to the needs which were established in discussion with Mrs Joseph and her various children. Lambeth Social Services should be commended for the way that they supported the Joseph family throughout Daniel's life and kept the family together, despite Mrs Joseph's (at times) somewhat unpredictable behaviour.

The Department persisted in working and collaborating with the family even after episodes where Mrs Joseph seemed to act against Daniel's interests, such as when she removed him in an unplanned way from his residential nursery and took him back to Trinidad. On her return to the UK with Daniel and several of her other children, they found her suitable housing.

Daniel's educational needs were met within the system which existed for deaf children (specialist residential nursery and boarding school). Daniel appeared to benefit substantially from the stability and developmental experiences provided at these establishments, as well as from the educational opportunities. We are however concerned that Daniel's family were not encouraged to learn to communicate with Daniel in sign language – and may even have been discouraged. There was also a considerable gap in his education when Daniel was eventually excluded from school. That was unhelpful for both Daniel and his family. His attendance at Southwark College however proved beneficial.

The plan for Daniel to go to Court Grange was arrived at appropriately after consultation with him. Social Services staff made very considerable efforts to obtain funding from the Further Education Funding Council, which was unacceptably delayed by the ineffectiveness of Lambeth Education Department.

The long delay in arranging funding for Court Grange may have contributed to Daniel becoming frustrated and leaving Ian Collie House, which was always meant to be short term accommodation.

We are aware that the Metropolitan Police are seen by some as racially insensitive to young black men in particular and are often perceived as over-reacting to incidents involving them. However it was clear to us that on a number of occasions Daniel appeared to receive an appropriate and sensitive response from the Police. When Mrs Joseph called the Police following the disturbance caused by Daniel after the visit to the London Arena to see the WWF contest, he was taken to the Police Station where the outcome was that he was seen by a Child and Adolescent Psychiatrist from the specialist deaf service and he was offered informal local psychiatric admission.

When the Police were called to Ian Collie House when Daniel decided to leave, the Police Officers were described as 'calming the situation' and they declined to intervene under Section 136 of the Mental Health Act (removal of a disturbed person from a public place to a place of safety).

After a malicious call the Police visited Carla Thompson's flat in the middle of the night to search for an alleged firearm which Daniel was supposed to have had. Again they seem to have handled that potentially dramatic episode with considerable restraint.

Even after the sustained attack by Daniel on Carla Thompson and Agnes Erume, and the extreme violence with which the Police had to contend whilst attempting to restrain and arrest him, the only significant injury to Daniel was where the handcuffs had bruised and abraded his wrists.

Considerable care was taken of Daniel in the custody suite of the Police Station with an examination of him being undertaken by the Police Doctor and the use of a sign language interpreter. He was recognised as a vulnerable young person. He was examined by a psychiatrist and was transferred to a psychiatric hospital, eventually being transferred again with a police escort to a more appropriate secure psychiatric facility.

As the Police are so heavily criticised when they get things wrong, it seems appropriate that they should receive commendation when they perform well.

Psychiatric Services are frequently criticised for responding to the mental health needs of young black men in a stereotypical way, often by using compulsory hospital admission and by overdiagnosing schizophrenia. He was treated sensitively at St Thomas' Hospital where they tried their utmost to accommodate his deafness, and recognised that they did not have the specialist skills or knowledge to assess his mental health properly. A tentative diagnosis of 'bipolar affective disorder' was made.

We also fully appreciate the enormous task which faces the National Deaf Service. There may not be the numbers of deaf people with mental health problems to justify a high level of funding, but it should not be forgotten that it provides a nationwide service dealing with patients right across the board. It has to provide services for children and adolescents, adults and elderly people. It is almost unique in having such a wide brief. Yet the NDS have only 18 beds for the whole of the South of England. Until late last year, there was only one Consultant Psychiatrist for adults and one for children and adolescents in the South of England.

We understand why the NDS can not at present provide 'assertive outreach' or any kind of service in an emergency, because they do not have the resources to do so as well as provide the excellent specialist 'everyday' services which they do. The NDS had no access to the Modernisation Fund, and currently have no access to the new Government funding for the NHS. We sincerely hope that this Report will remedy this unfortunate situation. That such a necessary and valuable service should be unable to operate in the way in which it would wish to for the benefit of its users because of lack of resources, causes us great concern. Despite the criticisms which we have had to make of the NDS in this Report, we have no doubt whatsoever of the dedication and skill of the professionals who provide such important services to their patients. We would hate to think that our criticism might in any way undermine the admirable work that Dr Nick Kitson and his team achieve every day against fairly hostile odds, especially on the funding front. We are only too aware from having talked to them at great length, that Dr Kitson and the NDS team who were responsible for Daniel's care, felt that when it came to responding to the situation of Daniel's deterioration in the community, their hands were, to all intents and purposes, tied by the policy decisions that had to be made because of resource limitations, and which meant that they could not offer effective outreach or emergency cover.

However we also hope that the NDS and the other two specialist units for the deaf in Manchester and Birmingham will not be so insular in the future, and will try to work towards more a collaborative and co-ordinated service. We consider that the national picture should be reviewed systematically and we sincerely hope that the issue of funding this much needed specialist service at a more generous level is given very serious consideration. Without greater resources, the NDS will continue to be unable to respond when it is most needed, and will be impotent when another Daniel Joseph needs its urgent help and intervention.

Before we end this Commentary and move on to give our recommendations we would like to repeat that we were extremely impressed by the high calibre of the professional witnesses we saw. If there is any fault to be attributed, it should be attributed to the system in which those professionals work rather to any individual. The Panel therefore welcomes the decision which has apparently been made not to take disciplinary action against any of the professionals involved in Daniel's care. However the system must be improved or the Care in the Community programme will continue to create apprehension if not fear amongst the general public, and we will continue to fail those dedicated professionals who

strive to do their best to help those people with mental health problems live as normal a life as they can.

The last word should be for Carla Thompson and Agnes Erume and their families.

Our remit has been to concentrate on the care and treatment given to Daniel Joseph, and therefore it may seem to Carla's family and to Agnes that they have somehow been forgotten in all of this. They have not. If this Inquiry can in any way improve the services which look after people like Daniel and thereby help to prevent a similar tragedy happening again, we hope that that will be a fitting tribute to Carla Thompson's memory and to Agnes Erume who suffered terrible injuries which she has borne with great fortitude.

Recommendations

These Recommendations are addressed to the current organisations now responsible for the services involved in the care of Daniel Joseph. We are fully aware that, following the case of Daniel Joseph, steps have been taken by all the bodies concerned in his care to address the issues highlighted by the incident. Some of the Recommendations which we make may already have been implemented or at least considered.

	Recommendation	Organisation(s) Concerned
1	There is no co-ordinated strategy for deaf people with mental health problems. The three national specialist services currently work separately from each other. They should collaborate to assess needs and demands and thereby to identify and prioritise necessary service developments. This process needs to be part of a long-term strategic plan which is regularly reviewed.	The NHSE, all three national specialist services for deaf people and regional commissioning groups
2	Specialist services for deaf people do not currently have the priority they deserve on the NHS Executive Agenda. They should be given a much higher priority. Without this the strategic work mentioned above cannot be implemented and integrated into the wider National Service Framework for mental health.	The NHSE, the three national specialist services for deaf people and regional commissioning groups.
3	There need to be robust emergency assessment and admission arrangements available to the NDS and resources made available to support and sustain such arrangements. The arrangements need to reflect the wide geographical area covered by the specialist services.	The NHSE, the three national specialist services for deaf people and regional commissioning groups.

4	<p>It is not uncommon for deaf people to be kept in hospital for much longer than hearing patients. Daniel himself remained at Old Church for five months longer than was necessary because of the combination of the non-availability of suitable accommodation and the necessary funding. This is inequitable for the patient and also an unnecessary burden on the specialist services and the scarce resources available to them. Health & Social Services Commissioners should ensure prompt access to an appropriate range of community facilities with varying degrees of support. This will require a systematic needs assessment undertaken in conjunction with the specialist services. This should form part of the long-term strategy for services for deaf people.</p>	<p>All Health & Social Services Commissioners and the specialist services for the deaf</p>
5	<p>A training and education network for those working with deaf people should be developed on a regional or national level, possibly centred on one or more of the specialist services, but also making use of new technology for distance learning, peer support and supervision etc. Services should also develop plans to retain staff who have skills and expertise in working with deaf people through appropriate career development opportunities, financial incentives and other retention packages.</p>	<p>The NHSE and all Health and Social Services</p>
6	<p>The apparent lack of awareness about the NDS and what it is contracted to provide as a service, and the likely infrequency of contact between the NDS and other individual agencies, requires that the NDS develops an information pack which informs those collaborating with it about its expectations of partnership working as well as its perceived functions and responsibilities. In particular, it should state clearly what its contractual limitations are.</p>	<p>South West London and St George's Mental Health NHS Trust</p>
7	<p>The NDS must be unequivocal from the outset in any contact with another agency about the NDS's functions and responsibilities. These should be based upon agreed protocols but ultimately will depend on individual care plans. Relying on a brief disclaimer on headed notepaper renders the service vulnerable to misunderstanding and this practice should be abandoned.</p>	<p>South West London and St George's Mental Health NHS Trust</p>

8	As part of the agreed Care Plan Protocol, the NDS should develop a CPA form which takes into account the particular needs of those patients and carers in contact with the service and the way the service operates.	South West London and St George's Mental Health NHS Trust
9	Wherever possible CPA meetings should involve all the key agencies, and most importantly also the patient and carers, to ensure that the care plan is comprehensive from the patient's and carer's perspective.	South West London and St George's Mental Health NHS Trust
10	The NDS should develop a protocol for all staff to follow to respond to situations of perceived risk, including circumstances when a case conference or clinical review should be called and a procedure to allow any member of the team to initiate such a conference or review.	South West London and St George's Mental Health NHS Trust
11	Any formal discussions between members of the NDS team at a Community Ward Round or elsewhere should be routinely recorded and the record easily accessible.	South West London and St George's Mental Health NHS Trust
12	Where a deaf person is admitted to hospital elsewhere pending transfer to the specialist service, the specialist service should use their best endeavours, wherever practicable, to support the patient and the local services by arranging to visit and advise. We recognise that to extend such a service beyond the immediate locality of these specialist services is likely to have resource implications. All such instances (whether it is possible to visit the patient or not) should be audited and the data used to feed into resource decisions.	South West London and St George's Mental Health NHS Trust and the other two specialist services
13	Whenever the NDS request an assessment of one of their patients by a non-specialist team, wherever practicable a member of the NDS team should participate in the assessment. This must not obviate the need for a sign language interpreter.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust

14	Except in an emergency, or where it is known that the patient communicates other than by sign language, no assessment of a deaf person by a non-specialist mental health professional should be undertaken without a sign language interpreter.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust
15	Throughout this Inquiry, effective communication has been an issue. We recommend that all organisations involved review all their communication and recording systems where possible against current good practice guidance.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust and Lambeth Social Services
16	Services should ensure that forms dealing with urgent referrals include explicit questions to elicit specific details about risk (notably the referrer's assessment of urgency, and those already involved)	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust and Lambeth Social Services
17	All mental health professionals should participate in multi-agency training on exchanging information about clinical risk and other aspects of risk management. This should be based on joint training strategy.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust
18	Local mental health services should establish protocols to manage situations where a patient temporarily moves a short distance outside their boundaries. These protocols should preferably be developed jointly with neighbouring services.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust
19	When a tertiary service first becomes involved in the care of individual patients, an explicit plan must be agreed with the referring service regarding the future roles and responsibilities of all those involved and how communications will be facilitated.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust

20	Every Mental Health Service and Social Services Department should have a protocol covering steps to be taken when any significant aspect of a care plan breaks down. It would be appropriate for the urgency of any review required to be included with other information on what to do if the care programme breaks down.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust and Lambeth Social Services
21	For someone considered vulnerable and incapable of independent living, a change in carers should always trigger a formal review of the care plan. In particular such circumstances demand special efforts to regain and retain contact with the patient, irrespective of whether they are saying that they refuse further contact with the professionals involved in their care.	South West London and St George's Mental Health Trust and South London & Maudsley NHS Trust and Lambeth Social Services
22	Training should be provided to all health care and social services professionals as part of their basic professional training on how to understand the complexities of working with deaf people and how to use interpreters.	All Professional Training Bodies and all Health and Social Service Employers
23	Health and Social Services should review their commissioning of sign language interpreters and develop collaborations with neighbouring services and other voluntary and independent agencies to improve the recruitment, availability and competencies of such interpreters.	The NHSE and all Health and Social Services
24	An easily accessible and regularly updated source of information on specialist services of all kinds should be made available (possibly using a source such as the National Electronic Library of Mental Health)	The NHSE and all Specialist Providers
25	Every Police Station should have available a standard protocol to initiate a mental health assessment. (In most services this starts with the Police contacting the local ASW). There should be a collaborative audit between the Police and their local mental health services to identify problems with this – such as excessive waiting or the availability of sign language interpreters. In London this should be dealt with by the Metropolitan Police on a pan-London basis within a jointly agreed framework for London.	All local Police and Mental Health Services

26	Every psychiatric catchment area should have a consultant forensic psychiatrist available on call to deal with people who are in police custody and are very disturbed, and protocols should be developed jointly by general and forensic psychiatry services to allow direct access to forensic inpatient facilities where this is judged to be clinically appropriate.	The NHSE and all local Mental Health Commissioners and all local general and forensic psychiatry services
27	All Mental Health Services should make some provision for secure beds – at a variety of different levels of security and intensity of care – which are accessible in emergencies, even in the absence of a clear forensic history.	The NHSE and all Mental Health Services
28	As soon as possible after any Serious Incident each agency involved in the care of the person who has committed the offence should hold a Serious Incident Review including all staff involved, however peripherally. There should be a protocol for such reviews, which includes an explicit statement of their main aims, and which should include such matters as staff support, team debriefing, and collecting information, and may also include the possibility of a joint agency review.	All Health and Social Services
29	Following a Serious Incident, staff of all agencies involved, however peripheral their involvement might have been, should have access to specialist support outside their own organisation. (This could be done for example through reciprocal agreements between neighbouring organisations). Staff should be actively encouraged to make use of these resources. If staff are merely told that such help is available if they wish to have it, there is a risk that they are made to feel that by taking up the offer of help they may be demonstrating particular vulnerability.	All Health and Social Services and all emergency services
30	Given that there is still a requirement for an Independent Inquiry to be held following a homicide by a mental health patient, any process resembling the Collaborative Review adopted in this case should be avoided.	All Health and Social Services Commissioners

31	There needs to be specific effort and resources devoted to organisational change within health and social services towards fostering reflective practice within a 'no blame' culture. Without specific attention, this change is unlikely to occur however well-intentioned practitioners and managers are.	The NHSE, the Social Services Inspectorate and all Health and Social Services
32	The Inquiry Panel should be invited to reconvene one year after the publication of this Report to consider and report on the progress made in implementing these Recommendations.	The Commissioners of this Inquiry and the Panel

Introduction

The national statistics of the number and demographic distribution of deaf people are generally considered to be inaccurate, due to the fact that some deaf people do not register as disabled with their local authority. It is known that certain geographical areas have a more concentrated population of deaf people because of the location of well established deaf clubs, schools for deaf people, further education facilities, mental health services and residential facilities.

There are 8.5 million people in Britain who are deaf or hearing-impaired. Approximately 75,000 of these consider themselves as part of a cultural and linguistic minority group whose preferred language is British Sign Language. This group is usually referred to as the Deaf community.

Deafness

Deafness maybe commonly perceived by the public and others as a unitary concept. However there are profound differences in the life experiences of the child who is born or who becomes deaf in early life, and those who are deafened after the acquisition of speech and verbal language. (The word “verbal” being used to mean the use of words).

Early profound deafness

The problem of profoundly deaf children is they cannot acquire speech and verbal language normally.

About the end of the first year of life, the hearing child begins to imitate speech, but without understanding. To do so, he has to both hear the speech of others and to monitor his own voice. He soon begins to associate names and words with people and objects, and so begins the process of internalisation of verbal language, i.e. of understanding. Slowly at first, but then with increasing rapidity, his language develops, and by the age of 4 years, the hearing child has already grasped most of the grammatical and syntactical complexities of his native tongue. Later, with further intellectual development and with education, he learns to read and write – he learns to understand and express in another form the verbal language he has acquired through hearing.

For the child who is deaf from birth or early age and whose deafness cannot be alleviated by an aid to hearing, the development of speech and verbal language are extremely difficult tasks. The majority do not develop intelligible speech for they cannot imitate the speech of others nor monitor their own voices. Of fundamental importance also is the fact that they cannot develop verbal language normally through hearing.

The deaf child has to develop verbal language through another sensory channel – through vision – by lip-reading or by the written word. Lip-reading, however, is extremely difficult

Appendix 1 Deafness

simply because of its inexactitude, for some of the sounds of speech are not accompanied by movements of the mouth or lips, while their movements are, in some instances, the same for different words. A more important aspect is that lip-reading pre-supposes knowledge of verbal language, which, in the case of a young profoundly deaf child, is poorly developed. Consequently, the deaf child has to acquire verbal language through the written word. This presents further difficulties, for the ability to read and write requires a certain degree of intellectual development, so that even normally hearing children with good language development are not capable of literacy in their early years.

The deaf child therefore has a long pre-verbal stage. He begins to acquire the rudiments of verbal language much later than his hearing peers, and even then progresses very slowly.

Deaf children receive special education but it is well recognised that the majority of deaf school leavers, in spite of special help, have difficulties with speech production and limited verbal language. Many deaf children are educated in schools where oral/aural methods are used for communication. These children are denied the use of British Sign Language, their natural language, in the educational process. However, many deaf children and adults use British Sign Language to communicate with each other, as they acquire this language naturally, often without the help of formal education in this medium of communication. Deaf children and adults experience difficulties in communicating with hearing people, and though reliance is placed upon the written word, this can lead to misunderstandings and confusion in the communication process.

For the deaf child born into a hearing family, which is the norm, the circumstances for social and emotional development are limited. The family is unprepared and often does not receive the appropriate advice or counselling. They may be actively discouraged from learning sign language and would therefore be unable to communicate effectively with the child effectively during its formative years. This means a deaf child does not have the same access to its own family's attitudes, values and beliefs. Nor are they given the opportunity to access those of the Deaf Community.

Deafness and mental disorder

There is no evidence to suggest that deaf people are more or less likely to suffer from a mental disorder.

In a mental health setting effective communication is a pre-requisite to diagnosis and treatment. Mental health professionals who do not have an understanding of the implications of deafness and facility in sign language may make assumptions on the basis of a patient's behaviour, attitude, literacy, general knowledge or academic achievements. Therefore their needs are often misunderstood and there is a serious risk of misdiagnosis and inappropriate treatment.

Psychiatric services for deaf people

Psychiatric services for deaf people began in the late 1960's currently there are three specialist providers of mental health services for deaf people in the UK, based at the following mental health Trusts.

- National Deaf Service, South West London and St George's NHS Trust (formally Pathfinders)
- National Centre for Mental Health and Deafness, The Mental Health Services of Salford NHS Trust
- National Deaf Mental Health Services, The South Birmingham Mental Health Trust

These services are staffed by deaf and hearing professionals, who have developed skills and experience in mental health and deafness and have facility in sign language. It can take up to two years for a professional to become proficient in sign language and able to function effectively in their role.

Each Service has an inpatient unit with 18, 24 and 12 beds respectively, providing assessment, diagnosis and treatment for deaf people with a wide range of problems.

Outpatient clinics are held at each service and at other regions throughout the UK. Day patient and community services are also provided. There are out patient child and adolescent services available in London.

In addition to the clinical role these services have a commitment to offer training and conduct research in all aspects of mental health and deafness.

Catchment areas are largely determined by the location of the in patient services. However there are currently no clear boundaries and referrals would be accepted to each Unit from across the country. Sources of referral are often atypical, as primary care professionals are often unaware of the needs of deaf people and the existence of the specialist services.

The large geographical catchment areas make it impossible for the specialist deaf services to provide effective local mental health services, offering appropriate aftercare, follow up and emergency responses without explicit co-operation and liaison with local psychiatric services.

The numbers of deaf people with mental health problems are too few to justify the establishment of services at a local level and mental health professionals with little contact with deaf people cannot be expected to provide quality services.

There are no specialist high or medium secure facilities for deaf people, however the high secure provision at Rampton Hospital, Nottingham, has a dedicated team of professionals

Appendix 1 Deafness

which gives patients a limited access to a range of medical and psychological therapies. There are also deficiencies in the provision of services for those who have learning difficulties, those who present with difficult and challenging behaviour and mentally disordered offenders.

The NHS Health Advisory Service conducted a thematic review of mental health services for deaf people. The report 'Forging New Channels' was published in 1998 with permission from the Department of Health by the British Society for Mental Health and Deafness. This report highlights the difficulties deaf people have in accessing appropriate services and suggested better planning and co-ordination between agencies responsible for commissioning and providing services.

The use of sign language interpreters

It is well recognised that many deaf school leavers, in spite of special help, have poor speech and limited verbal language: they have developed facility in sign language and will be able to communicate at varying levels of proficiency using this medium.

It is a common misapprehension that writing assures more effective communication and many professionals will often resort to the written word. Many studies have shown that the average deaf adult cannot read or write at a level to communicate effectively. (This should not be interpreted to mean that there are no deaf adults who can read or write well). Therefore in order to carry out an assessment of a deaf person, mental health professionals are dependent on the use of sign language interpreters.

Professional sign language interpreters develop their skills through training and practice over a long period of time. Interpreting is a complex process that requires a high level of skills and knowledge, knowing both sign language and English does not qualify a person as an interpreter.

The assessment process relies on effective communication, allowing the patient to give an account of his experiences and the psychiatrist's ability to understand him. The interpreter needs to understand the point of questions in the psychiatric interview; this requires them to have knowledge of the subject and an awareness of the way in which the interview will be carried out.

Level of language or the presence of a mental illness may affect the content, structure and style of a deaf person's communication, the interpreting process in this context is more than just translating language.

The Council for the Advancement in Communication with Deaf People (CACDP) has produced a Code of Ethics, which offers the interpreter guidelines for practice. These guidelines suggest that the Interpreter should remain impartial and not give opinions, advice or support to any side. This should not preclude the sharing of experience that may help professionals who have no knowledge of deafness or the communication process.

Conclusion

The assessment and treatment of deaf patients is often complex and time consuming even for professionals with special skills and expertise. The history of misdiagnosis and inappropriate treatment suggest there is a need to educate the wider population particularly those health care professionals that may come into contact with a deaf person. It is not possible for services to be provided effectively by the use of interpreters as assessment and treatment requires ongoing direct communication provided by professionals who have:

- A sound basis of clinical knowledge in psychology, psychiatry, psychotherapy and the especial psychiatric problems of deaf people
- An understanding of the psychological and sociological implications of different types of deafness
- An ability to communicate effectively using sign language
- An understanding of developmental issues and of disorders of communication

The deficiencies in the current provision of services for deaf people need to be addressed. This can be achieved through comprehensive needs assessment, the rationalisation of current resources and the development of a system that enables these services to develop and progress.

Psychiatric presentation and its relevance to the homicide

The most consistent psychiatric diagnosis given to Daniel has been of bipolar affective disorder. This remained his working diagnosis at Broadmoor Hospital. However, it is noteworthy that on discharge following his 9-month inpatient admission to a unit specializing in psychiatric disorders among the deaf, staff there did not consider themselves able to state a definite diagnosis, presumably because the clinical picture was not sufficiently clear.

Prior to his admission to the Maudsley Hospital following the homicide, Daniel's most prominent mental state abnormalities were grandiose ideas (notably of going to the United States, being accepted as a World Wrestling Federation (WWF) wrestler, and becoming famous), and rapid signing. For each of these phenomena, significant doubt remains whether they can be considered *consistent* signs of mental disorder. While Daniel's belief that he would become a famous wrestler initially appears delusional, there is clear evidence that this belief was not only condoned by family and friends, but very actively fostered. For example, when Matthew Gillett took Daniel to a wrestling match, Daniel was not discouraged from taking with him some bags packed for his journey to the United States. Similarly, Carla Thompson asked Drs Edgar and Bonner, when they visited Ms Thompson's home, not to discourage Daniel's ambition to become a professional footballer. Thus this phenomenon fails to meet one of the key features of a delusion, namely that it is out of keeping with the individual's personal and cultural background. Thus while it is likely that Daniel was delusional at times, but this particular mental state phenomenon cannot be taken as a consistent marker of an abnormal mental state. Similarly, Daniel's signing was recognised as very rapid at times. Also, while those who use sign language often adjust their rate of signing when communicating with someone with limited signing competence, it was recognised that Daniel sometimes ignored this, and continued signing at his preferred rate, even when he was not particularly grandiose. In other words, his rapid signing was sometimes an isolated phenomenon, not linked to any other possible mental state abnormalities and therefore this also was questionable as a consistent marker of mental disorder. It may also be relevant that Daniel's rapid signing has often been noted when he met someone able to sign after a period without contact with people who could communicate effectively with him (for example, when he was seen at Carla Thompson's home).

Daniel was clearly psychotic on his admission to the Maudsley Hospital following the homicide. The clinical presentation at that time is consistent with mania with psychotic features (F30.2 in ICD-10). However, this presentation, along with the earlier pattern of his mental state, also fits with the diagnosis of an acute polymorphic psychotic disorder (F23.0 in ICD-10). The main features of this latter diagnosis are that the onset of the psychosis must be rapid, and the mental state fluctuates considerably. Other diagnoses which need to be considered are schizoaffective disorder, or even schizophrenia. However, a thorough review of all the information available pertaining to the changes in his mental state failed to find any clear justification for either of these diagnoses, with one exception. While at Broadmoor, Daniel made a sudden and unprovoked attack on a

Appendix 2 Psychiatric presentation

member of staff. There had been no definite warning signs that this might happen, with only non-specific changes in his mental state. After the attack, Daniel's explanation was evidently delusional.

In relation to the homicide, the key question is - was Daniel psychotic prior to this event? If so, had another psychiatric assessment been done, it might have been possible to admit him to hospital under the Mental Health Act. There is clearly no means of reaching an unequivocal answer to this question, because Daniel was not seen by any mental health professionals for some weeks prior to the homicide, and his deafness would certainly have impaired his communications with those at Carla Thompson's flat who saw him regularly during this time. However, from those interviewed by the Inquiry, a very consistent picture emerges of Daniel remaining calm and amiable until very shortly before the homicide, with the exception of an episode of anger towards his brother four days before the homicide. Daniel most likely understood that his brother had come to Carla Thompson's flat to persuade him to return to hospital, and under these circumstances, it is perhaps not surprising that he showed anger. Apart from this incident, several people who saw him in the days before the homicide found no cause for concern in his behaviour. His girlfriend, Kirsty, was apparently happy to go with him to an unfamiliar flat. He had also been allowed to help with some decorating. During this time, nobody in contact with him was able to communicate effectively with him, and it remains possible that had someone been able to do so, evidence might have been elicited of delusions or other mental state abnormalities indicative of psychosis. In schizophrenia, prominent delusions and/or hallucinations can occur in the absence of other mental state abnormalities. However, as noted above, there is little evidence from the rest of his psychiatric history to support schizophrenia as his diagnosis, apart from the episode noted above while he was at Broadmoor. On the other hand, if he were becoming manic, his presentation at this time would be highly atypical. If, in the context of a manic episode, he had delusions and/or hallucinations, one would also have expected more florid behavioural signs of mania, such as overactivity and excessive risk-taking. Such signs are usually evident even to untrained lay people, but those who were with Daniel in the days prior to the homicide reported no such behaviours. Nevertheless, it is important to acknowledge that there is no satisfactory substitute for a thorough mental state examination, which in Daniel's case would have needed a sign language interpreter skilled at working with people with mental illness who are deaf, and preferably also a psychiatrist with the similar skills and experience.

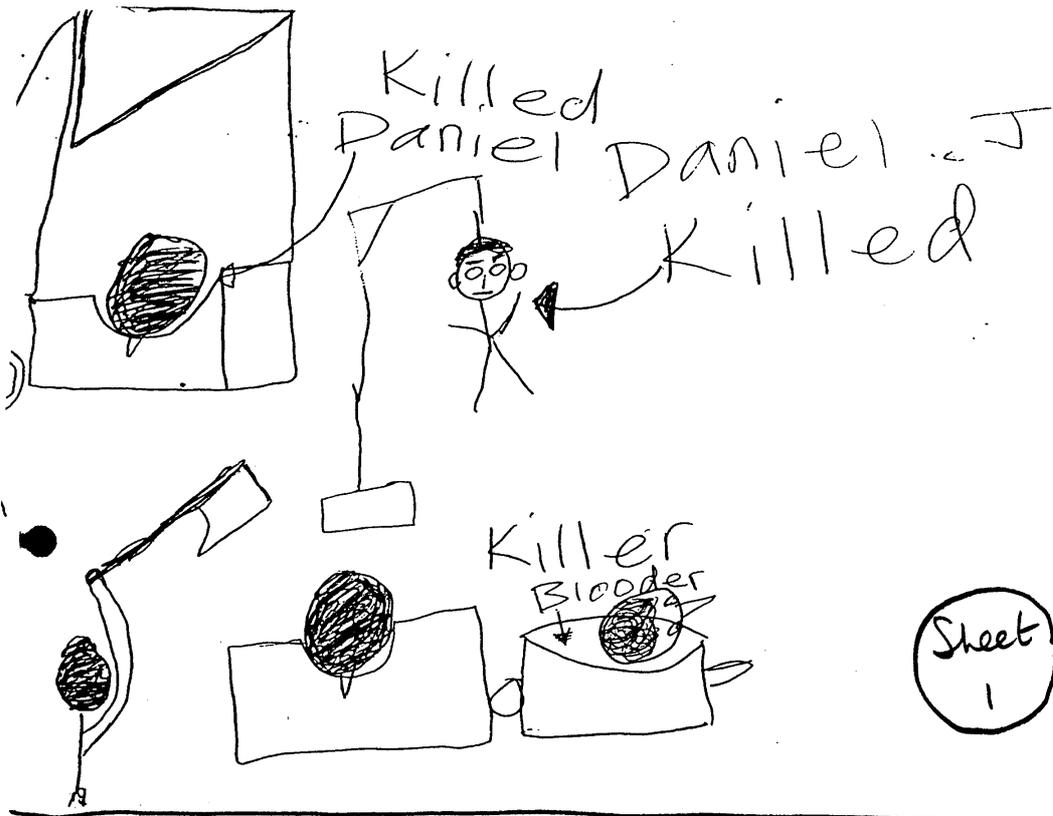
On this basis, even if further psychiatric assessments had been done following the home visit in December 1997, it is questionable that the Mental Health Act could have been used to bring Daniel back to hospital. It was suspected that his mental state was deteriorating during the time he was staying at Carla Thompson's home. However, it is not clear, from what we learned from those who had been with him shortly before Carla Thompson's death, that a mental health assessment could have determined that, according to the Mental Health Act, Daniel was suffering from a mental disorder *of a nature or degree which warrants [his] detention in hospital*. Clinicians vary in their threshold for determining that patients fulfil this criterion, and Dr Kitson made it clear that his threshold would be relatively low. Dr Kitson said that, on the basis of the

Appendix 2 Psychiatric presentation

information in Dr Edgar's letter following the assessment in December 1997, he (Dr Kitson) would have determined that Daniel was detainable on Section. However, regardless of whether the Mental Health Act could be applied, it is unclear whether it needed to be. There is evidence that Daniel could in the past be persuaded by those who knew him to adhere to management plans (for example, when he was first admitted to Southwestern Hospital in 1996, he agreed to voluntary admission despite being disturbed; he was dissuaded from taking his discharge from St Thomas' Hospital; and he remained an inpatient at Old Church for much longer than his mental state required. It remains possible that, had he been seen at Carla Thompson's by someone he knew, like Selma Daley his community nurse, or Dr Kitson, he might have been persuaded to return to hospital voluntarily, or to move to more suitable accommodation.

From the accounts of those who were with Daniel prior to the homicide, it appears likely that, as late as the evening before this event, he showed little if any disturbance. On that evening, he and Kirsty were together in a flat in Streatham, and they apparently had an argument, as a result of which Kirsty left the flat, leaving Daniel alone for some hours. What happened during this time remains unclear. However, what we have learned indicates that this period was crucial in determining Daniel's actions the next morning.

Daniel has been reluctant to describe his experiences and feelings at the time of the assaults on Carla Thompson and Agnes Erume. He has been asked about these on several occasions, but details remain sketchy and inconsistent. However, it is very likely that he was psychotic at this time, particularly given that he was floridly psychotic some hours later when assessed at Brixton Police Station. As described by witnesses, his behaviour during the assaults appeared bizarre. However, in retrospect, it is also striking that much of this behaviour appeared to mimic that seen during television wrestling, and it is unclear how well, if at all, Daniel appreciated the extent to which television wrestling is staged and choreographed.



TEL 999 Police

Want Killed Daniel

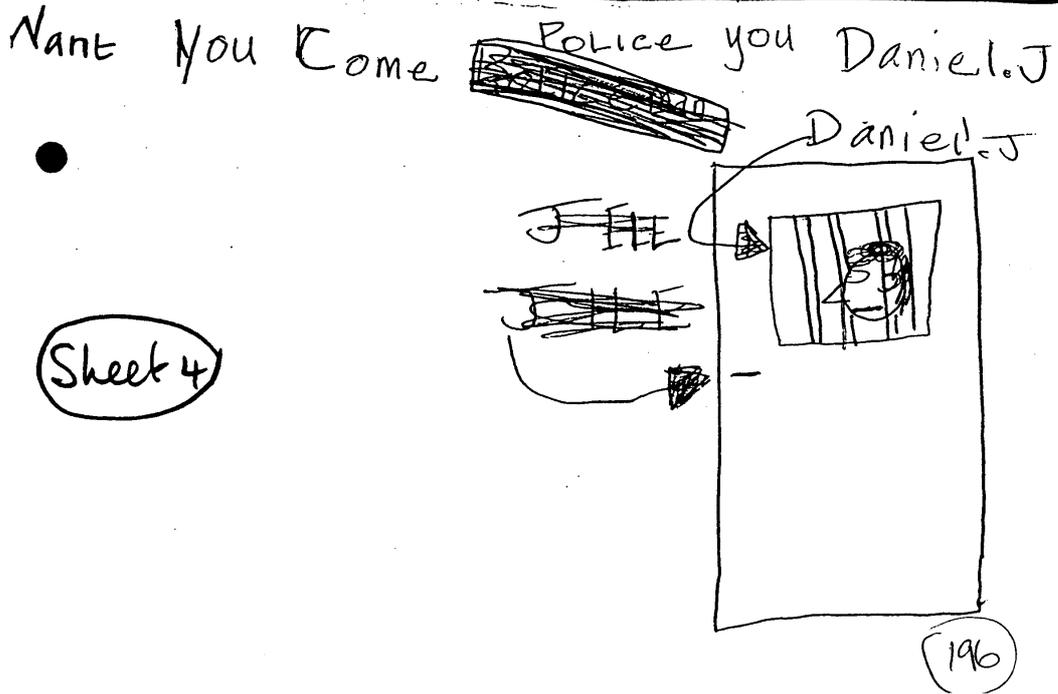
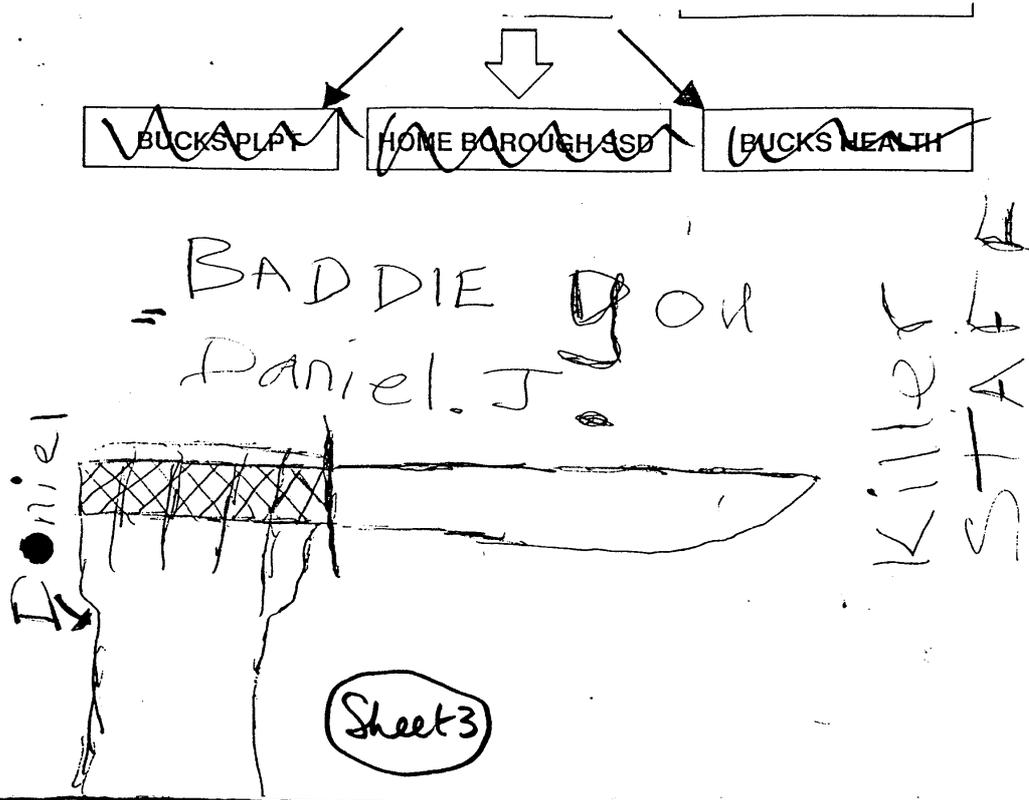


(NB)

Daniel asked for paper and drew these pictures. He did not want to discuss th with me.

ofones
24/11/9

(Sheet)



Monday School and ~~School~~
 Tuesday School
 Wednesday School
 Thursday School
 Friday ~~School~~ home
 Saturday ~~School~~ home
 Sunday School home 5.00
 Back School

Sheet 5

home

Sheet 6

AGE 16 Daniel J

AGE 14 Daniel J

School
Worked

Photocopy
24/11/93

C Jones

Daniel wrote the week out and added school - home as indicated. He made it clear to me that he wanted to stay until Friday and

197

School playground wrestlers warned: this is dangerous

by Richard Reeves
Society Editor

THEY sound like names from Bible study or geography lessons. But Kane, China and Jericho are the latest threat to Britain's schoolchildren.

The heroes and heroines of US-style professional wrestling, they make a living pretending to hurt each other on primetime TV. Now their moves are being copied in playgrounds across the country.

'We have had one child off school for days with a hurt neck and a series of other injuries,' said the headteacher at one London junior school. 'It is really very frightening. They are playing, but the moves involve things like dropping each other on the head, and slamming heads against the ground or a post.'

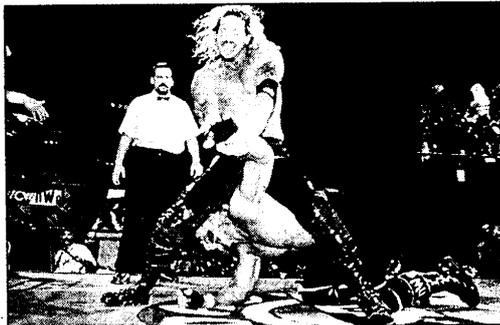
She has written to parents warning that any wrestling in the playground will result in immediate suspension. 'They have little matches with a referee, and know all the moves,' she said. 'It is only a matter of time before there is a serious injury.'

The dangers of schoolchildren mimicking such moves as 'bronco-busters' and 'choke slams' have prompted the National Union of Teachers to ask for national guidelines from the Government's working party on school security.

'There is a danger that children will permanently damage each other trying armlocks or banging heads,' said the union's John Bangs. 'Parents need to be made aware that these programmes are not harmless.'

A spokesman for the Department for Education said teachers had a responsibility to keep the children in their care safe. 'If children are at risk of being hurt, then it may be that disciplinary action is required,' he said. 'We support whatever action schools have to take to keep children safe.'

The wrestling fad has been



'They are playing, but the moves involve things like dropping each other on the head, and slamming heads against the ground or a post.'

Children copy US-style professional wrestling as seen on TV.

Photograph by Penny Johnstone

spread by computer games and a popular toy, set to be in the top 10 of Christmas best-sellers. The 'Bashin' Brawler' is a 2ft-tall doll modelled on American TV wrestling stars. Some stores are refusing to stock it, fearing it will encourage dangerous play. The doll screams when its head is hit against the floor — one of the 'moves' that most worries teachers.

Education experts warn that the 'stunt' violence in wrestling shows can mislead younger children. 'What is possible in a carefully choreographed bout on a canvas ring is not possible, for real, on a concrete playground,' said David Regis, from the University of Exeter's education and health unit.

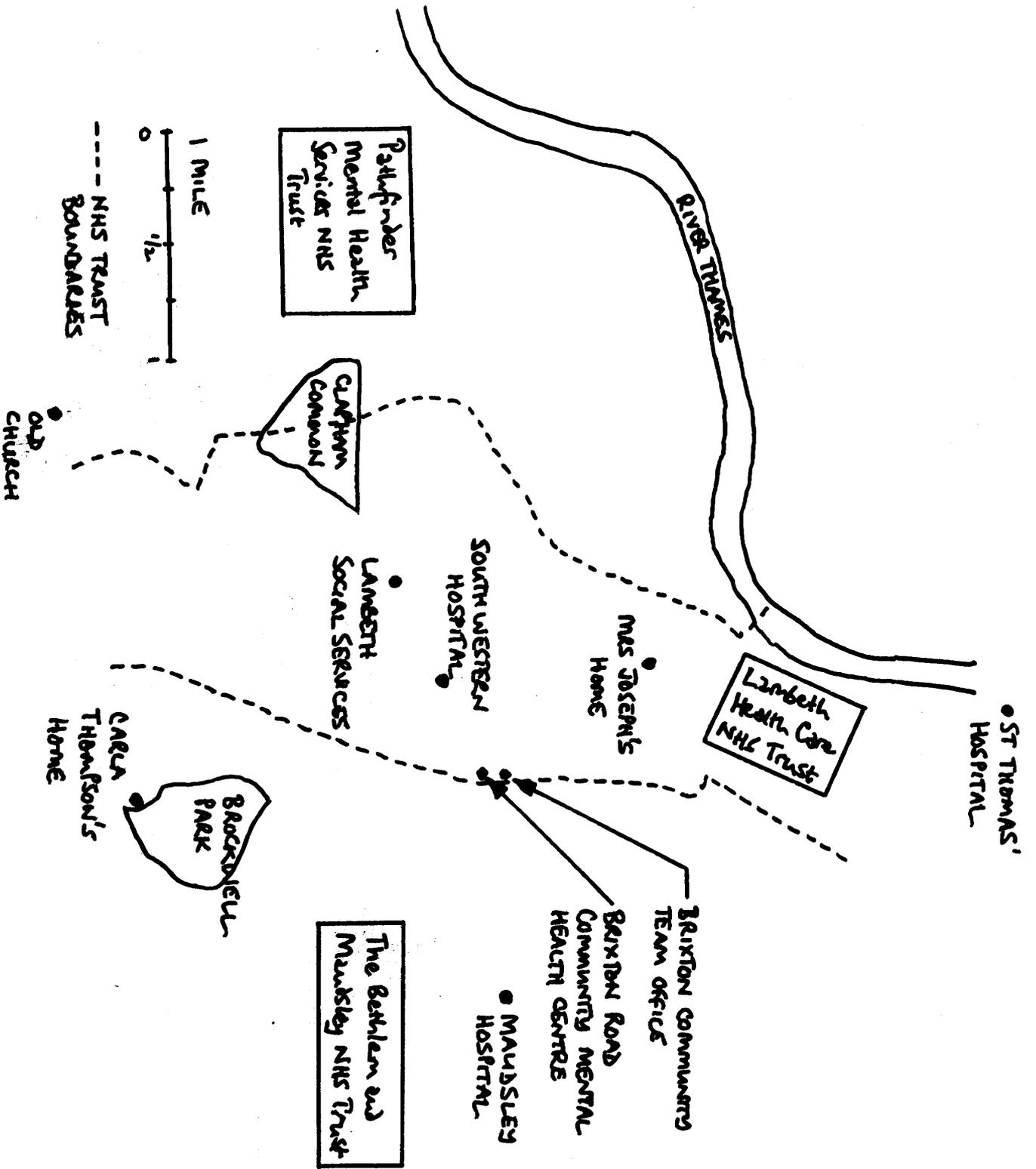
'Youngsters enjoy testing their strength against each other, but they have to know the consequences. The prob-

lem with this sort of programme is that children see violent moves, but no one getting hurt.'

The London headteacher agreed that young children often failed to understand that the bouts were acting designed to please an adult audience. 'We have to try and explain to the children that what they see on the TV is not real, and that to do the same moves on their friends could really hurt. We've had bad bruises, scrapes and serious nosebleeds.'

Regis said there was a clear distinction between pro wrestling and judo or karate lessons. 'The first skills you learn in martial arts are to fall properly and safely, and to use strength with caution. The whole attraction of American wrestling is that the participants don't really get hurt — that would spoil the fun.'

Appendix 5 Catchment areas: Map



APPENDIX 6 Leaflet on Community Health Teams and Rapid Assessment Team in Lambeth

SOUTH WEST SECTOR

Title	Lewin Road Community Mental Health Centre
Address	55-57 Lewin Road, Streatham, London SW16 6JZ
Telephone	020 8243 2600 (ansaphone outside working hours) 01816646406
Fax	020 8243 2642
Location	Lewin Road, Streatham
Description	Two adjoining semi-detached buildings on three floors, situated in a quiet residential road. There are pleasant gardens at the rear of the building. Well appointed space available for group and individual therapeutic work.
Hours	See Services
Contact	Ken Wong 020 8243 2600
Emergency	Crisis Service available between 9.30am and 4.30pm. Contact your G.P. or Emergency Services at St.Thomas' Hospital outside these hours.
Referral	Referrals accepted from any professional/agency associated with the client, or self referrals.
Suitable	For people between the ages of 16 and 65 who require assessment or treatment or information on mental health.
Unsuitable	For people with Primary Drug or Alcohol problems.
Language	Mainly English - Interpreting Service available.

LEWIN ROAD - SOUTH WEST SECTOR

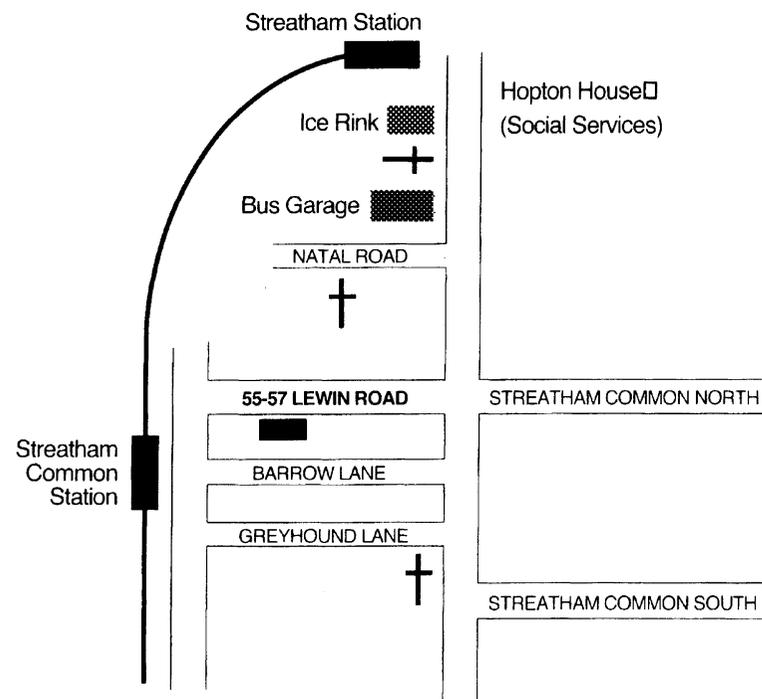
Community Mental Health Centre
55-57 Lewin Road, Streatham Common

Southern Sector Consultants:

Dr. K. Gupta
Dr. A. Boocock

Buses 109
159
118
249

Stations Streatham
Streatham Common



APPENDIX 6 Leaflet on Community Health Teams and Rapid Assessment Team in Lambeth

ACCESS ARRANGEMENTS

The Trust's mental health services are sectorised, north, central and south, and are based on the catchment area of Consultant Psychiatrists. The community and hospital based services to be accessed are determined by the address of the person to be referred.

Non-Emergency Referrals

1. Referrals of persons living in the southern sector may be made to:

Lewin Road Community Mental Health Centre
55-57 Lewin Road
Streatham SW16 6JZ
Tel: 020 8243 2600
Fax: 020 8243 2642
(referral forms available on request)

2. Referrals of persons living in the northern and central sector may be made to:

Brixton Road Community Mental Health Centre
332 Brixton Road
London SW9 7AA
Tel: 020 7411 2900
Fax: 020 7411 2901

SERVICES NOW ON OFFER INCLUDE:

BRIXTON ROAD AND LEWIN ROAD

Case Management Team

One psychiatrist, a team leader and a team of case managers offering assertive outreach, follow up and ongoing support to clients who experience severe/enduring mental health needs. This team offers intensive support for people who would have previously been lost to follow up.

The teams also offer groups such as Depot Groups, Alliance Groups, and Carer Support.

Hours of working:
Monday Wednesday and Friday 08.00-20.00.
Tuesday and Thursday 09.00-17.00
Saturday 0900-17.00

Out-of hours Helpline

An out-of-hours, 7-day-a-week telephone helpline is available for clients and carers as part of the care plan for case management clients.

APPENDIX 6 Leaflet on Community Health Teams and Rapid Assessment Team in Lambeth

BRIXTON ROAD AND LEWIN ROAD

Assessment & Treatment Team

A multi professional team that assesses everyone referred for mental health care. Assessments are carried out on either an urgent or routine basis, dependent on the client's needs. It offers focused interventions to clients with a multitude of presenting problems. This team has access to Cognitive Analytical Therapy, Behavioural Therapy Psychotherapy, and the Child and Family Psychiatry Team as well as offering groups such as anxiety management, daily living skills, a range of family interventions, art therapy and brief counselling etc. Members of this team are also available for joint assessments and advice on the management of clients to other health professionals as well as carers.

Core hours 9.00-17.00

Crisis and Rapid Assessment Team

Two members of the team with a psychiatrist are available daily to respond to any request for rapid assessment and intervention. The attachment of a community consultant speeds up the admission process if appropriate.

Hours 9.30-16.00 Monday to Friday

Alliance/Compliance Groups

Three, weekly ongoing groups, facilitated by a doctor and a nurse, providing a treatment option to the Lewin Road Service, and targeting those with serious and enduring

mental health problems who can benefit from receiving their care within a group framework. Referrals from within the Community Mental Health and Hospital teams. The focus of treatment is on compliance issues, solving of side effect dilemmas, education about illness and its treatment, and management of residual symptoms. It enables a week-to-week monitoring of mental state, supervision of medication and administration of depots.

Voluntary Services Department

We provide a community-based volunteer service for people with mental health difficulties who live independently or in group homes or hostels. Volunteers come from wide ranging backgrounds and serve to complement and supplement the role of the mental health worker. Our services include befriending schemes, organising social activities and offering practical help and support.

For more information contact:
Judy Clark, Voluntary Services Co-ordinator
Tel: 020 7411 2948 Monday to Friday 9.00-5.00

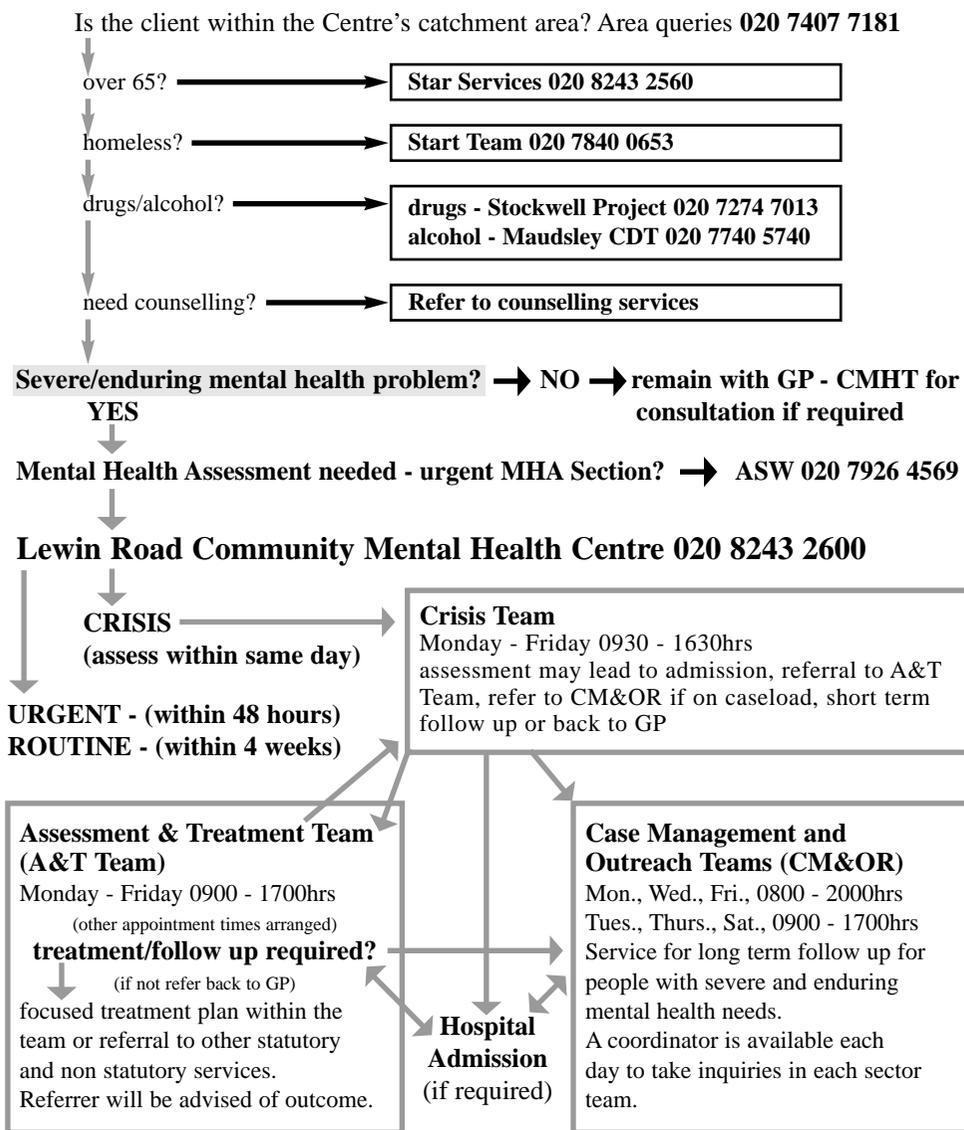
Asian Mental Health Service (Amardeep)

One nurse with knowledge of Asian language and culture, assessing members of the Asian community who are reluctant to use the existing Mental Health Services.

Hours 09.00-17.00 Monday to Friday
based at Effra Day Centre
Tel: 020 7926 1043

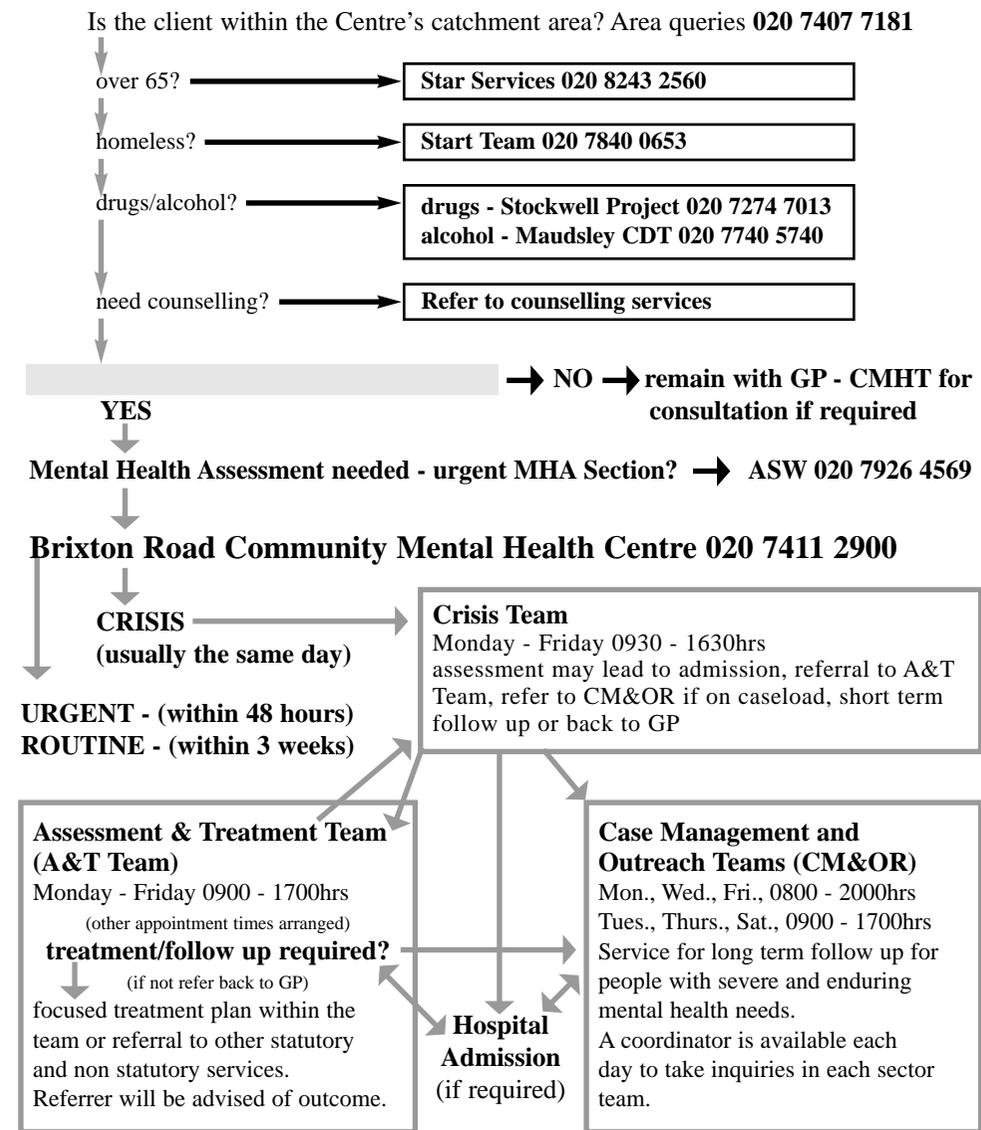
APPENDIX 6 Leaflet on Community Health Teams and Rapid Assessment Team in Lambeth

GP Referral To Lewin Road Community Mental Health Centre



Consultants:	Dr Anne Boocock Dr Kamal Gupta
Team Leaders:-	
Assessment and Treatment Team:	Chris Hart
Case Management & Outreach Team:	Godfried Attafua

GP Referral To Brixton Road Community Mental Health Centre



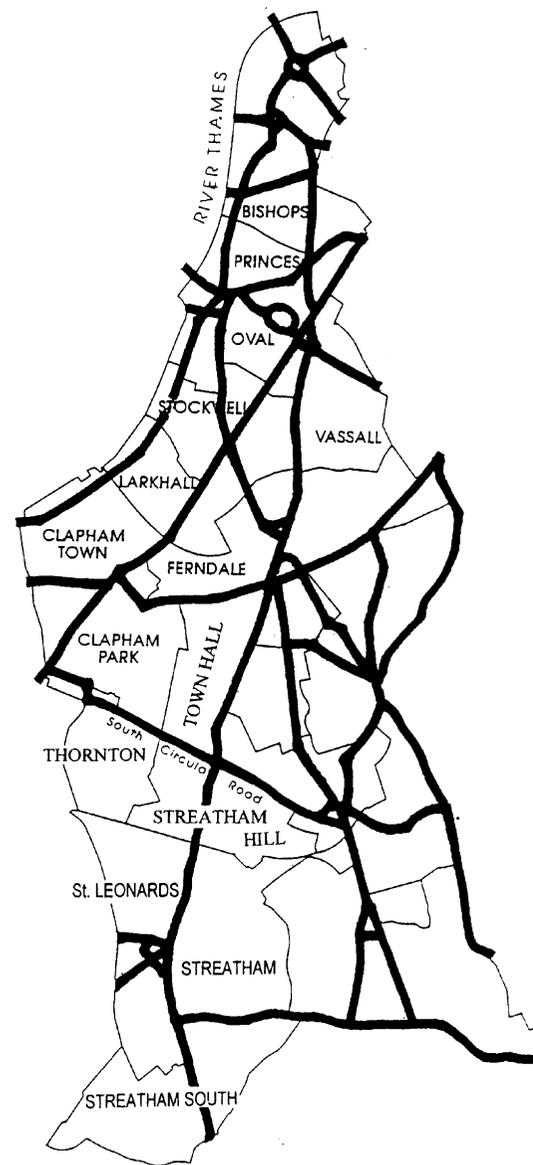
Sector	Consultant	Team Leaders
Northern	Dr Teif Davies Dr Ros Ramsay	Jessie Thailan (CM&OR)
Central	Dr Nadia Davies	Neil Atkinson (CM&OR)
A&T Team	Dr T. Davies-North Dr N. Davies-Central	Carolyn Nield

The Ward Catchment Area will be reviewed in 2000-2001

Northern Sector	<u>Brixton Road</u>
Electoral Wards:-	<ul style="list-style-type: none"> Bishops Princes Oval Stockwell Vassall
Consultants: Dr T Davies and Dr R Ramsey	

Central Sector	<u>Brixton Road</u>
Electoral Wards:-	<ul style="list-style-type: none"> Larkhall Clapham Town Ferndale Clapham Park
Consultants: Dr N Davies	

Southern Sector	<u>Lewin Road</u>
Electoral Wards:-	<ul style="list-style-type: none"> Streatham Wells St Leonards Streatham South
Consultants: Dr Gupta	
Electoral Wards:-	<ul style="list-style-type: none"> Town Hall Thornton Streatham Hill
Consultants: Dr A Boocock	



APPENDIX 6 Leaflet on Community Health Teams and Rapid Assessment Team in Lambeth

CENTRAL SECTOR AND NORTHERN SECTOR

Title	Brixton Road Community Mental Health Centre
Address	332-334 Brixton Road, SW9 7AA
Telephone	020 7411 2900
Fax	020 7411 2901
Location	Brixton
Description	Large pleasant building on five floors. Small garden area at the back of the building. Well appointed space available for group and individual therapeutic work.
Hours	See Services
Contact	Sue Lewis 020 7411 2900
Emergency	Crisis Service Monday - Friday 09.00-16.00 Contact Emergency Services at St.Thomas Hospital or your GP outside of these hours.
Referral	Referrals accepted from any professional/agency associated with the client.
Suitable	For people between the ages of 16 and 65 who require assessment or treatment or information on mental health.
Unsuitable	For people with Primary Drug or Alcohol problems.
Language	Mainly English - Interpreting Service available.

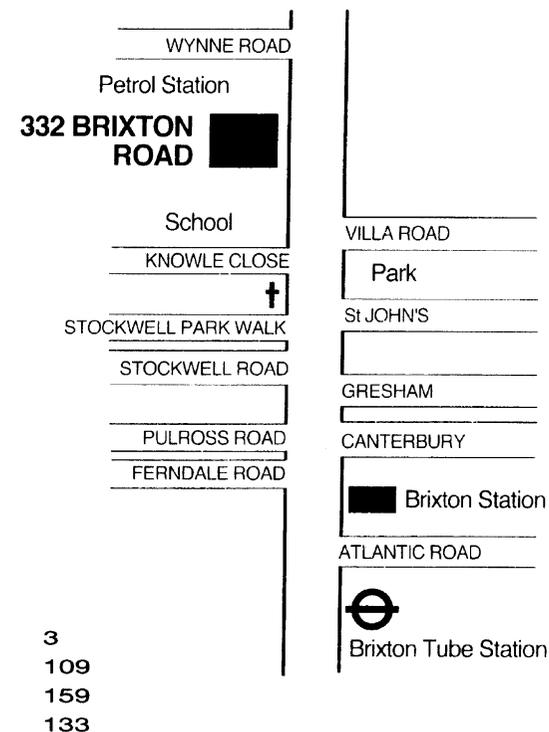
BRIXTON ROAD - CENTRAL AND NORTHERN SECTOR

Community Mental Health Centre 332 Brixton Road, SW9 7AA

Central and Northern Sector Community Consultants

Central Dr N Davies

Northern Dr T Davies
Dr R Ramsey



Buses 3
109
159
133

Tube Station Brixton

Rail Station Brixton

APPENDIX 6 Leaflet on Community Health Teams and Rapid Assessment Team in Lambeth

DO YOU WISH TO COMPLAIN?

You have the right to use our service, and the right to expect the highest standard of service to be given to you. You may wish to make your concerns known to the Facility Manager details below. Should you wish to complain about the service please do so to the following:

The Chief Executive

Mr Stuart Bell
South London and Maudsley NHS Trust
Reay House
108 Landor Road
Stockwell SW9 9NT

or

The Complaints Manager

Quality Department
South London and Maudsley NHS Trust
Reay House
108 Landor Road
Stockwell SW9 9NT

*The Manager for Brixton Road is Sue Lewis
who can be contacted on 020 7411 2900*

*The Manager for Lewin Road is Ken Wong
who can be contacted on 020 8243 2600*

The Community Health Council is an independent body set up to monitor local health services. The CHC Staff can provide you with advice and support in making your complaint if you wish. They can be found at:

Lambeth Community Health Council
2, Cleaver Street
Kennington SE11 4DP
Telephone 020 7582 3238

PHILOSOPHY

The multi professional teams are committed to maximising the quality of life of individuals in the community experiencing mental health problems.

Our intention is to offer care of the highest quality enabling and empowering clients and their carers to identify needs and work towards negotiated goals together

Individuals are treated as such, dignity and respect is inherent in every aspect of our work.

The staff are sensitive to the differing needs of the local population, and we try to ensure that no individual feels excluded from the service on the grounds of gender, race, culture or sexual orientation.

We welcome feedback and involvement in our service evaluation from users, carers, local G.P.'s, and other referrers and organisations.

1. The Service for Deaf People in London at the time of the homicide

1.1 Adult Services

The National Deaf Services (NDS), together with similar services in Manchester and Birmingham, provide the only three mental health services for deaf people in the UK. There is some minimal Deaf specialist provision within Rampton High Secure Hospital

The NDS offers assessment and management of psychiatric, behavioural, emotional, communication and social problems that effect the mental health of deaf people, ranging in severity from those who require counselling to those who are seriously mentally ill, requiring inpatient care under compulsion, including those transferred direct from high secure hospitals.

The Adult Service provides 18 beds, and up to 18 day places, for acute mental illness, rehabilitation, the treatment of challenging behaviour, or psychotherapy. It has 60 places in its associated rehabilitation community homes network, together with a further 20 day care places contracted out to a “Clubhouse” managed by Sign, a charitable organisation, and a variable number of work experience and other day care facilities provided by other agencies.

The Adult Service also provides domiciliary and outpatient services across the whole of the south of England, a family therapy clinic, in conjunction with the NDS’s Deaf Child and Family Service, and consultation to other non-NHS providers of services for deaf people. In order to meet the demands of the national catchment area, the Adult Service currently holds regular clinics in the following venues;

- King’s Cross – to serve North East London
- Exeter
- Newton Abbott
- Bristol
- Bath
- Canterbury

Further clinics are held in response to intermittent demand at:

- Poole Social Service Department in Dorset
- Swindon
- Suffolk

The NDS, in comparison to the other two Deaf services, also has the largest established network of associated supported accommodation in the community. These are managed by voluntary sector organisations. As a result of its pioneering work in supported community housing and community psychiatry for deaf people, and the density of the population base in London, the NDS has a significant ongoing caseload of deaf people with severe and enduring mental illness.

To aid access, referrals are accepted from any source, though subject to GP or consultant confirmation.

At the present time the NDS is neither commissioned nor resourced to provide emergency or assertive outreach services.

There is special expertise within the NDS in rehabilitation, family therapy, group and individual analytic psychotherapy, cognitive behavioural therapy, child and adolescent psychiatry, learning disability and autism. The expertise in the other specialities, for example, services for older people, forensic psychiatry and addictions, are provided through the staff's generic psychiatric skills. Where necessary staff draw on experts within the Trust's services for hearing people.

In order to ensure that services are delivered by staff who can communicate fluently in sign language and who understand the complexities of "deaf culture", the NDS pioneered the systematic recruitment of staff who are themselves deaf sign-language users. Deaf staff currently comprise over one third of directly employed staff, and one half of all staff employed in the network. This policy has now been followed by other deaf services in the UK and is slowly being accepted across the European Union.

Although the NDS is the only NHS service in the south of England with the required expertise to respond to the needs of this specific client population, it is not resourced to replace the role of existing secondary services.

1.2 Child and Adolescent Services

The Deaf Child and Family Service is the only such service nationally and as such has a truly national catchment area, although referrals are predominantly from the south of England. Children and adolescents were seen by the Adult team until this service was formally established through Supra-Regional funding in 1991. The Deaf Child and Family Service could not yet be described as comprehensive and requires further development.

Regular consultation is provided by the Deaf Child and Family services to:-

- The Royal School for the Deaf, Margate
- The Royal School for the Deaf, Exeter
- Oak Lodge School, Wandsworth

- Elmfield School, Bristol
- Hamilton Lodge School, Brighton
- Outreach clinics at the Nuffield Centre and Basildon Essex

The Deaf Child and Family Service also now has an outreach team forming the core of an inpatient unit under development, funded by Department of Health NSCAG revenue, due to open in January 2001, and is also leading a bid to develop a national Deaf Child and Adolescent Mental Health Outpatient Service, with other provider partners systematically chosen from NHS Regions in key urban centres across England.

2. Funding arrangements and service development

2.1 The early development and funding of the NDS

The service was formally established in 1978, through funding directly from the Department of Health. It was originally a “Regional” service, though this was always a misnomer. It went on to receive “interim” Supra Regional designation and funding in 1987.

Following its de-designation as a Supra Regional Speciality in 1994, the NDS was commissioned through a mixed economy of a Consortium comprising of the former South Thames Health Authorities. This accounted for approximately 50% of activity and income. The remaining 50% of the required income was generated through Extra Contractual Referrals (ECR). Exposure to the unpredictability of the Internal Market placed a considerable burden upon the NDS in the form of a demand to increase activity levels and decrease costs to meet its financial targets. This led to the need to aim for 100% occupancy of beds. This resulted in the two beds, previously designated to provide emergency admission from the community housing network, being filled with ECR patients. The NDS was also actively promoted across England to ensure that activity levels were sustained. This resulted in a reduction through increased caseload of domiciliary visits, at one time performed in 50% of first assessments.

Dr Kitson was the sole consultant within NDS from 1984, and the sole consultant in the adult service from 1991 until the appointment of a consultant colleague in June 1999. Additionally he was the service leader as the Clinical Director. He had consultant responsibility for approximately 250 patients at the time of Daniel Joseph’s care in NDS. Of those 250, 18 were inpatients and the others were roughly equally divided between:

Community Housed patients: of whom 75% had schizophrenia and all had severe and enduring mental disorders;

Other Community Team patients: most of whom had severe and enduring mental disorders;

Referral Team patients; whose disorders and severity varied from severe and enduring, to minor, who, if they had been hearing, would have been treated in primary care or non NHS counselling services.

Dr Kitson was supported by a four day per week Associate Specialist Psychiatrist with good signing skills and a full time staff grade psychiatrist with developing signing skills. There was a variable number of trainee psychiatrists, however these would not be attached to the NDS long enough to gain sign language skills.

The service was necessarily heavily dependent on the team of four Community Psychiatric Nurses (CPN). These were the only other group of community staff with significant psychiatric training and who had stayed in the service long enough to gain significant signing skills.

2.2 Service Development

Since its de-designation as a Supra Regional Speciality Service development has only been possible through the mechanism of ECR income generation. Through the annual business planning cycle the service has consistently identified within its longer term aims the need for national, strategic development in, for example, Deaf Assertive Outreach, Forensic, and Addiction Services. However, service demand for such a small population is unpredictable and highly volatile. The insecurity associated with heavy reliance upon ECR income has not provided the service with the stability required to support investment for any meaningful developments.

The South Thames Consortium did support a minor increase in its contribution in 1997 of approximately 4% in recognition of the increased South Thames caseload of the Deaf Child and Family Service. However, some Health Authorities in the Consortium received, pro-rata, more activity from the NDS than others. Those with a geographical proximity to the NDS seemed to be getting a greater contribution for the resources which placed strains upon the Consortium arrangement. The paradox for the Consortium was the need to provide an effective and coherent strategic lead whilst, at the same time, attempting to support the interests of its constituent members. As a consequence, service developments were therefore necessarily led by the NDS with emphasis on the more immediate term. As a consequence, developments were targeted at maintaining the referral base and financial viability of the core service.

2.3 Service Legal Agreements

Since 1999/2000, ECR income has been replaced by Service Level Agreements, but this had not as yet provided any greater stability, with activity levels being highly variable and often sparsely spread across a wide geographical area. Neither has it provided any opportunity for the development of the service.

2.4 Future commissioning arrangements

South West London and St George's Mental Health NHS Trust has been active in pursuing discussions with the London Region with a view to establishing the NDS as a regionally commissioned speciality. The Trust hopes to see the service

commissioned through a consortia of Regions covering the Eastern, South Eastern and South West as well as the London Region. Commissioning at this supra regional level appears to be the only approach which can ensure that service development can move away from the reactive and opportunistic nature of either ECRs or multiple SLAs towards a longer term strategic focus.

3. Why specialist mental health services for deaf people are required

3.1 Mental health and deafness – the knowledge base

There is little scientifically rigorous current knowledge on mental health and deafness. What there is has been provided from staff of the three specialist units, including the NDS (cf. Hindley et al, also Checinski), in their own private or clinical time. This adds further to the burden upon them. The major body of evidence is poor and relies on clinical populations researched in the 1960s and 1970s in US, Scandinavia and the UK. There have from time to time been academic units in the US, but none in Europe. Neither purchasers nor providers have a significant evidence base on which to rely. The assessment of need required to inform health improvement plans currently has to rely on the extrapolations from the demand for current services. The demand in a largely hidden and 'silent' dispersed population, whose first language is not English, is inevitably heavily biased to the services that are already known to be provided, rather than giving a true indication of need.

3.2 Prevalence

The deaf population who need to use manual communication is approximately 1/1000 of the general population. Deaf people have particular cultural characteristics, varied and often complex communication modes, a significant prevalence of multiple disability, of between 25% to 30%, including organic brain damage. Mental illness can, therefore, present in characteristically different ways.

There is no clear evidence of a different incidence or prevalence of any of the major mental illnesses among deaf people compared to the general population. However, there is clear evidence of a greater prevalence of behavioural and emotional disorders with the onset usually occurring in childhood and adolescence (cf. ICD 10 F90-98) and their counterparts in adult life of the order of 1.5 to 5 times that in general populations. (*Refs: Hindley P, Hill P, McGuigan S & Kitson N (1994) "Psychiatric disorder in deaf and hearing impaired children & young people: a prevalence study" J Child Psychol, Psychiat. 55.5 917-934; Checinski K (1991) Preliminary findings of the study of the prevalence of psychiatric disorder in prelingually deaf adults living in the community. Proceedings, Mental Health & Deafness conference, St George's Hospital Medical School.*)

3.3 Communication needs

Sign Language interpreters are an evident solution. However many deaf people feel inhibited in their presence. The use of sign language interpreters for mental

state assessment or the psychotherapies, both of which rely heavily on the emotional levels of communication observed by direct human reactive intercommunication, is not ideal. The effectiveness of interpreters is also limited by communication disorders, including the thought disorders of the psychoses.

The HAS report: *“Forging New Channels”*, published in 1998, stated that deaf mental health service users expressed the view *“...that deaf people most value being able to communicate in their preferred language with someone who is also aware of the cultural differences that exist between those who are deaf and those who can hear”*, also, *“...they also valued the opportunity to learn social skills. They considered this would not have been possible in a general mental health service”*.

3.4 Access

The deaf community is not predominantly localised in specific districts unlike many other minority cultures. Because of the dispersed population, it is not possible for health Regions, let alone Districts, to achieve the critical mass to viably support and maintain the expertise required. This is even more difficult for less urban regions. There is therefore a need for centralised yet for many geographically distant, expert services, such as the NDS, to work collaboratively with generic secondary services to ensure that deaf people have adequate access to the required range of services.

The speciality of mental health services for deaf people is not about providing a specialist service to the general population, so much as a wide general service to a special population. That population has severely limited access to health services of all types and levels.

Psychiatrists and other mental health professionals for deaf people therefore have to cover a wide spectrum of mental health expertise: from forensic psychiatry to learning disability; from infancy to old age and from primary to tertiary care, so are not just limited to general adult psychiatry.

Appendix 8 List of Witnesses

1. Daniel Joseph
2. Agnes Erume, surviving victim
3. Claudette Joseph, Daniel's Mother
4. Matthew Gillett, Daniel's 'Stepfather'
5. Clara Varga, Mother of a young man who used to frequent Carla Thompson's flat
6. Jim Kiltie, family friend of Joseph family
7. Alison Stacey, Teacher from Penn School
8. Jenny Freeman, Teacher from Penn School
9. Dr Angela Skuce, Daniel's former GP
10. Dr Nick Kitson, Consultant Psychiatrist, National Deaf Service (NDS)
11. Dr Peter Hindley, Consultant Child & Adolescent Psychiatrist, NDS
12. Dr Louise Hamblin, Associate Specialist, NDS
13. Selma Daley, Community Psychiatric Nurse (CPN), NDS
14. Jane (Finn)Wiltshire, CPN, NDS
15. Valerie Leach, Social Worker, NDS
16. Toby Robinson, Social Work Team Manager, NDS
17. Ruth Woolhouse, Psychiatric Staff Nurse, NDS
18. Grant Payne, Care Assistant/Relay Interpreter, NDS
19. Dr Teifion Davies, Honorary Consultant Psychiatrist, Senior Lecturer in Psychiatry, Guy's, King's and St Thomas' School of Medicine
20. Dr Nadia Davies, Consultant Psychiatrist, Lambeth Healthcare NHS Trust*
21. Dr Simon Edgar, Specialist Registrar (SpR), Lambeth Healthcare NHS Trust*
22. Dr Tony Wong, Staff Grade Psychiatrist, Lambeth Healthcare NHS Trust*
23. Dr Claire Bonner, Senior House Officer (GP Vocational Training Scheme)
24. Jenny Park, Social Worker Lambeth Social Services Sensory Impairment Team

Appendix 8 List of Witnesses

25. Julia Hookway, Social Worker Lambeth Social Services Sensory Impairment Team
26. Alex Cranwell, Social Worker Lambeth Social Services Sensory Impairment Team
27. Jim Heron, Team Manager, Lambeth Social Services Sensory Impairment Team
28. Jenny Towland, Sign Language Interpreter, Lambeth Social Services
29. Lorraine Roof-Spence, Approved Social Worker, Lambeth Social Services
30. Tricia Wright, Approved Social Worker, Lambeth Social Services
31. Claire Squire, Team Leader Brixton Community Team, Bethlem & Maudsley NHS Trust*
32. Mohammed Hussenbocus, CPN, Brixton Community Team, Bethlem & Maudsley NHS Trust*
33. Terry Stanley, Deaf Services Manager, Harding Housing Association
34. Riet Saward, Assistant Care Home Manager, Harding Housing Association
35. DCI Sue Hill, Metropolitan Police
36. DS Theresa Defanis, Families Liaison Officer, Metropolitan Police
37. Chris Butler, Director of Nursing and Operations, Pathfinder Mental Health Services NHS Trust (now Chief Nurse and Deputy Chief Executive, South West London & St George's Mental Health NHS Trust)
38. Dr David Roy, Medical Director, Lambeth Healthcare NHS Trust (now Joint Medical Director, South London & Maudsley NHS Trust)
39. Dr George Szmukler, Medical Director, Bethlem & Maudsley NHS Trust (now Joint Medical Director, South London & Maudsley NHS Trust)
40. Steve Cody, Assistant Director, Lambeth Social Services

* On 1st April 1999 Lambeth Healthcare NHS Trust, Bethlem & Maudsley NHS Trust and Lewisham & Guys NHS Trust merged to form the South London & Maudsley NHS Trust