

**REPORT OF THE
INDEPENDENT
INQUIRY TEAM INTO
THE CARE AND
TREATMENT OF DN**

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Terms of Reference

Independent Inquiry into the Care and Treatment of DN Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of DN, and in particular:
 - 1.1. The quality and scope of his health and social care and any assessment of risk.
 - 1.2. The appropriateness, quality and adequacy of any assessment, care plan, treatment or supervision provided, having regard to:
 - 1.2.1. His past history
 - 1.2.2. His psychiatric diagnosis
 - 1.2.3. The prominent role of primary care in his treatment and care
 - 1.2.4. His assessed health and social care needs
 - 1.2.5. His use of alcohol and illegal substances
 - 1.2.6. His history of violence to others and particularly to his family
 - 1.2.7. His relationship with another user of mental health services
 - 1.2.8. Any risk to the children of his partner
 - 1.2.9. The effectiveness of liaison working across primary care, secondary and specialist mental health services, and between mental health, criminal justice and Child and Family services.
 - 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:
 - 1.4.1. Were based on assessed risk and or reflected an element of risk
 - 1.4.2. Were effectively drawn up, carried out, communicated, monitored and reviewed
 - 1.4.3. Were complied with by DN.
2. To examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between and within the various agencies involved in the care of DN or in the provision of services to him, in particular whether all relevant information was effectively passed between the agencies involved and other relevant agencies, and whether such information as was communicated was acted upon adequately.
3. To examine the adequacy of the communication and collaboration between the statutory agencies and any family or informal carers of DN.
4. To prepare an independent report and make such recommendations as may be appropriate.

INTRODUCTION

Sometime between 22.30 on the night of Thursday 4th June and the early hours of Friday 5th June 1998, DN killed his paternal grandmother at her flat in Tower Hamlets. The homicide was brutal and there were sexual overtones. Her body was not found until Monday 8th June, despite the fact that DN had invited friends into her flat over the weekend, while her body was lying in the bedroom.

DN denied killing his grandmother, but was charged with her murder after considerable evidence, including forensic evidence, implicated him. He still continued to plead not guilty and only changed his plea to guilty of manslaughter on the grounds of diminished responsibility very late in the day before the trial in late March 1999. Psychiatric evidence was put forward to support this plea, which was accepted by the prosecution and the court.

However, because he had a previous conviction for GBH, DN came under the provisions of the 'two strikes and you're out' Crime (Sentences) Act 1997 which meant that he received an automatic life sentence, despite the conviction being for manslaughter rather than murder. The judge (upheld in the Court of Appeal) held that there were no exceptional circumstances which would allow him to deal with DN any differently. He was therefore sent to Belmarsh Prison, rather than to a secure hospital setting, where he remained until he was transferred to Rampton High Security Hospital under Sections 47 and 49 of the Mental Health Act 1983 (a Hospital Order with restrictions) in January 2000. The Inquiry team visited him at Rampton in May 2001 and spoke to him at length before they started interviewing any other witnesses.

DN first came under the care of psychiatric services in 1991 when he was 21 years old, when he was sent to a medium secure hospital under a Hospital Order following convictions for GBH, kidnapping and unlawful imprisonment of a child and possessing an offensive weapon. He had entered a guilty plea to the charges. The circumstances of the incident which led to the convictions were bizarre in that DN had attacked and injured a man with a knife at Liverpool Street Station and had removed a young boy who had been travelling with the man (who we understand was in fact the boy's uncle), on the basis that DN believed the child to be in danger of abuse from the man.

A few months earlier in 1991, DN had attacked and badly injured his older brother, and had also assaulted his uncle and his younger half-brother, but charges were either dropped or never brought in respect of these attacks.

In mid-October 1991, DN was admitted to Kneesworth House, an independent sector medium secure psychiatric hospital in Hertfordshire, because there was no NHS secure bed available in East London. He remained at Kneesworth until February 1992, when he was admitted to the interim secure unit at Hackney Hospital.

Despite spending some four months as an in-patient at Kneesworth and more than four months at Hackney, a clear diagnosis was never made, although the Discharge Summary from Kneesworth House suggested that DN was suffering from a mental illness; and in prison and at Hackney Hospital, he was treated with anti-psychotic medication which seemed to improve his mental state.

Towards the end of his time at Hackney, a differential diagnosis including ‘borderline personality disorder’ was suggested by the Senior Registrar in Forensic Psychiatry, and from then on DN appears to have been given the ‘label’ of personality disorder which may well have affected the way he was regarded. No other attempt was made at a formal diagnosis prior to the homicide. Matters were made more difficult owing to the fact that no final summary was ever prepared of his care and treatment while he was in Hackney Hospital.

A diagnosis was also made more difficult by virtue of the fact that DN was a habitual (mainly non-opiate) drug user. He had been introduced to cannabis as a child by his father who apparently was a drug smuggler and dealer, and he told us that he had taken cannabis regularly since his mid-teens. Prior to that he had sniffed solvents and butane gas and had tried LSD and had certainly used cannabis, but from his mid-teens, cannabis was taken on a regular if not daily basis, as well as other ‘harder’ drugs such as cocaine, amphetamines and ecstasy on a more occasional basis.

In a period of probably about five weeks before the index offence, he had spent most of a £9,000 inheritance from his father on drugs, this time mainly crack cocaine and cannabis. We remain unclear to what extent this concentrated and excessive drug use was a factor in the homicide.

What is notable about DN’s care and treatment is that from the time that he left the interim secure unit at Hackney in June 1992 (he actually absconded a couple of weeks before he was due to be discharged but while he was still under section) he was managed almost exclusively by his GPs and in fact was never again seen by a consultant psychiatrist – or in fact anyone more senior than an Senior House Officer (SHO) in her first six months in post – prior to killing his grandmother in June 1998.

His GPs were a husband and wife practice with a particular interest in mental health problems. There were several occasions over the five years that they looked after DN when they recognized that they might be out of their depth with him and sought the advice and help of the local psychiatric services, only to find that he was returned to their sole care fairly quickly. DN was, however, on the whole compliant with taking his medication throughout that five year period.

Given his past forensic and psychiatric history, it is perhaps surprising that his management and treatment was carried out entirely by the primary care services, with only the short-lived involvement of the local Community Mental Health Team (CMHT) to whom the GPs referred DN in 1994, 1996 and 1997. We are aware that his experience in Hackney Hospital in 1992 had not made DN receptive to any suggestion that he might need psychiatric help again, but we felt from the outset that we would have to examine closely the reasons for the lack of involvement of the psychiatric services after 1992.

In all we interviewed 43 witnesses. [A list of witnesses can be found at Appendix 2.]

The first was DN himself, whom we visited at Rampton High Security Hospital in the last week of May 2001 and talked to for about two and a half hours. There was initially a problem in obtaining his consent to the Inquiry Panel having access to his medical, prison and other records, but he eventually gave it to us on the condition that we did not identify him by his full name, as he wished to protect his wife and her

children (the youngest of whom was his, born some months after his arrest for his grandmother's homicide). Since the Inquiry could not be conducted properly without access to these records, and they could not be used without his consent, the Panel agreed to his request.

Very early on we talked to DN's mother and his brother, J. They gave us a much broader picture of DN's childhood and adolescence than we ever could have obtained from the records, and we are grateful to them for their assistance. We were struck by the fear that DN's mother has had of her son for many years, despite her obvious love for him, and were also very aware of J's deep and unrelenting anger at his brother.

Much later on we saw DN's wife, M, and we particularly commend her courage in meeting with us and discussing matters which were clearly deeply distressing to her.

We interviewed almost all of the professionals who had had any involvement with DN, and even asked to see some who had had no involvement whom we thought perhaps should have done. We talked to people in a supervisory capacity over those with some involvement, even though they themselves had no direct contact with DN. We saw some people who, since the killing, had come into a position which had previously been occupied by someone with some involvement with DN, in order to find out what if any changes had been made in the three years since the incident.

Some people who gave evidence to us had had no involvement whatsoever with DN. They contacted us and asked to give evidence about matters relating to the local mental health service which cause them concern and of which they wished the panel to be aware.

Mindful of how stressful an inquiry process can be, and aware that many of the witnesses we would be seeing had already been interviewed for the internal inquiry, we kept the interviews as informal as we could within a structured interview setting. Each interview was recorded and later transcribed and sent to the witness so that they were able to correct or amend the typed record before signing it and returning it to the panel to be used as an 'aide memoire'. We hoped that a more informal approach would encourage people to talk to us, rather than just answer questions from the panel, and on the whole we feel that we achieved this.

We are grateful for the openness with which most witnesses gave their evidence. We also appreciate the tolerance with which those who had already been put through the stress of the internal inquiry approached yet another stirring up of unwelcome recollections.

We are also conscious of the fact that it could not have been easy for family members to tell their stories to us. Emotions were still raw, even after the passage of considerable time, and it was clearly difficult to re-live the memories of the tragic events of June 1998. We appreciate the fact that they came to talk to us.

It couldn't have been easy for DN either, but he was open and frank with us, and answered all of our questions seemingly without holding anything back. He deserves credit for this.

We are aware that this case was complicated by DN's excessive use of illicit drugs, but, given his clearly psychotic and violent behaviour in 1991 which had led to him being sent to medium secure units under a Hospital Order for a period of some eight months, we consider that perhaps the role that drugs played in his life, especially their effect on his illness, was not fully appreciated. His use of illicit drugs coloured people's perception of DN, and obscured their view of his underlying mental illness.

Having said that, there is no doubt that the homicide was committed after a heavy and concentrated drug 'binge' involving mainly crack cocaine, which makes it extremely difficult to estimate just how mentally disordered DN actually was at the time. The police who investigated the crime and DN's brother J are clearly of the opinion that DN was 'bad' and not 'mad', but this is too simplistic a dichotomy to explain DN's behaviour. Various psychiatrists who examined him while he was on remand pending trial were of the view that he was suffering from a mental disorder at the time of the offence and recommended that a Hospital Order should be made so that he could be assessed and treated.

Like many – if not most – of the other homicides by people suffering from a mental disorder which have been subject to independent inquiries, the nature of the killing of his grandmother could probably not have been predicted. Although at times the risk of violence to others was identified, there was never any proper clinical risk assessment carried out.

There are however several aspects of DN's care and treatment which we consider should have been dealt with differently. We will deal with these in more detail in the Commentary and Analysis section of this report.

The Inquiry Panel is, however, very aware that it has had the considerable benefit of hindsight, as well as having access to all of DN's records. We wish to make it clear that if we make any criticism of any individual action or lack of action, 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.

There are sections of DN's life which are blank to us. We have undertaken a thorough review, but there are still gaps and unanswered questions. We also cannot be certain as to the accuracy of some of the accounts given to us either by DN or by others, when they were inconsistent with accounts reported in the notes and records we have read.

But we present our Report with confidence that we have done our best to piece together all of the relevant and important information, so that our findings and recommendations can highlight what needs to be addressed to try to ensure that the tragedy which occurred in this case is not repeated in the future.

Having said that, we are all too aware that there are several similar Inquiries being conducted at the moment in the same Trust, and we are deeply concerned about the implications of this.

The Mental Health Trust covers four separate boroughs – Tower Hamlets, Hackney, Newham and the City of London. DN came within the catchment area of Tower Hamlets and therefore our main focus for the purposes of our report and recommendations is on Tower Hamlets.

We have made some comments in this Report about the current state of mental health services in East London. We wish to make it clear that these comments are based on the limited evidence which we heard (mainly about Tower Hamlets), and may not reflect an accurate picture of current services across all four boroughs.

We understand that working practices and standards differ between different areas within the Trust; however our recommendations are relevant to the whole area covered by the Trust. Indeed, we anticipate that many of the recommendations which we have made will be relevant much further afield than East London.

DN's grandmother must not be forgotten in all of this. She paid the ultimate price for her generosity of spirit to her grandson, even though she was, on her own admission, abused by him at times.

Our remit has been to concentrate on the care and treatment given to DN, and therefore it may seem as though she has been an insignificant factor in this whole process. She was not.

If this Inquiry can in any way improve the services and the attitudes of professionals who look after people with severe and enduring mental problems and thereby go some way towards preventing a similar tragedy happening again, then we hope that that will be a fitting tribute to her memory.

BACKGROUND

DN was born in November 1970. He is of mixed race, having a white British father and a mother who was black and was born in Jamaica. His mother was only 17 when he was born and already had a year old son, J, by the same father, whom she later married. J is DN's only whole sibling, although he has two half-brothers with the same father and a half-brother and half-sister with the same mother. J spent most of his childhood living with his paternal grandmother, S, who was later to be the victim of the homicide by DN. His mother was only 16 and unmarried when J was born, and was persuaded by S soon afterwards to let J live with her. DN remained with his parents.

When DN was about five years old, his parents' relationship was such that his mother felt that she could no longer stay with her husband and she found it difficult to cope with DN on her own, so one day she left DN at a police station on her way to work, with a note pinned to him with his name on it. From that time onwards he lived with his father. He continued to have contact with his mother.

According to DN and his mother, DN's father was a drug smuggler and dealer who spent a considerable amount of time abroad 'on business'. When his father was away, DN would stay with S, his paternal grandmother. DN lived with his father until he left home at the age of 18, although he continued to see his mother.

His mother described him as being a loving, helpful child who was always very smart and very clean. She did not recall any real problems until after he left home, although his brother J told us that he had felt that DN "*wasn't the full ticket*" from about the age of five. He also said that DN used to collect little knives such as penknives from an early age.

We were unable to evaluate the significance of this, particularly because J was the victim of violence at the hands of his brother and there is no documentary evidence of any mental illness during DN's childhood.

DN told us that he was introduced by his father to cannabis on an occasional basis when he was about eight years old, and that by his 16th birthday he was a regular cannabis user and had remained one ever since. He said that he also inhaled solvents and butane gas on a daily basis in his early teens. From about the age of 16 he also occasionally took other drugs such as LSD, ecstasy, cocaine, amphetamines, and heroin. He told us that he felt that his mental health problems began around this time when he began taking these drugs on a more regular basis.

DN left school at 15 and when he was 16 he started stealing cars and found himself in trouble with the police. In 1987 he had convictions for taking a conveyance, reckless driving and driving while disqualified and with no insurance. He was fined a total of £85 and his licence was endorsed for each offence. He was banned from driving before he was old enough to have a driving licence. He had no further convictions until 1991 when he was 20. He does not seem to have ever held down a job for any length of time, although he was a stonemason for a while.

DN told us that when he was 18/19 there were two occasions when he felt that the radio started talking to him – the people were not talking directly to him but he interpreted what they were saying as signs for him to follow. He did not tell anyone about these occurrences and they apparently then stopped.

It was in 1991, when he was about 20, that DN's mental health problems first became evident to others as well as to himself. In a four month period from April to August 1991, several events occurred which illustrated a fairly rapid deterioration in his health and behaviour.

On 18th April he stole a £7,500 diamond ring from a Mappin & Webb concession in Selfridges. He apparently asked to see the most expensive ring and then attempted to run off with it.

He was at this time living on his own and he told us that he began to read the Bible a great deal. He told us that he would sit reading it all day and he said that he started to believe that he was one of the “*angel prophets*”. He also told us that Bob Marley's music had a particular significance for him.

He then began to read the story of David and Goliath and became paranoid about his brother J. He told us:

“I was reading the Bible and I was picking up messages that he was Goliath...”

He said that he then began to train “*for the battle with J*” which he believed would happen on a certain day. He felt very fit and told us that at that time he was not taking many drugs – “*only the occasional marijuana joint*”. He also described himself as feeling “*invincible*”. The night before the day in question he told himself that if he woke up at six o'clock the following morning then it was meant to happen. He told us that he woke at six o'clock to a Bob Marley song playing on the radio and took it as a sign that he had to fight his brother.

He went round to his brother's home and waited for him at the bottom of the stairs at his block of flats. When J emerged, DN shot a steel ball bearing at him from a large catapult, hitting him on the head. When J chased him and grappled with him, DN stabbed him around the head and in the neck with a knife which he took from his pocket. J was quite seriously injured and spent several days in hospital, and DN was arrested and was charged with GBH with intent in respect of this attack. The incident happened at the end of May 1991 and he was remanded in custody overnight at Feltham Remand Centre and later bailed to stay with relatives.

DN told the Inquiry Panel the story about David and Goliath and his belief that there were signs pointing him to what he had to do, when we saw him at Rampton High Security Hospital in May 2001. We have not found any evidence that he at any time told anyone else that he was having such thoughts, despite having discussed the incident with several psychiatrists, both in 1991/2 and after he killed his grandmother in 1998.

If what he told us was the truth about his mental state at that time, then it throws some light on the series of incidents that occurred in fairly quick succession thereafter, and perhaps gives a clearer picture for a possible diagnosis at that time.

While he was on bail, DN carried out three further apparently unprovoked attacks, two of them on relatives and one against a total stranger.

The first victim was DN's maternal uncle, whom DN hit over the head with a glass bowl, causing an injury which required stitches. The second was his younger half-brother. DN apparently accompanied him on a late night walk to the park with his dog, and suddenly attacked his brother, sticking a large pin into his neck.

In respect of the first incident, DN told us that he was with his uncle at his maternal grandmother's house and they were listening to a radio station when the DJ said something about "ending right on the dot", and at that moment DN looked out of the window and saw a red dot on a motorcycle which was somehow reflected on his uncle and "something in his mind just triggered something about blood. So I knew that I had to draw blood from my uncle and that something bad was going to happen". He also told us that he had in fact first drawn a knife on his uncle and had struck him with the bowl to stop his uncle hitting him when he saw the knife. He had not actually used the knife on this occasion.

Once again the Inquiry team appear to be the only people in ten years who have been told this version of events, namely that the attack was triggered by apparent signs from the radio and the red dot on the motorbike. It is therefore difficult to know whether these incidents happened in the way that DN described them to us, although they make more sense from a diagnostic point of view than mere unprovoked assaults. DN did not discuss the incident with his half-brother with us.

Charges were brought against DN in relation to the attack on J, but he was not convicted and we believe that the charges were dropped at the last minute. No charges were brought in respect of the attack on his uncle.

In July 1991, DN was convicted of being in possession of a bladed article – a machete which he stated he used to cut grass – and fined £100. He lodged an appeal to the Crown Court. We do not know the circumstances of this offence.

On 13th August 1991 at Liverpool Street Station DN assaulted and struck a man with a machete, causing severe injury to his hands, and snatched a young boy from this stranger and ran off with him, before being stopped and arrested. He was charged with GBH, kidnapping, unlawful imprisonment and carrying an offensive weapon, and remanded in custody at Feltham. He was committed for trial at Knightsbridge Crown Court.

DN told us when we saw him at Rampton that he had been sitting on a train and a man was sitting on the other side of the carriage with a small boy. The boy started to quote passages from the Bible which DN had recently been reading and seemed to relate to what was happening at the time, and DN felt that there was something wrong with the relationship between the man and the boy. They got off the train and he saw the man bending the boy's arm, and he then confronted the man and pulled out the cut-down machete which he said that he always carried with him 'for protection'. He said that he thought that the man was a paedophile and

was going to harm the child. (We understand that the man was in fact the boy's uncle.)

We noticed that the explanations which DN gave us about these events in 1991 had religious or Biblical connotations, and indeed he seems to have turned to the Bible or religion in some way at the times when he appeared most unwell.

The Feltham notes record that DN's mother telephoned the remand centre the day after his arrest, and told them that DN had changed over the last two years, had attacked members of the family and was likely to undergo violent mood changes for no apparent reason during which he would attack people. She said that she thought her son was "*a paranoid schizophrenic*" and needed psychiatric help.

On 15th August DN told the Manager of the hospital wing at Feltham Young Offenders' Institution that he had to wear a religious symbol and that he and his brother '*were at war*'. He refused to discuss why he was in prison with the prison medical officer, showed pressure of speech and '*no firm contact with reality*'.

He went to court on 22nd August and attempted to leap over the dock, and it was noted that he was '*made unfit for governor's adjudication*'.

On 27th August it was recorded that his behaviour was bizarre in that he was wearing his clothes inside out and demanding a hat to wear, but he was not a management problem and was not on any medication. He was noted to be unfit for court until he had been assessed by a psychiatrist.

On 30th August 1991, DN was interviewed by Dr Neil Boast, then Senior Registrar in Forensic Psychiatry at St Bartholomew and Hackney Hospitals, working under the supervision of Dr David Ndegwa, Consultant Forensic Psychiatrist. Dr Boast also interviewed DN's mother and then prepared a psychiatric report for the court. The report concluded that DN was fit to answer charges in court and that the probable diagnosis was that he was suffering from paranoid schizophrenia, but that drug abuse may be implicated in the aetiology of the condition.

He also recommended that the court should consider a hospital order under Section 37 of the Mental Health Act 1983, and that DN required assessment and treatment in a medium secure unit because of his lack of insight into his developing illness and its effect on others.

On 1st September the Feltham notes describe DN as '*unpredictable*' and on 10th September it is recorded that at about 00.45 hours he demolished his cell and had to be removed under restraint. Later that morning he appeared more settled and told staff that he gets "*paranoid*" and had heard a bell ringing in his head the day before. He wanted someone to talk to but there was no-one available. He agreed to take, and was started on, anti-psychotic medication.

On 17th September, the notes state:

'This man's mother's account of his behaviour (14.8.91) and his present offence indicate an appreciable degree of dangerousness; he has no insight and there is obviously a threat to the public here.'

On 23rd September, Dr Boast interviewed DN's father at the psychiatric outpatient clinic at Hackney Hospital. Following this interview, Dr Boast wrote a supplementary report for the court suggesting that his earlier diagnosis of paranoid schizophrenia may be incorrect, and that the development of paranoid ideas and changed behaviour appears to have started in response to specific life events, reactivating earlier childhood experiences. However his opinion that DN's symptoms represented a mental illness within the meaning of the Mental Health Act 1983, and his recommendation for a hospital order, remained unchanged.

On 11th October, DN came before the Crown Court at Middlesex Guildhall on the charge of theft of the ring, and a hospital order was made for admission to Hackney Hospital.

There wasn't a bed available in the Interim Secure Unit (ISU) at Hackney Hospital at that time and so on 18th October DN was 'redirected' from Hackney and admitted to Kneesworth House Hospital, an independent sector medium secure hospital in Hertfordshire, under the care of Dr Graham Petrie, Consultant Psychiatrist.

In an initial interview with Dr Petrie, DN said that in relation to the theft of the ring, he had been under pressure from drug dealers to whom he owed money. The attack on his brother J had taken place because J had been intent on attacking him with a knife. DN's catapult had been "at the ready" because he had been aiming at birds with it when his brother came at him. When he was hit by the ball-bearing, J fell and DN picked up his knife and ran off and J had chased him and was injured by the knife in the ensuing scuffle. The incident at Liverpool Street Station had been the result of DN being convinced that the man was abusing the child who did not seem to know him, and therefore DN felt that he had to interfere to protect the child.

On admission to Kneesworth House, medication which had been prescribed at Feltham was stopped.

In the first few weeks at Kneesworth House, DN did not show any overt signs of mental illness and was not a management problem, other than it was suspected that he was smoking illicit drugs at times (especially when his father visited).

On 8th November he was escorted to court to answer charges in respect of the Liverpool Street Station incident. Both Dr Petrie and Dr Boast submitted reports to the court. Dr Petrie expressed the view that at the time of the incident, DN was suffering from paranoid psychosis from which he was recovering, but he had not been at Kneesworth House long enough for a full assessment to take place. Dr Boast was of a similar view, and stated that DN would require assessment and treatment in conditions of medium security, and would need to be observed for several months while free of medication in order to assess whether his mental illness would recur. Both doctors recommended that he should remain subject to a

hospital order. No plea was entered on this occasion and DN returned to Kneesworth House after an uneventful attendance at court.

Early in the morning of 18th November, DN left the hospital under escort of two Kneesworth House staff to appear at Thames Magistrates Court on the charge of GBH against his brother J. When they arrived at court, DN became upset and argumentative when his escorts suggested that he should be detained in the custody area until his case was called. The custody officer did not feel obliged to take him into custody, so they went to the public waiting area, DN assuring them that he had no intention of absconding. He then telephoned his paternal grandmother and asked if he could go and visit her briefly as she only lived a couple of minutes round the corner from the court. He said they could handcuff him if they were concerned about him absconding. The court hearings were not due to start for another hour, and so the Kneesworth House staff agreed to take him. Once inside his grandmother's flat, they removed the handcuffs, and initially there was no problem. They all had a cup of tea and then DN went into the next room to find an ashtray. After a couple of minutes one of his escorts followed him and found him sitting smoking and was again assured that DN had no intention of running off. After a few more minutes he went to fetch a drink from the kitchen and very quickly left the flat.

Although he was immediately chased by one of his escorts, he was nowhere in sight and the police were informed that he was a detained patient under a hospital order, that he had assaulted a complete stranger in the past as well as his brother, and that his brother may be in danger. A warrant was immediately issued for his arrest.

At 9.30 that night, DN's father telephoned to Kneesworth House to say that DN had been arrested by the Hackney police at his mother's home and was being held in custody. His father explained that it was DN's 21st birthday and he had gone to see a girlfriend. He was returned to Kneesworth House the following evening, having been charged with unlawful escape from custody.

On 25th November DN was once again escorted to court where the Crown Prosecution Service offered no evidence in respect of both the escape from custody charge and the GBH against J, and therefore both cases were dismissed by the magistrates.

There is an important national issue which is highlighted by the dropping of these charges. This quite often happens when an offender is discovered to have a mental health problem. Sometimes charges are never even brought if the police think that it is more of a 'psychiatric matter' and there is therefore no point in charging the offender. Had charges been brought and a conviction obtained, the Court would have the power to make a hospital order if the offence was serious enough to warrant a prison sentence, or a probation order with a condition attached that the offender should undergo psychiatric treatment. This is often a missed opportunity to help the person with mental health problems. Even a police caution has merit, as it is recorded and can be used in future risk assessment.

Of course, if charges are never brought or are dropped, there is no conviction and therefore often no record of an act of violence which has been committed by that person. Even if the offence is known about by the professionals who are later dealing with the offender, the fact that a charge is not pursued to conviction often gives them the impression that the offence was not all that serious.

If there is no knowledge of a previous violent offence, or a mistaken belief that the offence could not have been particularly serious because charges in relation to it were either dropped or not brought in the first place, this can affect any subsequent risk assessment of the person concerned. It can also result in a hospital order being made without a restriction order by a judge having to deal with the offender, when they may well have made the restriction order had they known the full extent of the person's violent behaviour.

On 10th December DN was due to appear at Knightsbridge Crown Court on the charges relating to the Liverpool Street Station incident. He left by car with two nurse escorts in the early morning. As the car slowed for the traffic lights at the bottom of Shoot Up Hill, DN, who was seated in the back with his window open, suddenly opened the rear door, using the outside handle and leapt out of the car. He was closely followed by the escort who had been sitting in the back of the car with him, and was soon caught and handcuffed. At the court he was placed in a cell until his case was called.

DN pleaded guilty to the charges of GBH and of possessing an offensive weapon, but entered a plea of not guilty to the kidnapping and unlawful imprisonment charges. He was remanded under a hospital order back to Kneesworth House, to be brought back to court for sentencing on 7th January.

During the return journey DN was handcuffed to the car door handle – apparently at his own request.

On 7th January 1992, in respect of the Liverpool Street incident convictions, the sentencing judge at Knightsbridge Crown Court once again made a hospital order under Section 37 of the Mental Health Act without any restrictions, and DN was returned to Kneesworth House.

The weekly summary entered in the notes on 19th January revealed that DN had become rather quiet and had begun wearing the same clothes for long periods of time, even sleeping in them, and was refusing to bath or shower regularly. Five days later Dr Petrie noted the deterioration in hygiene and the fact that DN was spending more time alone 'thinking' and recorded '*This could be a significant deterioration*'.

During the night of 25th January, when staff entered DN's room to carry out a night check, DN sat up suddenly and threw a bin at them.

On 30th January DN was seen by Dr Petrie who could find no evidence of hallucinations or delusional symptoms. Several members of staff however continued to get the impression that DN might be becoming unwell and Dr Petrie advised a 'wait and see' policy.

Shortly after this a bed became available at Hackney Interim Secure Unit (ISU), and on 13th February 1992 DN was transferred there, still under Section 37 of the MHA.

In the Discharge Summary from Kneesworth House, Dr Petrie said that there had been no evidence of ongoing psychosis while he had been there and at the time of transfer to Hackney there was no sign of mental illness. He gave a discharge diagnosis as follows:

*'? Delusional (paranoid) disorder. Persecutory type. In remission.
? Brief reactive psychosis. In remission.
? Cannabis delusional disorder. In remission.'*

Dr Petrie also wrote a letter dated 12th February 1992 to Dr Boast at Hackney Hospital, detailing events that had happened in the four months that DN had been at Kneesworth House. He wrote:

'We have not found any signs of mental illness while he has been with us and he has admitted to no symptoms. He has, however, agreed with me that he was not functioning normally at the time of the offence on the train, but he has not been able to enlarge on this.'

Dr Petrie concluded his letter:

'I think that this patient needs further observation and that he will be very vulnerable to illegal drug abuse on discharge. He will, therefore, need very careful supervision in the future, when he is finally discharged'.

Dr Petrie told us that he felt that this was “not a job we had finished” when DN left Kneesworth House, and that DN had not spent enough time there for him to be in a position to make a proper diagnosis. He described him as “something of an enigma”. He felt he was likely to be vulnerable to further breakdown and illicit drug use and therefore required close monitoring.

It should be noted that DN had not been given any medication whilst at Kneesworth House, but that the effect of the anti-psychotic drugs which he had been taking whilst at Feltham would have continued to have had a beneficial effect for some time after they were stopped. His gradual deterioration towards the end of his stay at Kneesworth House may have been caused by their diminishing effect.

At Hackney Hospital, DN was under the care of Dr Ndegwa, Consultant Forensic Psychiatrist, and his team, which included Dr Boast.

One of the first entries in the Hackney notes is a description of an incident which occurred on the evening of 18th February, just five days after DN had been transferred. DN was being visited by his father when he started to fight with him and apparently hit him over the head with an empty plastic bottle. A member of staff intervened and DN, although still angry, was persuaded to continue the visit under close observation without any further trouble.

Two days later it was recorded that DN was isolating himself and appeared to have ‘some paranoia/suspicion’ about hospital food and water. He always carried a bottle of water filled from a tap in the bathroom and was refusing to eat any hospital food, eating only food brought in by his family and friends.

He was said to be uncooperative in giving information or performing any task which would help in his assessment. He was recorded as being *'very argumentative and at times verbally threatening'* when pressed for information. He apparently did not think that there was anything wrong with him at all and believed that he should be discharged immediately or at least as soon as possible.

When interviewed on 20th February, DN's father made it clear that he did not think that DN had any mental illness and that keeping him in the ISU was causing him more harm than good and therefore he should be discharged. He dismissed his son's criminal record as being the result of growing up in his father's friends' company and put his behaviour down to social problems rather than mental illness. He described DN as being a helpful boy who loved children and he said that the Liverpool Street incident could be explained as evidence of his caring attitude towards children.

Dr Ndegwa reviewed DN a few days later when he was still being argumentative and uncooperative, suspicious and paranoid, and refusing to eat hospital food. Dr Ndegwa's plan was to start depot medication the next week.

There is no evidence that drug screening was carried out at that stage.

There are only two entries in the clinical notes for the first two weeks in March 1992, which show that DN was showing no symptoms of psychosis, but was still isolating himself, refusing to eat hospital food and *'tries to test limits'*.

The nursing notes reveal that DN was resentful of being in the ISU and was consistent in his insistence that he was not mentally ill and fully expected to be discharged when the assessment was completed. He also said that if he wasn't to be discharged he wanted to be transferred elsewhere, as he would not remain at Hackney. He was kept under close observation as he was considered a high absconding risk.

On 18th March Dr Jeremy Coid, Consultant Forensic Psychiatrist, took the ward round and the notes record that he advised:

'Try and explore more of his religious belief – go with a fine tooth comb through every detail regarding his index offence.'

With the benefit of hindsight and all of the relevant medical and other records, we found that there appeared to be a strong link between an increase in DN's religious thoughts and a deterioration in his mental illness. Unfortunately there is no evidence in the medical records of Dr Coid's advice being followed.

On 20th March, DN had made himself some sandwiches in the kitchen, and one of the other patients thought they were for everybody and reached to take one. DN became very angry and hostile, swore at the man and picked up a chair and then dropped it. He became threatening, but when given space, calmed down without further incident.

The following day, DN was again involved in an altercation with another patient, and both men had to be restrained. DN continued swearing for about another 15 minutes and then took a deep breath and controlled himself, and explained that he had been watching a programme on television when the other man had switched channels.

Over the next few days, DN was more relaxed and began to participate more in group activities.

On 26th March, DN was taken to a dentist appointment, and while waiting to be seen, asked if he could go outside for a cigarette and was escorted outside. He then started to have a heated dialogue with the nurse about his future on the ISU, threatening to run off and warning the nurse not to try to stop him. He then ran off.

The following day, DN telephoned the unit twice, the first time saying that he was going to see his grandmother and then he would come back to the unit, and the second two hours later to say that he had been to his grandmother's but needed time to go to see his mother, and he asked if he could come back at 6pm that night. He was told to return within the next half hour or the police would be informed. He insisted he was going to his mother and would try to be back within the hour. The police were informed that DN was going to his mother's and three quarters of an hour later DN's mother telephoned the Unit, most upset that a crowd of police officers had turned up on her doorstep. DN did not however turn up at his mother's home, nor did he return to the unit.

There was no further news of him until 1st April, when in the early hours of the morning he was found asleep on a ferry at Dover, and when he couldn't be woken he was taken into custody by the police, who then contacted the ISU. Four members of staff from the unit went to Dover to fetch him.

He ran off again on the way back and during the chase, tried to wave down a car and took a bicycle. He was finally caught close to Homerton Railway Station and was angry and aggressive to those accompanying him and had to be restrained for the rest of the journey back to Hackney, where he was held in seclusion because of his *'highly aroused state'*.

He was reviewed that afternoon, and although initially aggressive and refusing medication, he then accepted oral medication. He told staff that he had gone to visit relatives in Amsterdam and had smoked two joints of cannabis but no other drug. A drug screen was performed.

Reviewed two hours later, he became aroused and angry when told he would be in the ISU for at least another month. He was given Stelazine and remained in seclusion for about 12 hours.

The deterioration which had been noted by Dr Petrie towards the end of DN's stay at Kneesworth House appears to have continued. Up until this time he had not received any medication for some five months.

Dr Ndegwa saw him on 3rd April. DN told him that he had been to Amsterdam and Paris while absent without leave (AWOL). He said that he had smoked two cannabis joints in Amsterdam, and had drunk half

a bottle of wine on the day of his arrest at Dover. Dr Ndegwa added night-time chlorpromazine to DN's medication.

A Case Conference had been arranged for the 13th April, and in the period leading up to it, DN was more cooperative and friendly, but seemed unable to accept that it was unlikely that he would be released after the conference. He threatened to *"do everything in my power to get out of here when my time comes."*

At the Case Conference, Dr Boast presented the case.

The clinical notes for the case conference record that the result of the SCID diagnostic assessment was *'Borderline personality traits.'*

Dr Jeremy Coid explained the SCID assessment to us as follows:

"This is an instrument by which you go through a list of questions which are based on the criteria for these conditions, and you get a score. There is a sort of cut-off and above and below the cut off determines whether they get that diagnosis. So I have trained people to use it from time to time, which I think is a really good discipline within the practice of forensic psychiatry.

The problem with it is, unless you have quite a lot of experience... you tend to start saying 'yes, this person has got a borderline personality disorder'. But if you are actually applying it to a person with a psychosis, what actually happens is that you get these personality disorder diagnoses, when actually you are getting around the edge of what is a psychotic condition. So I think it can be incorrect. I believe that you can have both borderline personality disorder and schizophrenia. I have seen cases who have both, very clear cut presentations...

So if you gave a large group of patients with schizophrenia a SCID 2, you would find a lot of personality disorder. But I would argue that it is not what you are actually finding. You are mislabelling it if you apply it too rigidly. I think that the only diagnosis amongst the range of personality disorders which is truly reliable in the case of severe psychosis is anti-social personality behaviour, and that is based on behaviours... The problem with a lot of the behaviours and the traits that you are trying to measure is that the whole picture is distorted by the psychosis. So it is very difficult to make an accurate diagnosis of personality disorder when you have got a very severe psychotic illness."

Dr Coid went on to explain that the score had to be five or more of the nine criteria for a diagnosis of borderline personality. Someone with a score of three or four would be diagnosed as having borderline personality traits. He also told us that he had no doubt that at that time DN had a paranoid psychosis and possibly schizophrenia.

The nursing notes record:

*'No diagnosis made. Possibly ? stress induced psychosis. ? drug induced psychosis.
? borderline personality disorder.'*

When we interviewed Dr Boast we asked him to try to recall how the diagnosis of borderline personality disorder had come about (his earlier diagnosis for the court reports seven months earlier had been probable paranoid schizophrenia), and why it appeared as the first diagnosis, before that of a delusional disorder. He told us:

“It is in that order, but it does not necessarily follow that I wrote it in that order because I thought personality disorder was more important than the delusional disorder. If so, it might be misleading because in terms of the offence and his other behaviour, the attack on his uncle and brother, I thought that psychotic mental illness was more important than his personality. It is probably not clear enough there, but there is an interaction between factors. I think it is necessary for him to be psychotic for him to have acted that way. The order is perhaps misleading.”

What is important is that the diagnosis of borderline personality disorder was the last one made by anyone from the psychiatric service prior to DN killing his grandmother. It was the diagnosis which has ‘stuck’ to DN ever since and may have influenced the way in which he was viewed and handled by those later involved in his care. The significance of the gradual deterioration without anti-psychotic medication and the rapid improvement in his mental state when the medication was restarted, does not appear to have led to a clear prioritisation of his diagnosis.

The next day DN had a heated argument with another patient, and staff had to intervene. The following day, DN was visited by his father who told staff that he wanted to take DN to Jamaica in two weeks’ time. Following a ward round later that day, it was decided to grant DN escorted garden parole.

On 21st April, DN’s father visited again and said that he was going to Jamaica for three weeks to look into a new business venture, and repeated that he wanted DN to go to Jamaica to look after his business. At the ward round the following day DN’s father was discussed and it was noted that he still appeared to have a negative influence on DN and was always trying to rationalise his son’s behaviour.

On 28th April DN told the nursing staff that he felt that he no longer needed medication and wanted to stop taking it, despite admitting that he was more relaxed and tolerant since taking it. The next day he had a one-to-one session about his medication and agreed to continue with his daytime medication until Dr Boast reviewed his medication in a month’s time. DN also asked if he could progress from garden parole to escorted ground parole. He said that he felt ready to be taken out and that he could be trusted. He said that he felt much better and was looking forward to being on a graded parole, so that he could either be discharged or transferred to an open ward.

The clinical notes following the ward round on the 29th April record that Dr Ndegwa had told DN that he was going to be on medication for life and would be given depot injections before discharge. The nursing staff were told to emphasise to DN the need to take medication and that he

‘will need a proper trial of medication as this seems to have worked in changing his attitude & ? paranoia but it is difficult to put one’s finger to it (sic).’

It was also decided that DN was not ready for ground parole.

On 13th May after the ward round it was noted:

'It appears he is much better & one wonders if it is fundamentally a borderline personality.

Staff doesn't trust him with escorted ground parole as he still doesn't meet the criteria on which he can be allowed ground parole.

Still has no insight into his behaviour or the need to stay in ISU, and once he is discharged he will be lost to follow-up most probably.'

At a clinical meeting a week later it was decided to increase DN's garden parole, but it was noted that he was *'still a high absconcion risk hence no ground parole yet'*. Consideration was given to starting him on depot medication.

By the time of the ward round on 27th May, the staff were thinking that DN could be considered for ground parole. It was decided that he could be started on 15 minutes a day escorted ground parole. DN's father spoke to Dr Ndegwa and told him that he wanted to get a flat and arrange something for DN in Jamaica. He offered his guarantee that he would not abscond.

At the 3rd June ward round staff reported that they thought that DN and other patients had been smoking cannabis the previous week, and that DN had refused to provide a urine sample. Otherwise he had kept a low profile. It was recorded that the plan was to start DN on 5mg Stelazine and then to discharge him in one to two months. Two days later Dr Ndegwa noted that DN had now admitted that he had been smoking cannabis and regretted his actions. He said he was happy to take depot medication in hospital and in the community.

On 5th June DN was taken to Wood Green Crown Court where his appeal against the £100 fine for carrying a machete in a public place was dismissed.

This was a separate incident from the Liverpool Street station assault when he injured the stranger with a machete.

At the ward round on 10th June it was decided to plan for DN's discharge in the second week of July. Four weekly depot Haldol 50mg was prescribed. At the ward round a week later it was decided to try DN on 15 minutes unescorted ground parole, to stop his oral medication (chlorpromazine and stelazine) and to increase the four weekly Haldol dose to 100mg.

DN continued to be no management problem, so the following week it was decided to increase his parole to allow two half day (four hours) per week unescorted parole to his grandmother's house.

On 29th June there was a Managers' Meeting to discuss the possibility of DN's discharge. We have seen an (undated) eight page report prepared by Dr Boast headed 'Appeal against Detention' which appears to be the report prepared for the meeting.

The report sets out DN's family, forensic and psychiatric histories, and describes how the Stelazine and chlorpromazine had produced a rapid change in his mental state after the absconding episode.

The report states:

'After medication he became considerably less tense, and reported a decreased and intensity of low irritable moods (sic). He also began to say that he was mistaken to attack the stranger on the railway train and that he might of misinterpreted (sic) the relationship between the stranger and his nephew. He recognises that his actions were impulsive, extreme and unjustified. Currently he sees himself as being mentally ill during the period leading up to the attack on the stranger, and feels that this resolved when he was in prison. He does not consider himself to have been ill during the time he was in hospital nor currently, attributing any disturbance in his behaviour in hospital to a combination of aspects of his personality and his circumstance. He shows some recognition of the effects of medication on his mental state, and has said that he will continue to take medication when he leaves hospital and for that reason he was started on Haldol depot injections.'

The section on Diagnosis read as follows:

- 1. Borderline personality disorder with some passive aggressive, obsessional, paranoid and anti-social traits. He admits to having ups and downs in his relationships, to being impulsive, moody at times, feeling angry and out of control and having thoughts of hurting himself. He also describes periods of feeling empty and board (sic) and having identity disturbance, although this is less marked. This condition appears to have responded to treatment with neuroleptic medication and interaction with nursing staff.*
- 2. Delusional disorder, persecutory type. There is evidence that Mr N suffered from paranoid ideation in the months around his offences and when he was first in prison. There has been no evidence of delusional thinking during the time he has been in hospital. His psychosis is typical of the type seen in people with borderline personality disorder under adverse psycho-social stress.'*

DN apparently presented himself confidently and coherently and agreed to take medication and to comply with any psychiatric follow-up which might be advised. The Managers' decision was that DN was to continue with his programme and would be discharged in three weeks' time.

On 30th June, DN was allowed his first four hour unescorted parole and left the ISU at 15.40 to visit his father and grandmother. He did not return.

We understand from what we have been told that DN left for Jamaica on the day he absconded from the ISU, using an airline ticket bought for him by his father. DN told us that he had been discharged from hospital at the Managers' Meeting. He did not return to England until the following year.

The ISU staff spent several days trying to find out where DN was. They contacted his grandmother and his mother, who told them that she didn't want anything to do with her son because of the way that he had treated her family – especially his brother whom he had injured the previous year. She said that she *'shuddered at the thought of him being loose on the street'*, but she denied that she feared for her own safety.

On 6th July 1992, the Section 37 Mental Health Act Hospital Order expired. It could only be renewed if DN returned to the ISU within 28 days. This was recorded in the notes after a ward round on 8th July, and was the last entry to be made in the Hackney Hospital notes.

There was never any final summary of his care and treatment written after DN absconded from the ISU. It was acknowledged by everyone whom we interviewed from the Unit that there should have been. In contrast Kneesworth House had a clear Discharge Summary and circulated it to all the relevant agencies.

DN remained in Jamaica until some time in mid-1993. We do not know very much about his time in Jamaica, but it seems as though he continued his use of drugs during this time. He returned to the UK because his father was seriously ill with cancer. As far as we can gather, DN went to live with his paternal grandmother, where his father was also staying and being looked after by his mother.

On 3rd July 1993, Dr Isabel Hodkinson, who together with her husband ran a GP practice in Tower Hamlets known as the Tredegar Practice, received a telephone call from DN's mother. She was not a patient of the practice, but DN's paternal grandmother was. DN had never been a patient of Dr Hodkinson or her husband, Dr George Farrelly.

DN's mother told Dr Hodkinson that her son was a schizophrenic, had been under the psychiatric services at Hackney Hospital, but kept absconding. He had gone back to the West Indies but had come back because his father was dying of cancer. She said that DN had been *"bizarre"* for a week, *"cutting his clothes and intimidating his brother."* She told the GP that DN was at his grandmother's home.

Dr Hodkinson telephoned the grandmother who said that the situation was awkward, and she would phone back, but she thought that the GP should *"leave it"*.

Dr Hodkinson was concerned and she made a visit to the grandmother's flat later the same day. The grandmother told her that DN had been back in England for a month and had been threatening to her and had hit her.

DN was at the flat and Dr Hodgkinson noted that she established a reasonable rapport with him, but that he was very defensive and angry. Amongst other things he talked about people persecuting him with guns. She formed the impression that essentially he was suffering from grief and distress but that he was emotionally isolated. She also questioned whether there was family dysfunction. She prescribed a month's supply of Stelazine 10mg, told him not to smoke dope, offered him support and asked him to come for review in one week.

On 8th July, Dr Hodgkinson telephoned Hackney Hospital to ask for DN's notes and discovered that they had been sent to the ISU in February 1992. She spoke to Dr Ndegwa and recorded in the notes that DN had absconded from the ISU the previous year, abetted by his father, and that the police were looking for him. She wrote in DN's notes about the 1992 admission:

*'Psychotic episode.
?? Drug induced ??
Good response to (medication)'*

Dr Hodgkinson wrote a letter to the local authority housing department to help her patient, and by early September he had been rehoused. The GP continued to prescribe Stelazine, which DN continued to take, attending the surgery on a fairly regular basis to collect his prescriptions.

In October 1993, DN's father died. DN attended the practice in November and December. He seemed to be doing well and was taking his medication.

On 11th January DN's mother telephoned the practice and spoke to Dr Farrelly. She said that DN had deteriorated since before Christmas and was now dishevelled and displaying "odd paranoid behaviour". She asked that DN should not be told "on any account" that she had called them. Dr Farrelly made a note to write to DN inviting him to come to see him as he had not had his prescription for Stelazine since November.

Two days later, DN's mother called again and this time spoke to Dr Hodgkinson. She said that DN kept coming round to her house and she didn't want him there as he had attacked her other son once. She described him as "not mad. He is evil and bad". She said that he was taking drugs and was calm, cool and calculating. She got very upset and said that if he turned up again, she would have to get her brothers to deal with him. Dr Hodgkinson concluded her note:

*'? Where is the problem?
He probably is uncompliant
? smoking'*

Dr Hodgkinson went to visit DN's grandmother later that day and saw DN there. She noted that he was restless and that his poor compliance had been mentioned and that depot medication had been suggested. An appointment was made for DN to attend the surgery the following morning.

DN did not attend his morning appointment with Dr Hodkinson on the 14th, but he turned up at evening surgery without an appointment and was seen by Dr Farrelly. He said that he had run out of tablets and was given a further prescription for Stelazine. He said that he had given up cannabis.

On 1st February 1994, DN's grandmother telephoned Dr Farrelly and said that DN's behaviour had been odd for a week. He had been spending a lot of time at her house and the previous day he had come out with an angry outburst when a hostel did not have a bed for him. She told the GP that he had frightened her and she would not let him in her home now. But she said that he seemed afraid or unwilling to go to his own flat. She said that she would call back if there were any developments.

Two days later DN attended the surgery and saw Dr Hodkinson, saying that he wanted to have his medication by injection. He said that he didn't think that the Stelazine was enough and he was feeling on edge. He told the GP that he was not taking any alcohol or cannabis. He was given Modecate 25mg and Dr Hodkinson referred him to the Community Psychiatric Nurses (CPNs), writing:

'D had a major psychotic illness in 1992 & was under section in the Regional Secure Unit at Hackney then. Their Δ [i.e. diagnosis] psychotic illness possibly drug induced & he responded well to treatment. He managed to abscond & left for the West Indies where I gather he has been well.

I became involved when he returned to the UK in July 1993....When I assessed him I found him to be very defensive and angry with some paranoid ideas although no clear delusional elements. He agreed to take Stelazine & things settled...

D remains very unforthcoming about his symptoms & only admits to being a bit 'antsy'... Today he requested depot medication as he says the Stelazine are not working & I have given 25 mg Modecate & some procyclidine & plan to review in 2 wks. He denies cannabis. He is extremely unkeen on seeing a psychiatrist.'

DN attended the surgery on 17th February and said that he wanted to continue with the Modecate as he felt much better and more settled and his thinking was much clearer. He was given a further depot injection of Modecate.

On 22nd February Dr Farrelly was contacted by Ralph Cheung, a CPN with the Bow Poplar Community Mental Health Team. They discussed DN and the GP told the CPN that the referral was being made so that DN's mental state could be monitored as he behaved oddly. Ralph Cheung said that he would try to make contact with him. He wrote to DN, stating that he had been unable to reach him by telephone and therefore would come to see him at home on the 14th March.

The meeting took place on 14th March and Ralph Cheung carried out an assessment interview, following which he filled in a standard assessment form which contained the following relevant information:

'Currently he is not using any illegal drugs. Had used cannabis in West Indies for about 6 months, 4 'joints' a day (in 1993)...

No abnormal beliefs or perceptual disturbances could be elicited and he denied the same when he was ill in 1992. He admitted to having persecutory ideas of other people tried to harm him (sic) He carried a small knife in his pocket to protect himself at the time...

He stated that he realised he was unwell in 1992. He does not have any psychotic symptoms for quite some time. He said that he would stay on his anti-psychotic injection as long as he needs...

D does not feel that he has any problems or concerns at the moment. He is contented with life in general...'

Ralph Cheung made the following comment in the section listing any problems identified during the interview:

'D lives alone, could be vulnerable. Might benefit from infrequent contact with our service to monitor his mental state.'

DN continued to attend the GP's surgery regularly for his depot injections. He was also receptive to Ralph Cheung's monthly visits. Unfortunately Ralph Cheung left the Community Mental Health Team shortly afterwards, his last visit (his third) to DN being on 20th June. His notes for that day record that DN did not think that it was necessary to continue maintaining contact with the service, and he was therefore discharged from the CMHT's caseload, having been told that he could re-refer himself if the need arose.

The Bow Poplar Team was set up in 1993 and was the first Community Mental Health Team (CMHT) to be set up in the area. It was a pilot scheme, set up with a Manager, about six CPNs, an Occupational Therapist, and a post-membership Registrar in psychiatry (Dr Laugharne) based with the team. There was also a Nurse Behavioural Therapist. In 1994 there was only one Consultant Psychiatrist in the area, Dr Eleni Palazidou. We believe that it is only more recently that she has attended the meetings.

We formed the impression that the CMHT worked mainly with people with less severe mental health problems such as anxiety and depression, and not specifically with people with severe and enduring mental illness. In 1994 there were no strong links with either forensic or drug services. The caseloads were high. Some of those we interviewed from the CMHT were frank in saying that discharging patients from the caseload was a welcome relief, and every opportunity to do so would be taken up, if there appeared to be no risk. However it was admitted that in 1994 there were no formal risk assessment tools available to the team.

When we saw him in interview, Ralph Cheung told us that because he had expressed a resistance to seeing a psychiatrist, DN was a person who needed some time to establish a relationship with the CMHT before he could be referred to a psychiatrist. Unfortunately, his relationship with the Team at that time was limited to only three visits, because of Ralph Cheung's decision to leave the service shortly after DN had been referred to it.

Under normal circumstances, DN would have been attending the clinic for his depot injections and would have met and perhaps forged a relationship with other nurses on the team through these regular attendances. However Drs Farrelly and Hodkinson somewhat unusually administered the injections themselves, and therefore there was not the link with the CMHT which might have led to DN continuing to maintain contact with the CMHT, if only to receive his depot medication.

We were also told that, although the GP's referral letter had mentioned that DN had been detained under section in the ISU at Hackney in 1992, and DN himself had told Ralph Cheung that he had been in Kneesworth on a Section 37 (a Hospital Order made by the Crown Court as an alternative to a prison sentence on sentencing), Ralph Cheung was totally unaware of DN's forensic history and that the three events which had led to the Hospital Order were all acts of violence. He told us that he would have treated the case quite differently had he been aware of this information, and that DN would not have been discharged so easily from the service.

Throughout the rest of 1994, DN continued to attend the Tredegar GP Practice for his depot Modecate and appeared to be well. He was actually collecting the medicine himself from the community pharmacy and taking it to the GPs surgery.

In October, Dr Hodkinson changed the dose from 4-weekly to 5-weekly. The GP records note in January 1995 that he had '*restarted cannabis*' but by March there was a note that that he was '*doing fine + off cannabis*'. The period between depot injections was increased by Dr Hodkinson to 6-weekly. This pattern continued through 1995, with DN attending regularly, although in July he attended one week early for his injection. He was apparently well until the end of the year. During 1995 he began a relationship with M – a young woman he had known since they were adolescents – after she finally ended a long relationship with the father of her four children.

M was also a patient at the Tredegar Practice and had been referred with a history of anxiety and low mood by Dr Hodkinson to the Bow Poplar CMHT in February 1995 from which time she was seen on a very regular (almost weekly) basis by one of the Team's CPNs, Tracy Upex.

On 6th December 1995 M reported to Dr Hodkinson that DN had been:

'making her life hell – smashed windows + door in – hit her in face. Very possessive.'

On 7th December 1995, DN attended the surgery and saw Dr Hodkinson. This is the entry she made in the notes:

*'Episodes of violence – isolated over 2 years but worse over last ? 8 months on average 1-2 x week. Tense black feeling when things go wrong/ feels back (sic)
M with another man NOT likely, + 'someone might give me a look'
Only answer to get arrested + go to prison - ? feels he needs punishment/punishing
Difficult for him to ask for help.'*

In the margin, Dr Hodkinson wrote quoting DN: “*It’s not me*”. She increased the dose of Modecate and also gave DN Stelazine.

A week later, DN returned to the surgery and said that things were easier with M. Dr Hodkinson wrote in his notes:

‘Prob schizophrenia / ? schizoaffective.’

On 18th December Dr Hodkinson wrote to Tracy Upex:

‘You may remember me mentioning D, M’s partner, at one of our meetings. He had an admission under section to Hackney in 1992 for a poorly defined psychotic illness ? drug induced ? schizophrenia. I met him when he returned to the UK mid ’93 as his father was dying. The family called me in as he was being threatening + had hit her (sic) I couldn’t really illicit (sic) any positive symptoms at that time, he had an angry manner + made some paranoid/persecuted sounding comments – but these could have been appropriate. He agreed to neuroleptics + has been on depot Modecate ever since.

I have been cutting the dose of 25mg Modecate from 4 wkly – 5 wkly 27.10.95 (sic) + 6 wkly 9.3.95 but M finally presented to me that he has been increasingly violent to her over the past 8 months. D describes a ‘tense black feeling’ when things go wrong – this might include someone giving him a look but he is also suspicious of M around other men (although he admits he doesn’t really think she’s unfaithful). When he gets this feeling he gets violent. He said ‘It’s not me’. There were no clear features of schizophrenia although he may experience some thought disorder – he says he ‘drifts off’.

We increased Modecate and gave stelazine + on review 1 wk later these feelings had much diminished and he + M were talking more. He is suspicious of mental health services, but as he knows you through M he would see you. I would appreciate your assessment about his functioning + any other possible inputs ?Open House? I think he does have a schizophreniform or schizoaffective illness. I’m seeing him regularly too.’

DN saw Dr Hodkinson again on 8th January 1996, when he reported that there was “*not really any more violence*” between him and M, but that he bottles things up and wants to run away and gets depressed. He said that he was taking the stelazine regularly and was given another dose of Modecate. He and M did not attend a joint appointment which had been arranged for 11th January.

They did however both attend the surgery on 29th January. Dr Hodkinson noted in DN’s notes:

*‘...Stop smoking dope daily –
feels awful without it/sad...
Still violent impulses’*

The GP prescribed fluoxetine as well as a further prescription for Stelazine. She also telephoned the ISU at Hackney to ask for DN’s records and arranged for him to have an EEG to exclude temple lobe epilepsy.

The EEG referral was arranged after Dr Hodkinson had discussed DN with Dr Richard Laugharne, who was the doctor attached to the Bow Poplar CMHT.

DN attended again on 5th February and admitted that he hadn't managed to stop taking cannabis. He was given a further injection of Modecate, but the plan was to make these three weekly and to gradually stop the Stelazine.

On 6th February, Dr Hodkinson wrote to Dr Eleni Palazidou, Consultant Psychiatrist at St Clements Hospital and the Consultant attached to the CMHT:

'We discussed this gentleman in our last joint meeting with the Bow Poplar Team and Richard (Laugharne) felt it would be helpful for me to let you know about him in case things go awry and he ends up coming to you under Section. He came under my care in the summer of 1993 after he returned to this country from the West Indies because his father was dying. Contact was made by his grandmother, but also by his estranged mother. He had been threatening and hitting his grandmother with whom he was staying and his mother...was concerned that D was threatening harm to one of his brothers. When I assessed him at that time he had reasonable rapport, was very defensive and angry and he has some persecutory or paranoid feelings towards the police but I was not sure that these were not appropriate. He also talked about going after people who were persecuting with guns. There was obviously a background of cannabis use and at that time I persuaded him to take some Stelazine and advised him to stop using cannabis. I also obtained a history that he had been under Section at Hackney and then sent to the Regional Secure Unit from where he absconded to go to the West Indies. I have not yet managed to track down notes at Hackney. I tried at the time without success and I am now trying once again.

Things then settled quite well on the medication and he himself spontaneously requested on-going Depo injections and has been reasonably well and stable taking Modecate 25mgs initially three weekly but then gradually extending the time. He was assessed by Ralph in early 1994 who really felt there was very little that he needed to offer D. Throughout this time he has remained adamant that he will not make contact with the psychiatrist because of his previous history. Over 1995 he was having his Modecate only six weekly and told me he was no longer using cannabis. It emerged that he had developed a relationship with another patient of mine...who is currently seeing Tracey Upex...I have to admit that I did express my concerns at that time in that they both seem to be very vulnerable people with quite difficult emotional baggage to bring into any relationship. The lid came off the situation before Christmas when his girlfriend M told me that he had actually been violent towards her on and off over the past two years but very much worse since about April 1995. Once again a psychiatric assessment is difficult in that he seemed to have no clear positive symptoms other than a vaguely persecutory atmosphere and a tense emotional blackness that seemed to be relieved by being violent. We jointly agreed that we should increase the medication and we also gave him Stelazine Spansules 5mgs bd prn...

Richard felt I ought to tell you about him just in case the worse happens and he does actually explode and ends up coming to you on a Frenzic (sic) Section, obviously I very much hope that this is not going to happen!... I am very conscious that I am rather out of my depth with him but it seems to be that I am the only person he is prepared to use and obviously I am keen to maintain my current reasonably working relationship with

both him and his girlfriend. I would be very grateful for any comments or advice you should have but basically this was just for information.'

We consider that if Dr Hodkinson was in fact feeling out of her depth, she should have made it clear that she needed help rather than stating that her letter was 'just for information'. Even though the letter could be described as ambivalent, we feel that Dr Palazidou should have responded by advising that it was important for her to see DN herself.

When we interviewed her and we referred her to Dr Hodkinson's letter and asked her what she would have suggested if the GP was concerned that her patient was deteriorating and she felt out of her depth, she told us:

"That I should see him. I must say that, although there are letters in response to Isabel's letters to me, we also had lengthy telephone conversations about it, so it is not that she was left alone until several months later....The information I had later following that letter is that he was settling and taking medication, and we waited to see how things would go and to see how we could try to get him into the service and engage him."

In our opinion, Dr Palazidou should have advised the GP that all possible steps should be taken to enable her to see DN herself. Telephone advice concerning the care and treatment of a patient with mental health problems who had never been seen by the person giving the advice is a poor substitute for a first hand assessment.

On 8th February Dr Hodkinson received a letter from Dr Ndegwa, Consultant Forensic Psychiatrist at the Hackney Medium Secure Unit who had had overall care of DN in 1992. He enclosed two reports from DN's notes (presumably those written by Dr Neil Boast) which set out the background to his admission to the Unit and the Discharge Summary from Kneesworth House Hospital. He said that he was still trying to locate the Hackney Discharge Summary.

In fact there never was one. There should have been. Dr Ndegwa did not see DN again to review his mental state and assess any risk, which we consider he should have done bearing in mind that DN had absconded less than two years previously from the ISU where Dr Ndegwa was the consultant responsible for his care.

DN saw Dr Hodkinson again on 26th February and still had had no success in stopping the cannabis. He said that without it he didn't want to do anything and had "*no inspiration*". He told her that he had started smoking cannabis from the age of 10 and had also taken crack and other drugs as a "*stop gap*". The GP queried whether he was describing '*a cannabis addiction pattern*'.

On 7th March DN met with Tracey Upex and had a lengthy session with her. He told her that his primary problem was his use of cannabis which he smoked "*all day at present – costing £15 every two days*". He said that he had tried stopping/cutting down but that when he hadn't got any cannabis he became

“*obsessed*” with the thought of getting some, and thought of shoplifting or bag snatching to get money, although he hadn’t acted on this. He thought that cannabis was reducing his motivation. He wanted to do a college course but didn’t know whether he could maintain this while he was still smoking. He described having been brought up in a culture where cannabis was frequently smoked, where he had been offered a puff by his father as a child, had smoked regularly since the age of 15 and had then started to help his father deal in cannabis.

He told Tracey that his admission to hospital under Section 37 MHA was as a result of smoking cannabis and other drugs and his chaotic lifestyle. He said that he recognised that he had a long-term illness and that the depot medication helped him.

Tracey Upex suggested that it might be more appropriate for DN to see another member of the Team as she was M’s Key Worker. She subsequently presented DN’s case to the clinical team and it was agreed that the team would contact Jeff Evans, a CPN attached to the Community Drugs Team (CDT), to see if any input could be offered by them. It was also agreed that DN’s Key Worker should be Carole Luby, an Occupational Therapist on the Team.

The following day, 8th March, DN attended Dr Hodkinson and told her that things were no better but that he wanted to stop his drug taking. Dr Hodkinson telephoned Jeff Evans of the CDT who said that the CDT psychologist or the local team could see DN.

On 11th March M telephoned Dr Hodkinson and said that she was feeling very low and depressed and that DN was not helping her. She said that he was “*acting weird + not taking tablets like he should.*” She said that she would like to “*leave him behind*”.

On 14th March Dr Hodkinson wrote to Tracey Upex to inform her that DN had announced that he wanted to stop using cannabis and that she had discussed his case with Jeff Evans of the CDT who felt that he could see DN, but that since the CDT worked mainly with heroin users, it might be more appropriate for DN to be seen by one of the Bow Poplar Team, or alternatively the CDT could work alongside them or support one of the CPNs in helping DN.

On 26th March M presented at the A&E Department of the Royal London Hospital stating that she had fallen three days beforehand. Whiplash and a fractured ankle were diagnosed. Her ankle was put in plaster which remained on until 13th May.

Much later on M admitted that her injuries had been caused by DN.

On 2nd April, Dr Palazidou responded to Dr Hodkinson’s letter and advised the GPs on the medication they were prescribing. She concluded the letter:

‘In general, it appears that he has a paranoid psychotic illness which does respond to treatment and which is aggravated by cannabis use. It would be helpful if, in addition to increasing his antipsychotic medication, you could persuade him to discontinue cannabis use.

I think it is essential to try to obtain his notes from Hackney so that you are aware of the level of danger he has presented in the past in order to gain some idea as to the risk he poses at present. It is worrying that he was treated in the Medium Secure Unit at Hackney. It might be a good idea for you to try and speak to one of the Forensic Psychiatrists at Hackney, either Jeremy Coid or David Ndegwa, who may know him from the past.'

On 8th April DN attended Dr Farrelly having apparently been assaulted by his girlfriend and having multiple scratches on his face.

DN saw Carole Luby on 15th April and told her that he had attended the CDT and was waiting for them to allocate him a key worker. She told him that she would only work with him if he pursued his original intention to stop his cannabis use. He confirmed that he definitely wanted help to give it up as it was *'damaging his mental health, limiting his resources and generally taking up a lot of time which he feels could be put to better use.'* He also expressed concern at the fights between himself and M. He said that M's foot was in plaster and he therefore felt that he couldn't withdraw his support even though he wanted to distance himself from her.

On 18th April Carole Luby recorded three goals for DN:

- (i) to come off drugs and therefore to start a programme with Jeff Evans at the CDT
- (ii) to withdraw emotionally from his girlfriend M
- (iii) to meet Susan Jordan, the Disability Education Advisor, and to start looking for courses.

On 13th May Carole Luby noted following an appointment with DN:

'D was anxious today and he showed me a very swollen left hand where he says he had hit a wall during an experience with his girlfriend where he had felt very angry and frustrated. I advised him to see the GP. D has put an application in for college, computer course, for Autumn 1996... He has not yet engaged with the Drugs Team as his KW is away. The violence that is escalating with his girlfriend is of concern. She has been advised to go to Limehouse Refuge.'

The following day DN attended Dr Farrelly and received his Modecate injection as well as prescriptions for the other medication he was on.

On 20th May M saw Dr Hodgkinson and told her that DN had been violent, not letting her out of the house and *'terrorising her and the kids'*. She said that his behaviour was odd (the GP notes query whether he was paranoid) and she had taken out a non-molestation injunction against him.

Carole Luby saw DN again on 24th May. He had still not been back to the Drug Unit, he said because he did not have the money for the fare, although he tried to walk there but had arrived late. She reminded him that under their agreement she would not be able to work with him unless he showed a commitment to managing his drug problem.

The CDT could find no records relating to DN even though it was accepted that he had attended at least once. Jeff Evans told us that ‘clients’ would get an initial assessment that lasted about 20 minutes and, if it was felt that they would benefit from the service, would be allocated a Key Worker and invited to return for a full assessment. He told us that the onus was on the client to initiate and maintain contact with their service.

DN told us that he had gone to the CDT, but no-one had tried to explain to him how they worked to try to get him off drugs. All that had happened was that he was told to keep a record of how much cannabis he was smoking throughout the week. He told us that he therefore thought “*if this is what it’s all about, why am I bothering?*” and he never went back.

Carole saw DN again the following day when he told her more about his relationship with M and the fact that she had taken out an injunction to prevent him from going to her home. However he said that he had met her elsewhere. He said that he was financially in a mess and had not put much time into doing up his flat. He had also not turned up to his appointment with the Drug Unit. Carole told him that she would not work with him unless he turned up to his next appointment. He said that he would.

At the end of the entry for the 25th May, Carole Luby had written ‘*Next appointment*’ which at some stage had been crossed out. In fact no further appointment was made for DN to see Carole Luby after that.

DN attended the surgery on 5th June for his depot injection and told Dr Hodkinson that the violence had increased between him and M again, that he was seeing Carole Luby although he was in two minds about it, was seeing Steve at CDT about his cannabis use and that he was still smoking it – but less. He had also had some LSD and Ecstasy in the last month.

On 12th June, Carole Luby went to the Tredegar Practice Meeting when DN was discussed. Dr Hodkinson told her that DN had said that he didn’t think that Carole was doing him much good. Carole Luby told the Team that DN would be meeting regularly with the CDT and she would be helping him to further his education and get into his flat to start to decorate it.

The next day Carole Luby wrote on behalf of DN to Susan Jordan, the Disability Education Advisor, sending her his details in order to try to get him on a course or find him a job. A few days later she received a reply, stating that an appointment had been sent to DN for the 3rd June but he had failed to attend or to contact them in any way.

On 14th June Tracey Upex wrote to Dr Hodkinson to inform her that M had telephoned her that morning to say that DN had been hitting her again and she felt very threatened by him. She said there had been other incidents which she had not told anyone about.

DN did not attend the GP surgery when he should have done on 24th June and he was again discussed at the Practice Meeting. Dr Hodkinson recorded that it was felt that he was putting out very mixed messages about the CDT and Carole Luby, and that the impression was that it was not clear whether

he really wanted to tackle the problem of his drug use and the lack of boundaries with M (despite the injunction). Carole Luby had made it clear at the meeting that there was little scope for working with him if he was still using drugs.

On 4th July Dr Hodgkinson noted a telephone call from Carole Luby to say that DN had not attended the Drug Unit and therefore the CDT had discharged him from their caseload.

On 9th July Dr Hodgkinson wrote again to Dr Palazidou to inform her further in the light of the information which had now been obtained regarding his admissions to Kneesworth House and Hackney in 1991/2. She wrote:

'The old notes from Kneesworth show that he was admitted on a Section 37 on charges of GBH and kidnapping in 1991 and there is documentation of episodes of extremely hostile and threatening behaviour across his admission. The diagnosis at this time was borderline personality disorder and a persecutory type of delusional disorder. There is no discharge summary from Hackney but that is probably because he absconded.'

'I am writing to you now because unfortunately he has stopped turning up for Depo injections and has not been attending sessions with Carol Luby or the Community Drug Team who are trying to help him address his extremely heavy cannabis use. The situation between himself and his Poplar Mental Health team has deteriorated and this may well participate (sic) him being further unwell. We are doing our best to track him down, but I thought it was wise to let you know what is happening as he may re-present through other avenues.'

The letter was copied to Carole Luby and Tracey Upex.

Dr Palazidou replied by return stating:

'I am rather concerned that he was discharged from Hackney without a discharge summary, even if he did abscond. I also wonder why he was not referred to myself as the catchment area Consultant and whether it is possible that he is still under the care of the Forensic Services at Hackney. I think this is very likely as, according to your letter, he was apparently treated at Kneesworth House a few years ago. I will write to Jeremy Coid to request information.'

Dr Palazidou did not however offer to see DN when he was found.

Dr Palazidou wrote the same day to Jeremy Coid:

'This patient was discharged from Hackney some time ago, having absconded from the ward (I am not clear as to the exact dates of his admission) and I understand that he was also treated at Kneesworth House in 1991 under Section 37 on charges of GBH and kidnapping.'

He now lives in Bow and I have received a letter from his GP informing me of her concerns about him as he has stopped attending for depot medication. I understand that the last diagnosis was that of “borderline personality disorder and persecutory delusional disorder”.

I do not recall this man being referred to myself and I wonder whether he is under the care of the Forensic Services at Hackney. I would be grateful if you could look into this.’

On 18th July Dr Ndegwa sent Dr Palazidou the reports from Kneesworth House and the Hackney ISU (which we assume to be Dr Boast’s 1991 and 1992 reports).

Also on 12th July Carole Luby received a telephone call from DN’s grandmother who said that she was very concerned because he had stolen videos as well as money from her and she wanted Carole to go round to talk to her. Carole said that she was on annual leave the following week but would come round the week after. She then telephoned Dr Farrelly to tell him about the phone call from D’s grandmother and also about one from M (about which there are no details).

On 13th July Carole Luby wrote to DN at his new flat as he had apparently moved in:

‘What has happened regarding your contact with the Drug Unit? You know we agreed that I would not be able to work with you unless you had started on a programme with your key worker.

Also Susan Jordan said that you had not turned up to an appointment she sent you regarding work.

I have heard from Isabel Hodgkinson that you have not been for Depo. We are concerned that you are not looking after yourself.

Once you have engaged with the Drug Unit I can start to support the changes you say you want to make in your life.

Please contact me after the 22nd July to let me know your intentions.’

On 15th July DN was discussed in a CMHT referral meeting. We do not have the details of what was discussed.

On 16th July DN turned up at the surgery without an appointment and was seen by Dr Farrelly. He wanted his injection. He said that he thought that he was OK but the GP told him that others were concerned that he was not OK and they discussed the situation and DN was apparently receptive. He said that he disliked Modecate as it made him “sleepy” and that he smoked cannabis “to dull the pain – loneliness etc.”

DN did not attend his appointment with the GPs on 23rd July as he apparently forgot it.

On 2nd August Carole wrote again to DN:

‘So long since I’ve seen you – I would like very much to visit you to see how you’re getting on and if you need support with getting on in your flat?

I suggest meeting you on 12th August at 11.30 atPlease let me know as soon as POSSIBLE if this is not OK’.

DN did attend the surgery on the 8th August and was given his depot medication and a further prescription for oral medication. He failed to attend again on 29th August but turned up for his injection on 2nd September, and told Dr Hodkinson that he was moving around as his flat was still not sorted.

On 12th August Carole Luby paid an unannounced visit to DN's grandmother's flat. DN was not in, but Carole took the opportunity to have a 'substantial chat' with his grandmother. She later recorded in her notes that his grandmother:

'had illuminated me as to how often he had verbally and physically abused her and her property and how often she had been frightened of him, particularly when she had refused his requests and demanded his own way.

I left a note for him saying I had called and would contact him again. However one more DNA and I will discharge him as he is not making any effort to engage.'

This illustrates a lack of any consideration of any association between DN's violence to others and mental illness.

On 29th September DN and M had a joint appointment with Dr Hodkinson. They discussed their 'tit for tat' relationship and DN was given his Modecate injection. He then said that he wanted his depot medication changed to Depixol and Dr Hodkinson prescribed 50 mg 4-weekly.

On 4th October Carole Luby wrote in her notes that, following discussion with Tracy Upex, she had discharged DN from her caseload as he had not responded to OT intervention, and had not followed treatment plans, in particular to attend the drug rehabilitation programme.

This decision illustrates how Carole Luby saw her role with DN as purely an occupational therapist rather than as part of a mental health team. The rest of the team seems to have done the same.

The same day Carole Luby filled out a form headed 'Closure Summary' giving the reason for the closure as *'did not engage with OT intervention. Did not work on Care Plan.'*

In the section headed 'Relevant Background Information' she wrote:

'Kneesworth Ho: Section 37. (GBH) 1991

Hostile and threatening behaviour – Personality Disorder, Delusional Disorder.

Uses cannabis heavily. Has been violent towards M (girlfriend). Also towards Grandmother.

Did not engage with Drug Rehab Unit'.

It surprised and concerned us that the CMHT could record the relevance of DN's history of violence which had led to him being detained under section in a medium secure unit at the same time as recording his present violent behaviour and yet still discharge him from the team, especially without him ever having been seen by a psychiatrist.

On 12th October Carole Luby wrote to Dr Hodkinson :

'Following a discussion with yourself and Tracey Upex, I have now written to D discharging him from my caseload.'

It was not until 26 November that Carole Luby wrote to DN to say:

'I am writing to confirm that you now discharged from our care as you no longer wish to see me.

If in future you need our services please contact your GP, Isabel Hodkinson who would re-refer you.

All the best for you and M's future together.'

The Closure Summary was not signed by the Team Manager, Brian Toye, until 6th December, 1996.

DN did not attend for his injection on 25th October but turned up on the 30th, saying that he had been assaulted two days previously and had been hit on the head with a hammer. He was seen by Dr Farrelly who described him as *'agitated'* and was given his depot medication.

M saw Dr Hodkinson on 1st November and said that she had also been attacked with a hammer and had a fractured nose and a scar to show for it. The attacker was apparently a relation of a girl who was keen on DN. DN had apparently been injured when he tried to help M.

She said that she and DN were planning to get married on 19th November.

DN turned up again with M on 8th November and Dr Hodkinson noted in DN's notes:

'It's a losing battle

Black blankness

Live up to expectations – be happy

Cannabis not holding it.

Angry at M

1 language

Feelings

D doesn't have to fix it.

Praying together

The shadow is inescapable

No magic about marriage.'

They turned up together again on 22nd November and DN was noted to be *'really pleased about marriage'* which had taken place three days earlier. He said that he was trying to straighten himself out.

DN attended on 28th November for his Depixol injection.

On 2nd December a very tearful M telephoned the CMHT asking to see Tracey Upex as soon as possible as she had split up with DN and he had moved out. They must have got back together again as the next note made by Tracey was on 13th December when M said that DN had told her the day before that he had been offered a 9 to 5 job at a friend's garage but she had been frightened as to how she would manage without him around and they had had a row about it. She then told him that she wanted some time on her own. DN subsequently said that he would try to find part-time work.

On 6th December both DN and M went to see Dr Hodkinson. DN attended again on 27th December and told Dr Hodkinson that towards the end of the duration of the monthly depot injection he felt '*more distant / hostile. Difficult to stay related to M*'. The injection was increased to three weekly. DN said that he was smoking about half an ounce of cannabis a week. Christmas apparently went well.

DN attended the surgery again on 17th January, 1997 and informed Dr Hodkinson that he and M had split twice since the wedding. M was talking about divorce. She wanted him to work but he found the discipline of regular work very difficult. He was still smoking about half an ounce of cannabis and was also taking cocaine. He said that he felt '*twitchy + shaky*' and didn't know how to face M. He was given his depot injection of Depixol.

On 4th February 1997 M attended what should have been a joint session at the surgery, but DN did not. M told Dr Hodkinson that she was really fed up with D but she was "*praying and feeling rooted.*" She said that DN was smoking a lot of cannabis, even in front of the children. She complained of recurrent violence and said that she felt that DN wasn't responding and was walking all over her. He was constantly questioning her as to who was in the house. Apparently DN was not living at her house at that time. She said "*I think that he is obsessed with me.*"

M attended the surgery again on 11th February and saw Dr Hodkinson. She said that she had been to visit him that day and he wanted to give her a present of stolen goods and she refused. As she was leaving he said "*you won't see me*" and she said "*OK*". He then went "*berserk*" and attacked her and kicked her while she was on the floor - all over her body including her head - and he also punched her in the head and face. The GP recorded various injuries on M.

On 13th February 1997 M attended the surgery and saw Dr Farrelly. She told him that she had reported DN to the police and he had disappeared. Dr Farrelly noted that M was very frightened that DN was going to harm her. She said that the children were afraid of him. She said that she wanted to go away and felt that her solicitors and the police wouldn't understand. Dr Farrelly discussed the matter on the telephone with a police woman who advised M to change the locks and to be vigilant. Dr Farrelly then telephoned the Adult Social Services who said that they could not help and advised him to contact the Children's Team. Dr Farrelly made a telephone call to the Children's Team who said that they could not help. They advised M to contact the Domestic Violence Unit or Women's Aid.

On 17th February M telephoned Dr Farrelly and said that she was in a women's refuge with the children. She thanked him and said that she would stay in touch.

On 21st February M spoke to Tracy Upex to tell her that she was in a refuge and she explained that DN had started to become physically aggressive towards her again. She thought that he had been increasing his drug intake and she could not tolerate his behaviour anymore.

DN did not attend for his appointment on 21st February.

On 1st March DN's mother telephoned the Tower Hamlets Emergency Doctors On Call Service saying that she was extremely worried about DN's behaviour and needed some advice. Their notes record:

*'Behaviour abnormal.
Delusions Fantasies
Wild ferocious animals
Already stabbed elder brother
Needs help.
Not on medication
Absolutely would not come to hospital
Son ferocious
Doesn't want him to hurt other people....deceitful, lies
Explained how section.
Rarely sees him
Advised sounds he will need Mental Health Section.'*

There appears to be no record of anything having been done following this phone call. We consider that such advice from the Emergency Service should have at least triggered some action.

On 10th March DN apparently committed a burglary for which he was later charged. He said that he had been at a friend's flat where an electrical fuse had burnt out. Not having a spare, his friend suggested that he broke into a nearby flat which was empty and should take a fuse from there. This he did, but on breaking in, he found that the flat wasn't empty and took the opportunity to help himself to various hi-fi equipment and electrical goods that he found there.

On 25th March DN came to the evening walk-in surgery but didn't wait to see a doctor.

The following day, 26th March, DN's mother telephoned in the afternoon *'in a state.'* She said that DN had just visited her and she said that he seemed unwell. He was threatening and hostile. She said that he was going to do someone harm. She also said that he had been terrorising his grandmother in recent weeks.

Dr Farrelly telephoned DN's grandmother to check on this information. She said that she had last seen DN three weeks ago when he wanted money. She refused to give him any and he had knocked down her door and set fire to the curtains. However he did not touch her. She told him to go and she made it clear that she will not let him back in. She said that she was not particularly worried about him and that he was *"not much different from usual."*

Dr Farrelly noted that DN had an appointment on 1st April with Dr Karen Sennett, a GP who was employed part-time by the Tredegar Practice.

That day Dr Farrelly referred DN back to the Bow Poplar CMHT. Carole Luby noted that Dr Farrelly had said that DN was “*on the loose*”. He was terrorising his grandmother. The note recorded: ‘*George feels he may be brewing for a blow-out*’. Dr Farrelly wanted someone to pick DN up and gave the address that he thought he was living at. But he advised it should be a male CPN who attended and Dr Farrelly said that he was going to pay a visit to DN’s flat to try to find him.

Dr Farrelly paid a visit to DN’s flat that evening but there was no answer. He left a note suggesting that DN came to see him the following day but he did not attend.

DN did not attend the appointment with Dr Sennett on the 1st April either. She telephoned the Bow Poplar Team and discussed the matter with Carole Luby. They advised Dr Sennett not to visit DN alone and she wrote in the notes that she queried whether he should be on the Supervision Register. She tried telephoning him and when there was no reply, she wrote to him asking him to attend the surgery.

On 3rd April, Tracey Upex met with M who was feeling more cheerful and positive. She said that she knew she had made the right decision to leave DN and to prosecute him for the injuries he had caused her. She said that she had tried other ways to help him overcome his difficulties but that she could see the pattern of his behaviour repeating itself.

On 4th April Tracey Upex, the CPN from the CMHT who was M’s Key Worker, spoke on the telephone to Dr Sennett and said that she had seen M and she was in a refuge in Bexley and planned to stay there permanently. M had seen DN that week and he seemed unwell. He was apparently dishevelled and had lost weight. He was due in court on 8th April for the assault charge against M. Tracey Upex said that the CMHT would take him back on to their caseload.

Dr Sennett faxed a letter to Carole Luby asking if the team could carry out a mental state assessment of DN and arrange follow-up. In the letter she set out his recent medical history and also the fact that he had assaulted his wife. She noted that his mother had contacted the surgery expressing her concerns that he was going to do someone some harm. She also noted that he had knocked the door down at his grandmother’s house and set fire to her curtains. His past medical history and past convictions for violent behaviour were also noted as was his use of cannabis and cocaine. She noted that he had not been seen at the surgery since 17th January. She asked if the team could carry out an assessment if he was contactable. She concluded the letter:

‘I wonder whether he should at least be on the CPA. ?? Supervision Order’.

This was a fresh pair of eyes looking at the case and seeing DN as someone (a) who posed considerable risk and (b) required ongoing care from the specialist psychiatric service. Implicit in the fact that Dr Sennett felt that he should be on the CPA is her belief that he was suffering from an ‘enduring mental illness’.

On 7th April Jo Williams, CPN with the Bow Poplar CMHT who had been allocated to be DN's Key Worker, noted in the records that DN had been re-referred from the Tredegar Road GP practice. She noted that he was presently in the community although his whereabouts were unknown, that he not been on depot medication for approximately four months and was suspected by the GP to be psychotic and 'at risk' in the community.

DN did not attend his appointment on 8th April at the surgery. On 11th April Dr Hodkinson telephoned Dr Palazidou to discuss the risks of the case. Dr Palazidou's advice was that they should try to obtain a Section 4 Mental Health Act Order (an emergency application) to get him into hospital for an assessment.

The same day Dr Hodkinson faxed a letter to Dr Palazidou setting out the following:

'As we discussed his wife ... left him and went into a refuge early Feb. He had been violent towards her long-term & it hadn't improved (as per her fantasy) following marriage in Nov 96.

We had negotiated Depixol 50 mg 3 wkly but he has DNAd for depot (having previously been a very good attender) since 17.1.97 - on assessment then things were difficult with M & he was shaky & twitchy, using his usual cannabis, but also some cocaine. Since then he has DNAd 4 appointments – we have now told our receptionists to call us immediately if he comes in. There is no reply at his flat & his grandmother tells us he's sub-let it & moved out. She took out an injunction because he set her curtains on fire and his mother (from whom he is estranged) says he has been threatening to do someone harm.'

She also faxed Dr Palazidou copies of her two previous letters to her and the Psychiatric Report prepared by Dr Neil Boast in June 1992 for the Hospital Managers' Meeting at the Hackney ISU, which set out in detail DN's forensic and psychiatric history at that time.

On 14th April, Jo Williams liaised with Dr Palazidou and Dr Hodkinson and the plan was that the GP and Mike Payne (Senior Registrar who worked with the CMHT) should pay a joint visit to DN to attempt an assessment. If he could be found then it was suggested that Section 4 MHA was to be initiated and it was noted that once he was located he should be referred to the forensic services.

As it had now been decided actively to pursue a Mental Health Act assessment, an Approved Social Worker should have been involved at this stage.

On 15th April Dr Hodkinson spoke to the Bow Poplar Team who said that they had allocated Jo Williams to be DN's key worker.

On 16th April Dr Hodkinson was contacted by someone from the Limehouse police station who said that DN had been a victim of a GBH assault earlier that year and that the defence team wanted disclosure of his medical history. She noted that that DN was due in court on the 13th May.

On 24th April DN turned up late in the afternoon at the surgery whilst Dr Farrelly was holding a teaching session with students. He said that he was trying to hold it together but felt that odd things were going on in his head and that he was having some paranoid thoughts. He felt that he needed medication. He did not feel he was going to harm anyone or himself. He told Dr Farrelly about the times that he had assaulted his brother and also the stranger on Liverpool Street station. He said that he didn't feel like he had then and said *"That was insanity – I don't understand that."*

Dr Farrelly gave DN his Depixol injection and also some oral medication which DN requested. An appointment was made for him to be seen again on 28th April or earlier as an emergency. Dr Farrelly left a message for the Bow Poplar Team on their answer machine.

This is another illustration of the GPs accepting responsibility for DN's assessment, treatment and care when this was a clear opportunity – especially in the light of recent events and plans – to have an assessment carried out by the psychiatric services.

DN turned up late for his appointment on 28th April but Dr Farrelly gave him a *'five-minute slot'* which he kept for emergencies. DN said that he felt better.

On 7th May DN turned up again without an appointment to Dr Farrelly's evening surgery. He was on edge and rather shaky. He was given a further Depixol injection as well as oral medication and told to re-attend in one week.

On 12th May Jo Williams telephoned Dr Farrelly to ask what involvement of the CMHT might be helpful to DN. Dr Farrelly said that he would discuss it with him.

This illustrates how the CMHT took a reactive rather than a proactive role in DN's care, and appears to completely ignore the concerns of the past few weeks.

We consider that the CMHT was in the best position to assess DN's needs.

DN did not attend his appointment on 14th May. On 22nd May Dr Farrelly completed a medical report for DN's solicitor for the court hearing. It set out his past psychiatric history, giving details of the 1991 incidents which led to his admissions to Kneesworth House and the secure unit at Hackney, and full information concerning his treatment since he had been a patient of his and Dr Hodkinson. He concluded:

'In summary, I feel D certainly has some form of mental illness and during stressful times can be pushed into a psychotic state. Anti-psychotic medication seems to help to stabilise him and I feel that it is important that he continues to have this.'

On 23rd May DN came to the surgery and saw Dr Sennett. This was the first time that Dr Sennett had actually met DN. He said that he was not eating well and was finding it difficult to cope with practicalities. He had been rejected by his wife and grandmother. He was sleeping a lot but was hearing no voices. He was given a further Depixol injection. Dr Sennett left a message on the CMHT's answer phone to request

that they see DN. She noted that she had discussed this with DN and that he was not asking for help, but was willing to see the Bow Poplar Team.

Dr Sennett also noted that she suspected that it was important that DN was under CPA monitoring because of his history.

On 27th May Jo Williams wrote to DN saying that she and a colleague would like to come to see him at his flat on 10th June at 12.30.

Dr Hodgkinson saw DN on 3rd June when he was apparently *'not too bad'*. He had been to Court the previous day in relation to the hammer attack on himself and M. The court appearance for his assault against M and the burglary charge was still awaited. He admitted that he was still taking cannabis and ecstasy and that he had been taking more of these as his medication had decreased. Dr Hodgkinson therefore decided to increase the depot injections to every two weeks. He also reported that he was shaky and had palpitations and his jaw locked and that he got angry quickly but he was not edgy. He was given his injection. Dr Hodgkinson noted that cannabis was *'a real problem'*.

On 9th June DN and his friend appeared at Thames Magistrates Court on the burglary charge and the matter was committed for trial at Southwark Crown Court.

On 10th June Jo Williams attempted a home visit but DN was not at home She left an appointment for 18th June. She liaised with Dr Hodgkinson who told her that she had seen DN and that he was using more illicit drugs recently to cope with his court appearances and that he was mildly disordered. She said that she would be seeing him in three days' time and would encourage him to keep his appointment with the CMHT.

In fact DN turned up that evening at the walk-in surgery because he needed his medical card for ID. He said that he had drunk champagne and had taken ecstasy the previous Saturday and was feeling *"trippy"*. Dr Hodgkinson advised him to try to stay away from *"those friends"*.

DN did not attend for his doctor's appointment on 13th June.

On 18th June at 14 minutes past midnight a call was made by DN to the Tower Hamlets Emergency Doctors on Call Service which was noted as:

'Patient is suicidal depressed, not making any sense.

Patient is with a friend who is pregnant.

? Might be in danger.'

A doctor called back at 00.20 but the line was engaged. They got through at 00.30 and the subsequent conversation with DN was recorded:

'Melleril tablets but hasn't taken for 4 days. Now says overdue for ?Modecate – wants me to give it to him now!

Explained that I do not have Modecate in my bag. Advised to restart melleril and see own GP re Modecate.'

M telephoned the surgery and spoke to Dr Sennett. She said that she was phoning from a friend's house where DN was staying because his flat was in a state. She said that he was threatening violence. Dr Sennett's note of the conversation was:

'He requesting hosp. as nowhere to stay tonight 'as long as I can leave the hospital for a walk'.

3 Egyptian friends want him to work for them & someone else wants him to work for the mafia.

Cannabis (next word illegible)

Propanol no help.

Didn't come for Depixol as too busy.

Frightened of someone – tears ++

No hallucinations.

Frightened of court case 25.6.97

Kicked chair

'God's spirit takes control. He'll save me. God will win'.

Threatened to kill himself if M not back with him. On phone

Said going to kill someone/hurt someone.

Man that on bail that M thinks may kill him.

(illegible) – people after him. No-one likes him.'

Dr Sennett advised them to come to the surgery where she saw DN and noted that his psychosis had increased and there was some risk of violence to others. She felt that he needed a full assessment. She telephoned Jo Williams and told her that DN was *'out of control and needing admission to hospital'*. He was using increased amounts of illicit drugs and had a court appearance next week for the assault against his partner. Jo Williams noted that the doctor's assessment had been that DN was delusional, frustrated and tearful and that he was threatening violence. The GP's impression was noted as a mixed picture of psychosis, drug use and the court appearance the following week.

Jo Williams spoke with Dr Palazidou who advised an admission to hospital through the A & E department at Whitechapel. After further liaison with Dr Sennett, the plan was for the doctor to send DN to the casualty department with M and a letter of referral. Dr Sennett said that she would page the duty psychiatrist and liaise concerning the admission.

Dr Sennett then wrote a referral letter in which she set out details of DN's worsening psychotic illness, his threats of violence to others and the need for a full assessment and diagnosis. She said that he had been worsening over the last week and had had his last depot injection on 3rd June. She recorded that when she had seen him, his speech and movement had been fast and agitated and he kept suddenly bursting into tears and becoming angry and kicking chairs. She reported his delusional thoughts, paranoid ideas and threats of violence. She also recorded that his wife felt that he might hurt the man who was on bail for attacking

them. And she also stated that he had suicidal thoughts at times but no present plans. She concluded the letter:

*'- Some psychotic features -?partially cannabis rel. - ? worse as court case due.
- Problem controlling violence in past.
- ?some manipulation coz wants wife back & also court case.'*

The fax was sent for the attention of Dr Alyas, the Duty Psychiatric Senior House Officer (SHO) at St Clement's Hospital, and Dr Farrelly's letter which he had written for DN's solicitor was faxed as well, with a note on the fax cover sheet that DN was due in court the following Wednesday. Dr Farrelly's telephone number was also given.

DN, accompanied by M, attended the A&E Department at Whitechapel that evening. It was a Wednesday evening. The Locum Psychiatric Registrar who saw him made the following detailed notes:

*'Old patient of Hackney with a history of ? Schizophrenia ?Drug induced psychosis. Also has a forensic history and at age of 19 spent one year in Feltham, then 6/12 in Kneesworth House and then 6/12 in Hackney ISU. Discharged and then moved out of the Hackney area.
Has had no psychiatric contact since his move - has been apparently well since then.*

Recently Dr Palazidou wanted to arrange an admission for assessment but he was unwilling to be admitted.

Currently C/O Lucifer Michael and other bad angels coming to get him like a 'phantom' - was unable to sleep last night due to the phantom gripping him around the leg.

Denies auditory hallucinations or other hallucinations apart from the 'phantom'.

Denies thought interference –

_ Somatic passivity elicited.

C/O suicidal ideas such as jumping from a window or taking an O/D.

_ notes written

very frightened of everyone being in collaboration against him.

Appetite poor _ food x 2 days

Sleep poor _ sleep x 2 nights

...Cannabis £10-15 / worth daily

A+B Casually dressed young man of mixed race with a large packed suitcase next to him.

Agitated ++

Suspicious ++ 'should I tell her or not?'

Not hostile.

Tearful ++ Seeking reassurance thro'out

...He was very agitated...very worried about what might happen to him.

Mood suspicious

Not obviously depressed.

Suicidal thoughts +

*Seemed to be hallucinating ...but denied this.
Paranoid delusions re angels and phantoms coming to get him.
_ Thought disorder
Cog Fn grossly N*

*Imp. Acutely psychotic 26 yr _ with a past hx of psychosis and forensic hx.
Continued cannabis abuse since D/C from ISU*

*Plan: Admit informally to St Clements
++'*

DN was admitted as an informal patient to Dundee Ward at St Clement's Hospital at about 21.30 on 18th June. His Consultant was named as Dr Palazidou.

We were told that at that time Dr Palazidou did not cover Dundee Ward. When there was no bed available on the ward covered by Dr Palazidou, her patients were sent to Dundee Ward which was under the consultant care of Dr Cobb and Dr Cookson.

The Ward Admission Summary included the information that he had a forensic history and abused cannabis. It stated that DN had said that he felt safe on the ward. He was noted as being pleasant and co-operative and '*no management problem.*'

A Care Plan Form was completed that evening which included the following:

'Aim of Care: For a full assessment of D's mental state so that a plan of care should be formulated.

Plan of Care:

- *To establish a nurse/patient therapeutic relationship based on trust and rapport*
- *Give D time to settle on the ward and to encourage him to ventilate any anxieties*
- *Assess his needs and wants holistically ensuring that factors that may be exacerbating health status be addressed...*
- *Liaise with the multi-disciplinary team'.*

He settled himself at about 23.30 after requesting medication to help him to sleep and after a urine specimen had been taken.

The following morning he was noted as being paranoid but he calmed down after reassurance from the nursing staff.

Vicky Barwood, Ward Manager of Dundee Ward, spoke to Jo Williams (the CPN who was DN's keyworker) on the telephone that morning and was told by her that DN had deteriorated over the past three

months and his drug use had also increased. She said that she had not been able to make contact with DN since his referral in April and he had avoided contact with the CMHT.

Further information was then written into the notes which referred to DN's past history of violence, that he had stabbed his brother and had been admitted to Feltham, Kneesworth House and Hackney Secure Unit. It was also recorded that he had recently assaulted his wife and that he was due in Court on 25th June.

Most, but not all, of that information was to be found in the May letter written by Dr Farrelly to DN's solicitor which had been faxed by Dr Sennett to Dr Alyas at St Clement's. Further information was given by Jo Williams. The CPN said that she would visit DN on the ward the following Wednesday, 25th June and then attend the ward round with Dr Cobb.

On the 19th June DN signed an Inpatient Contract agreeing to certain conditions:

- ' 1. No alcohol or drugs (other than those prescribed) to be consumed throughout treatment.*
- 2. No violence or threat of violence will be tolerated.*
- 3. You may be breathalysed or asked to give a urine specimen at any time, and your locker and belongings may be searched without warning.*
- 4. Visits from outside may be restricted.*
- 5. You will be expected to co-operate fully in the daily activities.*
- 6. Failure to comply with any of the above will result in discharge.'*

We question the appropriateness of such contracts on an acute psychiatric ward.

Clearly there is a legal problem for the hospital if a patient is found to be taking illegal drugs on its premises. However, we are concerned that, under the terms of this contract, it seems that a patient will be discharged (presumably whatever their condition!) if they are found to be in breach of its terms. Term (6) does not appear to allow for any discretion to be exercised.

This legal dilemma must be addressed at national level.

DN was reviewed on 19th June by the SHO, Dr Zaubia Alyas. She was in her first SHO training year and about 5/6 months into her first psychiatric SHO post as Dr Cobb's trainee.

After talking to DN she noted his poly-substance abuse, cataloguing his use of amphetamines, crack cocaine, heroin, all brands of ecstasy and valium. [Cannabis was not included in the list.]

She recorded that he felt that spirits were controlling him and also entered other people – he could tell by looking into their eyes. He said that he and his wife had the spirit of the Holy Ghost in them and people with spirits in them were visiting his bed-sit in his absence to check up on him.

Her impression of him was that he had overvalued ideas about spirits rather than delusions and questioned whether it was drug induced. She asked for a urine test to be carried out.

We consider that an SHO in her first post does not have sufficient expertise to develop a management plan on the distinction between overvalued ideas and delusions.

Dr Alyas's impression is in stark contrast to the assessment carried out by the locum Registrar in the Accident & Emergency Department on the previous evening.

She noted that he had been in Feltham for ABH having attacked his brother with a knife and also the GBH and shoplifting offences were recorded and the fact that he had been detained under Section 37/41 MHA. **(In fact, there had been no Section 41 Restriction Order.)** She noted that there were no old notes available but queried whether he was psychotic when violent. She noted that care should be taken with visitors bringing drugs onto the ward.

At the end of the 19th June morning nursing note written by Vicky Barwood were the words:

'Dr Alyas has requested he is assessed for Section 5(2) if wanting to leave.'

This was a very appropriate request.

At 20.00 Vicky Barwood wrote up her evening note which recorded that DN had been calm and appropriate in his behaviour. She noted that he had made no request to leave the ward other than to use the public telephone. Level 2 observation was maintained.

The night-time nursing note showed that DN was somewhat restless and agitated, demanding and attention-seeking. He was given medication to calm him and to help him to sleep, but with no effect. He was therefore given more medication.

On 20th June, Vicky Barwood telephoned Dr Hodgkinson for more information about DN. The GP recorded that she was told that he was happy as a voluntary patient at that time.

Dr Hodgkinson told Vicky Barwood that DN's admission to Kneesworth House had been as a result of an assault and also possibly the kidnapping of children whom he believed were going to be harmed. She told the nurse that she had sent his past notes about his forensic history to Dr Palazidou, and Vicky Barwood made a note to get hold of them. She also noted the two criminal charges for the assault on M and the theft of the ring which were due to be heard the following week.

M telephoned the ward that morning to tell them about the assault charge she was bringing against DN which was due to be heard in Court on 25th June.

A note made by Vicky Barwood timed at 14.00 on 20th June stated that DN had remained in bed until 11.00, but appeared calm and appropriate in his behaviour. She described him as suspicious at times,

asking staff if they were watching him, and wrote that his speech appeared vague at times, but there was no evidence of perceptual disturbance. Again there was no aggressive behaviour noted and DN had made no attempt to leave the ward. Level 2 observation was maintained.

A note made at 20.25 records that DN had gradually become more disturbed as the day wore on, becoming verbally abusive and threatening physical violence. He apparently had stormed out of the ward at 16.30 because he had been refused access to some of his possessions, in particular some screwdrivers, but had returned an hour later, calm, settled and apologetic. He admitted to drinking a can of lager whilst out and the nurse recorded a suspicion that he had also obtained illicit drugs. He had apparently been calm and appropriate since his return.

The GP records show that Dr Alyas had telephoned the surgery on 20th June to say that she had no notes on DN, and the information was faxed through by Dr Sennett.

Dr Alyas made a detailed note in the clinical records that day. She set out the history of the referral, his mental state when examined by the GP and by herself on admission to St Clement's Hospital. She also recorded that Jo Williams had informed them that the GPs had made three referrals to the CMHT in the past two years, and that the CPNs had made repeated attempts to become involved but had failed to make contact with him. She also recorded that Dr Palazidou wanted DN's admission so that a formal assessment could be made.

DN's past forensic history was also listed by her and details of his past admissions under section in Kneesworth House and Hackney Secure Unit. The diagnosis made by Dr Boast in 1991 of borderline personality disorder and delusional disorder of persecutory type was also noted.

This note made by Dr Alyas shows:

- (a) That she was in possession of all the necessary information about DN**
- (b) That she had read and absorbed all that information**
- (c) That she was aware that Dr Palazidou wanted an assessment to be carried out and that the CMHT had found it difficult to engage with DN.**

Dr Alyas also recorded that she had been unable to review DN that day as he had left the ward after an argument with a Nurse who had concluded that as he was an informal patient and not deemed to be sectionable he should be allowed to go. A note was made to ring the GP and M at the women's refuge. Dr Alyas concluded her note:

'Probably needs further assessment and persuasion to stay in hospital.'

The night note for 20th June showed that DN requested medication to help him sleep and he then slept well through the night.

A note made at 08.50 hours the following morning, 21st June, recorded that DN had come to the office and handed in two small pieces of cannabis to the nursing staff. He said that he had smoked some cannabis whilst off the ward the previous afternoon but hadn't had any more since then. His property was then searched in his presence and with his agreement, and no further illicit substances were found.

According to the nursing notes DN seemed quite pleasant and very interactive that morning. He had his breakfast and went to bed for a while. He woke up at about 10.30 and asked to make a phone call upstairs. When he was given permission to do so he apparently left the ward unauthorised and returned 15 minutes later at about 11 o'clock. When he was approached by the Acting Ward Manager about this unauthorised behaviour, he became verbally aggressive, using abusive remarks. The duty doctor, Dr Alyas, was called to assess him.

Dr Alyas's note of that encounter was as follows:

- ' - returned to ward last night*
 - gave in some cannabis*
 - left again this am. Told nurses he was going to make a phone call and ran off ? to use drugs. Showed me a receipt from police where he reported theft of wallet (has a form with a (date) stamp on it)*
 - when confronted about this by the nursing staff started shouting and swearing*
 - on taking to another room told me that he was being accused of using drugs when he really just went to report an incident to the police*
 - agreed to provide urine sample if went out but senior nurses feel that this will not guarantee him not losing his temper or abusing so feel he either needs to be on a Section or be discharged*
 - there was considerable tension when this decision was taken and I felt he will become volatile again if challenged about anything and also feel his problems are related more to his anti-social personality*
- Plan - has agreed to see his GP on Monday*
- Informed Dr Palazidou*
- To have a realistic assessment of mental state need to admit to a Secure Unit that can ensure no drugs in his system and properly assess his mental state*
- Needs specialist nursing - suggest referral to forensic team*
- Happy to go as would see himself getting deeper into the system - this indicates that he is not using this as a manipulative admission to get out of the impending court case but generally seeking help that cannot be offered here.'*

The nursing note shows that DN packed his belongings and was discharged from the hospital leaving at about 11.15. It recorded that he had chosen to take his own discharge and that he would make an outpatient appointment with his consultant through his GP. 21st June 1997 was a Saturday.

An Incident Report Form signed by the Acting Ward Manager and dated 30th June (nine days later) stated:

'Pt. DN left ward without informing staff. Returned fifteen minutes. Became verbally aggressive, intimidating & threatening in manner.

Seen by Dr Alyas (duty dr)

Mr N discharged himself'.

We are concerned that the decision to discharge DN was made by a very junior doctor without any consultation with a more senior colleague, and without a detailed assessment of his mental state (which was the main purpose behind his admission) and risk having been carried out. Dr Alyas appears to have forgotten her own note of the previous day that DN *'probably needs further assessment and persuasion to stay in hospital'* and her earlier request that an assessment for a Section 5(2) MHA should be initiated if DN wanted to leave the ward.

Section 5(2) enables an informal patient to be detained for up to 72 hours if the doctor in charge of his treatment reports that an application under section 2 or 3 of the Mental Health Act (compulsory detention for assessment/treatment) ought to be made.

Although this lack of assessment could not have had a direct effect on the homicide which occurred a year later, we do feel that it may have had an indirect influence, for the reasons set out in the Commentary and Analysis Section of the Report.

Dr Farrelly recorded a telephone call on Monday 23rd June from DN's solicitor saying that DN had been arrested recently and was in police custody. The solicitors were suggesting a court order to send him back to hospital.

It is clear from the records that the hospital did not let the GPs know that DN had been discharged. Jo Williams only discovered the fact on Tuesday 24th June when she telephoned the ward to ask after him.

DN was arrested almost immediately after his discharge – on 22nd June. We understand it was for breaking into and taking a car which he then crashed into a concrete bollard. He was charged with Taking without Consent, Dangerous Driving, Driving without Insurance and Theft of a pair of sunglasses he found in the car. He was held on remand pending the court hearing due on 25th June.

A long and detailed Summary was to be found in the Hospital notes and a copy with a handwritten note saying that it is a draft was also in the CMHT notes which we received, but it is not to be found in the GP records. It appears that it was never sent to them.

It was unsigned and undated, but we now know that it was prepared by Dr Alyas. She told us that she was about to go on leave and therefore made detailed notes to be typed up later.

The Summary concluded:

“ IMPRESSION

This volatile man is very sensitive to any form of confrontation and therefore cannot be managed safely on an open ward, he quickly lost his temper on two occasions where senior nurses gently confronted him about perfectly reasonable concerns and spiralled in a matter of minutes to use intimidating rastafarian cussing and no doubt if he hadn't decided to exit from these 2 confrontations there would have been physical aggression.

In fact to his credit he was able to actively and correctly leave on 20/6/97 to defuse the situation. On 21/6/97 I interrupted his argument with the senior nurse to try and diffuse (sic) the tensions arising between the two of them. He agreed to come and talk to me and was quite calm and rational and able to explain where he had been and come to the sensible conclusion that he was likely to be sectioned if he remained in Hospital any longer and therefore we should try and sort his problems out as an outpatient.

The overvalued ideas about spirits that seem to be my only positive finding and may be understood partly in a cultural context. These ideas are almost certainly modulated by his erratic use of hard and soft drugs - the exact amount of which he is reluctant to go into - it is likely that his response to psycho-social stress is to use more drugs which make him delusional and from his GPs accounts these delusions are fairly responsive to low-dose depixol.

We can speculate that the stress in this case may be the guilt associated with beating his girlfriend up and losing this supportive relationship or if he has a true anti-social personality, the stress of another court appearance and the possibility of a further spell in prison.

FOLLOW UP PLANS

- *He has agreed to go and see his GP Monday morning and via her come and see Dr Palazidou as an Outpatient for help with his problems.*
- *He probably needs to be referred to the local Forensic team too.*
- *Ideally if repeat admission is necessary it should be to ITU where his challenging behaviour can be dealt with more safely.'*

It is unclear to us why Dr Alyas would have believed DN when he apparently agreed to see Dr Palazidou, when she had noted just two days earlier that the CMHT had failed to engage DN over a lengthy period of time.

The CPA Meeting planned for 25th June did not take place. We feel it should have done. The handwritten 'Discharge Summary' in the Nursing Notes dated 21st June states that a CPA form had been completed. In fact only his name and date of birth had been entered on the form. The rest of the three page form is empty.

DN apparently pleaded guilty at Thames Magistrates Court on 25th June to all of the charges against him, which were the assault against M and the various driving related offences committed on 22nd June. The case was adjourned to 16th July for sentencing. In the meantime he was held on remand in Brixton Prison.

On 9th July DN pleaded guilty to the burglary charge at Southwark Crown Court and the matter was adjourned for a Pre-Sentencing Report (PSR). He was again remanded in custody.

On 16th July the other matters came back before the Thames Magistrates Court for sentencing. A detailed PSR had been prepared by Rene Plen, a Probation Officer with the Inner London Probation Service (ILPS), and there was also a three page handwritten report dated 23rd June from a Dr Martin Feakins, a psychiatrist from The Royal London Hospital who had been one of the duty psychiatrists on that day and who had seen DN and his solicitor.

Dr Feakin reported that DN had suffered a severe mental illness in the past and was still receiving prophylactic medication for it. He said that impulsive behaviour was characteristic of borderline personality disorder but that there was no clear evidence on the day he saw DN, other than his behaviour, that his illness had relapsed. Dr Feakin recommended to the Court that a full assessment of DN's psychiatric history should be obtained, with communication with his GP and St Clement's Hospital.

The PSR report detailed DN's past personal, forensic and psychiatric history and highlighted the fact that before these current court appearances DN had not come to the attention of the authorities for some five years. The report concluded:

'I understand that, on the last occasion, no view was expressed with regard to sentencing options. Mr N is, nevertheless, aware of the very serious view which is likely to be taken of his actions on this occasion, and that, as a consequence of his involvement in these matters, he may have placed his liberty in jeopardy. It is evident from my discussions with him that he is not finding it easy to cope with the experience of custody at present. However, in the absence of a detailed psychiatric assessment, it is difficult to comment, either with respect to the likely impact of a term of imprisonment, or to suggest that consideration be given to the imposition of a Community Penalty. The situation is, moreover, further complicated by the existence of the outstanding matter in relation to which Mr N is appearing before Southwark Crown Court. In all these circumstances, therefore, I do not feel able to offer a constructive proposal to the court today.'

On 16th July, the Stipendiary Magistrate decided he had insufficient powers to deal with the case and that the matter should be committed to the Crown Court for sentence; it was transferred to Southwark Crown Court to be dealt with along with the burglary charge.

A form was sent by the Court Duty Probation Officer to the Inner London Probation Service which said:

'Please note: Defence wanting the Court to make a Probation Order with a condition of psychiatric treatment. You may need to discuss this in your report.'

A further psychiatric report was prepared for the Court by Dr Richard Pearson, a Senior Registrar Forensic Psychiatry at the Maudsley Hospital. Dr Pearson had apparently read DN's prison medical records and Dr Feakin's report, and had also contacted St Clement's Hospital by telephone and received a (1992) psychiatric report from Hackney Hospital ISU. He had also discussed the case over the telephone with Dr Farrelly.

The report detailed DN's personal history, including his extensive drug abuse, his past psychiatric history and his explanations of the index offences. In his report Dr Pearson stated that DN did not believe that any of the offences were drug or mental illness related, appearing to believe that they were the inevitable consequence of the lifestyle he was currently leading and his poor relationship with his wife.

The report concludes:

'Mr N is a 27 year-old man who has a history of paranoid psychosis (a serious mental illness where a person suffers from false beliefs about their relationship with the rest of the world). Before treatment, he was involved in several seriously aggressive acts, which resulted in him receiving a Hospital Order. Since the 1990s he has been on depot antipsychotic medication (regular injections) and, although at times his compliance has been poor, he has remained relatively well. When well, as at the present time, Mr N is a pleasant co-operative man who has some insight into both his offending behaviour and illness. He expresses a desire to stay clear of drugs which he knows are detrimental to his mental health, but his ability to stay abstinent once in the Community must remain in doubt. Both Mr N and his GP have agreed that once he is released from prison they will involve the local community psychiatric team in an attempt to more closely monitor his progress. At this time, I am making no recommendation to the Court for a medical disposal in this case.'

A further lengthy PSR was prepared by another probation officer, Anderson Smith. He first interviewed DN in Brixton prison, had read the previous PSRs and had perused the psychiatric reports prepared by Dr Pearson and Dr Feakins. He also had seen the letter dated 22nd May 1997 prepared by Dr Farrelly and had discussed DN with Dr Hodkinson and Dr Palazidou. He had also spoken to M at her insistence. She apparently stated very clearly that she was willing to stand by her husband and support him.

Mr Smith wrote:

'There is perhaps no clear diagnosis in this case, although any diagnosis might prove to fall on a mixture of the psychiatric process and Mr N's deprived background. I understand his mother was estranged from his father at an early stage, and his father used cannabis and cocaine. Mr N lived with his father until he died in 1993 from cancer. Mr N himself has used cannabis quite heavily, in addition to other substances, and might start again to the detriment of his health. According to Dr Hodkinson, Mr N is not seen as a real threat to the community but is violent to his family. I am reminded, however, of Mr N's appearance at Knightsbridge Crown Court in 1992 when he was charged with GBH after stabbing his brother and the kidnapping and false imprisonment matters, involving a child, when he, Mr N, was in possession of a knife.'

I understand an assessment for Mr N's suitability for probation supervision in the community with a condition of psychiatric treatment is required. Such a disposal is quite possible, although Dr Palazidou at St Clements Hospital will need to see Mr N (in custody) before any judgment is made about the risk he poses to the community. Although Dr Palazidou is aware of Mr N's case, she has not met him and is concerned about the availability of out-patient services in the local community to suit the defendant's needs. As the doctor who would be responsible for his case, she is particularly worried about the impact of Mr N's drug abuse on his psychiatric condition and the extent of risk posed to the community. Of course, if Mr N, when released, decides to move to his wife's address, it would further complicate the situation and the psychiatric assessment of risk will have to be made in the appropriate catchment area.

In my view, the court will want to weigh carefully the likelihood of the defendant's compliance with psychiatric care in the community and probation supervision, and the risk he is likely to present to public safety, I gather that whilst using appropriate medication he thinks clearly and presents well, with a responsible attitude. This was the case when I saw him recently at Brixton prison, however, his records indicate instances when he has been unwell and the public was placed at risk.

Conclusion

The following options, therefore, are before the court:

(a) Custody

Such a sentence might have an adverse effect on Mr N's long-term situation and protecting the public might be better served by the making of a Hospital Order.

(b) Hospital Order

This disposal would protect the public and assist in the defendant's recovery and should not be overlooked in my view.

(c) Probation order with a condition of psychiatric treatment.

If the court wishes to make such a disposal, a further four week adjournment will be necessary for further psychiatric assessment of suitability for out-patient treatment and the setting up of treatment and support services for immediate intervention from the psychiatric and probation services locally.'

The matter came before Mr Recorder Tudor Owen for sentencing on 15th August 1997 at Southwark Crown Court. The Defence team had not at that time obtained their own psychiatric report and asked for a further adjournment for that purpose. The judge and his lay colleagues were apparently not satisfied that DN's psychiatric history had anything to do with the offences, so they decided to sentence him that day. The judge apparently commented that the PSR before them was a very good one and had made no proposal although it stated the alternative options clearly. The Defence suggested that the PSR had made definite proposals.

This was yet again an opportunity for Dr Palazidou to see DN and perhaps influence the outcome of his care and treatment. The Probation Officer had discussed DN with her. At the very least she

should have written to the Court to support the need for an adjournment so that his mental state could be assessed.

After a lengthy mitigation speech, the judge ordered a 12 month prison sentence for the burglary, a six month consecutive custodial sentence for the aggravated vehicle taking, a one month concurrent prison sentence for the assault and a one month concurrent prison sentence for the theft charge. DN was therefore committed to prison for a total of 18 months and was confined to The Mount Prison. His estimated date of parole was 23rd March 1998.

On 27th October 1997, Jo Williams wrote to Dr Farrelly to confirm the discharge of DN from the Bow Poplar CMHT in the light of his recent custodial detention. She wrote:

'As you are aware, we were unable to engage with D as he avoided all contact with our team.'

On the same day, Jo Williams filled out a Closure Summary form which gave the following background information:

'Referred by GP to offer support. History of psychosis, multiple drug use and criminal behaviour. Brief admission to Dundee Ward this year just prior to court appearance. In prison until March/April 1998 Did not engage with CMHT and avoided all appointments'.

His current status was given as being on the CPA level 2.

In fact, DN was never within the CPA. He should have been.

The risk factors were given as 'criminal activity' and 'assault on his partner'.

The reasons for closure were given as the fact that he did not engage with the CMHT and the fact that he had a custodial sentence until 1998.

The future plan was for the GP to monitor his arrival back to the area and to administer depot medication as before and to re-refer to the CMHT if required.

DN was discharged from the CMHT's caseload and was therefore not taken up by them automatically on his release from prison. Nor was he referred back to the CMHT by his GP as had been anticipated in Dr Pearson's report for the Court.

The Probation Officer assigned to DN was Harry Matthews. He went to see DN in prison on 23rd October 1997 and completed a Throughcare Initial Assessment Check List in which he put DN in a low risk category, although he had flagged up 'mental disorder' and 'violence aggression' (sic) on the form. He did however comment that DN would need reassessment on release.

He also made the following note on the Record of Contact sheet:

'Mr N appeared to be reasonably coherent and lucid despite background psychiatric information which pointed towards possible psychotic paranoia disorder. He said he is receiving drugs in the prison which is helping to control him and he has not been using illicit drugs. He believes it is the mixture of illegal drugs plus his prescribed drugs which has caused the mental breakdowns in the past. He spoke quite frankly and openly about this and his previous Hospital Order...'

DN was apparently in the 'drug free' wing, a fact of which he was proud, according to M. However DN told us that he was still able to get access to drugs, sometimes every few weeks.

When he saw DN on 23rd October, Mr Matthews apparently also explained to DN that he would be released on Licence – which meant that he would be under the supervision of a probation officer and must comply with any conditions of the Licence – and the Licence requirements were explained to him.

The Mount prison records were apparently sent on to Belmarsh Prison after the homicide and now cannot be found. We therefore do not know how DN was or how he behaved during his time in custody. He himself told us that he was not well whilst he was in prison and he certainly was released on antipsychotic medication.

However, DN wrote two letters to Harry Matthews whilst he was in prison, one of which gave us some insight as to how he was. In it he said that he did not know how he had coped over the last couple of months and that prison had been really stressful for him. He said that if it hadn't been for his family he would have '*cracked by now*'. He also informed him that that following his release, he was going to spend two weeks to one month at his grandmother's home whilst he and M got acquainted with each other again.

DN was released on 23rd March 1998 on a four-and-a-half month Licence, to be supervised by Harry Matthews. There were no special conditions attached to the Licence. He reported that day to Harry Matthews and was accompanied by M. The day after DN's release, Mr Matthews completed an Initial Supervision Plan in which he once again put DN in the lowest of the three possible risk categories, the other two being 'risk aware' and 'risk concern'. He wrote on the form:

'Mr N has not indicated any level of risk either to himself, to the public or to staff at this stage, although there is a psychiatric history but nothing to suggest anything recently, certainly not in respect of the previous offences, current sentence or Licence. This is a situation that will be monitored should there be any deterioration in his mental condition, but at this stage there is no cause for concern that I can assess.'

Harry Matthews then had to complete a multiple choice checklist for 12 different categories, putting only one tick under each heading for the most appropriate item in the category. Under the category of Substance Misuse, he ticked 'heroin' although cannabis was clearly the most appropriate item to tick. Under the heading of Violence he ticked 'None'. Under the category of Health he ticked 'not known' although one of the choices was 'mental disorder'. 'Not known' was also ticked under the heading of Relationships.

We queried whether or not this was in fact an assessment which actually related to DN as his name on the form appeared to be the only item we recognised as an identifying factor. Nothing else seemed to relate to him!

When he saw us, Mr Matthews was extremely frank in admitting that he had clearly ticked the wrong categories. He also told us that on the basis of the Pre-Sentencing Report which had been prepared for the Court, he would have put DN in the 'risk aware' category, but had put him in the 'low risk' category on the basis of his interview with him in prison and the lack of any adverse feedback from the prison staff. Had he been in the 'risk aware' category, Mr Matthews told us that he would have been much more 'proactive' following DN's release from prison.

The Supervision Programme Objectives were set out as follows:

1. To ensure that he settles back with his wife into their own fixed accommodation
2. To assist him in the process of gaining employment/training or to go about how to set up his own business (sic)
3. To monitor drug situation and ensure that he does not go back to drug abuse
4. To monitor mental health issues to avoid any possible relapse - saw no evidence of this anyway at this stage
5. General compliance with Licence and his behaviour.'

DN attended the Probation Office regularly as required until 11th May 1998. There was a week's gap between the first two visits, two weeks until the next, and three weeks after that. He was then due to report to the Office on 1st June 1998. He failed to turn up and Harry Matthews wrote to him at an address on the same estate as his grandmother; this belonged to a friend of M and she had stayed there for a short time before going back to Greenwich. DN had stayed there a couple of times with M following his release from prison.

Just prior to his release, medical staff at the Mount Prison had written to Dr Hodkinson to inform her that DN had been on medication whilst in prison. He had been having a depixol injection every three weeks and was also on Melleril and procyclidine. The letter said that he would have a week's medication given to him on his release.

DN attended the surgery on 31st March, eight days after his release, and said that he was doing OK and had no paranoid ideas or hallucinations. He was stable on medication. He made an appointment to see Dr Hodkinson on 17th April. He had apparently been given his last injection the day he left prison and was due for his next depot on the 17th.

DN turned up for his appointment with Dr Hodkinson on 17th April. He had stopped taking the Melleril and procyclidine but was still wanting his depixol injection and was given it by Dr Hodkinson.

He said that he was now in college studying English and Mathematics, and that he was '*off cannabis*'. He requested anger management counselling and therefore was given a long appointment by Dr Hodkinson for a few days later.

This session took place on 28th April 1998. DN said that his concern was that he was too aggressive, that he had a “*short fuse*” and got very angry. He described his anger as verbal and not currently physical. He said it would happen after a personal remark or someone saying something sly about him. He said it didn't happen very often and had only happened once since he had come out of prison.

He admitted that he had gone back to using cannabis on most days, although much less. He said he didn't think that he could stop without help.

He said that he was not getting paranoid. He was in college and had three two-hour sessions. He was “*good friends*” with M and he had been living between his own place and M's.

He said that he took cannabis in the mornings “*to help his mind unwind*”. He said that he felt “*shitty*” in the morning – and “*miserable*”. He took cannabis in the evenings to help him relax. He said he was more likely to be ratty in the evenings and said he could control his angry feelings sometimes. He was “*out of social contact with cannabis*”.

DN was due for his depot injection on 8th May but he did not turn up at the surgery for it.

He attended on 19th May and was given his Depixol injection by Dr Hodkinson.

He attended again on 29th May, complaining of a swollen ankle which he had injured while he was drunk. He was seen by an assistant doctor and was given paracetamol and reassured. He was reminded that he had an appointment in two weeks' time when his next injection would be due (on 9th June).

DN killed his grandmother during the night of Thursday 4th June / early hours of the morning of Friday 5th June. She was last seen alive at about 10.20 on 4th June.

We have tried to piece together what was happening to DN from the time that he was released from prison until the time he killed his grandmother. To do so we have had to use the Police Witness Statements of people whom we did not interview, as well as the evidence from DN himself, M and DN's brother J.

As far as the police statements are concerned, it must be said that there were noticeable inconsistencies, with many of the witnesses having to give several statements before all the ‘facts’ emerged. This may be partly explained by the fact that most of them were obvious beneficiaries of DN's liberal handing-out of drugs following his inheritance and during the drug binge referred to below.

M's and J's evidence

M told the police that when he first came out of prison, DN seemed so different. He appeared to be off drugs completely and started going to college. They decided to take things slowly to see if their

relationship could work.

About five weeks before the homicide, DN's father's flat (which had remained in the family after his death in 1993) had been sold back to the Council and the proceeds of sale were divided between DN, J and their grandmother. DN had received about £8,500.

DN apparently spent most of this (he had about £1,500 left) on drugs, both for himself and friends or for dealing.

At this time DN was living at his grandmother's flat.

M said that it was about the middle of April that she realised that DN was using drugs again and not long afterwards he dropped out of college.

Around this time, M discovered that she was pregnant with DN's child.

DN told us that during the last few weeks before the homicide he was using large amounts of crack cocaine (£50 and £25 rocks) several times a day. He was still smoking cannabis but not so much and also using other drugs such as ecstasy and amphetamines but only occasionally. Most of his drug binge was on crack cocaine.

On Sunday 31st May J turned up at his grandmother's house at about 19.00 to drive her to Bingo. DN asked if he could come along for a ride. After their grandmother had been dropped off, DN asked his brother if he would give him a lift to see M in Greenwich, which he did. J told us that he was extremely scared on that journey as DN was extremely edgy, wanting the music on the radio blaringly loud, and hitting the dashboard with a Stanley knife which he took from his pocket. As they neared the Cutty Sark, there were lots of tourists and the traffic was heavy. DN apparently reacted aggressively when someone turned to look at him, and J had to calm him down to prevent him from *'having a go'*.

When they arrived at M's home, she apparently came out to the car to speak to J and asked him to talk to DN and make him face up to his responsibilities now that he was going to be a father. She was concerned that he was slipping back into his old ways and was acting strangely at times.

J left DN at M's. M told the police that DN stayed until about 23.25. She told us that he had lost a lot of weight and seemed drawn and distant. He had let himself go and was scruffy and unclean. In her police statement she had said that he kept being sick but denied that it had anything to do with drugs, saying that he and his grandmother had been drinking scotch the night before.

He apparently telephoned M the following morning, saying that he would be round later, but he never turned up. Therefore when he called her the next day she didn't pick up the phone. (She had a caller number display on her telephone.) She continued to ignore his calls for the rest of the week.

M told us that on the Saturday evening DN had called her saying that he was in a terrible state. He just kept saying “*I don't know what I've done*” and “*Oh God oh God M you are never going to forgive me.*” She tried to calm him down and asked what he'd done and he just said they really needed to talk. Her police statement says that during the phone call he said that his life was upside down and asked if they could meet for a chat. She asked him how his grandmother was and he said that he hadn't seen her for a couple of days and she had thrown him out of the flat.

He turned up at her home in Greenwich on the Sunday and she told us that he was not himself at all. She described him as “*just not like D*” and he was crying. He stayed overnight at M's home and then left in the morning, returning on the Monday evening. She said that that evening he kept going on about a ring he had given her with a Lion of Judah on it which he wanted her to give back to him so that he could wear it. She refused. She said that he was talking nonsense and talking to himself. He then picked her young daughter up and said “*You're not going to see D for a little while, but pray for Mummy and pray for D*”. He then kissed the little girl and left. It was about 20.00.

Her police statement in some respects gives a different version of those two days. In it she says that DN had telephoned her on the Sunday at about 15.00 and asked if he could come round. She said that he could and he said he would come straight away. When he didn't arrive she got upset and telephoned the grandmother's flat a few times but there was no reply. She thought it a little odd but didn't worry unduly.

At about 21.00 he turned up, by which time she was upset. She was vomiting and he rubbed her back and asked if she was alright. They talked and he mentioned getting baptised. M asked him why his grandmother had kicked him out and he said that it was because he and a friend had been smoking cocaine in the bedroom. He told her that he was ashamed to say that he had spent a thousand pounds on crack cocaine in the last couple of weeks.

She noticed that he had a scratch on his knuckles and asked him how he had got it. He said that he had punched a man outside a nightclub who was drunk and had made a racist remark to him. He said that he had two new friends (we think that these must be the two Somalian youths mentioned by witnesses in statements set out below).

She then told the police that they had talked about their relationship and had ended up making love. She described DN as “*a really gentle and considerate lover*”.

The following morning M took the children to school and DN walked with them, holding her daughter's hand. He then went off at about 09.30 saying that he would phone later. At about 12.30 he called from a payphone and just said “*I just called to say I love you*” before hanging up. He called again from a payphone at about 13.30 saying that he had paid the deposit on a black dress for M and was going to buy her a pair of boots.

At about 18.30 he rang again to say that he was on a payphone at Greenwich Hospital and had no money for the bus fare to her house. She said that if he loved her enough he would walk, and he turned up at about 19.00. M said that she was going to Church and he said that he would go with her. He then asked if he

could have a bath. After the bath he asked if he could wear the Lion of Judah ring which she was wearing. When she refused, he began babbling about the Lion of Judah. She said that he was not like he had been the day before and seemed to be acting in the same way as when he was ill just before he went to prison. As she left for Church with the children, M said that she didn't want to leave him in the house because of the way that he was acting. He said that he was going and wasn't coming back (M said that he was always saying that). He then picked up her daughter and said "*D is going. You won't be seeing D for a while.*" As he left he traced M's face with his finger repeating all the time "*Cool, cool, chill, chill.*" This was just after 20.00.

The following morning she phoned to speak to DN's Probation Officer to ask him to have a chat with him, to be told that they had had a call to say that DN was in custody.

Documentary Evidence

The telephone records for the grandmother's flat show that in the early hours of Thursday 4th June, five calls were made from the property to a live sex chat line, the talking time totalling almost 20 minutes.

Witness 1

A woman who lived near to the grandmother's flat gave evidence to the police that at about 17.00 to 18.00 on Thursday 4th June, she had passed the flat, the front door of which was slightly ajar, and heard adults arguing inside. The following morning at about 10.15 she saw DN standing on the balcony which ran along the flats, and described him as "*seeming weird*". He apparently accompanied her for a short while, and she said that he kept grinning all the time. She saw him again about 16.00 that day, and he seemed quite different – upset and unwilling to look her in the face.

Witness 2

A friend of DN's gave a witness statement to the police in which he said that on the morning of Friday 5th June he had gone round to DN's grandmother's flat but there was no reply. While he was standing there a woman came to the flat saying that she was concerned that the grandmother hadn't turned up for work. The friend therefore went round to the rear of the flat and called for DN, who then came to the window and shouted at his friend to go away. He said that he was stressed out and that his grandmother had had a go at him. He then told his friend not to come round again and that he would come to see him. DN apparently stayed at this man's flat on the night of Saturday 6th June, arriving at about 23.00, saying that his grandmother had kicked him out, and staying until about 13.00 on the Sunday.

Witness 3

A man who worked in a shop near the flat gave evidence that on Wednesday 3rd June he had seen DN on several occasions walking past the shop with two Somalian youths whom he had not seen before. He saw DN several times on Friday 5th June, and he appeared very agitated and confused. He saw him several times again on Saturday 6th June including in a local pub in the early afternoon. DN was with the two

Somalian youths again. He said hello to DN and although he answered him, he was described as being distant and not concentrating. He appeared agitated and paced up and down while he drank. After they left, the barmaid apparently commented that she felt there was something wrong with them and she felt scared. The witness saw DN again in the morning of Monday 8th June. He shook hands with him. Throughout the morning DN walked from the direction of the flat to a nearby street and back again.

Witness 4

DN's co-defendant in the 1997 burglary charge also gave a statement to the police. He had seen DN at about 17.00 on Friday 5th June. He had a silver bicycle with him. They chatted for a short time. About half an hour later he bumped into DN again. He no longer had the bike with him and was carrying a small radio cassette player. They stood chatting "*about old times*" for a while and then DN invited his friend back to his grandmother's flat to smoke a 'spliff'. When they were outside the flat, DN showed his friend what appeared to be a Post Office bank book and he recalled seeing the figure £2,700 in it and also noticed withdrawals of about £100 per day.

Once inside the flat, the friend was surprised that the living room was in darkness although it was still light outside. The curtains were closed and the lights switched off. DN said that he had to "*sort the electricians out*" and disappeared for a couple of minutes. The friend sat in the grandmother's chair and thought that it was strange that her ashtray, which was always next to her chair, was empty. Whenever he'd visited before it was always full with cigarette butts. When DN returned his friend asked where his grandmother was and DN said that she was at Bingo.

DN fixed the light by taking a bulb from a table lamp and replacing the ceiling bulb with it. He didn't open the curtains. They then rolled and shared a joint of cannabis. DN apparently didn't sit down but walked around the room the whole time. The friend left after a short time. He didn't see DN again.

Witness 5

This witness gave four statements in all, each one after the first recounting some incident which he hadn't mentioned in the previous one/s. The following account of his evidence is compiled from all four statements, but may be inaccurate because of the way that his evidence unfolded. He was also clearly under the influence of cannabis throughout the material weekend and it is therefore extremely difficult to evaluate how accurate his account really is.

He told the police that he had met DN for the first time on 30th May when the witness was with his cousin and two other Somalian friends walking through a local market. DN was smoking a 'spliff' which they could smell was cannabis. The witness's cousin went up to DN and asked him if he had any more and DN produced some 'greens' (herbal cannabis) from a carrier bag and gave him about £20 worth for free. When the witness asked if he could have some for free, DN said that he wanted money from him. They arranged to meet him back there in about 20 minutes and went home to get the money. When they discovered that they didn't have any, they decided to try to persuade DN to give them some cannabis. They met up with him again and told him that they had no money but that they would pay him next time. To their surprise

he rolled them all a joint which they smoked. They sat talking and smoking for a couple of hours.

On Monday 1st June, DN came to the witness's flat. He had with him cannabis resin, a pipe and some powder which he said was crack cocaine. He gave the witness the cannabis without asking for any money and smoked the crack cocaine himself. He was apparently already pretty 'high' when he turned up and they continued smoking for some time. DN was talking very fast.

After a while the witness and DN went out and DN introduced him to a friend of his who gave DN some 'skunk' (a form of cannabis). They had a couple of joints and then left.

The next time that the witness heard from him was at about 04.00 on the morning of Friday 5th June when he turned up at the witness's flat and got him out of bed. DN immediately sat down and started smoking crack cocaine in a pipe. The witness asked him what he was doing there at that time of the morning. He hardly knew DN, but let him do what he wanted because DN was giving him cannabis.

The first account of what happened next was that DN shut the living room door and put the hi-fi on very loud, playing his own tape which he had with him. He was told to turn the music down by the witness. He was described as being "jittery" and his eyes were big and wide. He said that he was in "big trouble" and that he could go to prison for eight years. He said that if anyone asked where he was on Thursday night the witness should say that DN was at his flat watching the football. He wouldn't say what the trouble was. After about 15 minutes he got up, brushed his teeth and left.

In his third statement to the police, the witness said that when he came round in the early hours of Friday morning he remembered that DN appeared strangely awake and alert for the time of day and that his eyes appeared massive and there were beads of sweat on his forehead.

In his fourth statement the witness then said that when DN turned up at 04.00 on Friday morning, he asked the witness to go with him and they went to the grandmother's flat which DN unlocked and they went inside. DN picked up a video recorder from beside the television in the living room and said "come on". He put the machine in a Selfridges carrier bag and they left. They got into a minicab and DN told the driver to go to a café in a road in Hackney. He told his friend that he was going to sell the machine to one of his Jamaican friends. They couldn't find the café he wanted and the minicab driver got fed up with driving around so they returned in the minicab to the witness's flat, where DN dropped him off and said that his friend could have the video machine. DN then left in the minicab. DN apparently took the video machine back again on Sunday 7th June and said that he had put it back in his flat.

He returned at about 14.00 hours on the Friday afternoon with some cannabis and a small quantity of crack cocaine. Every one at the flat smoked some cannabis while DN smoked 'crack' in his pipe. He seemed quite happy and said that he had some money and gave the witness £20 and told him to keep it for later to get more cannabis. There seemed to be something wrong with his left leg and he was walking funnily. He said that he had got drunk the night before and got beaten up at a pub. DN and one of the other young men went out to get some kebabs and a cheeseburger which they all ate on their return.

Some time later that day, DN asked the witness to go with him to get some more cannabis. DN used a phone box to call his drug dealer and they then waited for about 15 minutes before the dealer turned up.

DN handed him money in return for cannabis resin.

DN and the witness then went to DN's grandmother's flat (the witness said that he didn't know it was the grandmother's flat) and DN let them in with a key. The house was silent and dark because the curtains were drawn in the living room. DN told his friend to sit down, which he did and began to roll some joints. DN went to the kitchen area and removed his tracksuit and trainers, leaving himself naked. He then put the tracksuit into the washing machine. The witness asked if he would wash the black jeans he was wearing, but DN said that it would take too long. He turned the machine on and left the room, returning about five minutes later wearing jeans, a jumper and a leather jacket. They shared a joint, sitting in the living room.

The witness then asked to use the toilet and was shown where it was by DN who walked in front of him. DN picked up a pair of women's shiny black shoes with an ankle strap from beside the toilet. He said that they were his wife's and took them out with him.

We believe that these may have been the shoes that DN put on his grandmother – along with other clothing – some time after her death.

As he walked back through the flat, the witness saw DN standing in a bedroom with the door half open. Propped up against a mirror which was on top of a cupboard was an open magazine with pictures of naked women. DN asked if he wanted a look and the witness sat on the bed and looked at all of the pictures in the magazine. As he did this, DN opened the top drawer of the cupboard and pulled out pieces of paper which he carefully tore into small pieces.

They then went back to the living room and the witness sat down. DN turned up the hi-fi and then fetched a bottle of brandy which he gave to his friend saying "*God bless you. This is for you to keep.*" He then put some crack in his pipe and began to smoke it. Shortly afterwards he left the room and went to the back of the flat and the witness heard the sound of air freshener being sprayed. DN then returned and sprayed the living room with air freshener. The witness said that he could tell that DN was "*very high*". They shared another joint.

During this time DN made a phone call in which the witness remembers the word 'pub' being used and DN asking if a message had been passed on. He told his friend that the call was about a lady who worked in a pub.

DN's grandmother worked in a pub. Some time on Friday 5th June, someone rang the pub claiming to be her son and said that she would not be coming to work because she had had to go to visit a sick relative in Dagenham.

DN fetched a hold-all into which he put a white towel and some soap. He said that it was for him to use whenever he visited the witness's flat. He tidied up the living room and they then left.

They returned to the flat and DN sat chatting for about three hours during which time he smoked all of the cocaine. He was very friendly. He then left for about twenty minutes and returned with about £25 worth of herbal cannabis and some more crack cocaine. He gave the witness half the cannabis and smoked the crack. He left again after about twenty minutes, returning a short while later. In his trainers which he took off, he had two Abbey National cash cards (which turned out to be in his grandmother's name), one of which he gave to a girl who was staying in the flat and asked her to look after it for him. He remained for a few hours during which he talked about his family. He was high on drugs by this time and talking a lot. He said that he needed a passport – any passport – so that he could get to Jamaica. He said – amongst other things about his family – that his grandmother had passed away. He left at about 23.00, saying that he had to go to see his girlfriend in South London.

He returned on the Saturday morning at about 10.00 and asked the witness to go with him to buy clothes for his wife. After their shopping stint, at about 14.00 they met with the dealer who had given DN the 'skunk' and smoked some joints together. DN and the other man were talking about crack and money which they owed each other. After about half an hour the witness and DN left and each went their own way.

DN returned to the flat in the early afternoon on Sunday with a white boy about 14 years old whom DN introduced as his son. **(As far as we know, DN does not have a son of that sort of age.)** He took the video machine away with him on this occasion. He returned again later on Sunday afternoon. He was riding a silver mountain bike. He said that he had no money and no drugs and that all he could do for them today was a Sunday dinner. The witness said that there was no food in his flat and DN said that he could come with him to his place to pick up some food. The witness and one of the other friends who were staying at the flat went with him to his grandmother's flat. On the way the witness gave DN back the Abbey National card which he found in his jacket pocket where the girl had put it without his knowledge.

Before they got there, DN told them to wait on a street corner and then only allowed the witness to go with him to the flat itself. DN unlocked the door and opened it just wide enough to get inside. He was looking all around him as if he didn't want anyone to see. The witness described being hit with a bad smell like rubbish. DN said "*Quick, quick,*" and they went inside. DN then locked the door from the inside. There was a carrier bag with some shopping in it on the floor in the kitchen which DN picked up, and he asked the witness to pick up a couple of bags of rubbish from next to the sofa to take outside. They left, having been in the flat for less than a minute.

Back at the flat they emptied the shopping bag which contained some spaghetti, ketchup, tomatoes, some tuna fish and some teabags. DN made up some joints which they all smoked. He then put a silver Yale-type key on the table and asked the witness to look after it. He didn't say what it was for. He also took off from his finger and gave to the witness a wishbone shaped ring which he said was a Versace ring. DN left shortly afterwards.

DN was next seen by this witness at about 10.00 on Monday 8th June. They smoked some cannabis for about half an hour and they then went to the market where DN picked out a black dress for his wife and asked the assistant to keep it for him until Saturday. He left shortly afterwards saying that he had to go to see his wife.

At about 19.00 the witness was in the local market when he heard that the police were round at DN's flat. At about 19.20 he went home and found DN sitting in his living room smoking crack. The witness shouted at DN "*What are you doing here? What's happening at your flat? – there's police everywhere.*" All DN said was "*OK. OK. I'm leaving now*" He picked up his belongings, which he had left over the weekend, and left.

Witness 6

Another witness was the 'cousin' of the previous witness and was staying at her cousin's flat. Her version of events, which she told the police, was that she first met DN on Thursday 4th June when he came round to the cousin's flat in the afternoon or evening. She was asked by her cousin to go into another room while the cousin and DN sat in the sitting room. The witness went through to the kitchen several times, passing through the sitting room, and noticed that DN was smoking crack cocaine from a drink can which he had put holes in. DN apparently left about 22.00 that night.

The next day, Friday 5th June, DN came round to the flat between 03.00 and 04.00. The witness heard DN say to her cousin "*I'm in trouble*". The cousin said "*what kind of trouble?*" and DN replied "*It's nothing – forget it*". Another witness who was staying in the flat described DN as looking sad, with very red eyes. He was talking very fast and the witness formed the impression that he was high on drugs. He had cocaine and cannabis with him, and he gave the witnesses 'spliffs' and smoked some cocaine himself. He then left after about 10 minutes.

DN returned at about 14.00 or 15.00 that afternoon. He brought more drugs with him and a bottle of brandy. He sat in the sitting room with the witness, the witness's cousin and the two Somalian youths. The witness said that there appeared to be something wrong with DN. He just kept talking, saying the same things over and over again and kept shaking all their hands. He seemed to be obsessed with tidiness and if he saw any mess, he tidied up. He kept searching through his pockets. The witness described him as "*quite weird*". DN noticed the witness's rings on her fingers and said "*That's some collection. Why don't you add this Versace ring to it*". He then gave the witness a gold wishbone ring (which was later discovered to have belonged to DN's grandmother). In a later statement the witness changed her story and said that DN had in fact given the ring to her cousin and she had later found it and started wearing it.

About 20 minutes later, DN went into his pocket and brought out a brown wallet. He asked if he could speak to the witness in the kitchen and, when they were alone, he handed her an Abbey National cash card in the name of DN's grandmother and asked the witness to look after it for him. He then left the flat, returning about an hour later. He had drugs with him and sat smoking crack cocaine. He left again, telling the witness the PIN number of the card. (The card was later returned to DN by the witness's cousin.)

He returned to the flat two hours later, at about 21.00, and just sat there talking until he left at about 23.00. On the Saturday he arrived at the flat at about 13.00 hours, bringing with him a rucksack which contained soap, a toothbrush, flannel, toothpaste, and some clothes. He had a smoke of 'crack' out of a drink can and then started dancing to a reggae tape which he had brought with him. He then asked if he could have a shower and remained in the bathroom for about an hour, changing into the clothes from the rucksack. He left in the late afternoon, leaving his other clothes.

On Sunday 7th June he arrived at the flat with a silver BMX bicycle. He was smoking crack cocaine. He started talking about his parents and his wife and how much he loved her. The witness described him as becoming "very weird". He said that his father died and left him and his brother £8,000 each and that he could get up to £300 at his bank every week. DN then said that he wanted to have Sunday dinner and they should go around his place to get some food. DN then left with the cousin and one of the Somalian youths who was there as well, returning about 20 minutes later with two supermarket carrier bags containing food. Apparently all the food was out of date and nobody attempted to eat it. DN also asked the witness if she would dye his hair for him. He kept going out and reappearing throughout the day. Her cousin told the witness that when they had gone to the grandmother's flat, he'd gone just inside the front door and there was a strong smell of something like bad rubbish.

On Monday 8th June DN arrived at the flat at noon and for the rest of the day kept popping in and out until about 21.00 or 22.00 after which he sat in the living room, smoking a silver pipe filled with crack cocaine. He said that his wife had kicked him out because he smoked some 'spliffs' in front of her children and they rowed and he left.

He was still sitting there smoking crack at about 22.00 when the cousin returned and told him to get his belongings and get out. DN apparently said "Are the police outside? I'm gonna go." He appeared shocked and he then left.

This witness gave a further statement to the police, in which she said that she had been confused about several matters which she wished to clarify. In the second statement she changed the days and times of some of the incidents described above.

It is difficult to be sure about exactly what happened over that weekend, as all of the witnesses who were with DN seemed to be making good use of the drugs he was being so liberal with, and their recollections may well have been somewhat blurred. Their accounts are certainly not consistent.

DN's grandmother's body was found at about 18.00 on Monday 8th June, after J had called the police when he couldn't get any response over the weekend, having arranged to take her to Bingo. The police broke the door down and found her on her bed in her bedroom. She was wearing a white bra, a purple slip, black hold-up stockings, black ankle strap shoes and a purple jumper. The forensic evidence showed that she had been dressed in these clothes after her death. It also showed that she had been sexually assaulted with a blunt instrument.

She had suffered multiple stab wounds to the chest and her skull had been fractured by a blow with a heavy object. There was extensive bruising over her face and body, and her nose and jaw were fractured. A blood-stained iron and a blood-stained kitchen knife were found. There was also bruising to the left side of the neck consistent with a forceful grip or compression of the neck.

The forensic evidence pointed to her having been attacked in the bedroom and having fallen to the floor where she remained bleeding for some time onto the carpet. She then moved or was moved onto the bed.

Semen matching DN's DNA profile was found on one of the stockings and on the pillow, and on a towel found between the victim's legs.

A palm print in blood was found on the door in the grandmother's bedroom. It matched DN's.

A two-thirds life-size toy rabbit (which belonged to the grandmother) was found in the bedroom used by DN. An area of fabric around the top of the left leg had been split open and some of the stuffing was protruding. No semen was found, but a number of dark curly hairs which could have been either Afro-Caribbean type head hair or pubic hair was found in the area between the rabbit's legs.

DN was arrested outside his grandmother's flat at about 23.35 on Monday 8th June, after he approached a police officer and asked "*What's happened here? I want to see my Nan and my brother.*" He was taken to Limehouse Police Station.

When interviewed, DN stated that he had not seen his grandmother for about two weeks. Over a period of four days between 9th and 12th June, DN was interviewed for a total of about six hours. He consistently denied having been in the flat since 29th May, and also denied events which were put to him as a result of police interviews with the witnesses as outlined above, such as telephoning the pub to say that his grandmother would not be coming in to work, stealing the wishbone ring, and giving the Abbey National card to the witness who said he did. On advice from his solicitor, he made no comment in relation to the presence of his palm print in blood on his grandmother's bedroom door.

On 13th June DN stated that he was hearing voices which were very bad and that he couldn't cope. He said that he was depressed. On 15th June he complained that people were talking about him. He was described as distant, aloof and guarded. He felt that people had set him up. On 19th June he was said to be smiling in an odd incongruous emotional expression. He spoke of everything being for a purpose and that he felt the creation and the Devil were fighting over something.

DN was charged with the murder of his grandmother. DN entered a plea of not guilty. He was committed for trial on 11th August 1998. The trial was fixed to take place on 22nd February 1999 at the Old Bailey. DN was remanded in custody at Brixton Prison and later transferred to HMP Belmarsh.

Despite the almost overwhelming evidence linking him to her death, DN continued to protest his innocence almost up until the trial. His protestations of innocence were frequently accompanied by demands that the police track down his grandmother's killer.

DN was seen at Brixton Prison by Dr Eleni Palazidou on 3rd July 1998. This was the first time that she had actually seen DN. She wrote a report at the request of the Medical Officer at Brixton Prison in which she stated:

- ‘1. I think Mr N is suffering from psychopathic disorder, a disorder of personality as categorized by the Mental Health Act 1983.*
- 2. According to his previous history, there appear to have been periods of psychosis consisting of paranoid delusions. At the present there is no evidence of active psychosis. It should be noted that he has been and continues to be on antipsychotic medication for several months. The use of illicit drugs, in particular cocaine and cannabis, have a significant role to play in the aetiology of his psychotic symptoms.*
- 3. Mr N is fit to plead. He is able to instruct his lawyer, understand the charges against him and follow proceedings in court.*
- 4. Psychopathic behaviour is not treatable and Mr N has shown no improvement in his behaviour whilst in medium security conditions and indeed absconded several times. Attempts to engage him in the community and help with his aggressive behaviour and drug use also failed to achieve any significant change. His psychotic symptoms have been reasonably well controlled and he has indeed complied with antipsychotic medication. It is recommended that he continues with this.*
- 5. I do not think medical disposal under a section of the Mental Health Act 1983 is appropriate.’*

In September 1998 DN told his legal team about an incident that they had not heard about before. He said that one day he was walking along and there was a phone box with the fire brigade and police around it. The firemen were washing the inside of the phone box which appeared to be covered with blood. DN said that he got a warm feeling inside and realised that he must have stabbed or shot someone in that phone box and that everyone must have been talking about it. Upon further questioning by his lawyers DN said that he never actually read anything about such a stabbing or shooting in the phone box and no one had mentioned it, so it was possible that he imagined the whole incident. He also told them that he was getting strange thoughts that he may end up hurting someone whilst in prison.

When we saw him at Rampton, DN told us about an incident when he was living in a block of flats and was watching a man unloading some boxes which DN thought were for carrying guns in. The man called out to DN and he thought to himself that the man was going to shoot him. He panicked and ran downstairs with a hammer and a machete and attacked the man. He believed that he had killed him.

He said that he later reported the incident to the police but they could find no trace of any incident like that on their books. He said that he had told M about it and she had said that he must have been

hallucinating, but it felt very real to him. He said that he remembered doing it.

DN'S mother also told us of an incident which she believed had happened shortly before he killed his grandmother. According to her she got a call from a Police Station in Hackney at about 03.00 one morning to say that DN had turned up at the Police Station with a suitcase saying that he had a body in it of someone he had murdered. There was no such body.

We asked the Police to check their records to see if there was a report of such an incident and were told that they could not find one.

At the request of the Court a psychiatric report was prepared by Dr James Anderson, Consultant Forensic Psychiatrist at Belmarsh. He interviewed DN on two occasions on 28th September and 5th October 1998. The duration of the interviews was three hours. DN told him that he had extensive experience with illegal drugs. He said that he used cannabis which had a 'mellowing' effect whereas cocaine made him feel 'numbed'. He admitted that after leaving prison in March 1998 he had used large amounts of drugs.

When seen by Dr Anderson DN apparently had no symptoms of significant mood disorder, and there was no evidence of thought disorder, and he described no active psychotic symptomatology. He did describe paranoid feelings that other prisoners were hostile towards him and described having had psychotic symptoms in the past. He said that when his father died strange things were happening. He described hearing the letter box opening, he also described hearing voices at that time of a man who had beaten him up when younger, talking to him saying "*Don't go to the hospital or I will hurt your dad*". More recently he described being at his wife's house and "*feeling myself getting scared and I started reading a Psalm from the Bible. My mind went completely blank.*"

Dr Anderson concluded that DN was fit to plead and stand trial. He reported that:

'He does have features of adult personality disorder of borderline emotionally unstable (impulsive) and dissocial types. He also has obsessional and paranoid personality traits. Mr N has also displayed symptoms of major mental illness in the past. He has been on depot antipsychotic medication for much of the last five years. Mr N also has a history of severe substance abuse.

Mr N does have features of personality disorder which could be legally classified as psychopathic disorder within the meaning of the Mental Health Act 1983. It is also possible that he has a mental illness within the meaning of the Mental Health Act. As such there are grounds for considering that Mr N may have a medical defence to the charge of murder. He will require further assessment by his local forensic psychiatric services before final recommendations can be made.'

Towards the end of 1998, DN's mental health and behaviour appeared to deteriorate. He spoke about people being led astray by the Devil and said that he felt unsafe with the other inmates. There were incidents where he displayed inappropriate sexual behaviour towards female staff at the prison. Just before Christmas he became difficult to interview, being irritable and angry. He was only let out of his cell with

three officers present. The medical team at Belmarsh referred DN to Dr Mary Whittle, Consultant Forensic Psychiatrist at the John Howard Centre (the Interim Secure Unit at Hackney Hospital) for an assessment with a view to transferring him to her Unit for assessment and treatment.

Dr Whittle saw DN on 16th December 1998, following which interview she wrote to the specialist registrar at Belmarsh a report which included the following:

'Initially he seemed suspicious, asking who had asked us to see him and saying that we would have 'fun' looking through his medical file. He said that he would have given some correct and some incorrect answers to people in the past to keep the people off his trail. He remained guarded throughout the interview. His affect was rather incongruous in that he seemed bemused and smiled. He sometimes looked perplexed and low in mood. Mr N denied any abnormality of mood. He told us that he had thoughts of harming himself though he had not done so. These included thoughts of cutting his wrists and hanging himself. He did not do so as the time had not been right. He said that he had made a pact with God 'to stay loyal to him until the end in there' as he pointed to his chest. When asked to explain he said that this meant giving people respect, watching what he says and watching what goes into his body. He thought he would be better off dead because of the situation he is in. Later in the interview he made a gesture towards his arm as if to inject himself, saying 'I just want out'.

Mr N's thought form was abnormal. He was tangential and over inclusive. He rambled onto topics inappropriate to the questions asked of him. When asked about the most difficult problem he encountered at the moment, he spoke of 'mental slavery' which he found difficult to explain and he gave the impression that we were expected to know what he meant by this.

When asked about the content of his thoughts he was guarded and found it difficult to explain. He said that, while people in the prison were not trying to kill him, they were trying to make life hard for him 'psychologically'. He had persecutory ideas and he became increasingly aroused when telling us that he thought that staff were spitting in his food. He was reluctant to give definite answers to exploratory questions about this but said that the food tasted peculiar. We were unable to establish fully if he gets on with the other inmates or not. He denied ideas of reference. When asked about interference in the privacy of his thoughts he answered that he 'would not like to say.'

He denied hearing voices but explained that, on waking up on the morning of our interview, he heard his own voice coming from the cell next door. He explained that there was no cell next door but he heard a radio and somehow his own voice was singing along with the radio. He said 'It didn't add up' and he decided to ignore it. He was adamant that this was not a dream though he found it difficult to explain experience fully.

I did not test Mr N's cognition. Mr N said that he did not feel well, that he is 'going through another psychosis period' and that he is having another breakdown'. He said that, if he was mentally ill there was nothing people could do to help him. Nevertheless, he also said he was not mentally ill whilst saying that he wanted help from various people and that he had suffered from drug-related illness in the past. He was not adverse to coming into a Secure Hospital although he

expressed a wish not return to Kneesworth House. ... He said that he would take anything to get him out of the situation he was in.

OPINION AND RECOMMENDATIONS

- a) There are indications that Mr N may have suffered from conduct disorder in childhood and that he has an underlying personality disorder. He has previously been diagnosed as suffering from borderline personality disorder complicated by drug misuse and psychosis. I think, however, that it is likely that he has developed a schizophrenic illness, (a mental illness within the meaning of the Mental Health Act 1983), which expresses itself through suspiciousness, formal thought disorder, paranoid beliefs and vague ideas about God etc though the diagnosis is complicated by abuse of illicit substances. Whether their role is causal or co-morbid with his illness, Mr N has relapsed into a psychotic state categorised by the above symptoms. The deterioration in his condition is likely to be associated with his discontinuance of regular antipsychotic medication by injection and he is currently taking only some oral anti-psychotic medication.*
- b) In view of the deterioration in Mr N's condition, I believe that he requires assessment and treatment in hospital for his own health and safety and the safety of other people. This would best be effected under sections 48 and 49 Mental Health Act 1983 at this time.*
- c) There are indications that Mr N that may not be suitable for transfer to a hospital offering conditions of medium security. The alleged offence is a very serious one and includes allegations of post mortem sexual assault. Mr N has committed serious violent offences in the past some of which had been associated with the use of weapons. He absconded previously while at medium-secure units ie Kneesworth House Hospital and while at the Interim Secure Unit at Hackney Hospital. At HMP Belmarsh, Mr N has shown sexually inappropriate behaviour towards women and has been placed on a three-man unlock for the protection of female staff.*
- d) Though I believe that Mr N needs admission to hospital for assessment and treatment of his illness, I do not believe that Mr Newman should be admitted to the John Howard Centre at this time. In my opinion the assessment and treatment of Mr N would best be provided in a maximum Secure Hospital, at least in the first instance. I will copy this report to the Medical Director at Rampton Hospital to seek an opinion. I would be grateful if you would liaise with him to expedite the referral.*
- e) In the meantime, as Mr N indicated that he was willing to take the depot anti-psychotic medication again, I suggest that this be recommenced as soon as possible.'*

DN's solicitor asked Dr Neil Boast (who was by now a Consultant Forensic Psychiatrist at the John Howard Centre in Hackney) to see DN and to provide a report. He was chosen because of his prior knowledge of DN. Dr Boast interviewed him on three occasions at Belmarsh Prison - on 23rd December 1998, 31st December 1998 and 9th February 1999.

On the first day that Dr Boast saw him, DN was not thought-disordered but did appear to be paranoid about officers and inmates. In respect of a flare up which he had had with a prison officer, he said that the man was a homosexual and he did not like the way the man was staring at him.

Initially, he denied hearing voices since he had been in prison, but then admitted hearing the voice of an officer in a demonic form. He would hear the words "Kill. Kill him. Grab his keys" being repeated. He told Dr Boast that it was like an inner conscience, as if he was talking to himself. He said that he also had the feeling that people had been trying to take him over mentally. He said that he would repeat Psalm 23 to himself as he believed that it would protect him against the Devil. He pointed to some marks including a scar on his right hand. He told Dr Boast that friends had told him that a microchip had been put into his hand or forehead. He then gave a rational explanation for the injuries and said it that he thinks that way and gets paranoid when he takes drugs.

Dr Boast's opinion was that DN was suffering from a relapse of a psychotic illness. His presentation, including concern about his food, was similar to that when he was in the Hackney Interim Secure Unit in 1992. Dr Boast agreed with Dr Whittle that the most likely explanation was a recurrence of that illness following withdrawal of antipsychotic medication in injectable form in June 1998. The context of the stress of the court case was probably an additional factor.

On 29th January DN's legal team had a consultation with him at Belmarsh Prison. The differences between prison and a Special Hospital were explained to him. He decided then that he would plead guilty to manslaughter on the grounds of diminished responsibility and he hoped that he would be sent to a Special Hospital.

He gradually began to give his lawyers an account of the night of the homicide. At first he said:

"I don't know what triggered it off. We watched TV together until quite late, both of us having a scotch. She'd come in from somewhere. She said she was going to bed. As far as I recall, I told her that I was staying up to watch more TV. Everything else is a total blackout for the next 24 hours".

His second version was more detailed:

"It was maybe voices that triggered it off. Maybe something ran through my sub conscience (sic) or conscience. I'm not sure whether what I remember is fact or my fantasy. I recall going to bed. In my sleep someone came and woke me up - a lady friend... and she said 'if you love me, have sex with that rabbit'. I said 'I do love you' so I had sex with it. Maybe it was witchcraft. Things went very dark. I came around to my conscious state. I'd been programmed up to commit the crime. I don't know for whose benefit. My grandma comes slightly into my memory. I remember going into her room, punching her in the face, and

knocking her clean out. Then I remember kind of banging her head against the floor to make sure she didn't come round. I got a knife from the drawer, lifted up her clothing and stabbed her in the chest. I feel that she is still out there and that I'm the victim. It's like a bad dream. Obviously I realised I'd done it at some point. Maybe I thought 'Oh my God, what have I done? Maybe just as the voice had said have sex with the rabbit it also said have sex with her. I had in the past taken some girls back to the flat. Maybe it was their clothing that I put on her but I can't be sure.'

Dr Verma, Consultant Psychiatrist at Rampton Hospital, followed up Dr Whittle's referral by visiting DN on 5th February 1999 at HMP Belmarsh. When discussing his grandmother's killing, DN categorically maintained that he was totally under the influence of drugs at the time and had no recollection of the events surrounding her death. Following his assessment, Dr Verma concluded that DN required a comprehensive assessment as an inpatient in an entirely drug-free environment which should be maximum security. He described him as *'a grave and immediate danger'* but he did not feel able to assist the court at that stage on the issue of DN's disposal under the Mental Health Act. He did however recommend that implementation of Section 38 (interim Hospital Order) should be considered if DN were convicted of manslaughter and a Hospital Order was deemed appropriate, provided Rampton Hospital Admissions Panel was willing to offer him a bed.

Dr Boast's third interview with DN was on 9th February. By this time DN had given his lawyers instructions to enter a plea of guilty to manslaughter on the grounds of diminished responsibility. Dr Boast recorded in his report the account of the homicide which DN gave him on that occasion:

'Mr N told me that on the day before he probably spent about £10 on cannabis buying an eighth of an ounce. He thinks that he saw his brother at some point and that his grandmother went to the bingo. He told me that he is not 100 per cent clear about what happened next. He told me that he woke up in the early hours of a Friday morning and what happened was as if he was in a dream. He told me that the experience is different from normal dreams. It was as if his memory is like a film. He said that he saw the face of his female friend and she said to him 'if you love me, make love to this rabbit'. He told me that the room where he was sleeping had a large rabbit. He said he did not know where it had come from and he had not bought it. He told me he felt as if his female friend had control over him, the control being more a mental one than a physical one. He told me he tried to have sex with the rabbit. At that point in the interview he laughed weakly saying 'it sounds funny it isn't funny. I'm in this prison'. (He looked tearful.)

He told me at this point the vision of his female friend disappeared but he still felt that she was controlling his movements like witchcraft. He went into his grandmother's room. He told me 'I had no reason, she was in control of me. She didn't say it verbally. Something was controlling me. It is like Alfred Hitchcock – Alice in Wonderland. I find it difficult to talk about it – it sounds so far-fetched'. With some reluctance he told me that what happened next was that his grandmother sat up and without reason he hit her and she fell over backwards. He recalls hitting her head on the floor. He told me that he then went and got a knife and stabbed her. Even more reticently he told me that he then penetrated his grandmother in her vagina and anus with a cucumber. He told me that he did not know why he had done this. He said he may have done, when asked about whether he had ejaculated. He told me that he finds it difficult to believe that he has done such a thing. He told me that his memory is such that he feels that what

occurred is not real and at any moment someone could come to him and say that it is a mistake.'

Dr Boast concluded his report:

'I think the following factors are relevant to the alleged offence. Mr N was deluded that he was being controlled to engage in bizarre, violent and sexually inappropriate behaviour against his will. That Mr N is not able to describe his mental state further is not unusual. Psychotic mental illness in ordinary terms involves loss of contact with reality and a loss of the capacity to be self-critical and self aware. I therefore think it important to take account of his previous witnessed behaviour during times of mental ill health. I note that he has been described as a kind, loving, sociable and affectionate person prior to the development of mental illness....

In respect of the 1957 Homicide Act I think that Mr N was suffering from a mental abnormality at the time of the offence, namely a paranoid psychotic mental illness. I think that condition substantially impaired his mental responsibility for his actions. An alternative view may be put to the court that Mr N induced mental abnormality through the use of drugs and that he should therefore be held responsible. As above I note that Mr N has a vulnerability to psychotic mental illness. Psychosis has occurred and when in the Hackney Interim Secure Unit continued despite him not abusing drugs. I also note the mental abnormality occurred despite him having treatment with antipsychotic medication. It may be argued that Mr N was reckless to the risk of him becoming ill by taking drugs. Whilst it might have been predicted that Mr N could act violently if he became ill it is difficult to see how he could have been reckless to the consequence of such an unusual offence.'

Dr Boast felt that by February DN was fit to plead, although in December he had thought him unfit due to the deterioration in his condition.

The prosecution appeared to be amenable to a plea of diminished responsibility. Therefore Dr Boast was asked to write an Addendum to his report to address the issue of possible disposal under the Mental Health Act, which he did on 17th February 1999. His opinion was that DN's case met the criteria for a Hospital Order under Section 37 MHA and would also be suitable for the imposition of a restriction order under Section 41. He pointed out that Dr Whittle had referred DN's case to Rampton High Security Hospital as he was more suitable for treatment in a high security hospital.

The case was due to be heard on 12th March 1999 but was adjourned because the prosecution wanted a report from their own Consultant Forensic Psychiatrist. Dr Philip Joseph reported on behalf of the Crown Prosecution Service on 18th March, having interviewed DN on the 16th. DN gave his most detailed account yet of events surrounding the homicide. Having given the same account of the toy rabbit incident as he had given to Dr Boast, DN then described the killing:

'They watched a bit of television together, but the deceased fell asleep during this period and then after waking up she said she was going to bed. The defendant watched television for a further hour and estimates it was now approximately 12-12.30pm. As he sat in the living room he said that something came over him and he became convinced that J and his grandmother were going to kill him

whilst asleep, one of these days. He was sure that they had mistreated his father during his illness and the same would happen to him. He was hearing voices in his head saying 'if you don't believe me, I wish you well', which meant that it was up to him that he could either listen to what he was thinking or take the risk of being killed. He said it was like he was hearing parts of a record. He decided that there was a danger that he would be killed and so he decided he would have to get rid of his grandmother.

The defendant then opened the door of his grandmother's room and she woke up as he did so. She told him to get out of there or she would call the law on him. He pushed her back and then punched her with a combination of punches as she was going backwards. She fell on the floor and seemed unconscious. He held around the neck and banged her head on the floor until he heard her skull crack. He said that he did not want to cause her pain but just get rid of her and so he went into the kitchen where he got a knife. He returned to his grandmother, he pulled up her nightdress and stabbed her in the left side of the chest. He said throughout the attack he knew that she was his grandmother.

After the attack he felt for her pulse but was not quite sure if he could feel it or if she was dead. He decided to go out for about an hour while she died properly, and so he went across the road and sat at a bus-stop. He estimated it was about 2am. He said he needed fresh air, and whilst he was sitting there he was thinking that he had done it. He said it was like nothing had happened and he had no emotional feeling connected with the killing. He thought to himself that if a police car went by he would tell them that he was waiting for a bus.

The defendant then returned his grandmother's home and saw her lying there. He decided to put a pair of stockings and shoes on her, following which he went to the fridge and took a cucumber which he then inserted into her vagina, anus and mouth. He described this as a 'disrespect' thing because of what she had done to his father. The defendant denied dressing his grandmother in any other clothes and denied having sexual activity with her. When asked how semen stains came to be at the scene of the killing, the defendant stated that he had sex with a woman the day before in his grandmother's bed which is how the semen had got there. When I pressed the defendant about whether he had sexual thoughts towards his grandmother, he said he had not really had thoughts of sex with her, but he remembers at the age of 15 years masturbating and ejaculating to a pornographic picture of a woman which looked like his grandmother.'

Dr Joseph also recommended a Section 37 Hospital Order together with a Section 41 Restriction Order. He also believed that Rampton High Security Hospital was the suitable hospital for DN.

Despite these recommendations and the fact that DN's plea of diminished responsibility was accepted, when the case came before the Court on 29th March 1999, the Judge felt compelled to sentence DN to life imprisonment in accordance with the Crime (Sentences) Act 1997. This was on the basis that he had committed two serious violent offences, the GBH with intent in 1991 and the homicide. Having assessed DN's responsibility, the judge fixed the relevant period of his detention at six years (being half the appropriate determinate sentence had DN been convicted of murder). Since he had already spent nine months on remand, the relevant sentence given was five years three months.

The decision to give a life sentence rather than make a Hospital Order was appealed but upheld, and DN was sent back to HMP Belmarsh.

DN's case became a legal benchmark on the issue of what is to be considered 'exceptional reasons' for the purposes of the Crime (Sentences) Act 1997.

Following the Court hearing, Dr Boast wrote to Dr Verma, Consultant Psychiatrist at Rampton, saying that he believed that DN should be transferred to Rampton under Sections 47 and 49 of the Mental Health Act as he believed that his case passed the 'nature' test if not the 'degree' test.

By chance Dr Neil Boast saw DN at HMP Belmarsh on 27th September 1999. The doctor was visiting another inmate and DN asked to see him. Following the encounter Dr Boast wrote to DN's solicitor:

'He superficially presented as well and was pleasant, but he seems to have developed the idea that the previous offence of which he was convicted was not him and that someone has been using his name. This is quite possibly a delusion.

I am aware that he is on a waiting list for Rampton Hospital. My own view, as you know, is that he should be in that hospital and whilst I appreciate that all secure psychiatric hospitals are running a waiting list it does seem a rather long period of time.

Although I am not formally involved in his case any more, I thought I should copy this letter both to the prison and to Rampton Hospital raising concern.'

DN was finally transferred to Rampton on 28th January 2000 where he has remained ever since.

Commentary and Analysis

We have deliberately included considerable detail in the Background section of this report in order that the events of June 1998 can be seen and analysed in their proper context. This Commentary and Analysis cannot and should not be read in isolation without reference to the Background. Any comments which 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 may not be properly understood.

We are acutely aware that adverse criticism in respect of the care and treatment of one individual can undermine confidence and morale amongst the professionals who have to deal every day with many other individuals, and who do so with nothing but a good outcome.

East London is a challenging area to work in and we sincerely hope that this Report does not make the challenge more difficult to take on. The Trust needs good and caring professionals to deal with the many and various problems which they encounter on a daily basis in their working lives, and we have no doubt that all of the professionals we interviewed possessed these qualities.

Although we have had to look at – and therefore comment upon – the actions of individuals, our concerns are really addressed at the system as a whole in which they work, rather than at any individual.

No-one but DN was responsible for the death of his grandmother.

What he did could not have been predicted, although we have pointed to some aspects of his care and treatment which could have been dealt with differently, and which might have prevented the tragic outcome – but we will never know if it would have done.

The care and treatment of someone like DN will always be more difficult when seen in the context of his habitual drug use and his anti-social behaviour (at times) as a result of it, but it is all too easy to point to drug abuse as the sole cause of such behaviour and to ignore the possibility that it may be caused by underlying mental illness, or personality traits, or a combination of any of these which is the most likely explanation.

Given the unpredictability and violence of the attacks on various people in 1991, which led to DN being committed under a Hospital Order to a medium secure unit for a period of some eight months, it is perhaps surprising that DN's subsequent care and treatment was almost exclusively managed by GPs.

We would like to make it clear from the outset that we found Dr Hodkinson and Dr Farrelly to be caring and dedicated professionals, who looked after their patients with skill and compassion. However it is possible that this dedication, coupled with a certain degree of naivety, may have led the GPs to have ‘held on’ too long to DN without any effective input from psychiatric services.

Although we may appear to be critical of some aspects of their management and treatment of DN, we are very aware that on many occasions they were ‘left holding the baby’, with no option but to try to deal with a difficult situation on their own. They are to be commended for establishing a good working relationship with DN which lasted some five years, where others did not appear to be able to sustain a working relationship with him for more than a very few months.

DN first came to the attention of Drs Hodkinson and Farrelly in early July 1993 after his mother had telephoned the surgery expressing her concern about his “*bizarre*” behaviour. She told them that he was a schizophrenic and had been under the psychiatric services at Hackney Hospital but kept absconding. She said that he was staying at his grandmother’s flat.

The grandmother was a patient of the practice and Dr Hodkinson very conscientiously made a visit to her flat later that day. She was told that DN had only been back in the UK for a month, but that he had been threatening to her and had hit her.

The GPs’ first knowledge of DN therefore was the report from his mother of bizarre behaviour and information from his grandmother that he was physically abusing her.

Dr Hodkinson saw DN at the flat, prescribed Stelazine and managed to persuade him to attend the surgery on a regular basis for review and further prescriptions.

Dr Hodkinson very properly telephoned Hackney Hospital to ask for information and spoke to Dr Ndegwa who told her that DN’s notes had been sent to the ISU in February 1992 and that he had absconded from the Unit later in 1992. She noted that she had been told that the reason for his admission had been a psychotic episode possibly drug-induced, and that he had responded well to medication.

Despite the fact that Dr Ndegwa was the consultant responsible for DN during his 1992 admission to the ISU and DN had absconded from the unit, there does not appear to have been any attempt by Dr Ndegwa to arrange for DN to be seen again by him or someone on his team, in order to assess his current mental state.

We feel that, given the background to his admission to the ISU, the circumstances of his departure from it, and the fact that DN had only come to the notice of the medical services again because of reports of bizarre and violent behaviour, arrangements should have been made for DN to be seen by the forensic psychiatric services in order to carry out an assessment of his current mental state.

If someone absconds and their Mental Health Act Section subsequently lapses while they are still AWOL, we consider that it is the responsibility of the service under whose care the patient

was detained to arrange the most suitable re-assessment of the patient when they re-present.

We are also critical of the fact that there was no Final Summary written after DN absconded from the ISU on 30th June 1992. However as we have recorded in the Background Section, everyone whom we interviewed from the Unit acknowledged that there should have been one.

Unfortunately Dr Hodkinson did not pursue the hospital notes until February 1996 and was therefore unaware until then of the full reasons for the admission in 1992, in particular the forensic history of violence.

Primary care practitioners are the front line staff in caring for patients in the community. Given the circumstances in which DN first came to her attention and the knowledge that DN's mental state in 1992 had warranted admission to an ISU, we feel that Dr Hodkinson should have ensured that she had as much historical information as possible about DN, considering the fact that she took on the role of being solely responsible for his mental health at that time. Getting his previous notes and records should be part of the risk assessment which it is necessary for any GP to carry out who is taking on a patient with a serious psychiatric (and, in DN's case, forensic) history. There does not appear to have been any real attempt by the GPs to carry out a risk assessment of DN, and we consider that there is inadequate training of GPs in how to assess such patients.

However we consider that DN should have been referred to the psychiatric services from the outset.

In January and February 1994, there were again reports from DN's mother and grandmother about his behaviour, and on 3rd February DN turned up at the surgery asking for depot medication as he did not feel that Stelazine was enough to keep him from feeling 'on edge'. Dr Hodkinson changed his prescription to depot modocate and very properly and promptly referred him to the Bow Poplar Community Mental Health Team (CMHT). Her referral letter concluded '*He is extremely unkeen on seeing a psychiatrist*'.

This view that DN was resistant to seeing anyone from the psychiatric services persisted throughout the five years that the GPs cared for him. However DN was on the whole compliant throughout and very seldom missed an appointment for his depot medication; he appeared open to the suggestion that he should become involved with the CMHT and the Community Drug Team (CDT) – even if his enthusiasm waned quite quickly – and even sought his own admission to hospital in June 1997 when he recognised that he was unwell.

We therefore asked Dr Hodkinson if DN was really that insistent and consistent in his refusal to have anything to do with a psychiatrist. She very frankly accepted that, after his initial adverse reaction to have anything to do with psychiatrists, she probably didn't check with him that often whether he would see a psychiatrist, and that she probably could have persuaded DN to be seen by one had she persisted in saying that she needed him to do so. She also admitted that her view of whether he needed a psychiatric assessment was coloured by his ongoing drug use and the belief that his behaviour might be explained more by drug abuse than by any mental illness.

Both she and Dr Farrelly described the psychiatric services as helpful but distant, and said that it would need an emergency situation for a patient to be seen by a psychiatrist.

Dr Farrelly described to us his impression of the current situation:

“Essentially they are a badly over-stretched service in terms of a hospital-based service. They are filled to capacity all the time – 110%. The fact that somebody has absconded – fine, they put somebody in their bed. That is the sense you have. To get somebody into hospital is not a therapeutic manoeuvre, it is purely to stop them from killing themselves or to stop them from killing someone else. That’s it... They have to be pretty extreme.”

When asked if there were any alternatives to hospital admission such as acute teams within the CMHT which could visit a patient say, twice a day, he told us that his impression was that the community team would not provide that level of support. He also said:

“I get the impression that the system is not really interested in knowing what our needs are... On the whole I don’t think [the consultant psychiatrists] are particularly interested in going into the community and finding out what is needed in the community. They are under siege, they are overworked and overstretched – 110% capacity – whatever you want to call it is a siege mentality. If they sat down and said: ‘This is an untenable situation. We are overstretched. We cannot provide this service’, they ought to articulate that upwards.

Similarly the hospital, where I have the same problem with the acute medical services. If you can’t admit people that you think should be admitted, you should tell people at the top that you can’t do this. But people just put their heads down and soldier on and make the best of it, but without feeding back that this is not good enough. This is in the news every day. We have that situation here in mental health.”

We also received information from other GPs in the area that the only way to get anyone seen urgently by a psychiatrist was to send them to Accident & Emergency at the hospital in the hope that they would be seen by the duty psychiatrist. They also feel that there is a gap between primary and secondary care in general as well as a gulf in secondary services between the ward and the community. We got the impression that there was a feeling of ‘them and us’ when it came to the links between the hospital based services and those caring for patients in the community.

Dr Ketley, a GP in East London who had no involvement with DN but who wished to come to talk to the panel, told us:

“The reality to make things better is that you must have everybody on board at every level, and that is the bit I am most disillusioned about – because unless you get the psychiatrists on board and seeing the value of working with GPs, then it is all a paper exercise.

I have to say in defence of the psychiatrists that general practice is a variable standard in the area. There will be practices whose ability to deal with mental health problems is pretty limited, and I have had

patients coming from those practices, but it ought to be perfectly possible to recognise who you are dealing with. This I have to say goes for the whole of the hospital services locally. They are very belittling of what general practice can do...

However, unless you can take people along with you and get them to see a value in it, it is just a paper exercise. One of the things I tried to develop was ‘Look, we can see some of these patients and do some of the work in primary care. We work together. As long as we have a good link-up as and when we need help, we are happy to see people if you will also see some of the other ones that we are dealing with – share things and have a fluid relationship’. But unless people see that as valuable we will never get anywhere.”

Even the Medical Director of the Mental Health Trust, Dr Jan Falkowski, seemed to share the view about the ‘them and us’ attitude in that, when we put to him the concerns which had been expressed by some GPs that the crucial CPA meetings – at which decisions were made as to what will happen to a patient on discharge from hospital – were held during a ward round at a time when they could not attend because it is in their surgery time, he told us:

“I think that, if GPs are honest and realistic, they will say that they do not have the time. Recruitment to general practice is even worse, particularly in London. We have very good GPs locally, by and large, way above the norm, but they do not have time to be involved, whether it is at six in the morning or nine at night. They cannot come. If you try to get GPs to meetings about planning for the NSF – we got two out of 400 in East London, even though they were all invited. They do not come to meetings because they do not have the time, because they would need to drop something else in order to make it. The issue about ward rounds is rather a red herring.

There is a problem, but it is very much a cultural one that has been driven by the drive to close psychiatric hospitals. The community is attractive and it is better paid and people are more autonomous. They can go shopping on the way to and from their home visit, which is fine, but all the best staff are leaving the in-patient setting and going into the community. The most disturbed and needy patients are those who are in-patients. The priority has been shifted towards the community. Rather than saying that someone who is in the community has reached the point where they need to be in hospital, the key worker should be fighting like mad to give that patient the best level of input they can – to get them into the community as fast as they can.

However what tends to happen is that CPNs, typically, are relieved when somebody disturbed is in hospital – they do not need to worry about it – they do not need to worry about coming to an inquiry. In the in-patient service they get hammered and that is a real problem.”

This problem of the attitude of ‘them and us’ must be addressed. It is perhaps unfortunate that the Medical Director’s current way of thinking is likely to perpetuate rather than solve the problem.

It is unusual for depot anti-psychotic medication to be administered by GPs. Apparently DN and one other patient were the only patients who were given depot medication at the Tredegar Practice. It is usual for anti-psychotic injections to be given by a CPN (Community Psychiatric nurse), and had DN’s medication

been administered by the CPNs, then it is possible that he would have forged a stronger link with the Bow Poplar CMHT, as they would have been responsible for seeing that he received his injections.

We feel that any path should have been followed which might have kept DN in closer contact with the psychiatric services, and allowing the CMHT to monitor his compliance and mental state was a fairly simple solution to the problem of keeping him engaged with the CMHT. Unfortunately, neither the GPs nor the CMHT ever seemed to have considered this option. We also understand that it was possible for DN to be seen by the CPNs at the Tredegar Practice. He would not have had to visit them at their base.

Another concern was that in 1994/5 the GPs extended the time between DN's depot injections without consultation with the psychiatrists. It must be said that on the whole he appeared well during this time and, the moment a deterioration in his mental health was reported to them towards the end of 1995, the GPs increased the dose again. However it then emerged that DN had in fact been increasingly violent towards M over the preceding eight months, which almost exactly coincided with the decrease in his medication.

The contents of Dr Hodkinson's 6th February letter to Dr Palazidou show that the the GP was clearly aware there was potential for disaster in the situation, and that she felt that she was 'rather out her depth with him'. Yet the letter was sent 'basically just for information'. This should have been a bolder and clearer request for help. It was almost two months before Dr Palazidou responded in writing, and even then there was no suggestion in that reply that DN should be seen by a psychiatrist. We believe that Dr Palazidou should have made contact with the GP immediately to discuss what was the best thing to do next in the circumstances. Although somewhat ambivalent, the letter from Dr Hodkinson was clearly a cry for help.

Dr Richard Laugharne, the Specialist Registrar attached to the Bow Poplar CMHT, used to attend practice meetings at the Tredegar surgery. We know that the GPs discussed their concerns about DN with Dr Laugharne at some of those meetings – he had even advised them to write to Dr Eleni Palazidou to express their concerns about him – but he was never asked to see DN. We asked Dr Hodkinson why no such request was ever made. She told us:

"I think it says something about the way that the team was set up. Richard was a registrar in the team but Eleni also had a registrar. The co-ordination of this team with the psychiatrist was not very good. They had not dismantled the trad ward-based hospital end of it all, so there was a kind of double running in the system... When you ask me questions I think 'Why wasn't it co-ordinated like that?', but I cannot tell you. I think the sense was that, if Richard saw him, it didn't go anywhere. So I cannot explain why we did not use Richard in that way but it probably was due to the structural dynamics of that whole set-up."

We asked Dr Laugharne to come to see us even though he had had no direct involvement with DN. He very kindly agreed to come even though it meant travelling from Cornwall where he is now based.

In 1994 Dr Laugharne had been appointed as Clinical Training Fellow at the medical school, which basically was a university post, involving approximately half his time being spent on research and the other half on clinical duties working as a psychiatrist with the Bow Poplar CMHT which had just been established. He was the first solely community based psychiatrist. He remained in that post until mid-1996 and no-one replaced him in the role of CMHT psychiatrist after he left.

When asked what he would have done, had he been asked how to deal with a patient who appeared to be reluctant to engage with the psychiatric services, he said:

“I can never remember refusing to see any patient that a GP had asked me to see, apart from some referrals where I do not think they are mentally ill, and I will say I do not think this is a suitable psychiatric referral...But if they had asked me to see him I would normally have written and offered him an appointment and see if he turns up. I have a lot of referrals that say ‘I’m not sure if he wants to see you’ and I would say ‘Let’s send him an appointment and see if he comes.’”

He also pointed out that one ran the risk of antagonising a patient by a letter from a psychiatrist offering to see him, especially when the patient was seeing his GP regularly for his depot medication. This could jeopardise the good relationship that had been built up with the GP. He later said:

“What probably happened is that (Dr Hodkinson) said ‘This guy doesn’t want to see a psychiatrist, but he’s taking his medication...I’m a bit concerned about him and I don’t know what to do because he is refusing to see a psychiatrist’. I probably said ‘This is a difficult situation. I think you should write to Eleni Palazidou about it and get her advice.’ In a difficult situation like that, I would have thought that it should be the consultant who gives advice, not somebody as junior as myself.”

We agree with the final sentence of what Dr Laugharne said.

He did however say that he did not often advise GPs to write to Dr Palazidou so he must have thought that DN’s case was “*a bit of a tricky one*”.

Dr Laugharne also confirmed that it would have been possible for him to have seen DN through the CMHT during the period of DN’s referral to the team in early 1996. He told us that he had an excellent relationship with the team members and, had any of them asked him to see DN, he would have done so.

We feel that is unfortunate that no advantage was taken of the fact that there was a community-based psychiatrist attached to the Bow Poplar CMHT between 1994 and 1996. This was another missed opportunity to try to bring DN into contact with a psychiatrist without having to send him as an out-patient to the hospital. We are not clear about the real reasons which may have made him resistant to seeing a psychiatrist, yet no-one seems to have suggested to him that he could see Dr Laugharne in the familiar surroundings of his GPs’ surgery.

When asked if he was really that against having anything to do with the psychiatric services if it didn’t involve going to hospital, DN told us:

“It’s not that I was against it. I just didn’t know what to expect.”

DN was referred to the Bow Poplar CMHT three times by the GPs, once in late February 1994, once in mid-December 1995 and again at the end of March 1997. None of these referrals lasted more than a few months before the team discharged DN from their caseload.

The first discharge occurred because Ralph Cheung, who had been DN’s Key Worker for a period of about four months, was leaving the CMHT. No follow up was arranged and therefore he was discharged, the reason being given that DN did not think that he needed to continue with the service.

DN had had only three sessions with Ralph Cheung at that time, but he seemed to be quite happy to have contact with the CMHT. We feel that it was far too soon to discharge DN from the service. He had only recently been started on depot medication – indeed he was referred to the CMHT the day that the depot medication was first given – and, as we have already stated, handing over the responsibility for administering the depot injections to the CPNs would have been a simple and effective way of ensuring DN’s continuing involvement with the CMHT.

The referral had been made so that DN’s mental state could be monitored. He was discharged almost before that purpose could be initiated let alone achieved. There is no indication that the CPA was implemented at this time. Indeed, some witnesses gave us the impression that the CPA has not been fully implemented in the area even now!

The second period of referral concerns us the most. DN had been re-referred to the team on 18th December 1995 when his mental health had deteriorated and M reported (and he admitted) that he had become increasingly violent over the past eight months. Dr Hodkinson had at that time stated that she thought that he had a schizophreniform or schizoaffective illness.

DN was seen initially in March 1996 for a lengthy assessment session by Tracey Upex, one of the CPNs with the CMHT, because he knew of her through her involvement with M.

Tracey Upex felt unable to be DN’s Key Worker because she had been M’s Key Worker for some time and she therefore presented his case to the clinical team and suggested that someone else should take him on as a ‘client’.

A trend has developed in various areas of clinical care to regard people with severe and enduring mental illness as ‘clients’.

The word ‘client’ implies a voluntary engagement with the mental health services. ‘Clients’ usually approach those offering a service and to a great extent, the momentum of the relationship depends on the ‘client’.

Carole Luby told us that the CMHT did not talk about ‘patients’. When asked why, she said:

“Patients are sick people. Clients have to take more responsibility for themselves.”

We believe there is an inherent danger in such an approach in mental health care as certain attitudes and assumptions come along with the label ‘client’, which may lead to the relationship becoming client-led. ‘Client’ is not, in our opinion, an appropriate term to apply to those with severe and enduring mental illness when they are unwell, especially those like DN who may be difficult to engage.

We feel strongly that – whatever label is used – people with severe and enduring mental illness should be viewed as ‘patients’ when they are actively unwell, in the hope that this will permit them to be treated more proactively and less reactively. There are unfortunately times when coercive treatments have to be resorted to in order to protect the patient and/or the community.

Carole Luby was appointed as DN’s Key Worker. She was the only Occupational Therapist on the team at that time. This was her first job and she could not recall whether she was a Basic Grade or Senior 2 at the time, but she was probably the latter. She told us that DN was an unusual client for her to have. As an OT (and a fairly inexperienced one at that) she would not normally be given responsibility for someone like DN with a history of violence (she was not aware at the time of the nature and extent of his forensic history although she had a *“broad general understanding of his past”*), a serious drug problem, and who was on depot anti-psychotic medication. However she did tell us that she had OT supervision at the hospital as well as supervision from the CMHT Team Leader and felt happy with the level of support she got. She very honestly said:

“In hindsight, I don’t think I had the experience and the skills at that time to handle all of the issues that D presented with.”

We share her view. It was absolutely appropriate for Tracey Upex to disqualify herself from being DN’s Key Worker given her on-going involvement with his partner M, but we consider that DN should have been allocated to another CPN on the team. In a mature, well-functioning multidisciplinary community team, one would not be concerned about the profession of the identified Key Worker, as expertise could be drawn from other members of the team where necessary. However in this case, we do have some concerns that because the Bow Poplar Team was not fully multidisciplinary, there was no social worker or consultant input, and the OT was fairly new to the post. We are unclear about the decision making which led to the choice of Key Worker, as according to the information we were given, we understand that there were five or six CPNs on the team at that time.

We are also very aware that both the GPs and the CMHT were in a very difficult situation because of their involvement with both DN and M. The GPs had the added complication of the fact that DN’s grandmother was also a patient of the practice. Dr Hodkinson told us that it was professionally quite difficult to have to deal with M and the grandmother as patients who were at times suffering at the hands of DN, while at the same time they were trying to treat DN for the mental illness and/or drug problem which were causing his violence towards them. It was perhaps inevitable that the GPs’ and

the CMHT's view of DN became coloured by M's reports to them of his behaviour towards her.

Carole Luby set DN three goals:

- (i) to come off drugs and therefore to start a programme at the Community Drug Team (CDT)
- (ii) to withdraw emotionally from M
- (iii) to meet with the Disability Education Advisor and to start looking for courses.

None of these goals refer to his mental illness and prescribed medication or risk. They should have done.

Carole Luby only ever saw DN four times – on 15th April (when he told her that he had attended the CDT and was waiting to be allocated a key worker); 13th May (when she noted her concern at the escalating violence between DN and M); 24th May (when she reminded him of his commitment to managing his drug problem which meant attending the CDT); and 25th May (when he told her that M had taken out an injunction against him and he was in a financial mess). There were no further appointments made for DN to see Carole Luby after 25th May, although the notes show that she was still involved on his behalf for some time after that date. He had kept all of his appointments up until then.

On 12th June, at a practice meeting, Dr Hodkinson commented to Carole Luby that DN did not think that Carole was doing him much good. On 24th June, at the next practice meeting, it was considered that DN was putting out very mixed messages about Carole and the CDT and it was not clear whether he really wanted to tackle his drug problem and his relationship with M. Carole Luby had made it clear at that meeting that there was little scope for working with him if he was still using drugs.

We are concerned that vital parts of DN's care were being ignored or neglected at that stage. Neither the GPs or the CMHT appear to have prioritised keeping him engaged with the CMHT.

On 4th July Dr Hodkinson noted a telephone call from Carole Luby to say that DN had not attended the CDT and therefore the CDT had discharged him from their caseload.

Five days later Dr Hodkinson felt the necessity to write to Dr Palazidou, setting out the information about DN's violent forensic history in 1991 which had been sent from Hackney Hospital, and warning her that he might be becoming unwell again.

There is a bit of a mystery as to exactly when the decision was made to discharge DN from the CMHT, but it was not that long after the GPs had expressed their growing concern about DN's mental health and the CMHT was hearing from M about his increasing violence.

This shows how the different parts of the service were working in isolation – one discharging, the other expressing concern.

On 4th October Carole Luby wrote in her notes that, following discussion with Tracey Upex, she had discharged DN from her caseload as he had not responded to OT intervention, and had not followed treatment plans, in particular to attend the CDT. On the same day she filled out a form headed 'Closure Summary' giving the reason for the closure as '*Did not engage with OT intervention. Did not work on Care Plan*'.

The form had to be signed by the Team Manager in order to ratify the decision. It was not signed by him until 6th December.

On 12th October, apparently after a discussion with Dr Hodkinson and Tracey Upex, Carole Luby wrote to the GP saying that she had now written to DN discharging him from her caseload. In fact it was not until 26th November that she wrote to DN to confirm that he was now discharged from the CMHT. As we have stated above, the Closure Summary was not countersigned by the Team Manager until 6th December.

We feel very strongly that DN should not have been discharged from the CMHT, particularly at a time when there were reports of his escalating violence and his own health appeared to be deteriorating – the Discharge Summary itself refers to his violence to his partner and grandmother:

'Kneesworth Ho: Section 37. (GBH) 1991

Hostile and threatening behaviour – Personality Disorder, Delusional Disorder.

Uses cannabis heavily. Has been violent towards M (girlfriend). Also towards Grandmother.

Did not engage with Drug Rehab Unit'.

On 8th November, DN told Dr Hodkinson that he was experiencing 'a losing battle. Black blankness...Cannabis not holding it' and by 6th December (after his recent marriage to M) he was acknowledging that he felt more distant and hostile towards the end of the duration of his monthly depot medication.

We can quite understand that Carole Luby might have felt that her role as an OT (rather than as a generic member of the team), trying to get him engaged in a drug programme and sorting out his work and social problems, was not getting anywhere, but there is a difference between discharging DN from her caseload and discharging him from the team altogether.

If nothing else, the GPs needed the support of the CMHT at this difficult time, and we can see that matters deteriorated quite quickly and dramatically over the weeks following his discharge from the CMHT.

Dr Hodkinson told us:

"What one has to recognise is that often you feel as though you are beating your head against a brick wall, so there is a tendency to say 'We will cope with what we can manage. You just carry on.'"

When asked by us how she felt about being left with sole medical responsibility for somebody who had the potential to be quite seriously violent, she replied:

“Very uncomfortable and very powerless in terms of what else we can do.”

She also said:

“I guess that in that 1996 phase where it was clear that things were getting out of control, a fuller mental health assessment might have been helpful, but it would also have to be the kind of mental health assessment that I do not see us having access to at the moment i.e. an assessment that was about trying to get to grips with whether it is possible to make changes in this person. Also there is a sense that maybe it wasn't possible to make changes.”

We agree that by this stage a fuller mental health assessment was required; however we don't believe that even by this stage there was a clear understanding of DN's mental illness, the extent of his drug habit and how these – and his underlying personality – were linked to his violence. Only after such an assessment could the possibility and feasibility of change be considered.

Perhaps the concept of DN being a 'client' rather than a patient was at the heart of his discharge from the CMHT. If they saw him as someone for whom they only had responsibility for as long as he wished to be engaged with their service, then the discharge is more understandable. If they had properly considered DN to be a patient who had severe and enduring mental health problems, then hopefully they would have done more to deal with his illness and drug problems.

The third referral was made by Dr Farrelly on 26th March 1997, after DN had assaulted M and she had reported him to the police and gone with the children to a Women's Refuge, and DN's grandmother had reported that some three weeks previously he had knocked her door down and set fire to her curtains. He had also not turned up for his injections since the middle of January, which was most unusual for him.

Carole Luby took the referral call from Dr Farrelly and noted that DN '*was on the loose...George feels he might be brewing for a blow-out*'.

On 4th April, following a discussion with Tracey Upex on the telephone, Dr Sennett faxed a letter to the CMHT asking the team to carry out a mental state assessment of DN and arrange follow-up. Jo Williams, a CPN with the team, was allocated to be DN's Key Worker. It seems, however, that she never actually got to meet him. We were not able to talk to her as she is now living in New Zealand.

DN reappeared at the surgery for his medication on 24th April after a three month absence. Over the next couple of months, DN's health continued to deteriorate. Jo Williams kept in contact with the GPs and she and a colleague, Ben Hannigan, made a couple of home visits in June to try to see DN, but he was not in on either occasion.

Jo Williams helped to arrange DN's admission to St Clement's Hospital on 18th June, and the following morning gave the Ward Manager, Vicky Barwood, important information about DN. She arranged to visit DN on the ward the following Wednesday and then attend the ward round. He was, however, discharged on Saturday 21st June and the following day was arrested and remanded in custody where he remained until sentenced to an 18 month custodial sentence on 15th August, with an estimated release date of 23rd March 1998.

Jo Williams 'kept tabs' on what was happening to DN, but on 24th October 1997, DN was once again discharged from the CMHT back to the GPs. The reasons for closure were given as the fact that he didn't engage with the team and the fact that he was serving a prison sentence until 1998. His current status was given as being on CPA level 2.

In our opinion DN should have been on the highest level of the CPA – and on the supervision register. In fact, DN was not on any level of the CPA at that or at any time.

We also consider that DN should not have been discharged from the CMHT on the grounds that he was in prison. At the time of closure, there were only five months remaining of his sentence. The psychiatric report prepared for the Court by Dr Pearson had concluded that both DN and the GPs had agreed that once he was released from prison, they would involve the CMHT in an attempt to monitor his progress, especially in relation to his intention to stay clear of drugs.

DN appears to have been labelled by the CMHT as someone who was difficult to engage; yet he always started off seeking help, and we believe that he could have been kept engaged had appropriate help been offered and if he felt that he was deriving some benefit from what was on offer.

As far as his non-engagement with the team was concerned, since his re-referral in April 1997, only one appointment had been made by the CMHT to see him – on 10th June. It is true that he wasn't in when they called, but events the following week showed that he was clearly very unwell at that time.

We believe that it was even more important for the CMHT to stay involved with DN because of his prison sentence. This was an opportunity to try to engage with him and to monitor his mental state at a time when he should be relatively drug-free after spending nine months in jail; and when the length of his sentence meant that he would be released on Licence, and therefore the Probation Service would be involved as well. It would have been very simple to have kept the file open to see whether and how the team could help on his release.

What could and should have happened was that:

- (i) the care co-ordinator should have provided the details of DN's background, mental health needs and current care plan to the prison health care service**
- (ii) the care co-ordinator should have visited DN in prison and in due course should have taken the lead in arranging a pre-release CPA meeting.**

This did not happen. It was left to DN to make further contact with the CMHT on his release from prison, which he did not.

The first thing he did when he came out of prison was to ask Dr Hodkinson for anger management counselling. He was virtually drug-free at the time, having been in the drug-free unit in prison. He enrolled at college and seemed to be trying to make positive changes in his life and his relationships. This was a critical time and he needed support and encouragement, especially not to go back to his heavy use of drugs.

On his discharge from Kneesworth in 1992, Dr Petrie had highlighted DN's vulnerability to drugs. He wrote to Dr Boast:

'I think that this patient needs further observation and that he will be very vulnerable to illegal drug abuse on discharge. He will, therefore, need very careful supervision in the future, when he is finally discharged.'

Dr Pearson in his pre-sentence report the previous year had stated:

'He expresses a desire to stay clear of drugs which he knows are detrimental to his mental health, but his ability to stay abstinent once in the Community must remain in doubt.'

If ever there was a time when the CMHT could have been effective in DN's care, this was it.

Whatever the custom and practice was in 1998, it should not be the case now that a patient in contact with specialist psychiatric services should be discharged from these services when sentenced to a term of imprisonment. We are not convinced that current practice reflects the expectation of continuous involvement.

We are aware that the CMHT had a heavy workload and can understand the temptation to reduce the caseload whenever possible, but we think that this could and should have been managed. The team was not as proactive as it should have been, and did not prioritise the care of patients with severe and enduring mental illness. We found it interesting in terms of priority that M (who suffered from depression and anxiety rather than any more serious mental disorder) was seen on an almost weekly basis by Tracey Upex.

At present it is not clear where the CMHT fits in between the primary and secondary psychiatric services, and instead of providing a clear and reliable link between the two, it appears to be floundering somewhere in between, with conflicting priorities. We are even more worried to hear that matters have not improved since the homicide in 1998. Indeed we were told by some witnesses that they have got worse. This cannot be allowed to continue or there will be more homicides and more inquiries and less available resources to try to put things right.

It has been difficult for us to make an informed judgment on what has been said about matters getting worse, since to test those views would have required us to widen the remit of the Inquiry. However we urge the new Trust to carry out a survey of front-line mental health staff to identify their views as to where there has been success in recent strategies and developments, and where there are still issues which need to be addressed.

We also have concerns about the role of the hospital-based staff, both in 1992 and 1997.

There should have been a Discharge Summary following DN absconding from the ISU in June 1992. He was a patient who had a violent forensic history and at the time of his transfer to the Unit from Kneesworth House, there was no clear diagnosis.

He had been in the ISU for some four months and various diagnostic tests had been carried out. The clinical notes record the result of the SCID diagnostic assessment (a Structured Clinical Interview for the DSM Diagnostic System) as 'Borderline personality traits'.

However Dr Neil Boast, who made the presentation to the case conference on DN, suggested a differential diagnosis of 'borderline personality disorder with some passive aggressive, obsessional, paranoid and anti-social traits' and 'delusional disorder, persecutory type'.

In 1992 Dr Boast was in his first senior registrar post in forensic psychiatry and was at Bart's and Hackney Hospital, working under the supervision of Dr David Ndegwa. (He rose to become Clinical Director of the forensic service until his recent resignation.)

This differential diagnosis was made as part of the presentation for the case conference. There is nothing in the clinical records which shows that Dr Ndegwa confirmed that diagnosis. At interview he was not clear whether he supported it or not.

Unfortunately it is the only diagnosis made by a psychiatrist over the next six years and one which appears to have influenced people's way of thinking about DN.

Because no Discharge Summary was ever composed, there was no definitive diagnosis for those subsequently looking after DN to work from. DN has been labelled with 'personality disorder' as his most probable diagnosis by almost everyone who has had sight of Dr Boast's case presentation report.

When DN came to the attention of Dr Ndegwa again in 1994 through Dr Hodkinson, and in 1996 through both Dr Hodkinson and Dr Palazidou, despite the fact that DN had absconded from the ISU and Dr Ndegwa had therefore not been able to complete his assessment of him, Dr Ndegwa did not arrange to see DN again. We believe that, even if a detained patient is AWOL until after the expiry of the section, the service which was responsible for his care and treatment during a patient's detention has a duty to provide more than just a Discharge Summary. (In DN's case there wasn't even that!) There has to be a Contingency Plan drawn up which includes a requirement for the patient to be re-assessed if he comes to the attention of any of the local medical services again. This

could be carried out solely by the forensic service or in collaboration with the general service.

DN should also not have been discharged from Dundee Ward when he admitted himself to St Clement's Hospital as a voluntary patient in 1997, without being seen by a senior doctor.

There is some question as to whether he actually demanded to be discharged, or was persuaded to discharge himself by the suggestion that he was likely to be detained under section if he remained on the ward. There is no form showing that he discharged himself against medical advice, and yet only two days beforehand, Dr Alyas (who was the duty doctor who had dealt with DN's discharge) had requested that he should be assessed for a Section 5(2) if he wanted to leave. Section 5(2) MHA enables an informal patient to be detained for up to 72 hours if the doctor in charge of his treatment reports that an application under Section 2 or 3 MHA (compulsory detention for assessment or treatment) ought to be made. The purpose is to prevent a patient from discharging himself from hospital before there is time to arrange for an application for detention under section 2 or 3.

Dr Alyas herself told us that *"It's very hard to say. I can't say for certain"* when we asked her whether he was discharged or whether he had discharged himself.

He had only been in the hospital since the night of Wednesday 18th June. He himself had requested to be admitted to hospital (although he said it was because he had nowhere to stay that night). The Ward Admission Summary stated that DN felt safe on the ward, and Dr Hodgkinson was told by the Ward Manager on the Friday that he was happy as a voluntary patient.

At the time of admission he was acutely psychotic and delusional, believing that phantoms were holding him down. The following day he was reviewed by the SHO, Dr Zaubia Alyas, and told her that he felt that spirits were controlling him and also entered other people which he could tell by looking in their eyes. Dr Alyas formed the impression that he had overvalued ideas about spirits rather than that he was delusional.

The nursing notes at the end of the day stated that he was calm and appropriate in his behaviour and had made no request to leave the ward.

On the next day, the Friday, the ward staff obtained a considerable amount of information from Dr Hodgkinson about DN's past psychiatric and forensic history and M had telephoned to tell them about the assault charge she was bringing against him.

DN got up late, was calm at first and then gradually became more disturbed as the day wore on, eventually storming out of the ward at about 16.30 after he had been refused access to some of his possessions, only to return an hour later, calm, settled and apologetic and admitting that he had drunk a can of lager while he was out.

At some stage during his hour's absence, Dr Alyas made a long and detailed note in the clinical record which included the fact that Jo Williams had informed them that the GPs had made three referrals to the CMHT in the past two years and that the CPNs had had great difficulty establishing contact with him.

She also recorded that Dr Palazidou had wanted DN's admission for a formal assessment to be made.

DN's past forensic history was also listed by her and details of his past admissions under section in Kneesworth House and Hackney Secure Unit. The diagnosis made by Dr Boast in 1991 of borderline personality disorder and delusional disorder of persecutory type was also noted.

She concluded her note:

'Probably needs further assessment and persuasion to stay in hospital'.

This note made by Dr Alyas shows:

- (a) That she was in possession of all the necessary information about DN**
- (b) That she had read and absorbed all that information**
- (c) That she was aware that Dr Palazidou wanted an assessment to be carried out and that the CMHT had found it difficult to engage with DN**
- (d) That she was of the view that he might need to be persuaded to remain in hospital.**

We therefore find it hard to understand why DN was allowed to leave (perhaps even encouraged to leave) the following morning to be followed up as an out-patient, when no formal assessment had been carried out, no-one more senior to Dr Alyas had seen him or even been consulted about him, and it was known that he had not co-operated in the past with the CMHT.

The only reason we can find is that DN was in breach of the contract he had signed, but this should not have taken precedence over his acute mental illness.

When he got up the following morning, DN voluntarily handed in two small pieces of cannabis to the ward staff and had allowed them to search his belongings. He admitted to having smoked some cannabis while he was away from the ward the previous afternoon but said that he had had none since. This appears to show that he was willing to co-operate and to adhere to the contract he had signed with the ward staff.

It is fair to say that he had gone 'AWOL' again on that Saturday morning, but this was only for a 15 minute period and was satisfactorily explained by a date-stamped form from a police station which appeared to show that DN had gone to report the theft of a wallet.

Fifteen minutes after he returned, he had left the Unit, having in that time packed his belongings and been 'assessed' by Dr Alyas. We question whether any kind of risk assessment could have been carried out in this very short period.

Dr Alyas's note for the 21st June states that senior nurses on the ward felt *'he either needs to be on section or discharged'* and that in her opinion he needed referral to the forensic team. On the 19th June, Dr Alyas had requested that DN should be assessed for detention under Section 5(2) of the Mental Health Act if he wanted to leave, yet no attempt was made by her to pursue this

option only two days later.

We fail to understand how someone can – at the same time – be considered either as requiring compulsory detention or as being well enough to be suitable for discharge. Also, if the doctor's assessment of the patient was that he needed to be referred to the forensic team, (i) why wasn't he referred? and (ii) why was he released into the community when the doctor considered that:

'This volatile man is very sensitive to any form of confrontation and therefore he cannot be managed safely on an open ward?' [This was written by Dr Alyas in her 'Discharge Summary' notes.]

If any risk assessment was carried out at all before DN was allowed to leave, it would appear to have been an assessment only of risk to the ward staff and not of any risk which DN might pose to himself or the community at large.

In her 'Discharge Summary' Dr Alyas recorded these 'Follow Up Plans':

- *He has agreed to go and see his GP Monday Morning and via her to come and see Dr Palazidou as an outpatient for help with his problems.*
- *He probably needs to be referred to the local Forensic team too.*
- *Ideally if repeat admission is necessary it should be to ITU where his challenging behaviour can be dealt with more safely.'*

The diagnosis was given as:

'Borderline Personality Disorder, Polysubstance abuse, Persecutory ideas in the context of a psychosocial crises situation (sic).'

Despite the fact that DN was being discharged on the understanding that he would contact his GP on the Monday in order to arrange outpatient follow up with Dr Palazidou, neither the GPs nor the CMHT were informed that DN had been discharged. The GPs were never sent a Discharge Summary, although the CMHT has a copy of Dr Alyas's typed notes (with a handwritten notation 'Draft') in its records. There is no date stamp on it and no covering letter, so there is no way of knowing when or how it came into the possession of the CMHT.

The notes themselves are unsigned and undated. During her interview Dr Alyas identified them as being the notes which she prepared a day or so after DN's discharge because she was going on leave and was concerned that there should be a summary in the notes. She expected that someone would prepare a formal Discharge Summary from her notes.

This appears to be yet another occasion when no formal Discharge Summary was prepared for DN.

In June 1997, Dr Alyas was an SHO in her first training year and about 5/6 months into her first psychiatric SHO post as trainee to Dr Cobb.

At the time there was no Psychiatric Registrar in post, and therefore we believe that Dr Alyas should have discussed DN with her consultant, Dr Cobb, before she allowed DN to leave the hospital on 21st June.

We are aware that an unusual set of circumstances had meant that Dr Cobb was not actually present at the hospital at any time during DN's short admission. He had attended a ward round on the Wednesday that DN was admitted, but the admission was not until the late evening, after Dr Cobb had left for the day. However, he was contactable on the telephone or on his pager throughout that period. Dr Alyas had contacted him many times about many patients during the time that she was his trainee, but she did not at any time contact him or the duty consultant about DN. No doctor responsible for the patients on Dundee Ward other than Dr Alyas was even aware of his admission.

We understand that part of the problem may have been due to the fact that DN was discharged on a Saturday, and Dr Cobb told us that at that time he did not take calls over a weekend (although he does now). It would therefore have been the duty consultant for the weekend who should have been contacted for any help or advice.

Part of the problem was also the confusion which arose as to who was actually the consultant responsible for DN's care. He was described as Dr Palazidou's patient, but there were no beds available on the ward which she covered at that time, and Dundee Ward where DN was admitted was an overspill ward which was the responsibility of Drs Cobb and Cookson. In 1997 Dr Palazidou would not see any patients on Dundee Ward, even if they were her own patients.

It seemed to us as though this practice was likely to breed the understandable feeling amongst the junior doctors and nursing staff, that they should only contact Drs Cobb and Cookson about Dr Palazidou's patients if the situation was really urgent.

It is fair to say that Dr Cobb felt that he should have been contacted by Dr Alyas and that she had contacted him on many other occasions.

We do not consider that it is safe practice for such a junior doctor to make decisions about the discharge of a complex and difficult-to-manage patient such as DN without consultation with a more senior colleague, particularly where – as in the case of DN – they have not been seen by any more senior doctor during their admission.

We wish to make it clear that if we appear to criticise Dr Alyas for the decisions she made on the 21st June, we are most critical of the system which allowed her to be placed in such a difficult position.

Although Dr Alyas made no complaint of the supervision or support which she received during her training period, we feel that there were unclear boundaries and guidelines in existence at that time

which could have led to confusion as to what were the proper steps to take when a situation arose like the one which occurred on 21st June.

We are also concerned that when we asked for his comments, the current Medical Director seemed to consider this to have been “reasonable” practice, which suggests that the conditions which allowed that decision in 1997 still exist today. This is an important clinical governance issue.

The Medical Director, Dr Falkowski said:

“It sounds as if the quality of care he received on Dundee Ward was probably reasonable. You might say ‘6 out of 10 – could try better’, but it does not sound as though it was a disaster. It certainly does not sound as though the disaster that eventually happened was directly related to that. Indeed, one could argue that during his time both in the private sector when he was in a secure setting and at Hackney, obviously there was the time for him to be fully assessed. A few days here or there in a psychiatric ward would not make much difference. To focus too much around that area – junior doctors admitting or discharging someone without a senior is not the end of the world.”

It is fair to say that on reflection Dr Falkowski reduced his marking to 2 out of 10 once he was made fully aware of the background to DN’s admission. It troubled us that he did not seem to have fully acquainted himself with the facts before he came to see us.

In our opinion this issue does need addressing and we have made a Recommendation accordingly.

Another area of concern is that the hospital staff failed to notify the GPs and the CMHT that DN had been discharged. The CMHT only operates from 9am to 5pm Mondays to Fridays. We are aware that he was discharged on a Saturday, but all reasonable steps should have been taken to ensure that by Monday at least the information had been communicated to them both.

There was also no CPA aftercare plan for DN. There should have been. The CPA meeting which had been planned for 25th June did not take place. It should have done, irrespective of the fact that DN had been discharged. This may have been an opportunity for the case to have been reviewed by a consultant psychiatrist. The nursing notes recorded that a CPA form had been completed. It had not. Only DN’s name and date of birth had been filled in. The rest of the three-page form was blank.

We feel very strongly about the circumstances surrounding DN’s admission and discharge from St Clement’s Hospital, because it was known to the hospital staff that DN was due in Court in a few days time in respect of various offences, including the assault on M.

Had DN still been a voluntary patient in the hospital at the time of the Court hearing, and had there been a full assessment of his mental health which could have been put before the Court, it is possible that the Judge might have been persuaded to make a Hospital Order or a probation order with a condition of psychiatric and/or drug treatment as had been suggested by the Probation Services, rather than rejecting those options in favour of a prison sentence.

We are aware that Dr Pearson, who prepared a pre-sentencing psychiatric report for the Court in July, spoke on the telephone to St Clement's before completing his report (which made no recommendation for a medical disposal of the case), but we do not know who he spoke to or what he was told.

Had a Hospital Order or a Probation Order with a condition for psychiatric/substance misuse treatment been made instead of a prison sentence, it is possible that DN's mental and drug problems could have been addressed with a good outcome, and he might not have blown all of his inheritance on drugs shortly after his release.

There would also have been a multi-disciplinary CPA aftercare plan, which should have ensured fairly close monitoring of DN following his discharge.

There would also have been liaison between the CMHT and the Probation Service which might have provided tighter supervision of DN when he was released or discharged.

As it was, the last five weeks of DN's grandmother's life, which was the time when he was spending his inheritance on a drug binge, was perhaps the time of least intervention from any of the professionals who had been involved with him over the preceding five years.

We are not seeking to suggest that, had any or all the professionals been closely involved with DN over this five week period, the homicide would not have occurred; but it is possible that the tragedy could have been prevented had someone been aware that DN was spiralling out of control, as he clearly was if the accounts given to the police are accurate.

We also have concerns about the role of the Probation Service following DN's release from prison on 23rd March 1998.

As we have already commented in the Background Section, DN's Probation Officer, Harry Matthews, was refreshingly frank with us about having made a mistake in putting DN in the 'low risk' category. Given his history of violence, his psychiatric history and his substance misuse, he should have been placed in the 'risk aware' category. Had DN been in the 'risk aware' category, Harry Matthews told us that he would have been much more proactive in his supervision of DN.

We consider that we must question the reliability and safety of carrying out a risk assessment by using a method solely reliant on ticking boxes. The only entry on the form filled out for DN that we recognised was his name! We did question whether in fact this was DN's form or someone else's.

Harry Matthews told us that the probation rules required DN to report at least four times within the first month of release and then fortnightly after the first month or six weeks. There also should have been a home visit made in May.

As it was, DN was only required to report on the day of his release, again one week later and a week after that. After those first two weeks, the next appointment was a fortnight later and after that, DN was only

required to report to the probation office every three weeks. There was no home visit.

The Probation Supervision Programme Objectives included:

'To monitor drug situation and ensure that he does not go back to drug abuse.'

Unfortunately that objective was not pursued in any way. Had DN been supervised more often and more proactively on his release from prison, Harry Matthews might have noticed when DN began his drug binge and steps could have been taken to nip things in the bud.

We were told that on one of the first few appointments, DN had about a half hour interview with a drugs counsellor from one of the partnership agencies working with the probation service in Tower Hamlets, who did not report any concerns that DN was abusing drugs; but unfortunately we now know that the drug binge did not begin until about five weeks before the homicide. Although Harry also told us that there were no obvious signs of drug abuse when he saw DN, the last time he saw him was 11th May.

DN should have been placed in the 'risk aware' category and should have been more frequently and more proactively supervised. Contact between the Probation Service and the GPs and the CMHT should have been established immediately after DN's release from prison and maintained on a regular basis.

The Probation Service did, however, notify the GPs when DN was due to be released from prison.

The Community Drug Team (CDT) also requires our scrutiny.

DN experienced problems due to his use of illicit drugs. Although he did not show any signs of physical dependence on drugs, DN saw his own drug use as the cause of many of his problems, and his family concurred with this view. DN himself reports heavy use of illicit drugs, especially cannabis and crack cocaine. He also reports having used most illicit drugs, including heroin, at one time or another.

The mental health service felt that drug use was a significant cause of his problems and referred DN to the local community drug team. Many observers, particularly the police, have ascribed the homicide to the effects of crack cocaine.

It is, therefore, not unreasonable to regard DN as an individual with a 'dual diagnosis' and the inquiry team was asked to consider how such individuals should be cared for in the future.

Dual diagnosis is a large and very crude category encompassing a broad spectrum of problems. At one end of this spectrum may be those who simply have a combined history of an anxiety disorder and an alcohol problem, and appear to be engaging with services and responding to treatment.

At the other end of the spectrum is a group of people with a dual diagnosis of substance misuse and mental illness, who manifest a number of key characteristics due to the interaction of drugs with a mental disorder:

- risk to self and others
- difficulty of engagement
- chaotic lifestyles
- long-term cyclical patterns oscillating between relative stability and great instability.

DN's adult life fits this pattern. It is also a pattern found in a number of other recent homicide inquiries, for example the Shane Bath, Christopher Moffatt, Mark Longman and Matthew Hotson Inquiries. Each of these inquiries focuses in part on the inadequacy of the response of substance misuse services to people who are not ready to engage with treatment. Recommendations for change are made in each report.

The Shane Bath Inquiry focused on a very chaotic young man who misused drugs and alcohol in an abusive manner. He was referred to substance misuse services; however, their response to 'clients' was based on the individual being motivated to engage. The report comments that:

'It should have been apparent shortly after starting to work with Mr. Bath that motivational interviewing was unlikely to be an effective approach to change behaviour in a severely personality disordered person for whom...a more assertive approach might have had a greater success. At the time there were no other options available for community treatment of alcohol and drug problems...'

The Christopher Moffatt and the Mark Longman reports make similar comments.

Christopher Moffatt's use of cannabis complicated the management of his condition. However, the local Drug Advisory Service's philosophy virtually precluded it from helping him:

'If a client does not want contact with our servicethat is seen as their responsibility, and it is respected. That has not changed over the number of years. The reality for a patient who has a serious mental illness, and believes that smoking cannabis fights the devil in his head, is that he will never seek, nor therefore receive, help from the services.'

'It is a very helpful service but not for the co-morbid patients.'

The report stated that the philosophy of the substance abuse service, which is based on a motivation to give up illegal drugs, made it impossible for the service to help someone like Christopher Moffatt, whose illness involved seeing the drug as bringing about an improvement in his mental state.

The staff of the Bow Poplar CMHT referred DN to the local Community Drug Team, run by a voluntary agency now known as Addaction. This service appeared to offer a model of good practice with complex patients. They could have an assessment on demand any day of the week through a drop-in facility. It was reported that approximately one thousand such individuals a year would access the assessment. However, after the assessment they would have to ring the service to see if they were going to be offered a service. Only one third of those who came for assessment rang for the second appointment. It seems likely that many of those who failed to ring are among the most chaotic and socially excluded.

As far as we can identify, DN was one of those who failed to follow up this initial contact.

It is our view that systems of accessing substance misuse services which are based largely on clients being motivated to attend, will have the effect of excluding some of the most vulnerable and risky patients.

Models of working with chaotic, dually diagnosed substance misusers which are based on those individuals showing motivation to engage with substance misuse treatment, seem doomed to failure.

It is however pleasing to note that the Tower Hamlets Drug Dependency Unit has developed its service so that there is a greater emphasis on keeping patients engaged with services. Addaction also report that their service has shifted to a system which makes contact with those who have come for assessment.

DN also spent periods of time in a number of closed psychiatric settings. These range from Kneesworth House and the John Howard Centre in the early 1990s to the hospital wing of HMP Belmarsh and Rampton Hospital. He also spent time on Dundee Ward at St Clement's Hospital. In none of these facilities did staff feel confident that drugs were not being brought in and being used by patients.

The issue of drug use in psychiatric settings may have caused DN problems in two main ways:

- It made accurate diagnosis much harder, because it is hard to know whether changes in mental state are due to a recurrent mental disorder or the use of drugs.
- In the case of Dundee Ward, drug use contributed to the brevity of his stay.

We recognise that the use of drugs is not the fault of the staff and managers of those units. It is a difficult problem to manage. The widespread concern that we discovered suggests that all psychiatric units should have a policy on the management of drug related incidents, and that there needs to be a debate at regional or national level about how best to manage this problem and the consequent development of national policy guidance.

We were also concerned that DN was known to be violent towards those who would be considered to fall into the category of 'vulnerable adults', namely his wife and his grandmother, as well as frightening M's children by his behaviour, and yet no steps were taken by anybody who knew about his behaviour to protect his 'victims'.

We consider that the professionals who were aware of the physical abuse should have reported it to the appropriate agencies as well as re-assessed whether or not DN's violence was linked to his mental health (or drugs misuse).

We are aware that, when M told Dr Farrelly on 13th February 1997 that she had reported DN to the police because of his assault on her and that she and her children were afraid of him, the GP telephoned the Adult Social Services and the Childrens' Team but both said that they could not help. There has to be a better response in such circumstances.

The London Borough of Tower Hamlets has recently developed its own policy and procedures document in response to 'No Secrets' (the Department of Health guidance on protecting vulnerable adults from abuse). It provides a clear and comprehensive procedure which the Inquiry Team welcomes. However, it is clearly vital that this document is widely disseminated in particular to community based mental health and substance misuse services and GPs.

We understand that at the time when we were conducting our inquiry, there have been several incidents which have led or will lead to independent inquiries being conducted within the area covered by ELCHA (now NELHA). We therefore strongly encourage those organisations involved to review the facts and issues raised in all of them to see if there is a common theme which needs to be addressed.

It may be that the facts and outcomes are very different, but it is evident that there still may be common concerns about the care, treatment and management of patients with severe and enduring mental illness within the Trust that must receive attention.

We are concerned that much-needed resources are being spent on investigating serious untoward incidents arising out of community care, when the resources are so obviously required to remedy the defects in the system which have led to the incidents in the first place.

We realise that this is a 'Catch 22' situation, but feel strongly that those responsible for vision, strategy and commissioning must ensure that resources are allocated to and directed towards better community healthcare co-ordination. The starting point has to be a comprehensive strategy to provide a strong linked service between primary care and the secondary specialist mental health services and between the general and forensic services.

Mental health services in East London appear to have been behind in developing a modern and effective service. There has been a failure of vision and an organisational systems failure which has affected this part of London, making it compare unfavourably to its peers in the Capital.

We have not been able to focus on the other mental health services in East London (City, Hackney and Newham) but we would urge the new Trust to review those services in the light of the recommendations made in this report to ensure that there are no common problems in those services.

There must be a drastic rethinking of the organisational systems in the area.

Unless there is a radical change in strategy and a higher priority given to resourcing and improving mental health services in the locality, things will not get any better – and they must.

We understand that this is currently being targeted.

We are aware that there has been an inordinate amount of change in both the structure and the management of mental health services. This has been both unsettling and damaging to the morale of the professionals who work within the services and their inclination to take steps towards positive change.

We hope that the current Mental Health Trust can move services forward.

It is essential for mental health services to be encouraged to develop a well-motivated and skilled work force in order to ensure safe and reliable provision of mental health care.

We are also concerned about the ‘them and us’ attitude that seems to exist between the hospital-based and the community-based services, and in particular that there are poor links in some areas between the consultant psychiatrists and the community professionals.

When we aired our concerns about DN being discharged by a junior doctor without consulting with a more senior colleague and asked him about induction for junior doctors in respect of discharge policies, the Medical Director, Dr Falkowski said:

“One would normally hope that the junior would seek advice, particularly from people in the community or the ward staff concerned. If there is a mixed picture coming from the ward staff, one would hope for more details from the CMHT. I would be interested to know whether there are any entries in the notes from the CMHT that had been concerned with him all this time, or did they just dump him as an in-patient and run? Sometimes the community teams expect the in-patient wards to sort all the problems out.”

Perhaps Dr Falkowski was speaking with his consultant psychiatrist’s hat rather than his Medical Director’s hat on when he said this, but given that he is the current Medical Director, we are surprised that his views appear to be out of step with the overall direction of modern mental health services.

It is essential that it is recognised from the Medical Director downwards that specialist psychiatric services must be more integrated across the community to reflect what is seen as normal practice elsewhere.

We realise that any Report of this nature has the potential to demoralise the professionals who face the challenge of working in East London, and we therefore hasten to explain that our intention in being somewhat ‘hard-hitting’ is to improve their working conditions so that their undoubted skill and dedication can have a freer rein to help those in need in their area.

Theirs is sometimes a thankless task, and we would not wish to leave them with the feeling that the good work they do every day is not appreciated. For every DN there are thousands of patients whose

lives have been improved and enriched by the help given to them by the primary and secondary services in East London. This should not be forgotten.

Recommendations

It may be that some of these Recommendations have already been addressed in the four years since the homicide occurred. We applaud such steps as have been taken. However, it is imperative that regular audits are carried out to ensure that policies are being implemented. We are aware that in response to this Report an Action Plan will be developed. We would expect such an Action Plan to include an audit cycle which addresses these Recommendations, as just developing policies – without proper follow-up – cannot guarantee a change in practice.

	Recommendations	Organisation(s) Concerned
	<p>GPs</p> <p><i>This case may well be a learning opportunity for any GP who has to treat and manage patients with enduring mental illness.</i></p>	
1	Any GP to whom a patient with a psychiatric history presents for the first time, should ensure that they obtain the patient's records as soon as possible, and there should be systems in place to pick up delays in receipt of such records.	PCT and all local GPs
2	All front-line primary care staff, including GPs, Practice Nurses and Receptionists, should receive risk assessment training, tailored to individual need. Training for GPs and nurses should include: violence and mental illness, assessment of suicide risk, the effects of drugs and alcohol on risk, and relevant provisions of the Mental Health Act. It is essential that the training in risk assessment is jointly carried out with local specialist mental health services. If it comes to a GP's knowledge that a patient has a forensic history which involves violence, all reasonable steps should be taken to discover the nature and detail of such violence.	PCT and all local GPs
3	If the patient is assessed by a GP as being at risk, either by virtue of their past history or their present conduct and mental state, he/she must be referred for formal assessment by specialist mental health services under the direction of a psychiatrist. If the GP considers the risk to be high, the referral should clearly indicate this and should request the direct involvement of a consultant psychiatrist.	PCT and all local GPs

	Recommendations	Organisation(s) Concerned
4	<p>Any GP who becomes aware that one of their patients has absconded within the last five years whilst detained under a section of the MHA, should refer the patient immediately for a psychiatric assessment, ideally by the service from which he absconded.</p>	<p>PCT and all local GPs</p>
5	<p><i>Having been admitted to hospital under a Hospital Order in 1991, DN was entitled to aftercare pursuant to section 117 of the MHA. Any referral to psychiatric or social services should then trigger a section 117 meeting to plan future care. This did not happen in DN's case.</i></p> <p>Any patient who presents for the first time, having absconded from hospital after admission under either Section 3 of the MHA or a Hospital Order and who is not currently under the care of psychiatric, social or any other relevant services, should be referred to one of those agencies – irrespective of the patient's wishes – in order that the patient's future care can be planned pursuant to Section 117.</p>	<p>PCT, MHT and all local GPs</p>
6	<p>'At risk' patients who are not currently under secondary care and who are 'difficult to engage' (i.e. are reluctant or unwilling to engage with secondary care) should be discussed with the local CMHT and psychiatrist. An interim care plan should be formulated around the patient's immediate needs, but should also include ongoing efforts to ensure that a comprehensive assessment is carried out. This may require patients being assessed at home or at the GP surgery instead of at the outpatients' clinic.</p>	<p>PCT, MHT and all local GPs</p>
7	<p>As a safety check, all GPs – with assistance from their PCT and CMHT – should set up a practice register of patients with serious mental illness or who have chaotic and unstable lifestyles associated with other mental health problems and/or substance misuse. This is a vulnerable group of patients with chronic relapsing illness, often failing to engage with services in a consistent way. Such patients need to be clearly identified by the primary care team and reviewed at regular intervals. Any who are considered to be at risk should be referred to the CMHT or other relevant agency for assessment for a multi-disciplinary care plan. If there is a need to share this information for audit purposes, the register can be anonymised to protect patient confidentiality.</p>	<p>PCT, MHT and all local GPs</p>

	Recommendations	Organisation(s) Concerned
8	All GP practices should meet with staff from their local CMHTs in order to review operational and clinical arrangements. As a minimum, these should ensure that patients with severe mental illness are regularly reviewed and that there is easy and effective communication between primary care and the CMHT.	PCT, MHT and all local GPs
9	The prescribing and administration of depot anti-psychotic medication in primary care should be reviewed. We suggest the following: <ul style="list-style-type: none"> • Depot medication should normally be prescribed and given by the CMHT • Depot medication should not be initiated in primary care • If the patient prefers to receive his/her depot medication from the GP, this should only be following a psychiatric assessment and by express arrangement with the CMHT, the initial doses being given by the CMHT • GPs and practice nurses giving depot injections should receive appropriate training. 	PCT, MHT, The Royal College of General Practitioners and all local GPs
	Hospital Based Staff	
10	The case of DN has highlighted a number of training issues which are pertinent today. There is a need to address: <ul style="list-style-type: none"> • risk assessment and management training across the whole Mental Health Trust • the particular problems associated with substance misuse in conjunction with mental illness, which in some cases can be further complicated by personality disorder • ward staff need training to deal with challenging and difficult to manage patients • all staff should be trained in the application of CPA policy and aftercare planning. <p>This needs commitment at executive level.</p>	MHT
11	No patient should be discharged by an SHO (other than as part of an existing plan) without consultation with a senior colleague.	MHT

	Recommendations	Organisation(s) Concerned
12	The Mental Health Trust should provide a locally produced 'Junior Doctor Handbook' for training schemes, incorporating written policies relevant to junior doctors and including discharge procedure.	MHT
13	When someone with a severe and enduring mental illness re-presents to medical services after absconding from compulsory in-patient care, the patient should be re-assessed by the psychiatric services (ideally the one from which he/she absconded) irrespective of whether the MHA section has expired.	MHT
14	<p>In all cases where a patient absconds from compulsory detention and does not return within one month:</p> <ul style="list-style-type: none"> • a summary of the treatment and care of that patient whilst an in-patient should be prepared and retained in the patient's clinical record • a copy should be sent to the patient's GP and to any other service involved with the patient to whom a discharge summary would normally be sent. <p>All Trusts providing in-patient compulsory care should ensure that this task is undertaken for any current and future patients who go AWOL for more than one month. This may mean that local policies will need to be amended to cover this situation.</p>	MHT
15	There should be no discharge from in-patient care without an aftercare plan in place.	MHT
16	The Trusts should ensure that all appropriate patients are on the CPA.	MHT
17	If a patient is admitted to hospital and then discharged before a CPA meeting can be convened, the meeting should take place as soon as possible after discharge.	MHT

	Recommendations	Organisation(s) Concerned
18	When a patient goes AWOL from compulsory detention under the MHA, a contingency plan should be drawn up which includes a requirement for the patient to be re-assessed if he comes to the attention of any of the local services.	MHT and the Department of Health
19	When any patient is discharged from in-patient care or goes AWOL, the patient's GP and any other agency involved in the patient's care should be notified (preferably by fax) of the discharge as soon as possible and in any event within 24 hours, with details of the aftercare plan and any contingency plan if AWOL. As a minimum requirement the GP should be sent: <ul style="list-style-type: none"> • the name of the consultant responsible for the patient's out-patient care • details of the patient's medication • the patient's CPA status and name of their care co-ordinator • the date of the next planned review • the statement of risk – particularly to others – according to locally agreed protocol. 	MHT
20	A Discharge Protocol should be formulated which covers: <ul style="list-style-type: none"> • reasons for discharge • arrangements for discharge and aftercare • decision making processes in respect of discharge. 	MHT
21	The Trusts should develop a protocol with the local police regarding the possession and use of illegal drugs by an in-patient on hospital premises.	MHT and the Police
22	As part of their continuing professional development, consultants in general psychiatry should be trained in the management and treatment of patients with mental illness and co-existing substance misuse, and how such complex cases can pose further difficulties in management in cases where there is also personality disorder and/or violence.	MHT

	Recommendations	Organisation(s) Concerned
	CMHTs	
23	The new Mental Health Trust should declare its commitment to promoting the importance of locality-based CMHTs with the active involvement of consultant psychiatrists as an integral part of the total service. This involvement of the consultant should be consistent across the Trust and will require leadership at executive team level.	MHT and the London Borough of Tower Hamlets
24	For all new referrals to the CMHT there should be a generic assessment which all members of the team should be trained to conduct. This assessment should be discussed at a multi-disciplinary team meeting at which a senior psychiatrist should be present and from which: <ul style="list-style-type: none"> • a care plan should be formulated. This may require a further assessment by a team member with a different professional background • careful consideration should always be given to the choice of allocated key worker and in matching the skills and experience of the professional to the needs and risk of the patient. 	MHT and the London Borough of Tower Hamlets
25	Care plans should be based on a comprehensive assessment of all of the patient's needs.	MHT and the London Borough of Tower Hamlets
26	There should be a full consultation with the patient's GP prior to a decision being taken by the CMHT to discharge the patient back to the GP's sole care.	MHT and GPs and the London Borough of Tower Hamlets
27	A patient referred to a CMHT who presents a risk to his own health or to others should not be discharged from the CMHT on the basis of non-engagement alone.	MHT and the London Borough of Tower Hamlets

	Recommendations	Organisation(s) Concerned
28	No-one should be discharged from the mental health services upon being sentenced to a term of imprisonment unless, as in the case of a lengthy prison sentence, the responsibility for delivering the care plan is transferred to the prison mental health care services, who would then have the responsibility for re-engaging local services when the time for the patient's release approaches.	MHT and the London Borough of Tower Hamlets
29	The same training issues apply for the CMHT as are set out in Recommendation (10) above, and should include when to notify child protection professionals that there are children in the same household as a patient who is violent, and in the case of adults at risk of violence from a patient, when to invoke vulnerable adult procedures.	MHT and the London Borough of Tower Hamlets
30	There needs to be clarification as to the point at which the consultant assumes clinical responsibility for a patient referred to the CMHT.	MHT and the London Borough of Tower Hamlets
	The Drugs Service	
31	The Drug Action Team should ensure that substance misuse services are adequately assessing the risks posed by those referred to them.	Drug Action Team
32	No-one referred by a GP or CMHT should be discharged from the drug service without a risk assessment being carried out.	Drug Action Team
33	The Drug Action Team should ensure that substance misuse services develop interventions which attempt to maintain engagement with chaotic and risky patients, irrespective of whether the patient is committed to the therapeutic process (e.g. outreach services targeted at such people).	Drug Action Team and the National Treatment Agency

	Recommendations	Organisation(s) Concerned
	The Probation Service	
34	When dealing with offenders who are mentally disordered and/or habitual drug users, the Probation Service should always consider applying for a Condition of any Licence, requiring the offender to undergo psychiatric and/or drug treatment following their release from prison.	The Probation Service
35	The Probation Service should ensure that: <ul style="list-style-type: none"> adequate training is given as to what Conditions can be applied for in respect of the Licence under which such offenders are released an audit is carried out to clarify whether the treatment options referred to above (a) are known about (b) are used appropriately and (c) pose any difficulties with other agencies in carrying them out. 	The Probation Service
36	Consideration should be given to devising an alternative ‘free text’ risk assessment system instead of a ‘tick box’ system. Whatever risk assessment system is used by the Probation Service, there should be: <ul style="list-style-type: none"> adequate supervision of the assessment and the final decision of risk taken audit and quality control systems in place. 	The Probation Service
	The Royal Colleges of Psychiatrists & General Practitioners	
37	The Royal College of Psychiatrists should give clear guidance on training schemes for junior staff in decision taking in respect of discharge and, through approval visits, should check that induction training covers this issue.	The Royal College of Psychiatrists and the MHT

	Recommendations	Organisation(s) Concerned
38	Psychiatric trainees should receive training in the management and treatment of patients with mental illness and co-existing substance misuse, and how such complex cases can pose further management difficulties in cases where there is also personality disorder and/or violence.	The Royal College of Psychiatrists and the MHT
39	There should be a clear statement from the Royal College of General Practitioners dealing with the issue of GPs taking primary frontline decisions about treatment and prescribing medication for mentally disordered patients. These matters should also be considered by the College as a training issue.	The Royal College of General Practitioners
40	The Royal Colleges should provide guidance as to the circumstances (if any) when GPs should maintain sole care of a patient with severe and enduring mental health needs, including the prescribing, administering and monitoring of psychiatric medication, without any secondary care involvement.	The Royal College of Psychiatrists and the Royal College of General Practitioners
	The Mental Health Trust and The Primary Care Trust	
41	The Clinical Governance Leads of the local MHT and the PCT together with the local Drug Action Team should consider all of the Recommendations in this Report, and in the annual clinical governance plans there should be particular focus on developing protocols and audits and training programs addressing the issues raised.	MHT and PCT
42	The Chief Executives of the MHT and the PCT, their respective Clinical Governance Leads and the Medical Directors (if a different person from the Clinical Governance Lead), need to develop action plans that will begin to address the sense of separateness which pervades the locality and has led to a feeling of ‘them and us’ between the primary service and secondary psychiatric services, the in-patient and community based services, and the general and forensic services.	MHT and PCT

	Recommendations	Organisation(s) Concerned
	<p>It may be that the best way forward is to develop protocols which govern working practices across those interfaces.</p> <p>It is essential that this way of working together is accepted at executive level and promoted positively.</p>	
43	<p>The Trust and the PCT should carry out a survey of GPs, the CMHTs and other relevant front-line mental health staff to identify where recent developments in mental health services in the area have been successful and where there are still problems which need to be addressed. Both organisations should encourage the setting up of a regular review mechanism between primary care and the CMHTs at a local level, to ensure that communication and referral of patients are working satisfactorily in the different areas of the Trust.</p>	MHT and PCT
44	<p>In considering the findings and recommendations of this Report, the Mental Health Trust should review mental health services in the totality of the Trust – not just Tower Hamlets – and should ensure that the recommendations are applied to all services where necessary.</p>	MHT
45	<p>The Strategic Health Authority should ensure, as a matter of urgency, that funds are invested into the area in order to bring local mental health services up to national standards.</p>	The Strategic Health Authority
	<p>General</p>	
46	<p>There needs to be a national policy on the issue of the legal liability of the occupiers or managers of premises such as a hospital on whose premises cannabis or heroin are prepared and/or smoked and/or dealt by an in-patient. As the law presently stands (Section 8 of the Misuse of Drugs Act 1971), the hospital would be guilty of an offence if it knowingly allowed or suffered such drug taking on the premises. This legislation should be reconsidered to take into account the fact that the present law encourages the necessity to discharge patients who are known or believed to be using drugs in the hospital.</p>	The Home Office and MHT

	Recommendations	Organisation(s) Concerned
	In the meantime there should be implementation of the guidelines in the newly published (2002) Department of Health 'Dual Diagnosis Good Practice Guide', in particular 4.6.2 and 4.6.3.	
47	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.	MHT and PCT

Appendix 1 - Diagnosis and Formulation

When we were first contacted to join the Inquiry Team it was suggested that the primary mental health issue would be the assessment, treatment and service provision for individuals with personality disorder. It became clear at an early stage, and in particular following our interview of DN, that the formulation of DN's mental health needs would not take this direction. Our original information from the commissioners of this Inquiry appears to have reflected the same confusion about his diagnosis which was characteristic of DN's contact with mental health professionals between 1991, and his current situation at Rampton Hospital.

It is not uncommon in current psychiatric practice for patients to attract more than one psychiatric diagnosis. The DSM diagnostic system encourages clinicians to think about diagnosis along more than one axis, encouraging consideration of personality and mental illness as well as other dimensions of need and disease. There is now an increasing number of patients with both mental illness and problem substance misuse or dependency syndromes. The correct diagnostic formulation in such cases requires careful and thorough assessment by professionals with the necessary training and experience in substance misuse and dual diagnosis. Without this there are dangers that the underlying mental illness is not recognised and patients are excluded or prematurely discharged by CMHT's and inpatient services with a diagnosis of *drug induced psychosis*. The risk of violence in individuals with a serious mental illness complicated by substance misuse is increased.

In forensic psychiatry, a subspecialty of adult psychiatry, one would expect clinicians to come into contact with a similar group of patients. However triple diagnosis is not uncommon, with patients suffering from a mental illness, with a history of substance misuse and an underlying personality disorder. Again, such patients require a careful and thorough assessment. Both the ICD (International Classification of Diseases) and DSM diagnostic systems are clear about the necessary criteria needed before a diagnosis of personality disorder can be made. The diagnosis is historical and not made on current presentation. The emergence of inflexible, pervasive and maladaptive patterns of thinking, feeling, behaving and relating to others should be manifest in adolescent years and *precedes* the onset of mental illness in cases where both conditions apply. Objective documentary evidence and reliable informants complement information gained from interview and mental state examination. Diagnostic inventories (such as the IPDE) can provide further support for personality disorder (and other diagnoses) when administered by *trained* clinicians. A diagnosis of personality disorder requires as much care and rigour as any other diagnosis in psychiatry, perhaps more so as the consequences can be so negative. Most clinicians are pessimistic about treatment for this group and the evidence base of treatment efficacy for most types of personality disorder is weak. Whilst there are a few services in the general adult and forensic services that provide care for individuals with personality disorder, a common outcome is that they are excluded from services. They are perceived as individuals with free choice, and if a service client does not cooperate with the clinical service, is not motivated, or if the provider has nothing to offer the client they part company. In those who in addition have a mental illness this can have unfortunate results. The illness may not be identified or if it is recognised the illness can be minimised or denied, with everything explained in terms of the personality disorder.

The diagnostic formulation should always remain a dynamic process. For those patients in contact with specialist and primary care health services new conditions can develop, and new information can help to develop the understanding of the individual. A person with a personality disorder can develop a mental

illness. The extent of substance misuse can change over time and this will effect presentation. It is poor practice for the first diagnostic judgements to be repeated as if this can never change. In psychiatry the first diagnostic formulation is often less than adequate, and time, experience and knowledge of the patient will inform and refine the diagnosis and treatment approach.

In order to undertake a clinical risk assessment and develop any sort of risk management strategy a case formulation needs to be developed. Risk is not a static phenomenon; it varies over time, both in quantity and the type of risk. In patients with dual or triple diagnosis each condition may influence risk, and the combination of diagnoses brings additional risks. For example non-compliance with antipsychotic medication can increase the risk of relapse and associated behavioural problems in a patient with a serious mental illness. Non-compliance is more common in those who also have a history of substance misuse.

The case of DN is characterised by many of the above pitfalls:

- **He never received a detailed diagnostic assessment at any time before the index offence which included a consideration of mental illness, personality disorder and substance misuse**
- **At various stages in his history he was assessed and treated as suffering from one or other of the above conditions**
- **He was excluded from specialist health services because his risk and complexity was unrecognised**
- **There was never any clinical risk assessment.**

Commentary on the Diagnosis and Management of DN by Health Services

In 1991, whilst on remand in Feltham Remand Centre, DN presented with clear evidence of psychosis. His behaviour was bizarre, and his speech was rapid and paranoid in content. His mother rang the prison to express concern that her son was mentally ill. There had in her view been a two-year deterioration following his failing of his driving test. He was described as sociable and friendly towards the family. She said that he was loving, affectionate, kind and helpful. When we saw his brother the report of his behaviour and personality was less enthusiastic. Nevertheless his mother's description and other information available to the panel do not suggest that before his mother became concerned about his behaviour he could be characterised in clinical terms as meeting the criteria for a personality disorder. The robustness of such a diagnosis must be further questioned because of the early onset of his use of illegal substances. He was introduced to cannabis as early as eight years of age. He was a regular cannabis user by his mid-teens and was an occasional user of hallucinogens, stimulants and opiates. There is no evidence that drug screening was conducted whilst he was on remand during this period.

His presentation suggested to Dr Boast that he had a serious mental illness and the first diagnosis made was of paranoid schizophrenia, and a hospital order was recommended. Perhaps a fuller appreciation of the extent of his violence and its relationship with his mental health problems would have led to a restriction order in addition to the hospital order. This was a missed opportunity and the outcome in this case could have been very different, as when he was again in contact with health services after his absconding he would have been brought back to the secure unit. His section would not have expired.

DN was without doubt a difficult man to assess even in a hospital secure environment. The discontinuity of care with part of his assessment at Kneesworth House and then in the Hackney secure unit, did not help to develop a therapeutic relationship which could have allowed a better understanding of his case to be reached. He was at times guarded and uncooperative and he absconded. For periods there was little to observe to suggest mental illness. At other times there were religious themes, he refused food, and these did raise the suspicion of a mental illness (Professor Coid raised these issues at the case conference in April 1992).

DN told the panel in great detail about his psychopathology during this period and around the episodes of violence leading to his period on remand in 1991. His account of delusional perceptions, persecutory and religious delusional themes, auditory hallucinations and delusions of reference would certainly suggest a schizophrenic illness. His psychosis appeared to improve on antipsychotic medication whilst he was on remand but this was stopped as part of his assessment at Kneesworth House. The clinical notes at Kneesworth House and the Hackney Secure Unit suggest that his mental state began to deteriorate over time as the effects of antipsychotic medication wore off. He improved again when medication was restarted at the Hackney secure unit.

It was before admission to hospital and whilst still on remand that the first concern about personality disorder emerged. Following an interview with DN's father personality difficulties were additionally suggested, and that his presentation could be understood by reference to his early childhood experiences. This information should have been treated with caution as over time it became clearer that father was not willing to work with the clinical team and actively encouraged his son to abscond and travel to Jamaica. The only other basis for a diagnosis of personality disorder was the assessment using a diagnostic tool (SCID) as it suggested borderline personality traits. No record is available of the scoring sheets to enable confirmation of the conclusions. This description of personality is not supported by the later Rampton hospital psychometric investigations. No diagnosis was reached at that time in relation to his substance misuse. There is no formulation to help understand why he presented with violence towards family members and strangers. The lack of a final summary after he absconded did not allow any subsequent clinician (or the panel) to come to any conclusions about the final formulation at that time. Perhaps many of the concerns set out above would have been dealt with if a summary had been produced at the time. The witnesses we interviewed had no clear memories of DN during this period to give the panel a better understanding.

When his clinical history was described (in reports) after this period, the personality disorder differential diagnosis was elevated to the most important diagnosis above mental illness. The diagnosis of borderline personality disorder was repeated on many occasions without supportive evidence and was really a repetition of Dr Boast's original diagnostic assessment, which was itself arguable and based on rather weak evidence.

His contact with health services from 1993 until the homicide was primarily through his general practitioners. His substance misuse was recognised by them but it was considered to be a separate matter. The complexity around his mental illness and substance misuse really required an assessment by an experienced psychiatrist, but this never happened. His general practitioners recognised he had a serious

mental illness. He complied with depot antipsychotic medication (for much of the time) and even went to the community pharmacy to collect prescriptions. However his treatment did not take into account his total needs, complexity or risk in a whole person way. The mental illness, his lifestyle, his use of illicit drugs, his violence, his personality and style of relating to others (such as his wife) were seen as separate matters. The domestic violence was viewed as an interpersonal issue, perhaps even related to the drug misuse, but the relationship with his illness was not recognised. Dr Hodgkinson appreciated that she was out of her depth and she sought advice. DN was reluctant to engage again with specialist mental health services. Perhaps with more persistence and with a consideration of other strategies it might have been possible to organise a psychiatric assessment earlier than June 1997. However despite being contacted, the forensic service did not offer to reassess a patient who had absconded from that service. Decision-making was hindered by the absence of a final case summary from the secure unit. Memory of this case was lost.

The absence of a senior psychiatrist on the CMHT was significant. CHMT contact does not appear to have had a mental illness or substance misuse focus. Clearly help with his financial situation and accommodation was a route to engagement, but the mental illness did not receive attention. He was on depot antipsychotic medication, but mental illness was not part of the CHMT consideration as this was dealt with by the general practice. His engagement as a service client rather than as a patient with mental illness perhaps allowed his non co-operation to be viewed as a rational decision, supporting discharge from the CHMT on a number of occasions. Patients with mental illness and other needs whose decision making may not always be so rational, require a more proactive and at times paternalistic approach than would be found in the service industry between provider and client.

His substance misuse was recognised but again as a matter unrelated to his illness and risk of violence. The involvement of drug services is dealt with elsewhere in this report.

When he was eventually admitted again it was to local non-secure services. He was not subject to a proper assessment. He did not see a senior psychiatrist. There was not a reassessment by the forensic services. The panel concluded that he was allowed (or encouraged) to leave the hospital rather than discharge himself. The difficulties that he presented to staff were not great, though he was challenging. Again an opportunity to reassess him was missed. There was a further missed opportunity to assess him in a hospital setting when soon after discharge from hospital he was arrested and he received a prison sentence. He was discharged from the CMHT because he received a prison sentence. This should not have happened as he lost contact with health services from that point until his arrest.

The killing of his grandmother was horrific, and the sexual element was unusual. His memories of that event are incomplete. His mental state was abnormal and continued to cause concern during his period on remand in Brixton prison. During the preceding weeks his use of illicit drugs and in particular cocaine was very high. It is impossible to determine how much of the killing can be attributed to his substance misuse and how much to mental illness. It is difficult to identify any connection between his underlying personality and this killing with bizarre sexual overtones. His presentation on remand was of a psychotic mental illness and it is noteworthy that he presented at that time with worrying sexual behaviour towards a doctor. This suggests that his mental illness was an important factor in understanding the killing and associated sexual

element. Although there is no evidence of drug screening the likelihood is that the sexual misbehaviour was related to his abnormal mental state at the time.

The law dictated that his history of previous violence could only result in a prison sentence, but eventually he was transferred quite properly to a high security hospital. The Rampton notes indicate continued confusion around diagnosis. There is a focus on the current presentation without a historical perspective. The clinical records suggest that as medication is reduced his mental state deteriorates, and in a similar manner to earlier periods of his contact with mental health professionals. He has caused concern in relation to sexual misbehaviour and there have been periods when religious themes have emerged. He has settled again with restabilisation on medication. When we saw DN on a mental illness ward he was on the waiting list for the personality disorder unit at Rampton Hospital. There is no formulation of risk in his clinical records. No discussion is recorded of the relationship between his mental illness, drug misuse and personality with his history of violence before and including the killing of his grandmother. The psychometric evidence in the Rampton psychology report of personality disorder is the first convincing evidence to support this diagnosis. The RMO's assessment using the Cloninger rating scale found no evidence of personality disorder; although further (PDQ-4+) personality inventory testing found no evidence of a *significant disorder of personality* he did score positively on the obsessive-compulsive, narcissistic and avoidant personality disorder scales. The personality assessment inventory indicates the presence of antisocial personality disorder. However the sort of detailed psychometric assessment undertaken by clinical psychologists experienced in the field of personality disorder (and used now in the work to develop the Dangerous and Severe Personality Disorder programme) is not yet available.

In summary, the panel was not convinced that he clearly met a diagnosis of a severe personality disorder and that there was evidence of this before the onset of his mental illness. His early history of substance misuse makes any assessment of his personality prior to the onset of his mental illness a questionable task. This is not to say that he does not have personality difficulties, which reflect his rather unstable childhood, and which are more prominent at times of crisis. His personality vulnerabilities may well have contributed to his illicit drug use problems, and would have coloured the manifestations of his mental illness. Despite the difficulties in the relationship with M, whom he subsequently married, the longevity of this relationship does not support a personality disorder diagnosis. The Rampton psychometric investigations thus far suggest a diagnosis of personality disorder may be valid as part of the understanding of his clinical presentation. However the evidence does not suggest that his personality is the primary factor in understanding his violence, or the occasions when he was brought to the attention of health professionals. It is surprising that even in Rampton Hospital personality disorder is described as the predominant diagnosis. A review of his history and even the association between his disturbed behaviour at Rampton Hospital and medication would suggest otherwise.

His use of illicit drugs, with encouragement from his father, became part of his lifestyle from an early stage. His use of drugs would meet the diagnostic criteria for harmful use but not a dependency syndrome. On its own, substance misuse does not explain his clinical history or the bizarre killing of his grandmother. Although there was a surprising absence of drug testing when he was in prison and in contact with health services, his current account of his psychopathology and drug use history, and his presentation, particularly in prison, Hackney Hospital and Rampton Hospital cannot be understood by reference to illicit drug abuse alone.

The use of cannabis and stimulants such as cocaine would, at times, have been the primary factors in explaining his presentation but of more importance would have been the interaction between his use of illicit substances and his psychosis. Research in this field suggests that drugs can reduce treatment compliance, alter the presentation of the psychosis, and increase the risk of relapse and of violence to others.

There is no doubt that DN has a serious mental illness. His psychosis (and we have viewed as of importance his descriptions of his psychopathology as well as his clinical history) suggests a schizophrenic illness. However the course appears to be characterised by a relapsing and remitting illness. This may be partly or wholly explained by his use of illicit drugs. An alternative explanation is that he has a schizo-affective illness. There is certainly evidence at times when he is clearly more bizarre and psychotic, of symptoms such as disinhibited behaviour and pressure of speech. A clinical possibility that has not been adequately explored is organic brain dysfunction, although an EEG requested by Dr Hodkinson in 1996 was normal. His long history of polydrug abuse and his lifestyle which would have increased the possibility of head injury, suggest this diagnostic possibility should be explored. There is no evidence of intellectual impairment. A clinical psychology assessment at Kneesworth house found DN to be of average IQ.

The importance of a robust diagnostic formulation which may be refined over time is that it helps to inform a logical risk management strategy. For DN, risk management will need to attend to the nature of his illness and its treatment, and involve work to enable DN to understand his illness, improve treatment compliance and co-operation with his clinical team. He will need to understand the dangers of illicit drug misuse for him and its contribution to his illness and violence.

The panel is not persuaded that there is convincing evidence of a personality disorder. That is not to say that he does not have personality difficulties which may impact upon his illness, illicit drug misuse and general lifestyle and require attention in a therapeutic relationship.

To categorise DN as an offender with a personality disorder is not only mistaken, it encourages a therapeutic approach that the evidence does not suggest is the most important factor in understanding risk in this case – and this would increase the risk of future violence as any future risk management plan would be flawed. In this case perhaps the first diagnosis was the nearest to the correct clinical judgement. There seems to be something about DN that encourages clinicians to focus on part of his clinical needs rather than the whole person.

Appendix 2 - List of Witnesses

No.	Name of Witness	Position/Relationship
1	Dr Gunawardene	Consultant Psychiatrist at Rampton Hospital – DN’s Responsible Medical Officer
2	Sharon Smith	Psychologist, Rampton Hospital
3	Sarah Cochrane	Social Worker, Rampton Hospital
4	Graham Goodwin	DN's Named Nurse, Rampton Hospital
5	D N	Inquiry Subject
6	Dr Isabel Hodkinson	GP, The Tredegar Practice, Tower Hamlets
7	Dr George Farrelly	GP, The Tredegar Practice, Tower Hamlets
8	Dr Neil Boast	Consultant Forensic Psychiatrist & former Clinical Director of Forensic Services, The John Howard Centre, Medium Secure Unit
9	J N	DN's Brother
10	Dr Eleni Palazidou	Consultant Psychiatrist, Tower Hamlets catchment area
11	Dr Petrie	Consultant Psychiatrist, Kneesworth House Hospital
12	Ralph Cheung	CPN, Bow Poplar CMHT
13	Tracey Upex	CPN Team Leader, Bow Poplar CMHT
14	Jeff Evans	CPN, Community Drug Team
15	Carole Luby	Occupational Therapist, Bow Poplar CMHT

No.	Name of Witness	Position/Relationship
16	Ben Hannigan	CPN, Bow Poplar CMHT
17	Harry Matthews	Probation Officer, Inner London Probation Service
18	Angus Cameron	Mental Health Manager, Inner London Probation Service
19	DC Tucker	Arresting Officer (Deputy Detective Inspector)
20	V N	DN's Mother
21	Dr Sennett	GP Assistant, The Tredegar Practice
22	Dr Jackie Ketley	GP, Crisp Street Health Centre
23	Dr Whittle	Consultant Forensic Psychiatrist
24	Dr Zaubia Alyas	SHO on Dundee Ward, St Clement's Hospital
25	Mick Morgan	Principal Manager Mental Health, London Borough of Tower Hamlets Social Services
26	Sarah Wilson	General Manager, East London & City Drugs Services
27	Dr Vanessa Crawford	Locum Consultant Psychiatrist, Drug Dependency Unit
28	Dr Jan Falkowski	Consultant Psychiatrist and Medical Director, East London & The City MHT
29	John Wilkinson	Head of Mental Health, North East London Health Authority (formerly East London & The City HA)
30	Dr Cobb	Consultant Psychiatrist, St Clement's Hospital

No.	Name of Witness	Position/Relationship
31	Dr Ian Cummings	Consultant Forensic Psychiatrist, Belmarsh Prison
32	M N	DN's wife
33	Bernadette Redmond	Specialist Health Visitor, Tower Hamlets Primary Care Trust Child Protection
34	Stuart Robinson	Principal Manager, Physical Disabilities and Sensory Impairment, London Borough of Newham
35	Dr David Ndegwa	Consultant Forensic Psychiatrist, Hackney Interim Secure Unit (now John Howard Centre)
36	Sue Butler	General Manager Adult Mental Health Services, St Clement's Hospital
37	Dr Sally Hull	GP, Jubilee Street Health Centre
38	Dr Richard Laugharne	Consultant Psychiatrist (formerly post membership Registrar in psychiatry based with the Bow poplar CMHT)
39	Professor Jeremy Coid	Consultant Forensic Psychiatrist, Hackney Interim Secure Unit
40	Vicki Barwood	Deputy Ward Manager, Dundee Ward, St Clement's Hospital
41	Gillian Cottew	Manager of Community Drugs Team (ADDACTION)
42	Dr Balakrishna	Consultant Forensic Psychiatrist and Clinical Director of Forensic Services, East London & The City Mental Health Trust
43	Peter Horn	Chief Executive, East London & The City Mental Health Trust, at time of interview

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