North East London NHS
Strategic Health Authority

# REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH AND SS

**Commissioned by East London and The City Health Authority and its successor North East London Strategic Health Authority**

**CONTENTS**

# Executive Summary

## THE INCIDENT

In the early hours of 20th April 2000 PH telephoned the police and called them to his flat. On arriving, the police found the body of an African-Caribbean woman. A post-mortem revealed that she had sustained 44 wounds, 22 of which had passed completely through her body. A samurai sword found at the scene was identified as the murder weapon; PH later said that he had bought the sword five weeks earlier.

At the time of the killing PH was 32 years old; his victim, SS, was 33; they had met some years earlier in a psychiatric hospital and both had been involved with mental health services for a number of years. Nine days before her death, SS had given birth to their son.

On April 24th 2000, four days after the event, PH revealed during interview that SS had been in a disturbed state of mind following her appearance at Stratford Magistrates Court on April 19th 2000. As a result of the Court appearance, SS had been granted bail on condition that she stay at PH's flat. PH later said that on arrival at his flat he had advised SS that she was unwell and needed to see a doctor. He reported that he and SS visited his brother and that during this visit SS 'flipped' and grabbed a fish tank and smashed it, flooding the floor then threw a coffee pot out of the window. PH and SS left his brother's flat, SS calmed down and they both went to PH's flat where she again became disturbed and started to throw things around. SS remained highly agitated until the early hours of the morning of April 20th. At some point during the early hours of the 20th PH attacked SS with the samurai sword.

PH remained in prison until 27th February 2001 when he was transferred to Rampton High Secure Hospital under Section 48 of the Mental Health Act 1983. He remained unfit to plead for a long time after his arrest, finally appearing in Court and pleading guilty to manslaughter on the grounds of diminished responsibility on October 23rd 2001. Following this appearance, PH was made subject to a hospital order with restrictions under Section 37 and 41 of the Mental Health Act 1983.

### Commissioning the Independent Inquiry

The Inquiry into the Care and Treatment of PH and SS was commissioned by East London and The City Health Authority in 2001. In recognition of the connection between PH and SS it was agreed that the Inquiry should look into the circumstances surrounding their care and treatment jointly. The purpose of the Inquiry was to review care and treatment thoroughly in order to establish what lessons could be learnt, and to make recommendations for the delivery of mental health services in the future and the way services work in partnership with other agencies.

Throughout the Inquiry, the Panel has been very conscious that it was looking at events in the past. The Panel has endeavoured to judge the care given to

PH and SS in the light of what was known to the professionals at the time, rather than with the benefit of hindsight.

## BACKGROUND

### PH's involvement with mental health services

PH first had contact with mental health services in December 1989 having been referred by his GP in the previous month. Following an assessment by a consultant psychiatrist, PH was diagnosed with an obsessional personality. He was subsequently referred to a second consultant psychiatrist who concluded that PH was suffering from mild depression and intermittent obsessive compulsive disorder.

The first of many admissions to hospital came in 1990. On February 26 1990, PH had become violent, smashing a door and two windows at his parents' home. He was admitted voluntarily to Goodmayes Hospital but left the same day, as he often did later on. During the rest of 1990 PH was admitted on two more occasions, the second admission in October resulted from an overdose of medication.

During 1991 PH was again admitted to hospital as his mental health had deteriorated. It was during this time that PH started intermittent contact with psychological therapies services in Newham. There is no record of admission in 1992 although PH continued to be seen as an outpatient.

By 1993 PH had largely fallen out of contact with mental health services. Although he approached psychology services in Newham during 1993, he did not take up any appointments offered to him. In July, PH asked to be referred to a consultant psychiatrist at St Mary's Hospital. He was seen at St Mary's in September but failed to attend any follow up appointments.

In January 1994, PH presented at Accident and Emergency in Newham General Hospital complaining of a range of physical symptoms and a feeling of not being able to cope. He was referred to a consultant psychiatrist but did not attend the appointment, and, for the remainder of 1994, PH did not attend any outpatients' appointments. In December, during a home visit by his consultant psychiatrist, PH confirmed that he had experienced murderous thoughts and was not taking his medication because of their effect on his feelings. He agreed to try a new medication, an atypical anti-psychotic, as the consultant psychiatrist thought that PH might be suffering from paranoid schizophrenia.

In February 1995 PH was admitted voluntarily to Goodmayes Hospital. He had been brought there by his sister and mother at his own request, following a violent incident at their home. He absconded from the ward shortly afterwards.

In September 1995 a very significant event occurred that involved PH holding two members of his care team hostage in his flat. PH was visited at home by

his female Community Psychiatric Nurse (CPN) and a female student nurse. He refused to let them leave his flat reportedly talking incessantly about his hatred for women, and becoming increasingly abusive and threatening. He later allowed both women to leave; the police were informed although PH was never interviewed or charged. The Panel considers this incident and the response to it to be of critical importance to the future management of and understanding of risk about PH by mental health services and other agencies such as the police.

PH was taken to hospital on September 25 1995 but despite being placed on section 5 (2) managed to leave the same day. He was brought back, placed under section 3 and transferred to the medium secure unit at Cane Hill. PH returned to Goodmayes in October 1995 having responded positively to anti-psychotic medication. PH was well enough to be discharged by the end of November 1995.

In 1996 PH did not attend outpatient appointments or Care Programme Approach meetings, although his mother did. He was admitted to Goodmayes Hospital as a voluntary patient on May 17 he absconded almost immediately and was discharged on May 28, in his absence. By August his mother had again become concerned about his mental health, indeed she was so worried that she called the police as PH had become very threatening. PH was admitted to Goodmayes Hospital for the ninth time on August 21 1996.

In November 1996 PH was transferred to the medium secure service at Hackney Hospital under section 3, and for the first time his medication was administered by depot injection. PH remained in medium secure services until April 2 1997 when he was transferred to Goodmayes Hospital. During his admission to Goodmayes he was cautioned by the police following a violent incident on the ward. PH was discharged in May 1997.

1998 was a period of relative stability; PH was successfully maintained in the community with the support of a forensic CPN and his mother. By July, PH had again become unwell and was admitted to hospital; he absconded straight away. He was readmitted under Section 2 in October; this was subsequently changed to section 3. During this admission PH had become violent and abusive towards female staff; he absconded twice. The police brought him back in the middle of December and PH was transferred to the Psychiatric Intensive Care Unit at Runwell Hospital where he remained until discharged by a Mental Health Review Tribunal on January 19 1999. The Tribunal decision to discharge was, in the Panel's view, flawed. In it's judgment insufficient consideration was taken of well-documented evidence and opinions provided by a forensic psychiatrist about the inevitability of PH's non-compliance with medication once discharged and the grave risks PH presented when left untreated.

Early in 1999, PH was arrested for throwing a brick through a neighbour's window and remanded to prison; however the case later collapsed and he was released in May. By December 1999, PH was expressing murderous thoughts about Irish women and had been implicated in an incident where a

woman was grabbed on the street and dragged into bushes only to be abandoned later with minor injuries. The police took PH into custody on December 17 1999 as a result of him making threats to kill an Irish woman. He was transferred to Goodmayes Hospital under section 3 and then moved to the Psychiatric Intensive Care Unit at Runwell Hospital. By January 2000 the advice and recommendations on the continuing management of PH from forensic psychiatry remained consistent with messages received over the previous five years. Poor compliance with oral medication was considered inevitable, and the use of depot was recommended as was community-based support from a forensic CPN. Crucially the need to identify and manage the risk to PH's current girlfriend was also identified.

In preparation for his discharge from hospital, an assessment of PH's community support needs was made in February 2000. This concluded that PH should only be visited by two male staff; that he needed an assertive outreach approach; that work should be done around PH accepting depot medication and that close liaison with the police should be maintained.

Plans were made to discharge PH on March 3 2000. The care plan was, in the Panel's opinion, inadequate with no reference to the risk posed to SS, his current girlfriend and no plans to work with PH and SS as a couple. PH was made subject to a supervised discharge under section 25 of the Mental Health Act 1983.

PH remained compliant with community visits from March onward and was last seen by his Forensic CPN on April 14 2000. PH was arrested following the discovery of SS's body on April 20 2000.

**SS's involvement with mental health services**

SS had been diagnosed with manic depressive psychosis following an admission to hospital during the time she was staying in New York in 1985. Her first contact with mental health services in England was in 1987 when she was admitted to hospital and diagnosed with bi-polar disorder.

In 1988 SS spent five months in hospital; one month of this admission was spent in a medium secure unit. Following her discharge, SS remained as an outpatient throughout 1989 but was admitted to hospital briefly in August 1990.

SS became pregnant in late 1990 and stopped taking her medication suffering an early miscarriage in January 1991. On January 20, SS's was admitted to Goodmayes Hospital under section 3, and was discharged five months later. From May 1991 onwards and throughout 1992, SS remained well.

Between May and July 1993 SS was admitted to hospital following a referral from her GP. During this admission her diagnosis was changed to manic depressive psychosis. SS was admitted to Goodmayes once more in October, where she remained until January 1994. SS was admitted to Goodmayes Hospital once more in November, her eighth admission.

Between June and September 1995, SS was admitted to hospital for the ninth time having been brought there by the police after smashing up her flat. By late September, SS had stopped taking lithium and again referred herself to services as she felt herself becoming unwell.

In July 1996 SS was admitted to Goodmayes Hospital; she was discharged in August. By March 1997, SS had again stopped taking lithium. SS was admitted to Goodmayes again between June and July 1997 having been taken to East Ham Memorial Hospital by the police.

In 1998 SS attended planning meetings sporadically, and when she did so she was supported by her family. SS expressed her unhappiness with her medication regime as she had gained a considerable amount of weight and by December that year, in agreement with her psychiatrist and care co-ordinators, depot medication was stopped.

In January 1999 SS did not attend a planned outpatient appointment but did attend her CPA meeting at the beginning of February. By late February SS was back in Goodmayes Hospital. In April, whilst on home leave she damaged a car and attacked passers by in the street. SS returned to Goodmayes and whilst there slapped a patient in the face. As a result SS was admitted to Runwell Psychiatric Intensive Care Unit for a short time. By the end of April SS was well enough to be granted home leave. Despite the plan to discharge her in May, SS did not return from leave and was discharged in her absence on June 1 1999. In September it was noted that SS had a new relationship although it was not clear how long this had been going on.

In January 2000, SS's GP wrote to the Community Mental Health Team confirming that she was pregnant. SS had stopped taking medication and in March had confirmed to her social worker that PH was the father of her child. SS indicated that she did not want any visits or medication.

SS's care team expressed concerns about her mental state during pregnancy. Following a CPA meeting in March that SS did not attend, her consultant psychiatrist wrote to a colleague that it was advisable to start making pre-birth plans given her high risk of mental illness following the birth. He suggested that they started making plans at the next CPA review meeting scheduled for 31 May 2000.

SS gave birth prematurely in Newham General Hospital on April 10 2000. Until that point her family were unaware that she was pregnant. It could not have been predicted that SS would have complications in her pregnancy which would lead to the premature birth.

SS's baby required specialist neo-natal care and was transferred from Newham General Hospital to the specialist unit at the Royal London Hospital. SS remained in hospital in Newham. On visiting immediately after the birth, SS's sister alerted maternity services that SS was becoming unwell and needed medication; an assessment was set up for the 14 April. SS's sister

was concerned that this would not be soon enough and over the next few days SS became increasingly hyper-manic. On April 13 SS left the ward and a plan was agreed to prevent her taking the baby should she visit that evening as she had indicated. SS's whereabouts couldn't be established until April 15 when SS's sister said that SS was at home asleep.

On April 18 SS was arrested following a violent incident at a neighbours' flat. She spent the night in police custody and was visited in the very early hours of the 19 by an ASW. Later that morning a forensic CPN visited SS, following concerns expressed about her behaviour by the custody sergeant. The CPN recommended that a full assessment be done; the assessment took place at Stratford Magistrates Court that afternoon. All four professionals involved agreed that she could not be detained under the Mental Health Act but would benefit from a voluntary admission to hospital and duly informed the clerk to the Court. Having been contacted during the day by PH and on hearing representations from SS's solicitor, the court bailed SS to PH's flat.

That evening SS broke windows and a fish tank in the flat of PH's brother, then went with PH to his flat. In the early hours of April 19, PH stabbed SS with a samurai sword.

## ISSUES ARISING FROM THE CARE AND TREATMENT OF PH

### Medication

PH was extremely resistant to medication, especially depot medication; he was also skilled at presenting well, not reporting his symptoms and of minimising his violent behaviour. PH had poor insight into his illness, rarely seeking treatment or keeping appointments. From 1995 onwards his lengths of inpatient treatment increased with five admissions resulting in transfer to secure care.

A key issue is whether his treatment should have been more assertive; in the five years to 2000, treatment was dependent on PH's compliance with oral medication. It was clear that PH's compliance with treatment could not be relied upon post-discharge. Under existing legislation, professional powers to compel a course of treatment remain relatively weak unless the person is detained under section or is subject to a restriction order under section 37 or 41 with a conditional discharge under section 73 of the Mental Health (Patients in the Community) Act 1995. The primary concern of PH's consultant psychiatrist was to maintain a therapeutic alliance with him; for some time this worked and he was maintained successfully in the community. During this time PH was intensively supported by his mother and a forensic CPN. All the attempts to persuade PH to accept depot medication in the community were unsuccessful; the only time depot was successfully administered was during his admission to medium secure services in 1997.

## Risk, offending and prosecution

The panel's view is that the police are reluctant to prosecute people with mental illness for violent incidents, particularly ones that occur in psychiatric hospitals. Despite several violent incidents PH was never prosecuted although the advice from forensic psychiatrists was that this was key to ensuring the delivery of effective care.

Decisions not to invoke criminal process, though appearing entirely humane, can have major implications for a patients' care pathway within the spectrum of psychiatric care. Two incidents involving PH might well have attracted prosecution: the hostage-taking incident in September 1995 and the assault on a woman in December 1999. In the view of the Panel, if a prosecution case had been pursued in relation to the hostage-taking incident, it could well have resulted in PH being detained subject a hospital order with restrictions.

The Panel's view is that the mental health service team could have made a more forceful argument to the police about the risk that PH posed, particularly to women. Its view is also that it was unrealistic not to accept that PH's risk would increase beyond that indicated by his behaviour between 1995 and 1999. The Panel also believe a more strenuous argument about the risk PH posed should also have been made at the subsequent Mental Health Review Tribunal hearing in January 2000.

It is clear that the decision to prosecute rests with the Crown Prosecution Service. The panel's view is that it was likely there was sufficient evidence relating to both incidents, particularly if forensic psychiatric opinion had been sought by the police, for prosecutions to be brought. The panel was struck by the difference a criminal prosecution and disposal to hospital under a restriction order could have made to the course of PH's care and treatment.

## Standardised or Structured Risk Assessment

The implementation of standardised or structured violence risk assessment is in the Panel's view less advanced in England than in countries such as Canada and the United States. The Panel concludes that the best predictor of violence following discharge is a simple, structured measure of psychopathy: the Psychopathy Checklist – Screening Version (PCL-SV). Had PH been assessed using this tool the Panel concludes that even though his main problem was mental illness rather than psychopathy, the results would have been useful in reinforcing the clinical impression of increased violence risk.

The most widely -used risk assessment methodology is the Historical, Clinical and Risk Management tool (HCR-20). PH had several risk assessments over the years he was involved in mental health services but never using HCR-20. The Panel's view is that in most cases the risks were implicit in the reports rather than being spelled out.

The failure to spell out the risks, particularly to women following the hostage-taking incident and the attack on the woman in 1999, had serious ramifications when it was identified in 2000 that PH had a girlfriend. The mental health team did understand the risk posed to female staff but the risk to other women including his mother was never fully looked at. The team did not investigate the risk to PH's girlfriend when they should have done. The Panel concludes that had a structured approach to risk assessment been undertaken and the overall risk to women explored, the team would have been compelled to look at the risk PH posed to SS.

The panel is clear that PH's management plans were not an adequate response to the known risks.

**Relationship between general and forensic services**

General mental health services provided the majority of care for PH although forensic services assessed him on several occasions and he did spend some months in the medium secure service at the John Howard Centre. A pivotal point in his care was the decision in 1997 of the Mental Health Tribunal to discharge PH from secure care to the care of a general ward. In the Panel's view this was an unhelpful decision that had a fundamental effect on the long-term outcome of PH's care.

The report also asserts that much of the forensic advice provided was not realistic in terms of what could be achieved in by teams in general services. This is particularly true when considering the likelihood of compliance with depot medication in the community.

In conclusion the Panel calls for much closer involvement of forensic services in the management of people by general psychiatric services who present a continuing high risk of violence in the community.

**The final discharge**

General psychiatry services inherited a serious problem; the advice from forensic services to administer depot medication was not easy to implement, given PH's lack of compliance and resistance to this form of treatment. The Panel accepts that it is not possible to force a patient to comply with medication unless subject to a restriction order, and to admit PH under the Mental Health Act because of non-compliance alone was impractical. The management strategy adopted in the face of this dilemma was, in the Panel's opinion, little more than hoping for the best. Over the years, this strategy became harder to defend as co-operation with and compliance by PH with treatment and services decreased.

The Panel is concerned that part of the justification for PH's management plan was that there was a high baseline of violence in East London and that serious assaults were commonplace therefore unremarkable. In the Panel's view, this is not an adequate reason to fail to confront the risks in this case, even if true.

The Panel concludes that the failure to institute an effective treatment plan was a long-running feature of PH's care in spite of the escalating risks he posed. The Panel state that local, forensic and general psychiatric services must in the future pursue a far more assertive approach to the management of any patient like PH.

## ISSUES ARISING FROM THE CARE AND TREATMENT OF SS

The Panel concentrated on looking at the care SS received around the management of her psychiatric illness and her pregnancy. The Panel's view is that SS's proper diagnosis was manic depressive psychosis, with an onset age of between 17 and 18 years old.

In order to consider SS's care, the Panel set their investigation around several key questions covering her lifetime diagnosis; the risks connected to her pregnancy and mental health and steps taken to mitigate these; and the assessment of her mental health made prior to her appearance in Court in April 2000.

### The risks of psychiatric illness after the birth of SS's child and steps taken to reduce this risk

It is well known that women with a history of manic depressive illnesses are at greatly increased risk of mental illness after childbirth when compared to other women. In SS's case this risk was increased still further by the severity of her illness, she had also suffered an episode of mental illness after having an termination in 1991. A post-birth episode is likely to be of the manic form and is likely to occur about 2 weeks after birth. In SS's case the onset of illness was far swifter and more complex due to the unexpected, premature birth of her son.

The Panel's investigation reveals that had the birth not been so premature – three months early – there would have been a great deal more pre-birth planning. The Panel surmises that given the severity of SS's mental illness the involvement of child protection services would have been very likely. When PH was identified as the father, this would have been mandatory because of the risks he was known to pose. Other areas of joint planning should have included a specialist in the psychiatry of childbirth, treatment and prophylaxis during pregnancy and immediately after birth.

The panel concludes that, had a referral to social services occurred at an early stage and a pre-birth planning meeting been held involving obstetrics staff, it is probable that SS's treatment post-birth would have been very different. The Panel is clear that the management of SS's care today would be different, given the publication in 2003 of the London Child Protection Procedures. These procedures clearly stipulate when to involve social services. If the criteria in these procedures had been applied in SS's case they would have mandated a pre-birth assessment.

The Panel considers the issue of SS's shared confidence with her social worker about her relationship with PH. The Panel's view is that the social worker should have disclosed this information to his supervisor in an effort to obtain guidance about wider disclosure. By doing so he would not have broken the law or guidance about confidentiality or consent, given the need to safeguard the child.

**Did SS develop a psychiatric illness after the birth of her son and did the assessment team have access to the information required to make this diagnosis?**

The Panel conclude that the evidence that SS suffered from typical puerperal mania following the birth of her child was overwhelming. This is substantiated by accounts from SS's sister, brother and ward staff at Newham General Hospital. It is also seen from the assessment made by the forensic CPN after SS was arrested on April 18 2000 for smashing up her neighbours flat – in itself an unusual act given that when well SS was not a violent person. The very quick onset of illness following birth was unusual, and she appeared calmer during the afternoon in Stratford Magistrates Court. This was not in the Panel's view an indication that she was well as symptoms of puerperal mania wax and wane.

The Panel concludes that the team who assessed SS at Stratford Magistrates Court did not make sufficiently robust efforts to obtain all the background information available from SS's case files. A diagnosis cannot, in the opinion of the Panel, solely depend on presentation at the time. Past history might have a vital effect on the assessment.

The Panel examines the assessment team and concludes that although the social worker knew SS, other members of the team particularly the psychiatrist were acting without detailed knowledge of her or her case.

**What went wrong, and what safeguards could have reduced the risk?**

The Panel's view is that the assessment team that attended Stratford Magistrates Court did not carry out a proper assessment of SS. The psychiatrist failed to equip herself with the full clinical notes, did not establish her history, was not aware of the recent birth or the content of the allegations against SS. A proper assessment would have resulted in a different conclusion about the appropriate course of action and treatment for SS.

## THE PERSPECTIVES OF PH'S AND SS'S FAMILY

### PH's family

During the course of PH's illness and involvement with mental health services, the professionals he came into contact with changed throughout. The one constant for PH was his family.

From the very start of PH's illness it was his family who initiated contact with mental health services. In the years that followed, his family and particularly his mother, initiated and remained in contact with services, attending CPA meetings both with him and frequently when he was absent. PH's mother was usually the first person to detect signs of deterioration and to raise her concerns with the care team.

The most successful period of PH's compliance with treatment was a few months during 1997. This success was a direct result of the support and supervision he received from his mother and his forensic community psychiatric nurse. In1998, PH's mother was increasingly concerned about his health and the aggressive behaviour he was exhibiting towards her; in 1999 she contacted Runwell Hospital asking that PH be put under section to hold him. She wrote letters to PH's consultant and eventually went to the police because of her fear about the risk PH posed to others and to herself.

PH's mother remained in contact with him in what were increasingly difficult times and even visited him on the day of the killing. PH's parents had not been aware of PH's relationship with SS and did not know about the pregnancy.

The Panel heard that Mrs H felt that at times she did not she get any help from mental health professionals. She said there was little continuity of care and the professionals did not see her as a key person, and her concerns were not taken seriously by staff. PH's mother wrote directly to the Director of Social Services in Newham about her son but did not receive a response.

The Panel concludes that, given the level of anxiety in PH's family, particularly during 1999, the response to PH's mother's concerns by Social Services was inadequate. The risk to Mrs H, both as his mother and as a woman, was never considered by the community mental health team. This was a clear deficiency in risk management plans.

**SS's family**

The family of SS remained in touch with her throughout her illness. The family stressed that SS was normally a happy-go-lucky person who usually recognised when she was becoming unwell. It was clear SS was not a violent person when well.

SS's family were never officially informed that SS had been arrested on April 18 2000 and taken to court. They also did not know that she had been bailed to PH's flat and indeed had never heard of PH.

The family's principle concerns are that they were not listened to, that SS should not have been discharged from hospital, and that the family's warnings about her deteriorating mental health after the birth of her son were not heeded and action taken to treat her in time. The family was concerned that SS had been bailed to PH's flat when he was a known risk to women, that PH was himself very ill and should have been in hospital.

## POLICING AND MENTAL HEALTH

The Panel examined the implications of not prosecuting PH when he had offended and concluded that, had he been prosecuted, it was likely that he would have been made subject to a hospital order possibly with restrictions attached. This would, in the Panel's view, have enabled a more assertive treatment regime to have been instigated.

The Panel refers to the Report of the Review of Mental Health and Policing commissioned by the NHS and Metropolitan Police Authority published in October 2005. The Panel fully endorses its conclusions and the recommendations it makes.

## RECOMMENDATIONS

### Risk Assessment and Management

1 We recommend that there should be a written record of a structured clinical assessment of violence risk whenever there is a transfer of care between mental health teams.

2 We recommend that the Trust should introduce a structured clinical assessment of risk as part of every CPA meeting in every patient with a history of violence.

3 We recommend the Royal College of Psychiatrists should review its guidance to psychiatrists on the management of violence risk, to take into account recent developments in structured risk assessment.

4 We recommend that the Trust should introduce a policy of involving families and carers in violence risk management, and their views should form part of the CPA documentation

### Co-operation and co-ordination between general and forensic services

5 We recommend that the PCT should commission a comprehensive forensic outreach service.

6 We recommend that the forensic outreach service should offer a full range of services from advice to general psychiatry teams, to full care in the community of patients who present a sufficient risk of serious violence.

### Liaison with the police and the decision to prosecute

7 We recommend that the Trust follow the approach pioneered by the South London and Maudsley NHS Trust with the Southwark Police. This process should amongst other things aim at agreement on a charging policy, as in Southwark, but it would have far wider objectives falling outside the scope of our report.

### Mental Health Assessments

8 We recommend that the Trust should write to all staff involved in mental health care reminding them of the principles to be applied when assessing patients for possible detention under the Mental Health Act 1983, namely:

- they should make all reasonable attempts to obtain relevant written records, and information from all other available sources
- they should review all available records, and consider all other information prior to the interview

- they should take all reasonable steps to ensure that they are briefed on the background events leading to the assessment request; and
- the assessment should consider risks of self-harm, violence to others, harm from others, including sexual exploitation, and inappropriate prosecution for acts committed while seriously mentally ill.

9 We recommend that trust clinical governance procedures and medical appraisals should make explicit reference to competence and performance in Mental Health assessments, including those at court and in other settings outside hospital.

**Pre-birth planning and Protocols**

10 We recommend that the Trust should ensure the adoption of a pre-birth protocol based on the London Child Protection Guidelines, familiarity with which should be part of the core competencies of community mental health services staff.

11 The Trust Director with responsibility for safeguarding children and the named Child Protection Nurse should ensure that policy imperatives and guidance on pre-birth and post-natal care of women with a history of mental illness are disseminated in a relevant and timely manner

**Documentation: Cumulative Clinical summaries**

12 We recommend the adoption of Cumulative Clinical Summaries and that the Trust embark on a consultation process with mental health teams to establish a timetable to implement this approach, taking full account of the additional human resources implications for this in the short term

13 The Panel experienced a great deal of difficulty in obtaining a complete set of all records, which were held in different teams and on different sites. We recommend that the Trust undertake regular audit to ensure the effective implementation of an integrated care records system.

**Confidentiality**

14 The Trust needs to ensure that its' staff have clear guidance on confidentiality, with illustrative examples. In any event better inter-agency liaison – we specifically recommend close liaison with the local police – absolutely requires clear thinking about the permissible extent and limits of mutual disclosure.

We can do no better than to reproduce Recommendations 25-27 of the MPA/NHS 2005 joint review report Mental Health and Policing:

*"R25 There should be a clear policy statement from a pan-London alliance that confidentiality will be respected, information will*

*only be shared when it is either in the best interests of the individual or there is concern for public protection and information will only be used for the purposes for which it is being shared. We recommend that there will be regular data cleansing in recognition that people's mental health status can change and improve. Systems and processes will need to be developed to achieve this.*

*R26 There is a need to clarify the legal framework, for example using case studies, making it easier for practitioners to understand the circumstances within which information can be shared.*

*R26 Where possible the individuals should be told that information is being sought from/shared with other agencies. The reasons for this should also be explained."*

## CHAPTER 1

## THE OFFENCE AND THE APPOINTMENT OF THE INQUIRY

1.1 In the early hours of 20 April 2000 PH telephoned the police on his mobile telephone and called them to his flat. When the police arrived he was wearing boxer shorts, and said in a calm voice "I don't think I can stay here any more". The police found the blood-stained body of an Afro-Caribbean woman. A post mortem revealed that she had sustained 44 wounds, mainly centred on the abdomen and chest, 22 of the wounds having passed completely through the body. A Samurai sword found at the scene was identified as the murder weapon. PH later said that he had bought the sword five weeks earlier.

1.2 PH was 32 years old. His victim was SS, a 33 year old woman, whom he said he had first met some years earlier in a psychiatric hospital. She had given birth to their son nine days before. Both PH and SS had lengthy psychiatric histories.

1.3 Neighbours had reported noises from 6 a.m., first tapping, then getting louder, and ending up as very loud bangs like furniture being hit, going on for 15 minutes. A neighbour who had previously been disturbed by PH's shouting and swearing had banged on his wall, and the noises had then stopped.

1.4 Four days after the event on 24 April 2000, PH related to Dr Kahtan (consultant psychiatrist) that his girl friend had been in a disturbed state of mind. She had been arrested and charged with criminal damage. She had appeared at Stratford Magistrates Court on 19 April 2000, and been granted bail on condition that she did not return to her flat. She gave his address as her bail address, and the Court had made it a condition of bail that she reside there.

1.5 Later PH said that after she had arrived at his flat he had advised her that she was unwell and should see a doctor. She went out and returned in an hour. They then visited PH's brother, and when they entered his flat she 'flipped', grabbed a fish tank and smashed it, flooding the room with water and fish. She picked up a coffee table and threw it out of the first floor window. PH escorted her away, took her for a walk, whereupon she calmed down. They returned to PH's flat, and rang his brother to tell him that he would pay for the damage. However at his flat she became disturbed again grabbed the television and started banging it on the kitchen table and cooker. She kicked the fridge-freezer over and started throwing soap, toilet paper and clothes around the flat. He felt that he needed to get out of the way, and so took off to his bedroom. She remained disturbed between midnight and 4 a.m. while she continued to thump about and shout. He fell asleep for an hour or two, and woke at 5.30 a.m. while she walked into his bedroom on several occasions. He tried to stay out of her way. At

this point he was unable to continue with the account, and his solicitor advised him not to.

1.6 PH told the police that he had grabbed a 3 foot samurai sword and attacked her with it. At the police station he had said, “What I did was wrong. Can I tell you why I did it? See, I have been controlled by a machine. I know it sounds stupid but it made me do it. I think she knew it was coming for weeks”.

1.7 On May 22 2000 he sent a letter to his prison governor in which he wrote the following:

> “I am being mentally tortured by a woman who is transmitting voices from an illegal machine that is trying to murder me in prison. This woman has been torturing me since 1998, and on 20 April tortured and ordered me to kill my girlfriend SS, something I did not want to do but had no choice as I was forced against my will by this evil machine operated by voices. This is the truth and therefore this woman on an illegal machine is responsible for the murder of SS…”

1.8 PH remained in prison until 27 February 2001, when he was transferred to Rampton Special Hospital under section 48 of the Mental Health Act (1983). PH was unfit to plead for a long time after his arrest. On 23 October 2001 he pleaded guilty to manslaughter by reason of diminished responsibility, and was made subject to a hospital order with a restriction order under sections 37 and 41 of the Mental Health Act 1983.

**Terms of Reference**

1.9 We were appointed to inquire into the case with the following terms of reference:

*1.1 To examine all the circumstances surrounding the treatment and care of PH and SS and in particular*

*1.12 The quality and scope of their health and social care and any assessment of risk*

*1.13 The appropriateness and quality of any assessment, care plan, treatment or supervision provided, having particular regard to*

- *Their past history*
- *Their psychiatric diagnosis*
- *The role of primary care in their treatment and care*
- *Their assessed health social care needs*
- *The interface between forensic and adult general psychiatric services*
- *The care of mothers at risk of post-partum illness*
- *Child protection considerations*
- *Carers assessments and carers needs*

*1.2 The extent to which their 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*

*1.3 The extent to which their care and treatment plans*

- *Reflected and assessment of risk*
- *Were effectively drawn up, communicated and monitored*
- *Were complied with by PH and SS*

*1.4 To examine the adequacy of the coordination, collaboration, communication and organisational understanding between the various agencies involved in the care of PH and SS or in the provision of services to them, in particular whether all relevant information was effectively a passed between the agencies involved and other relevant agencies, and whether such information as was communicated was acted upon adequately*

*1.5 To examine the adequacy of the communication and collaboration between statutory agencies and any family or informal carers of PH and SS.*

*1.6 To prepare an independent report including such recommendations as may be appropriate and useful to the services involved and their commissioners, and presenting it to East London and The City Health Authority or its successor organisation, the North East London Strategic Health Authority.*

1.10 In PH's case, the key question is whether the extent of the danger that he proved to be should have been anticipated, and the killing prevented. He had first come to the attention of psychiatric services 11 years before, and had first been admitted as an in-patient in 1990. Towards the end of that period he was an in-patient on many occasions, with a diagnosis of schizophrenia. By early 2000 the chronicity of his illness, and the relationship between its symptoms and medication, was fully apparent. He was known to be capable of aggression and violence when he was unwell, and had been treated in conditions of medium security on several occasions, but the level of violence he displayed on 20 April 2000 was far more serious. The killing occurred 5 weeks after a 'supervised discharge' (section 25 of the Mental Health Act) from Goodmayes Hospital.

1.11 For SS, the important question is whether she received proper care, particularly during her pregnancy, and after so recently giving birth. She had suffered from manic depression for many years. Her care coordinator, an Approved Social Worker (ASW), her general practitioner (GP), and a psychiatrist, who had come to the court to assess her before the hearing, the day before the killing, attended the magistrate's court hearing on 19 April 2000. We think that she was much more seriously ill than was recognised at that stage and so have asked ourselves whether her clinical team should have been far more concerned about her mental health than they were. Hence we ask whether, instead of staying with PH, she should have been receiving in-patient treatment, or at the very least been found accommodation much better suited to her volatile and vulnerable state?

1.12 Throughout our Inquiry we have been very conscious that we are looking back, fully aware of the dreadful event which took place on 20 April 2000. We have endeavoured to judge the care given to PH and SS in the light of what was known to the professionals at the time, rather than with the benefit of hindsight.

## CHAPTER 2

## PH'S PSYCHIATRIC HISTORY

### Premorbid history

2.1 PH was born on 5 September 1968. Labour was delayed and prolonged, and he needed resuscitation after birth. It was a long time before he cried, and he was difficult to feed.

2.2 A number of his relations suffered from mental disorders. His maternal grandmother and a maternal cousin suffered from mental illness. His mother's niece was admitted to a psychiatric hospital in 1989 with suicidal depression. At around the time of the onset of PH's illness his brother became ill with a diagnosis of schizophrenia.

2.3 As a child he was reported to be timid, bad-tempered and became easily upset, throwing tantrums. He was sometimes too frightened to go to school and he often took things personally. But in his later school years he became more confident and outgoing. He had friends, and enjoyed sports.

2.4 He left school without any qualifications, having frequently truanted. His first job was as a casual labourer with his uncle. He enrolled on a carpentry course under the Youth Training Scheme, but was either thrown out, or gave up, asking to be sacked so that he could obtain unemployment benefit. He was unemployed for a year. He tried other jobs, the longest being for two weeks. He then worked as a meat packer for six months, after which he worked as a scaffolder, which was his father's work, for nearly five years. But in 1990 he became uncaring, withdrawn, and sometimes aggressive and violent.

2.5 He had had his first girlfriend at age 11 and his first sexual experience at age 13. When he was 17 he developed a relationship with a girl friend, and they were happy for a while, but he treated her badly, and was reported to have beaten her. She broke off the relationship, which upset him.

2.6 His psychiatric history, as later revealed, began with obsessional symptoms when aged 10-12. They began again at age 14, but he did not come to psychiatric attention until 1989, when he was 21 years old.

<u>Events of 1989</u>

2.7 PH's first contact with psychiatric services came in November 1989. His GP recorded on 15 November that he had been suffering from a 3-year obsession with which he could not cope. He was referred to a

psychiatrist, Dr Lefebvre, whom he saw on 11 December 1989. He diagnosed an obsessional personality, and wrote, “If his obsessions become pathological, we shall have to do something about it”.

2.8 Dr Lefebvre referred PH to Dr MacMillan, a psychiatrist at Goodmayes Hospital, who saw him on 12 December 1989, and concluded that he was suffering from mild depression and intermittent obsessive compulsive disorder. PH declined the offer of medication.

Events of 1990

2.9 On 7 January his then GP, Dr Comyns, was asked to see him by his mother, and his note referred to obsessive compulsive neurosis. The following day he was prescribed Prothiaden, an anti-depressant. Although he was much improved by the end of January, his symptoms returned with a vengeance on February 6. He dared not look at children in case he discovered that he was attracted to them, and these ruminations made him very agitated. On 26 February he became very violent, smashing a door and two windows at his parents home. A diagnosis of depression and anxiety state was made, and the same day he was admitted to Goodmayes voluntarily under Dr Lefebvre, the first of many admissions.

2.10 On admission he said he had lost all interest in life, which was not worth living. He had suicidal ideas, poor appetite and weight loss. He said he had smashed up his parents’ home because he was not getting help from the hospital. He had been angry and upset when he had been denied admission on 19 February, and became violent as a result. A diagnosis of obsessive compulsive disorder was again made. However he left hospital the same day very shortly after admission, as he often did later on. His father brought him back to the hospital the following day, when he conceded that he had not been taking his medication.

2.11 During the next two months he was seen as an out-patient on several occasions. On 25 April he was admitted to Goodmayes as a day-patient, but was a very poor attender. On 15 May he requested in-patient admission, saying that he was feeling worse than before, and staying in bed most of the day. On 18 May he reported having had a fight with his father. His medication was increased to Lofepramine 210 mg/day and Carbamazepine 600 mg/day. On 22 May he said he was feeling better and wanted to return home, where his parents were willing to have him. A diagnosis of borderline personality disorder and depression was made and he was discharged home.

2.12 Although he seemed to be coping well when seen at out-patients on June 18, by early August he was again reporting suicidal thoughts. His general practice duty doctor, Dr Hussain, prescribed chlorpromazine on 8 August, and diazepam was added the following day. When seen with his mother on 10 August, she reported that he had been getting relief

from self-harming. He had cut himself the previous day and said that he wanted to kill or stab someone, which would make him feel better. He said of himself "I am not in control of my feelings, or my own mind. Life is a burden."

2.13 On 21 August he was admitted to East Ham Memorial Hospital under Dr Lefebvre, "after an aggressive episode at home", in which he had threatened his parents and siblings and broken some windows. He was still troubled by fears that he was a child molester, and was ruminating about being a hunchback and deformed. On admission he threatened to hit a nurse. Though he signed a contract agreeing to stay in hospital and abide by ward rules, he left the same day without telling anybody. He returned the following day, and was discharged on Chlomipramine 100 mg/day and Thioridazine 175 mg/day. The diagnosis remained borderline personality disorder and obsessive illness.

2.14 Further crises at home followed. In September he attended East Ham with his mother, after he had self-harmed and locked himself in his bedroom for long periods. He had again been saying that wanted to kill or stab someone. He was offered admission but refused.

2.15 On 10 October 1990 he took an overdose of Melleril, which he said was a cry for help. Despite the addition of Carbamazepine, which he may well not have been taking, his obsessions and ruminations continued.

Events of 1991

2.16 Dr Hodgson (psychiatrist) had seen PH shortly after his admission to St Andrews Hospital in October 1990, when he had been admitted with a Melleril overdose. He had decided to refer him to the Psychology Department, and it took some time before he could be seen.

2.17 His first session with Ms Bennett, clinical psychologist, was on 29 January 1991. She found no biological features of depression, but his mood was low and he had a very negative view of his capacity to change and of the future in general. She found him still ruminating about his 'hunchback', which he linked to his work as a scaffolder. He also had basic existential doubts about the meaning of his life, but no suicidal ideation. He said he 'didn't have the guts' and that it would 'seem a waste'.

2.18 She thought that some further exploratory work would be worthwhile, looking at his self-image, and current life transition – from adolescence to adulthood - and possibly some cognitive intervention aimed at his ruminations. PH cancelled one session due to illness, but returned to see her on 19 April 1991.

2.19 At this session she found him very different from the session in January. He was much more animated and made better eye contact. He said he was feeling 'more like his normal self. He said he had left his job as a scaffolder, and was actively seeking alternative work, though in fact he remained unemployed from that point on.

2.20 Although he said he still had worries, they intruded little and no longer disabled him. His social life was active and he could see a positive future for himself. He did not think he needed any further help.

2.21 His one request was that he needed medical support for re-housing. Ms Bennett told Dr Lefebvre that he would probably be the more appropriate person to write a recommendation in view of his longer contact, but that she would be prepared to provide a report.

2.22 However PH was giving a different account to his GP. On 15 April his GP had noted "Depressed – thinks nothing helps" and depression was mentioned in two further GP notes of 7 May and 30 May.

2.23 On 17 June he re-contacted the psychology department, saying he was feeling bad again.

2.24 On July 9 1991 he was admitted to East Ham Memorial Hospital under Section 4 of the Mental Health Act after threatening to kill himself, and taking an overdose of 46 tablets of Gamanil. He refused a stomach wash out and later said he had lied about the overdose. He walked out of the hospital an hour after admission, returned of his own accord, but then twice absconded the following day. When interviewed by Dr Lefebvre he said he was hearing voices calling his name. The possibility that he was pre-psychotic was raised. Compulsory detention was not thought to be justifiable and so he was discharged.

2.24 At around this time, the precise date is not known, he moved into his own flat.

2.25 At his third session with Ms Bennett on July 23 1991 he told her about a new rumination, that his face was becoming lop-sided, which he said had led him to attempt suicide. He said he genuinely wanted to die, and was convinced that he would never be free from intrusive thoughts: "as soon as one thought goes, another thought comes". Despite his despair he did however say that he thought he had the potential for a full and happy life. Indeed he had of his own accord conducted a 'desensitisation' programme in relation to his fears of paedophilia – making a graded approach to children, and testing his reactions. He also said he had overcome his compulsive washing.

2.26 Ms Bennett saw him again on 22 October. He had deteriorated. He was looking pale and tired, and was troubled by new ruminations. He was unemployed and trying to live on £25/week. He was only seeing

his family once a month and rarely seeing friends. He prayed every night that he would not wake up in the morning.

2.27 When Ms Bennett saw him on November 14 she thought his mood had deteriorated still further. He was overwhelmed by intrusive thoughts. She asked for a review of his medication and CPN involvement. She wrote to Dr Lefebvre saying that, though she had felt on 22 October that stopping his medication might be sensible, she now thought that it needed to be reviewed in the light of his increasing distress and decreasing ability to cope. She felt he was more likely to co-operate with a medication regime than he previously had been.

Events of 1992

2.28 As a result of Ms Bennett's concerns PH was seen by Dr Smith in the psychiatric out-patient clinic. He had doubled his medication of his own accord without obtaining any benefit. Dr Smith further increased his medication to Clomipramine 20 mg qds and Melleril 100 mg tds.

2.29 Dr Milovanovic a psychiatrist saw PH twice in March 1992, when his persistent intrusive thoughts and worries were noted.

2.30 In May 1992 his GP Dr Patel, noted that he had stopped all his tablets, and could not be convinced to resume them. Prothiaden was prescribed, but he may well not have taken it.

Events of 1993

2.31 PH remained out of contact with psychiatric services until January 1993, when he made fresh contact with Newham's Psychology Department. He was requesting further help with his obsessional ruminations. When he attended Mr Webster, Clinical Psychologist, on 19 January 1993, he was again very negative about the possibility of change and the future in general. As before, however, he denied feeling suicidal and said he 'didn't have the bottle' to take his life. He was offered further appointments, but did not take them up.

2.32 In July 1993 he approached his GP asking for a referral to Dr Richard Evans a psychiatrist at St Mary's Hospital, and was seen by Professor Montgomery (psychiatrist) at St Mary's on 23 September, who noted his obsessions about contamination, fears of perversion, and his feeling that the right side of his face was different. He was engaging in rituals involving washing and order. PH apparently recognised that these were foolish, and tried to resist them, but without success. Professor Montgomery felt that his dysmorphophobia verged on the delusional at times, but was nevertheless still part of his obsessive compulsive disorder. He encouraged him to start treatment with Sertraline (an anti-depressant) 100 mg/day, and offered him follow-up appointments. PH failed to attend subsequent out-patient appointments on 25 October and 22 November 1993.

Events of 1994

2.34 PH attended the Accident and Emergency Department at Newham General Hospital on 19 January 1994 complaining of left-sided chest pain over the previous year, anorexia, swelling of the chest, sleeping excessively and being unable to cope. He was referred to Dr Feldman (psychiatrist), but he failed to attend her psychiatric clinic on 24 March, and continued to miss psychiatric out-patient appointments for the remainder of 1994.

2.35 In October 1994 PH's social worker, Mr Pretim Singh, became concerned about his isolated and distressed condition, and asked his GP, Dr Patel, to arrange a domiciliary psychiatric visit. PH had apparently told Mr Singh that he wanted to see a psychiatrist, but due to his phobias did not feel he could attend her clinic.

2.36 On 19 December 1994, in response to a request, Dr Joan Feldman, a consultant psychiatrist, went to his flat to see him. She was dismayed that neither Mr Singh nor Dr Patel was present, but nonetheless proceeded to interview him without background notes. He told her that he did have murderous thoughts, in relation to people whom he thought were trying to humiliate him. He said that he did not go out during the day as people looked at and jeered at him. She advised him that she thought that he did have a mental breakdown and that major tranquillisers would help him. He brought and showed her Melleril and Lustral tablets and told her that he had been asked to take both of these prescriptions; but that they got rid of his finer nuances of feeling which he could not do without. However he agreed to try Risperidone and to come and see her as an out-patient. He also agreed to attend East Ham Centre to learn yoga. Dr Feldman thought that he suffered from paranoid schizophrenia.

Events of 1995

2.37 On 9 February PH was brought by his mother and sister to Goodmayes Hospital and admitted as a voluntary in-patient. The previous night he had gone to his parents' house at midnight, been refused entry, and had climbed up and smashed a window. The following evening he had returned very distressed, started punching himself, and then picked up a knife and threatened his father, but then dropped it. He had threatened to burn their house down if not taken to hospital.

2.38 On admission it was elicited that he had not taken any medication for 18 months. His obsessional thoughts had deteriorated, and he was double-checking everything, switches, doors and locks. He regarded himself as emotionally and physically ill, but not mentally ill. He told the nursing staff that he felt guilty about being attracted to girls aged 6 and upwards. Less than 24 hours after admission he reported feeling cooped up, but suddenly optimistic about the future. It was not felt that

there were grounds for detaining him, and it was agreed that he should go away for the weekend. He did not return.

2.39 PH failed to attend psychiatric out-patient clinic on 11 April.

2.40 On May 1 he attended a Care Programme Approach (CPA) meeting with his mother. Treatment with Fluoxetine 20 mg/day and Trifluoperazine 15 mg/day was agreed.

2.41 A further CPA meeting was held on July 12. Dr Malekniazi, locum consultant psychiatrist to Dr Feldman, reported that he was complying with chlorpromazine 200 tds, and that he was more stable.

2.42 On 18 September 1995 an event occurred which became known as the 'hostage-taking incident'. Marion Jones (CPN) and Sue Longley (student nurse) visited PH at his flat because he had failed to keep his appointment on 21 August. Marion Jones recounted it as follows:

> "Visit 18/9/95. 2.20 – 3.40 pm. He opened the door quickly – ushered us into the living room. Initially talked calmly but then moved around the room. Said he wanted us to see what it felt like to be him, trapped in his mind. Therefore he was not going to let us out. Hovering by the exit door, then punched the cupboard door several times, making his knuckles bleed. Threatened to punch Sue but stopped short. Said he would stab us with a kitchen knife. Said he didn't care about himself and could keep us there for days. Throwing a spoon around the room, saying that he could hit us in the eye. Throwing lighted cigarette ends around the room. Said he had murdered someone this morning. Using abusive language to denigrate women then put on a tape and said we could go when we had listened to it but changed his mind. Said he could rape us and talked about his sexual life, or lack of it.
>
> Eventually calmed down. I said I had an appointment at 3.30 pm and people would be wondering where we were. He said he didn't care, but then said we could go but don't come back.
>
> I have seen PH several times before. He is usually verbally abusive and threatening but directs this at 'those people out there', and contradicts himself. This visit his threats were directed at us and he appeared to be 'out of control'. When he did calm down his behaviour appeared to be quite histrionic".

2.43 Sue Longley's account mentioned that he talked incessantly about his hatred for women, in a particularly abusive and threatening manner. At one point he approached her and swung his fist towards her, stopping just short of her face.

2.44 Both the police and PH's GP were informed. Dr Feldman, who could not be contacted that day, was told the following morning. A planned CPA meeting was brought forward to 27 September, 8 days later.

2.45 We consider this incident, and the response to it, in greater detail further on, when we discuss the question of criminal prosecution. At this stage we note simply that though the police were informed, PH was never interviewed, and it appears that at no time were criminal charges against him ever contemplated. When much later, on January 28 1999, his case was reviewed by Dr Philip Lucas, consultant forensic psychiatrist, he recommended that:

> "In general terms, it is extremely important to document in detail each incident of violent behaviour as it occurs. If at all possible, charges should be brought against him if and when such incidents occur…."

2.46 If PH had been prosecuted for his behaviour on 18 September 1995 he could have faced very serious criminal charges, included threatening to kill, and false imprisonment. Doubtless he would have been dealt with under the Mental Health Act, rather than receive a penal custodial sentence. The high probability, in our view, is that he would have received a hospital order under Section 37 of the Act, but he might well have received a restriction order as well under Section 41 of the Act. Both for SS, and for him, the future might have been very different.

2.47 On 22 September Pat Fernandez (community services manager) wrote to Dr Feldman stating that PH was distressed and probably needed treatment. He expressed hate and anger towards women, whom he threatened to rape and kill.

2.48 The same day, bravely in our view, Dr Feldman paid another domiciliary visit to his flat with Dr Patel the GP. She wrote:

> "PH seemed extremely angry and irritable, but was co-operative towards us. He told us he could not stand all the suffering he had been through over the past years, which involved his face being pulled down, and his nose then being involved, and this in some way causing him to be made to walk. He also said that he wished that I had taken him into hospital and give him an injection so that he would die, but of course I would not do that. He said he wanted to die, but then seemed to contradict himself by talking about being very agreeable to coming into hospital and agreeing to take medication. He insisted he had brain damage, not schizophrenia. I agreed to do a CAT scan to look for this".

2.49 He agreed to being admitted to hospital and was taken there by ambulance. Dr Feldman had instructed that he should be put on a section 5(2) restraining order if he tried to leave, but despite this he managed to abscond the same day. The police were contacted immediately and he was eventually brought back on 25 September.

He remained on the ward for 12 hours, but then absconded yet again. He was found in some bushes and brought back. Dr Feldman decided that he should be detained under section 3 of the Mental Health Act, and he was transferred to a secure unit at Cane Hill Hospital.

2.50 On 26 September PH was transferred to the Special Assessment and Supervision Service (S.A.S.S) Medium Secure Unit at Cane Hill Hospital under section 3 of the Act, under the care of Dr Murphy. He applied to a Mental Health Review Tribunal the following day, though this application never reached a hearing.

2.51 PH remained at Cane Hill Hospital until 27 October 1995, when he was transferred back to Goodmayes. At Cane Hill he was reported as having responded well to Sulpiride 400 mg and Lorazepam, and become more friendly and co-operative. His preoccupation with his facial symptoms diminished greatly. He presented no management problem on the ward. Since PH lived far away from the Cane Hill catchment area, Dr Murphy and his team had no further involvement with his care and treatment.

2.52 On return to Goodmayes Hospital on 27 October he said that he had learnt that he could not abuse the system. However within a week he had absconded. He was returned on 10 November by his mother, to whom he had gone when he ran out of money. He was formally discharged on 14 November after being assessed as stable by Dr Feldman.

2.53 Despite her ordeal two months earlier his keyworker remained Marion Jones. A CPA meeting was planned for 31 January 1996, and he was to be followed up in out-patients.

2.54 PH was assessed for occupational therapy on 13 and 15 November. He had been unemployed for 5 years, and the therapists were pessimistic about their chances of motivating him. They suggested that he attend the Worland Centre for group work and monitoring, but he never took this up.

<u>Events of 1996</u>

2.55 As before, PH failed to attend follow-up appointments. On 4 March 1996 Dr Mayaki, Senior House Office (SHO) to Dr Feldman, wrote that due to his failure to attend, he would not be sent another appointment. He failed to attend a CPA meeting on 28 March 1996, though he mother attended. Dr Feldman wrote to his GP Dr Patel that day:

> "We were all concerned that he seems to be not eating that much on account of the fact that he spends all his money on street drugs, possibly mainly cannabis. We wondered whether you could possibly prescribe some vitamin and protein supplements for him if he agrees to this. We all feel that he would be better off on major tranquillisers,

but he refuses to take these. Our social worker Lorraine Walker and CPN Fred Okine went on a visit to see him. They thought that he had low self esteem, was saying quite hostile and aggressive things such as he was pleased about the children who were killed up in Scotland. They also felt that he was rather drowsy, possibly due to cannabis. We are all not sure how we can help PH because he is not compliant with anything we have to offer him…"

2.56 On April 18 PH underwent a brain scan, which was reported as normal.

2.57 On 17 May 1996 PH was again admitted as an informal patient to Goodmayes Hospital due to deterioration in his mental state. He had stopped taking medication. He absconded the next day. On 23 May he returned, but wanted to be discharged and was not thought detainable. He was formally discharged on 28 May in his absence.

2.58 Events followed their previous course. He failed to attend a follow-up out-patient appointment on 30 May, and as before, Dr Mayaki wrote to Dr Patel saying that he was not going to be sent another appointment.

2.59 His CPN, Saty Byatt, attempted to visit him on 27 June 1996, and believed that he was at home, but his flat door was not opened.

2.60 Due to concerns voiced by his mother about his mental state at a CPA meeting on 3 July (which PH again did not attend) it was decided to arrange a mental state examination, which took place on 10 July. This time the police were in attendance outside the building, and the visiting team consisted of Dr Malekniazi, locum consultant psychiatrist, Dr Patel his GP, Loraine Walker and Cathy Newcombe (approved social worker). They found Paul living with a female friend who was an ex-psychiatric patient. His flat was neglected. He complained of noise from neighbours, which affected his sleep. He was smoking cannabis from time to time. Though initially upset about the visit, he became more co-operative.

2.61 On examination he was thought to be rather stable with partial insight. He admitted to stopping his medication, but denied suicidal ideation or auditory hallucinations. He was not thought to be 'sectionable'. Dr Malekniazi wrote, "He is not a danger to himself and others". He was given a prescription for Droperidol and Procyclidine sufficient for a few weeks.

2.62 As so often before, PH deteriorated. His mother had become concerned after she found him distressed and crying. His flat was unkempt. On 20 August he had been very threatening, which led her to call the police. He had said, "If people are laughing at me I will kill them" and added that the only reason he had not killed someone was that he would end up in prison. He felt he was born evil. He had not taken medication for 3-4 weeks. On 21 August he was therefore admitted to Goodmayes Hospital (his 9$^{th}$ admission).

2.63 Following admission he wandered aimlessly round the ward, interacting very little with others. On September 10 a nursing note recorded that he had threatened to burn the hospital down and kill the staff. On 13 September 1996 he was detained for 3 days under section 5(2) of the Mental Health Act after threatening to set fire to a house.

2.64 PH remained as an in-patient at Goodmayes until 18 November 1996, when he was transferred to the Medium Secure Unit at Hackney Hospital under section 3 of the Mental Health Act under the care of Dr Neil Boast, forensic consultant psychiatrist. Dr Boast had assessed PH on 15 November at Goodmayes, and it is worth setting out parts of his assessment in some length, constituting as it did a comprehensive review of his history, and the reasons for his admission under section.

> "Thank you for your letter of 11 November 1996 referring PH to the East London Forensic Psychiatry Service. He was referred because he had made threats to kill several people including nursing staff and he appears mostly to dislike female and black staff. He had threatened to beat staff with a baseball bat and put the bat in different parts of their anatomy. More recently he had threatened to stab, shoot, or burn the ward down and we were told by his key nurse that he was aroused for approximately 15 minutes when making these threats."

2.56 Referring to the 'hostage-taking incident' Dr Boast wrote that he thought there was a sadistic element to his behaviour.

> "Although PH has a background of obsessionality his beliefs about his body are held with such intensity that it would be difficult to describe them as anything else than delusions. His irritation that people are not responding to his complaints in the way that he wants is I think a factor, which increases considerably the risk of violence. In addition he has an extremely misogynous viewpoint. Although I note that he is said to have treated a previous girlfriend badly I note that in the past he described his mother in favourable terms, whereas currently she appears to be lumped into the general category of women. The nursing staff and I both considered PH to be suffering from a delusional disorder. As discussed with you we would recommend that he is considered for detention under section 3 of the Mental Health Act. Subject to this occurring we would be prepared to admit him to the Crozier Terrace Secure Unit. A bed is available. I would propose in the first instance to manage him if possible without medication and to thus assess his ability to control his temper without the effect of anti-psychotics. It is of interest that PH improved in Cane Hill Hospital on a combination of anti-psychotic and tranquillising medication, whereas if he was suffering from an obsessional disorder one would expect that it would be anti-depressant medication that would have the best effect. "

2.66 The application under section 3 of the Mental Health Act was made by Cathy Newcombe, approved social worker, supported by medical recommendations from Dr Feldman and Dr Soares. PH remained at the Crozier Terrace Medium Secure Unit until 2 April 1997.

2.67 When reviewed at a Case Conference on 23 December 1996 Dr Boast noted that PH remained fixed in his view that he had structural brain damage, possibly arising from a head injury. Dr Boast did not think his presentation was consistent with the previous diagnosis of depression or obsessive compulsive disorder. Psychological testing of his personality traits carried out on 17 December had shown the highest level for schizoid, followed by avoidance. He was described as guarded, sensitive to personal ridicule, aloof, tending to intellectualise and fantasise. On the Stroop test he was described as just within the threshold for brain damage. Dr Boast did not feel that it was possible to make an overall risk assessment until the outcomes of treatment of anti-psychotic medication was known.

Events of 1997

2.68 PH had applied to a Mental Health Review Tribunal (MHRT) following his compulsory admission. This was heard on 21 January and decided that he was appropriately detained, but the tribunal said that it did not think he needed conditions of medium security. In a letter to Dr Feldman on 23 January Dr Boast pointed out that this recommendation was not in accordance with his opinion. He had argued to the Tribunal that PH had not yet responded to treatment – he was still convinced that he suffered from a physical illness – and that a return to Goodmayes in open conditions ran the risk of a release of aggression. He mentioned that one of his nursing staff had observed PH concealing medication within his cheek, and tablets had been found in his room. He had deferred a trial of depot medication in view of PH's insistence. He invited Dr Feldman to re-assess PH, and if she felt that he was inappropriately placed he would agree to his transfer back to Goodmayes.

2.69 On 25 January PH was again caught pretending to swallow his medication. When confronted he was defensive and aggressive, and refused to co-operate with staff. He was told that he would be required to show evidence of chewing to convince staff, or else he would be given medication in liquid form.

2.70 On 27 January he was given a Flupenthixol depot injection for the first time. He was very unhappy about this and complained to his father, who, however, thought that his mental state was much improved. Given his usual non-compliance with oral medication, particularly as an out-patient, depot medication was the only way to achieve a medication regime likely to be effective. As will be seen, other forensic psychiatrists later on felt that it was the key to successful treatment of

PH. Save for his treatment in early 1997 under Dr Boast, it was never tried again.

2.71 On February 4 he refused to have blood taken for tests, and he complained of unspecified side effects of Flupenthixol. Dr Feldman visited on 7 February, and concluded that he was not yet ready for a return to open ward conditions. PH acknowledged that he had improved on medication, and felt calmer as a result. A further injection of Flupenthixol was administered on 18 February after much persuasion.

2.72 By the end of February he appeared much more settled and interacted well with staff and patients. He was allowed escorted parole to local shops and on 24 February 2-3 hours escorted community leave. On February 28 he was allowed to visit his flat, which had been cleaned and re-decorated by his parents. When he met his mother on an escorted home visit on March 7, she felt that it was the first time for years that she had seen him so calm and well, and for the first time in many years he showed affection to her. Her only concern was that he seemed to have slowed down considerably.

2.73 PH was transferred back to Goodmayes on 2 April 1997, still under section 3 of the Mental Health Act. On 11 April Dr Boast wrote to Dr Feldman, summing up his views:

> "I think with treatment the situation has hopefully become much clearer. Although PH holds misogynist views I think this admission has shown that they are disinhibited or released when his psychotic illness becomes more severe. I spoke to his mother on the telephone on several occasions and she told me that she was very pleased with the progress he has made in that he has become far less paranoid and hostile. I think however that problems remain. I am not convinced that PH reliably reports symptoms, in that when he has partially recovered I think that he is "well enough" to consciously withhold information about his mental state given his strong motivation to get out of hospital. Additionally as you know he did not take oral medication in our unit reliably and was strongly opposed to the idea of going on to regular injections of medication.
>
> My view is that past events are the strongest predictor of the future and in this case the things that can be readily predicted are that PH will wish to come off depot anti-psychotic medication, that if he goes on to oral medication he will not take it reliably and that if he does relapse he will become hostile and irritable, delusions of bodily change and general paranoia recurring as before. If there is a fear that he is relapsing I think that he should only be visited at home by two staff, at least one of whom is a man. If he needs to be detained in hospital because of relapse due to non-compliance I think there would be strong grounds for attempting to control his illness by way of initial

injection of Clopixol acuphase (if he is hostile and aroused) followed by depot medication".

2.74 After his transfer to Goodmayes on 2 April 1997, PH was unsurprisingly quick to request an end to depot medication at a ward round on 4 April. Dr Feldman acceded to his request. We explore this decision in Chapter 3 in much more detail. Dr Feldman would have faced many difficulties had she tried to insist that depot medication be continued. PH had been a detained patient under section 3 since November 17 the previous year, but by common consent his condition was markedly improved. If she had not discharged the section shortly after his transfer to Goodmayes then it is likely that a tribunal would have done so. As soon as PH ceased to be under a section he had a right to refuse medication. He would undoubtedly have refused further depot injections, saying that he would agree to oral medication instead, even though many would not have been convinced that he would genuinely comply.

2.75 If Dr Feldman had tried to insist on continuation of depot injections in the community after his discharge from section 3; one must ask what she should then do if faced with a refusal. Immediate re-imposition of a section was not a decision she could make on her own. The agreement of an approved social worker and another medical practitioner would have been required, and might have been difficult to obtain if he presented as relatively well. Even if it had been possible to re-section PH, a tribunal might have re-discharged him.

2.76 He was started on Clopenthixol on April 4, and this was changed to Olanzepine 10 mg/day orally on 18 April and his section 3 was rescinded. PH's mother telephoned that day to say that PH had not been taking his oral medication. A pre-discharge ward round was held on 22 April, attended by Nigel Ryan, his forensic CPN, and Louis Ali, his social worker. PH claimed that he had been taking his Olanzepine over the previous weekend, but again his mother said that he was not taking his Olanzepine. Dr Boast's fears seemed to be borne out even sooner than he might have expected.

2.77 It was also a concern that on 22 April PH assaulted a patient on the ward while staff members were busy with another patient. He had attacked him after accusing him of stealing from his locker. Although the assault was witnessed, he denied that he had started it. The other patient wanted to press charges, and the police were involved, giving PH a verbal warning and caution.

2.78 On 6 May 1997 a discharge ward round was held, attended by Saty Byatt (CPN), Ted Kennedy (keynurse), Nigel Ryan (Forensic CPN), Louis Ali (social worker), and Glenroy Glaze from the Worland centre. Any problems with compliance seemed to have been overcome because PH's mother was taking his medication to his flat on a daily

basis, and watching him take it. PH was advised that he could stay out of hospital provided he took his Olanzepine.

2.79 The period after PH's discharge from Goodmayes in May 1997 was in many ways the most successful period of 'community care' that he enjoyed. He remained an out-patient until July 1998. A great part of the credit, in our view, must go to PH's mother and Nigel Ryan.

2.80 At a nursing assessment attended by his mother held on 14-15 May 1997, his mother had identified the warning signs when her son began to deteriorate:

> "irritability, usually aimed at her, being rude and aggressive, anxiety, pacing the room and expressing an uneasiness of being in the company of others,
>
> very moody, again results in verbal abuse particularly geared towards women,
>
> Self-neglect. Not eating, not attending to his hygiene, flat left unkempt,
>
> Commences use of illicit drugs cocktailed with alcohol,
>
> Ritual of throwing water over his face and constantly viewing self in the mirror".

2.81 PH was visiting her flat every day to receive his medication from her. He had first departed to the toilet immediately afterwards, but when confronted had agreed to stay in her presence while taking it.

2.82 From 12 August 1997 Nigel Ryan had been in contact with PH at only fortnightly intervals, a decision made after evaluating his compliance with the treatment plan, and thought justified by the low level of risk he appeared to pose during his re-integration in the community. On 5 November 1997 it was felt that PH had been compliant and remained stable. He had not engaged in ritualistic behaviour, and had displayed a healthy level of tolerance when confronted by frustration. He was also showing responsibility in keeping appointments, and in taking the initiative by making prior contact to rearrange if he could not make it.

2.83 PH himself recognised that since starting Fluoxetine and Olanzepine he had experienced no adverse side effects.

<u>Events of 1998</u>

2.84 On 29 January 1998 PH was cautioned at Forest Gate Police Station for possessing cannabis resin, but the alliance between Nigel Ryan and PH's mother seemed to be maintaining his stability. On February 13 a CPA meeting concluded that Nigel Ryan was working very well

with him, and he said he was taking his Olanzepine, monitored by his mother.

2.85 The first indication of concern arose on 2 April, when PH telephoned the police to say that he was being chased by a gang. A week later his mother reported that she had not seen him for a week, and that he had not been to collect his medication. A neighbour reported that the last time she had seen him he did not look well. He had lost weight and looked unkempt.

2.86 On April 17 Dr Feldman saw PH with Nigel Ryan, who was worried about him and had requested an urgent appointment. His mother had become concerned that he had become paranoid. He was having murderous thoughts and wanted to harm people, and thought that women were laughing at him. He had told the police that a gang of kids kept coming round to his flat, making threats and calling him a "nutter". Dr Feldman increased his Olanzepine to 15 mg/day and gave him a prescription.

2.87 From this point onwards many other of the warning signs of deterioration began to appear. PH missed an out-patient appointment on 14 May, and a CPA meeting on 20 May. The latter meeting was attended by Peter Johnston, who had replaced Nigel Ryan as his CPN. PH's mental state had become a concern to his family. On 22 May Dr Feldman wrote to Dr Patel (GP) about a further CPA meeting that day, which PH had not attended because he was in Cornwall. He had had an argument with his parents, and his father had forbidden him to come to the house. Regular monitoring of his medication was therefore no longer possible. He was spending a lot of time at his brother's house, but had agreed not to be there when the home helps were there, because they were frightened of him. However it appeared that he had not shown any signs of mental illness since his dose of Olanzepine had been raised.

2.88 On June 11 he failed to attend out-patient clinic.

2.89 On 22 July his mother had brought him to Goodmayes Hospital because he was afraid that he was going to be killed at midnight. He absconded a few hours after arriving. A Missing Persons Report recorded that he was not well mentally and could be at risk to others.

2.90 Four days later PH's mother wrote to Dr Feldman voicing her concerns and describing his recent deterioration. She feared for his safety. She felt he had become completely paranoid and suffering from delusions. He believed that there was a conspiracy to overtake the country, and only he and the government could see it. He was travelling to Cornwall to hide from people whom he believed were going to kill him. He was talking of 'deadlines' on his life. His physical health was affected, such that he was not eating properly, nor taking care of himself. He was pitifully thin. She appealed to Dr Feldman to help him. She added that

he had in fact stopped taking his medication a few months after his discharge in 1997.

2.91 Dr Feldman retired from practice at this time, and PH came under Dr Amir Bashir, Staff Grade Psychiatrist.

2.92 PH remained out of contact for two months, but was then brought to Goodmayes Hospital via A & E by his father on 26 September 1998. He presented as miserable looking, with poor rapport, low mood and avoiding eye contact. He had suicidal thoughts, persecutory delusions and auditory hallucinations. He said of himself, "I am unwell and should be sectioned in hospital". He absconded the following day but was brought back by the police on 28 September. As before, he refused depot medication, and in view of his non-compliance with medication and absconding he was sectioned under section 2 of the Act, and prescribed Olanzepine at 10 mg/day and Droperidol 5 mg qid. On 2 October he again refused depot.

2.93 On 8 October 1998 an eye witness confirmed that he had verbally and physically threatened a member of staff at King George Hospital A & E Department. Without provocation he had attempted to slap her on the face, but had caught the side of her face as she moved back. He then went on to push her to the ground. The staff called the police for help, but he left the area before the police arrived.

2.94 The following day he deliberately bumped into another member of staff in a corridor at Goodmayes Hospital and swore in her face. When he was confronted he completely denied the first incident and claimed that the second was an accident.

2.95 He appealed against his section 2, but a Tribunal hearing on 19 October confirmed his detention. It gave these reasons:

> "The patient has a ten year psychiatric history with eight admissions (including two admissions to secure units). The medical report describes a hostage-taking incident. If the incident is accurately described in the report, it is indicative of a very high risk to others. If it is as described by the patient in evidence, it is unfair to the patient and the notes should be corrected. The patient has a history of non-compliance with medication in the community with the consequence that he develops paranoid ideation. The Tribunal was satisfied that when the patient was unwell he poses a risk to others and possibly a grave risk. There was no dispute that the patient has a mental illness, the patient recognises this and agreed to take medication to reduce his symptoms. The evidence before the Tribunal was that the symptoms of paranoia had reduced in intensity but the patient remained irritable at times as evidenced by his argument with his parents earlier in the day. The Tribunal concluded that the section should be upheld in order to continue to monitor the effect of the oral medication and to monitor the patient's mental state as a premature

discharge would be likely to lead to an early relapse "(Signed Mr D.Mylan).

2.96 Detention under section 3 was initiated on 26 October. The same day PH handed a written note to nursing staff, which read as follows:

"Early this year, I really can't remember the date but I was on my bike and felt very upset and angry and when I passed a woman I punched her. I really don't understand why I did this terrible thing. It was just pure frustration. The guilt of it is driving me crazy and I want to confess when the police come. I am willing to confess to them. I can't hide it anymore". (Signed PH)

2.97 No further action was taken. Though the incident was self-reported, there was no reason to doubt that it occurred. It was significant because it was a clear-cut incident of physical assault on a stranger, showing that he was capable of motiveless aggression and violence.

2.98 In the following days there were further signs of his deterioration. On 1 November he was found lying on the floor of the laundry room, watching the machine spinning. He was "extremely paranoid" and threatening female staff. He declined Clozaril and depot medication. It was felt that he was not swallowing his medication, probably hiding the pills in his mouth. Treatment with Droperidol 20 mg/day in liquid form was therefore started. On 10 November he again refused depot medication, saying that it caused problems with his legs. It was decided to refer him to the Secure Unit at Runwell Hospital. He gave assurances that he would stay on the ward, but absconded and remained absent without leave (AWOL) for the next three weeks. He had apparently managed to borrow £200 from his father, and travelled to Scotland. He was brought back by the police on 30 November, but went AWOL again 3 hours later. The police managed to find him, and returned him to Goodmayes once more on 15 December.

2.99 The next day he was transferred to Runwell Hospital under Dr Acharya, still under section 3 of the Act. There he apparently took his Olanzepine and became co-operative.

<u>Events of 1999</u>

2.100 While at Runwell PH appealed against his section 3, and an MHRT heard his application on 18 January. The Tribunal decided to discharge him, giving these reasons:

"We received evidence from the medical representative that PH no longer displays any symptoms of mental illness. PH himself told us that he believes his illness in the past was due to use of cannabis which he has now given up and that he will in future co-operate with aftercare arrangements and continue with his present medication

which he finds calming. In the circumstances there is no justification for the section remaining in force". (Signed Brian Cooke, President)

2.101 We found this decision superficial. Even a cursory review of his medical records would have shown that it was not possible to rely on his claims that he would take medication. The explanation may be that the case for continuing detention was inadequately presented to the Tribunal by a junior member of the medical team at the Hospital. That was the explanation suggested by Dr Philip Lucas, consultant forensic psychiatrist, who had been asked to assess PH by Dr Bashir on 16 November 1999.

2.102 Dr Philip Lucas's assessment of PH's case was written on 28 January 1999. He wrote it without seeing PH, despite several attempts to do so. When PH's case was first referred to him he had gone AWOL, and so was uncontactable. Dr Lucas tried again in early December 1998, but again PH was AWOL. He made a yet further attempt on 19 January 1999 when PH was back at Goodmayes Hospital, but the latter left the ward while Dr Lucas was gathering information prior to interviewing him.

2.103 However he had access to the (by then) copious notes and reports that had been written on PH, and his assessment was penetrating and clear-cut:

"…As you know, I have so far been unable to interview PH and my assessment is therefore incomplete. To summarise what I have been able to gather, it appears that he suffers from a paranoid psychosis which is associated to hostility to women. There has been a recent escalation in his aggressive behaviour from threats to actual physical assaults, although there was a serious incident involving the holding of hostages in 1995. His psychosis has in the past responded at least partially to anti-psychotic medication but he has not complied with oral anti-psychotic medication in the community. There was a general view from the nursing staff that when partially treated, he becomes guarded and is able to hide his abnormal mental state from psychiatric professionals, hence his discharge by the tribunal on 18 January 1999. In such a state he is capable of a complete denial of any violence. He also demonstrates striking ambivalence towards the prospect of therapeutic help as, for example, when he agreed to stay to see me and then left just before he could do so.

Following the discussion I had with you on the 19 January 1999, it is reasonable to make some suggestions about future management. Because of the escalation in PH's level of violent behaviour towards women he requires detention and treatment with depot anti-psychotic medication as soon as possible. I am sure that this can only be carried out in a locked ward and arrangements for his detention in such a ward should be negotiated as soon as possible so that he can be treated when he next appears. It seems quite clear that the risk

PH posed was reduced by the intensive involvement of Nigel Ryan. In particular, Mr Ryan's regular contact with PH's mother seemed very helpful in establishing PH's mental state. If possible, either Mr Ryan or a successor should be involved in planning meetings as a matter of urgency. As we discussed, contingency plans should be made to facilitate treatment of PH when he does appear. In general terms, it is extremely important to document in detail each incident of violent behaviour as it occurs. If at all possible, charges should be brought against him if and when such incidents occur. It is clear that PH will not comply with oral medication and, in my view, depot anti-psychotic medication post-discharge is vital if the risk he poses is to be sufficiently reduced for him to live in the community. Particularly in view of his ambivalence, consideration should also be given to a supervised discharge following his next admission…"

2.104 Dr Philip Lucas's advice raises important issues. His firm recommendation that incidents of violence by PH should be both well documented and prosecuted whenever possible is discussed in greater detail below. One further such incident, in December 1999, went unprosecuted, as all previous incidents had been. Prior to the events of 20 April 2000, despite a further admission to Runwell Medium Secure Unit PH, he was not given depot medication.

2.105 PH's whereabouts remained unknown until 19 February 1999, when he was arrested for throwing a brick through a neighbour's window. He was remanded in Pentonville Prison. After just over six weeks there, on 4 April, he was transferred under Sections 48 and 49 of the Mental Health Act to the secure unit at Runwell Hospital. There he was prescribed Risperidone 4 mg/day. He was assessed as lacking any insight.

2.106 He was brought to trial on 14 May 1999, but the case against him was dismissed due to the non-appearance of a witness. The authority to detain him further at Runwell Hospital thus lapsed. Yet again he was taken to Rosemary Ward at Goodmayes Hospital, from which, yet again, he absconded on arrival, refusing to stay even to see a doctor or to collect medication.

2.107 For a while all further attempts to achieve PH's attendance at out-patient clinics or CPA meetings, or to locate him, failed. His mother contacted the ward on June 6 1999 to voice her concern. That day, she said, he had spat in a woman's face. She reported it to the police, who called at his flat, but he would not open the door.

2.108 On 20 August 1999 Dr Richard Duffett, who had taken over responsibility from Dr Bashir, wrote to Inspector Faulkner at Forest Gate Police Station, saying that he would be happy to see PH under section 136 of the Mental Health Act should the police pick him up and suspect him to be suffering from a mental illness, or on remand if he had offended.

2.109 Around 6 December 1999 a woman reported to the police that a man fitting PH's description had grabbed her in the street, dragged her along the pavement near to his flat, and then dropped her, said sorry, and returned to his flat. There was a suspicion that he had tried to drag her to an area out of sight of bystanders.

2.110 Then, on 17 December 1999, PH visited his parents' house at 4.30 a.m., stating that he wished to "kill and eliminate an Irish woman", "this woman has to be driven away" and "I am the only one who can do it". These threats appear to have been aimed at an Irish woman living near PH. The police were informed, visited his flat, and took him to Forest Gate Police Station. He denied ever having made these threats, but his family confirmed that they had been uttered, and that he apparently believed that she and her family were persecuting him.

2.111 He initially denied assaulting the woman in the street, but later switched to saying that he had bumped into her and apologised, but had not dragged her along the ground or otherwise assaulted her.

2.112 He refused to accept voluntary admission, and an application to admit him under section 3 was therefore made and he was initially detained again at Goodmayes Hospital. Due to the risk of his absconding he was transferred to Runwell Hospital on 20 December 1999. He was treated with Risperidone, and became relatively settled there, though he was noted on 30 December to be making "bizarre complaints about Irish people".

<u>Events of 2000</u>

2.113 Just as Dr Neil Boast had made recommendations about his future treatment in April 1997, and Dr Lucas had done in January 1999, so Dr Duffett received advice from Dr William Obomanu, consultant in forensic psychiatry, on 25 January 2000.

2.114 As others had done before, Dr Obomanu noted his poor compliance with oral medical medication, and thought that he should be started on depot medication. He recommended that a Forensic Community Mental Health Nurse should be involved when he returned to the community. He felt that further exploration was required to identify people who might be at risk, including his current girlfriend. He suggested counselling and supportive psychotherapy with regard to his use of illicit drugs. When discharged, he advised the highest level of care programme approach, and use of the 'supervised discharge' provisions in the Mental Health (Patients in the Community) Act 1995. Finally he urged assessment by the occupational therapy department to ascertain his level of functioning in his flat, with the possibility that he might be better placed in a hostel where he could receive more support.

2.115 PH was transferred back to Rosemary Ward from the Newham Centre at Runwell on 7 February 2000.

2.116 As Dr Obomanu had recommended, advice was sought from a Forensic Community Mental Health Nurse, Tom Leahy, who interviewed PH on 27 January 2000 and reported on 16 February 2000. As others had done, he strongly recommended a 'supervised discharge' when he returned to the community. He pointed out that this would give rise to a power to convey a patient to a place where he can have a full mental health assessment. He advised two male mental health workers working with him in the community in view of his aggression and violence to women in the past. He envisaged 'assertive outreach' interventions, including out-of-hours visits if necessary. He proposed that 'some work should be done' by his RMO and key nurse exploring the issues around him having depot injections rather than oral medication, and finally he proposed close police liaison.

2.117 PH had applied for a Mental Health Review Tribunal against his section 3 detention. In the event this Tribunal never took place, but on 21 February 2000 Dr Duffett submitted his Psychiatric Report to the Tribunal. The report referred to incidents in PH's past when he had been aggressive and had made threats to kill, but made no mention of the occasion on 26 October 1998 when he had self-reported an attack on a woman who was a stranger to him. The incident on 6 December 1999 when he had again attacked a woman in the street was mentioned without any elaboration in the following two passages:

> "PH was admitted on section 3 from the Police Station where he had been accused of assaulting a woman."

And:

> "In Summary: PH is a 32 year old Caucasian man who suffers from paranoid schizophrenia. He tends to be very guarded about his symptoms and he usually comes to the attention of the police and psychiatric services following assaults on women, which indeed resulted in his current admission."

The report gave no indication that Dr Duffett had significant concerns about the danger PH represented to other people

2.118 A pre-discharge section 117 meeting was held on 18 February 2000. The planned discharge date was 3 March 2000.

2.119 An Occupational Therapist, Mimi Spence, assessed him on 2 March 2000. Contrary to the advice of Dr Obomanu that professionals should not visit PH alone, Ms Spence visited PH's flat unaccompanied. She felt that he had the skills necessary to be independent in personal and domestic activities of daily living. She noted that "PH has a girlfriend

who he has been seeing for about 14 months. He states that he spends most of his time with her rather than in his flat…"

2.120 A "Hospital Discharge - Care Plan" completed on 23 March 2000 was as follows:

Plan of Care:

- PH to be seen by CMHT West every week – alternated by CPN and social worker
- 3-monthly CPA meetings to be held at designated place
- To comply with medication
- Next CPA meeting 7 June 2000

Medication:

3 mg Risperidone

**Consultant Psychiatrist**

Dr Duffett

**Contingency Plan (*including action to be taken in event of relapse or crisis)***

- Contact Ken James and or Tom Leahy
- Ken James to contact ands liaise with Sergeant Lechey concerning concerns with PH's wellbeing

PH signed the plan. It did not contain any reference to a relationship with a girlfriend, although by this time Dr Obomanu had recommended that exploration was required to identify people who may be at risk, including his current girlfriend. There was no evidence that the CMHT involved either PH or SS, saw them as a couple, or sought to explore the nature of the relationship. This suggests a lack of clarity about the requirements of care management in its widest context.

2.121 The requisite forms to authorise a 'supervised discharge' under section 25 of the Mental Health Act were completed, and PH was so discharged on 17 March 2000.

2.122 He was compliant with community visits from the date of his discharge until his offence. Tom Leahy saw him on 24 March and 14 April, and Ken James saw him on 31 March and 7 April. When Tom Leahy and Ken James visited PH they asked whether he was taking his medication, and was assured that he had. They checked the medication bottles, and the contents were consistent with PH's assurances. PH's mental state appeared to be stable.

2.123 On 20 April 2000 he was taken into custody following the discovery of the body of SS at his flat.

## CHAPTER 3

## ISSUES ARISING FROM THE CARE AND TREATMENT OF PH

3.1 Chapter 2 of this Report sets out the lengthy course of PH's treatment. He was without doubt a very difficult patient, extremely resistant to medication, and especially depot. He often 'tongued' oral medication. He was uncooperative and unreliable, and skilled at concealing, or not reliably reporting his symptoms, particularly when he was partially treated. He could therefore present as quite well when he was not, and he was thus capable of convincing the unwary that he was asymptomatic when he was ill.

3.2 He was often untruthful. He denied conduct that had been reliably witnessed, and minimised his violence and aggressive behaviour. He nearly always showed a strong motivation to get out of hospital, and frequently walked off open wards within hours or sometimes minutes of admission. It made little difference that he might be under a section unless he was in a secure setting.

3.3 He had poor insight into his condition. Only on rare occasions did he positively seek treatment. He frequently failed to attend follow up, whether out-patient or CPA meetings. When community mental health team members went to his flat he sometimes refused to answer the door. He left letters unopened. Sometimes he would simply take off, to Cornwall or Scotland, and go out of contact altogether for weeks or months.

3.4 Faced with a patient with these features, psychiatrists often have to choose between the lesser of evils. A coercive approach may be at the expense of therapeutic alliance, though in PH's case there was often neither coercion nor alliance.

3.5 Until September 1995 he was a relatively infrequent in-patient, spending only just over 30 days in hospital in the period of nearly six years since the onset of his illness in 1989. After 1995 the pattern changed. His periods of in-patient treatment became much longer. Between September 1995 and the date of the offence on 20 April 2000 he spent nearly a third of his life in hospital with five significant admissions, all of which involved transfer to secure institutions. Post-1995 he became what is often called a 'revolving door' patient.

3.6 Apart from a single conviction for shoplifting in March 1992, he was only prosecuted once, for throwing a brick through a neighbour's window in February 1999, and this charge was dismissed when a witness failed to appear. He was once cautioned, on 29 January 1998, for possession of cannabis resin. Up to 20 April 2000 his criminal record was therefore virtually clean. Yet in terms of his conduct he

'offended' on many occasions. The chronology below sets out the instances when he voiced, threatened or carried out acts of violence.

## Chronology

| Date | Incident |
|---|---|
| 12th December 1989 | Dr Lefebvre noted that a year before he had started hitting his girlfriend. |
| 26th February 1990 | Dr Hussain (GP duty doctor) noted that he had smashed a door and two windows. |
| 9th August 1990 | PH's mother said he had cut himself and said that he wanted to kill or stab someone. |
| 21st August 1990 | PH had broken some windows at home. |
| September 1990 | PH's mother said that he had cut himself and wanted to kill or stab someone |
| 19th September 1994 | PH told Dr Feldman that he had murderous thoughts towards people in the streets. |
| 8th February 1995 | After being refused entry to his parents' house, PH smashed a window. The following day he started punching himself, then picked up a knife and threatened his father. He threatened to burn their house down. |
| 18th September 1995 | PH held a CPN and trainee nurse hostage at his flat, making violent threats to kill, assault and rape them. |
| 22nd September 1995 | PH was recorded as having said he felt hate and anger towards women, whom he threatened to rape and kill. |
| 20th August 1996 | PH's mother recorded him as having said "if people are laughing at me I will kill them". |
| 10th September 1996 | A nursing note records that PH had expressed a wished to burn the hospital down and kill the staff. |
| 13th September 1996 | PH was detained under Section 5 (2) after threatening to set fire to a house |
| October 1996 | PH's mother said he threatened to stab his father. |
| 10th October 1996 | PH felt he needed a brain scan, and that the only way to deal with the situation was to acquire a gun and kill the doctors and nurses responsible for his care. |
| 15th November 1996 | A social services assessment recorded that he had a 'hit list' of people he intended to kill, including Dr Feldman. |
| 16th November 1996 | PH was recorded as having threatened to kill members of the nursing staff |
| 19th November 1996 | Dr Boast recorded that he had threatened to stab or shoot people. |
| 27th November 1996 | A letter from PH said that he was "ready to kill anyone and bear the consequences". He would shoot them all then himself. |
| 7th February 1997 | PH threw a lighted cigarette on the carpet and became 'aggressive, abusive and volatile', threatening staff with violence. |
| 17th February 1997 | PH's mother said he was having murderous thoughts and wanted to harm people. |
| 15th October 1998 | PH told nursing staff that earlier in the year he had punched a woman in the street as he passed her on his bicycle. |
| 25th October 1998 | PH threatened to slap a nurse's face, and caught the side of her face as she moved back. He then shoved her in the chest, pushing her to the ground. |
| 9th November 1998 | PH deliberately bumped into a woman in a hospital corridor and swore in her face. |
| 19th February 1999 | PH was arrested and remanded in custody at Pentonville Prison after hurling a brick through a neighbour's window. |

| Date | Incident |
|---|---|
| 6th June 1999 | PH spat in a woman's face. |
| 6th December 1999 | PH assaulted a woman in the street, dragged her along the pavement, then apologised and left her. |
| 17th December 1999 | PH told his mother that he wished to kill and eliminate and Irish woman who lived a few doors away. |

3.7 Despite his virtually clean criminal record, his admissions to medium security in the second half of the 1990s brought him into contact with forensic psychiatrists, who urged more assertive treatment, in the form of depot medication, but this was never pursued once he had been transferred back to Goodmayes.

3.8 A key issue is whether his treatment should have been more assertive in view of his increasingly aggressive and disturbed behaviour. Although there were some alterations to his post-discharge arrangements between 1995 and 2000, they all depended on his compliance with oral medication. By early 1997, if not before, it had become clear that he could not be relied upon to take oral medication post-discharge.

3.9 Assertive treatment would have meant imposing a significantly stricter medication regime on him, effectively conditioning his liberty on acceptance of depot medication, to which he was powerfully opposed. Forensic psychiatrists urged depot medication, though they recognised in evidence to us that there would be many practical difficulties implementing this approach when he was discharged.

3.10 As his illness progressed, worrying incidents accumulated. A longitudinal view showed a clear correlation between abstinence from medication and disturbance and volatility. Permitting him to become non-compliant in the community became increasingly risky.

3.11 Checks and balances written into the Mental Health Act deny psychiatrists sole freedom to decide how a patient will be managed. Current legislation gives relatively weak powers to psychiatrists and mental health professionals seeking to manage civil patients in the community. This does not matter when a patient is naturally compliant, but PH was never that.

3.12 Intensively monitoring his medication in the community was only achieved during one phase of his treatment, when his mother required him to take his medication daily in her presence in the period following his discharge from the John Howard Centre and then Goodmayes Hospital in April 1997, and for a while he co-operated. Even then, one cannot be sure that he was not deceiving her some of the time. When he ceased to visit her, this control lapsed.

3.13 Faced with the prospect of depot medication by injection he was consistently resistant. It was only tried in February/March 1997 when he was in medium security. He saw it as degrading and undignified, and complained bitterly of the side effects. The oral medication that he was prescribed was usually in the form of 'new-style' atypical anti-psychotics, like Risperidone. At the relevant time depot medication was only available with 'old-style' typical anti-psychotics. On the one occasion when depot was used, those closest to him, like his parents, felt that he became far better than he had been for a long time, relaxed, affectionate, and 'like his old self'. PH himself acknowledged that he was feeling well, but this did not conquer his opposition to depot medication. It is a matter of speculation whether, if a trial of depot medication had been maintained for significantly longer, he would have developed insight into its overall benefit to him, and come to accept it.

Medication and treatment

3.14 Attempting to insist upon depot medication would have required great determination, and may well have been thwarted as long as he remained a civil patient. Throughout the time that PH was being treated (and still today) there has been no legal power to condition discharge on acceptance of medication unless the patient has received a restriction order under Section 37/41 of the Act, and is 'conditionally discharged' under Section 73 of the Act.

3.15 A 'supervised discharge', introduced by the Mental Health (Patients in the Community) Act 1995, and used in PH's case in March 2000, imposes a duty to review if a patient refuses or neglects to receive specified after-care services, or fails to comply with requirements as to residence, attendance (e.g. for treatment) or giving access. This is backed up by a 'power to take and convey' the patient to any place where he is required to reside or attend. But there is no power to treat such patients without their consent once they have arrived at, or been conveyed to, the place where they are to receive treatment. Nor does it provide an automatic power to re-admit when the patient becomes non-compliant. That issue must be assessed in the usual way.

3.16 In the absence of depot medication there was probably no effective method of reducing and controlling risk in PH's case. But one has only to explore the dilemma facing Dr Joan Feldman in March 1997 to understand the difficulties involved. This was undoubtedly a key moment in his psychiatric history. He was transferred back to Dr Feldman's care at Goodmayes Hospital on 2 April 1997 having received three depot injections at fortnightly intervals at the John Howard Centre Medium Secure Unit. Dr Neil Boast's determination to try depot medication had survived a second opinion under section 58 of the Act. He correctly predicted that PH would wish to come off depot anti-psychotic medication, and that if he went on to oral medication he would become non-compliant.

3.17 Dr Feldman, who became his RMO once more when PH was transferred to Goodmayes from the John Howard Centre, faced the difficulty that on 15 May 1997 his section 3 would have required renewal at its 6-month anniversary if he had not been discharged. At that stage he could re-apply to a Tribunal for discharge. She thought it unlikely that a Tribunal would support further detention. Indeed, if she had maintained depot medication, and, ex hypothesi, he then presented as well, a Tribunal would have been all the more likely to discharge him.

3.18 She also had to consider the possibility that if she had sought to insist upon depot medication after discharge, PH might simply have gone out of contact in view of his antipathy to this form of medication.

3.19 Moreover she had to ask herself whether PH could have been re-sectioned at the point of refusal (assuming he could be found), before deterioration in his mental state became apparent.

3.20 The first difficulty would be that even if a second medical practitioner had been willing to recommend re-admission (which would logically have implied admission for treatment under section 3) it would be necessary for an Approved Social Worker (ASW) to agree to make the application, something that could certainly not be taken for granted. Dr Feldman had confronted this problem in mid-September 1996 when two medical recommendations had been made for his admission under section 2 of the Act, but an Approved Social Worker (Les Barron), had taken the view that PH was not 'sectionable'. Even if an ASW had agreed, PH was highly likely to seek discharge from a Tribunal after being re-sectioned, and we sympathise with Dr Feldman's view that it would have been an uphill task to dissuade a Tribunal from doing so.

3.21 Dr Feldman told us about the occasion when she had visited PH at the Hackney secure unit:

> "Neil [Boast] asked me to go and see him in his forensic unit, his medium secure unit, and see whether I thought he should come back [to Goodmayes], and I said he should not. He was on depot and said: "Get me out of here. Please, please get me out of here". I said "But if you come out of here, you will come off you depot", and he said: "Yes, I will. But you can't keep me here for ever, so why don't you let me come out? I promise I will accept oral medication, but I won't take depot"."

3.22 Dr Feldman was asked about the practical difficulties of administering a depot injection to PH in her unit:

Q Would it have been a matter of actually holding him down, to give an injection if you wanted to?
A Most definitely. He just wouldn't have it. I knew that would happen. He knew that would happen. It was only a question of when.

3.23 Her decision to accede to his wishes, and to use oral medication, was made fully aware that he would probably definitely withdraw any further consent or co-operation to depot injection. As she put it, "I knew he was going to stop, and I wanted to retain therapeutic alliance".

3.24 If she was correct in believing that she was unable to maintain his depot medication, then her desire to secure the best therapeutic alliance possible was certainly a reasonable, if not the best, strategy. She explained it thus:

> "What I think we were trying to do was say "We can't keep you long-term in a forensic unit. We'd like to, but we can't. We have to keep you in the community". So now what we are going to do is to build an alliance, we've got a forensic CPN – which was a huge bonus, we had never had that sort of thing before – so we're going to have as far as we can a good monitoring team, a forensic nurse and the oral medication, and that combination we are hoping will stand in. Because there is no way he is going to have the insight, there is no way he is going to have the injection, so we have got to go down a level and have that."

3.25 Dr Boast, who had initiated PH's depot medication at the John Howard Centre, fully understood Dr Feldman's decision when we interviewed him:

> "The difficulty here is that ideally [depot medication] is what somebody like PH needs, but there are limits to what you can do in general psychiatry and in the community. You can't enforce medication in the community, and it seems to me some sort of compromise was reached. It is not quite explicit, but the idea was that he would have follow-up from Nigel Ryan, who is a very good community nurse, and the oral Olanzepine. …In that era, as in all eras really, general psychiatry faces a great deal of bed pressure, and the idea of keeping somebody in hospital because they wouldn't take depot in the community just is not a viable option…"

3.26 Dr Feldman's attempt to keep PH on the rails in the community was relatively successful for a while. Much of the credit lies with his mother and with Nigel Ryan. But after about a year, almost certainly because of non-compliance, he became more unstable. If his early co-operation had been maintained, there would have been a way to accommodate his objection to depot medication, and maintain his stability, but this was shown to be a false hope. We understand why Dr Feldman tried to achieve a therapeutic alliance at that stage. But once her attempt, under the most favourable possible circumstances, had proved to be unsuccessful, the lesson needed to be borne in mind thereafter.

3.27 Dr Amir Bashir, locum consultant psychiatrist, took over PH's care when Dr Feldman retired in August 1998. PH was out of contact with

psychiatric services at that time, but he was brought back top Goodmayes by his father on 26 September 1998. On at least three occasions Dr Bashir proposed depot medication to PH, but he always declined. He referred his case to Dr Philip Lucas, consultant in forensic psychiatry on 16 November 1998, by which time he had deteriorated again. Dr Lucas's was the second forensic psychiatric voice urging depot injection. On 29 January 1999 he advised:

> "….It is clear that PH will not comply with oral medication and, in my view, depot anti-psychotic medication *post discharge* [our emphasis] is vital if the risk he poses is to be sufficiently reduced for him to live in the community… "

3.28 This seemed to be a call for the very approach that Dr Feldman and Dr Neil Boast had regarded as infeasible. We therefore explored the issue further with Dr Lucas.

Q Is it your understanding that if he had been on depot medication …and then been discharged into the community, one of the options available to the team looking after him would be to detain him at a very early stage, if he'd refused his depot medication, before he became floridly psychotic?

A In fact I don't think it could have worked really. I don't think you could get social workers to have agreed to his detention the day he arrived on Rosemary Ward [Goodmayes Hospital], after coming out of the Newham Centre discharged by a Tribunal.

3.29 Dr Amir Bashir, to whom Dr Philip Lucas's recommendations were directed, recognised the likely benefit of depot medication, and made a further attempt to persuade PH after his return to Goodmayes. But as with all previous attempts he was unsuccessful. By the time Dr Bashir received Dr Lucas's recommendations PH had absented himself from Goodmayes, and Dr Bashir had no further opportunity to treat PH under detention and security. As he put it to us:

> "After Dr Lucas's report, and even before that, I discussed with him [PH] about depot, but I have to say he would present in a way that one thinks that perhaps we should not impose too much, and we should give him time and he would understand and he would have a rapport with us, but I then realised he never would. But we never got hold of him after that to give injections."

3.30 Just as Dr Feldman had received advice from Dr Boast, and Dr Bashir from Dr Philip Lucas, so Dr Richard Duffett, who was PH's consultant psychiatrist in the months preceding the homicide, received advice from Dr William Obomanu, Consultant in Forensic Psychiatry, to give PH depot medication. His reasoning was the same as before, that PH had a long history of poor compliance with oral medication. Dr Obomanu wrote on 25 January 2000:

"Given his long history of poor compliance with oral medication, he should be started on depot medication at the present time since the current presentation gives no indications that his insight or attitude towards medication have changed significantly."

3.31 At the time that this advice was given to Dr Duffett, PH was in the Newham Centre under Dr Acharya, and so Dr Duffett was not able to act upon it immediately. His first opportunity to do so would have arisen on 7 February 2000, when PH returned to Goodmayes. He explained his approach to us thus:

"I believe I discussed with him going on depot anti-psychotic and it had been a previous recommendation as well. At that point, he was adamant that he was not willing to do so. Although he was still on a section 3, he had previously won appeals, he appeared in many respects to be very well and no clear positive symptoms had been recorded. He had previously been discharged on appeal and I felt really unable to do so. Also while it might have removed covert non-compliance, he had shown ability to disappear in the community completely even following discharge from hospital, so I thought at that point I would be unable to implement that in a way which was likely to work in the community."

3.32 Dr Duffett's reasoning had many echoes of that of Dr Feldman, Dr Bashir, Dr Boast and Dr Lucas. He too foresaw a risk in trying to insist upon depot medication, namely that it could result in the loss of even the minimal level of co-operation that they hoped from him.

3.33 We asked Dr Duffett whether he had ever been involved in the care of a patient where a CMHT had resolved that, if the patient refused depot medication, that would be grounds for an immediate re-assessment with a view to detention in hospital. His answer was as follows:

"….I do not think I have had one where that has occurred and I do not know of my general [psychiatry] colleagues who have implemented successfully such a plan in that, because someone was not taking depot anti-psychotic, they would have been detained. In PH's case, catching him to do the assessment would have been a major problem. We had been trying intermittently for most of the previous six months to have contact with him, which had included visits to his house, which was only just round the corner from the CMHT."

3.34 Tom Leahy was the forensic community mental health nurse who supervised PH following his 'supervised discharge' on 17 March 2000. He had written a lengthy appraisal of PH on 16 February 2000 which had included a recommendation that:

"…some work should be done by his RMO and key worker on exploring the issues around him having a Depot injection rather than

oral medication, if he remains reluctant to accept the depot injection, and then these may be explored further when he is in the community by his care co-ordinator".

3.35 He too was unable to recall a case where the trigger for detention was the refusal of a depot injection.

3.36 Thus despite three reports from forensic psychiatrists, and a further recommendation from a forensic community mental health nurse, that PH should be on depot medication, the only trial of depot was at the John Howard Centre in February/March 1997. It was never tried again. Once discharged into the community, he was always allowed to return to an uncertain regime of oral medication with which he always became non-compliant sooner or later. The risk that he presented was never agreed to be of such a high order as to justify a resolute policy.

3.37 Whilst this may be understandable, it can hardly be seen as satisfactory. The failure to pursue a more resolute policy was due to two important prevailing perceptions: first that the clinical team would not enjoy the support of mental health review tribunals (and/or possibly an ASW) for any more resolute approach, and secondly that the services available, and particularly medium secure facilities, would not respond to the needs of such a policy.

3.38 This in turn raises the question of how risk was perceived. We turn to this issue, and how risk was assessed.

**Risk, offending and prosecution**

3.39 A form of custom and practice seems to have developed between the police and mental health care professionals resulting in reluctance to invoke the criminal law against those presenting as mentally ill, particularly when the event occurred within a psychiatric hospital. Psychiatric hospitals rarely press for charges to be brought, though the police are normally notified of serious incidents. Aggression and violence in the community can also reveal a different standard for those who, after arrest, are admitted direct to a psychiatric hospital. If the victim does not press for charges to be brought, the offender's admission to hospital is often seen by the police as an acceptable and satisfactory resolution.

3.40 Numerous witnesses appearing before us either accepted or stressed how perceptions of a patient shifted when there was a forensic psychiatric history, in other words when a hospital order had been made by a criminal court. Perceptions shift even further if a patient has a restriction order as well. In PH's case, as we have noted, Dr Philip Lucas, consultant forensic psychiatrist, stressed in his report of 19 January 1999 how important it was that PH should be prosecuted if he offended again. But his was a lone voice. Until his homicide, all of

PH's hospital admissions had been as a civil patient under Part II of the Mental Health Act.

3.41 For patients with a forensic history past violence tends to be highlighted in reports and assessments. The 'index offence' is often described in some detail. An unprosecuted incident, by contrast, can disappear almost without trace, the very fact that it was unprosecuted suggesting that it must have been relatively trivial, if not a misunderstanding. A vivid example of this occurred when we interviewed Ken James, PH's social worker during his final 'supervised discharge' prior to the homicide.

Q When you were describing familiarising yourself with what in 10 years had become a huge stack of paper, I had the impression that it wasn't clear to you whether the hostage-taking incident had really occurred at all. Would that be correct?
A Yes
Q You thought it might be an unfounded accusation?
A Yes. Not just that incident.

3.42 Another example of this had occurred in October 1998, when an MHRT considered an application by PH for discharge. His application was refused, but the Tribunal in the course of its reasons said:

> "The medical report describes a hostage taking incident. If the incident is as described in the report it is indicative to a very high risk to others, if it is as described by the patient in evidence, it is unfair to the patient and the notes should be corrected…"

3.43 The Medical Member of a Tribunal enjoys full access to the patient's medical notes, and could therefore easily have tracked down the detailed statements made at the time by the two women held hostage. Any doubt in the Tribunal's mind could have been settled then and there.

3.44 Decisions not to invoke criminal process, though appearing entirely humane to those involved, can have major implications for a patient's care pathway within the spectrum of psychiatric care. When risk is highlighted by convictions it is more likely that teams will seek real compliance with medication, particularly if disturbing behaviour is known to follow a period of non-compliance.

3.45 We explored whether, if PH had been prosecuted for the more disturbing offences, it was possible that events would have turned out very differently. Two offences in particular might well have attracted prosecution, first the 'hostage-taking incident' on 18 September 1995 and second the assault on a woman on 6 December 1999. Both of these incidents seemed to us to have been amply serious enough to justify criminal process. It is not without relevance that in a further

incident, voluntarily reported by PH to nursing staff on 26 October 1998, he admitted to having punched a woman as he passed her on his bicycle. The incident had occurred some time earlier, and PH's confession was never reported to the police. Yet assaults such as this have sometimes resulted in a hospital order with a restriction order.

3.46 We asked Dr Neil Boast for his views on both of the first two incidents. On the former he said:

> "One of the things that is surprising is that forensic opinion was not sought at that time, but had I been approached at that time I would have recommended that the service approached the police in the strongest terms to have PH processed through the criminal justice system. Had I been contacted at that point I would have admitted PH to the John Howard Centre. I don't think PH would have got a restriction order, but if he had been on a section 37 at that time there would have been some reinforcement of risk."

3.47 We received evidence from the police about the second of these offences, which occurred on 6 December 1999. Their account was as follows:

> "He started running on the spot and then ran straight at the victim, barging into her. This knocked her into a wall that supports a grass mound, and caused the injury to her hip. She fell on the grass. The suspect did not try to take her bag. He grabbed her wrists and tried to pull her over the grass to an area where they would be shielded from public view."

After this, he suddenly apologised and ran off.

Dr Boast commented as follows:

> "…going back to my view that he should have got a 37 [hospital order] and not a restriction order [section 41] at that time [1995], if he had got the 37 the case might have gone several ways and his insight might have improved such that subsequent events did not occur, or in fact it may have made no difference to the pathway of subsequent relapses and problems. By the time you are coming on to in 1999 there had been a number of assaults on women, and if you are looking at the criteria for a restriction order the criteria are the antecedents of the offender."

Dr Boast was in no doubt that the offence of 6 December 1999 should have attracted a hospital order with a restriction order under sections 37 and 41. By analogy with the airline industry, he characterised both the hostage-taking incident and the offence of 6 December 1999 as 'near misses', which could easily have had far more serious outcomes.

3.48 Dr Philip Lucas's views on the 1995 'hostage-taking incident' were clear-cut:

Q If he had been prosecuted and you had been writing a court report would you have urged a Section 37? If so, would you have urged a restriction order on the court?
A I think I probably would have urged a Restriction Order. I have quite a low threshold, and I think in this sort of case it would have been helpful for the patient and that's been my practice. I don't think of it as something we would try to avoid, certainly in this sort of case where there is difficulty getting adherence to medication.

3.49 On the incident of 6 December 1999 Dr Lucas told us:

> "I think by then, had I been asked, almost certainly I would have suggested a hospital order with a restriction. There was enough evidence at that point, which I have been through and thought about."

3.50 The implications of this approach, if it had been accepted by a Crown Court, would have been very significant. We questioned Dr Lucas further:

Q When you previously were asked about the difficulties of assertive outreach in seeking to insist upon continuation of depot medication, if he was being managed as a restricted patient, would it fair to conclude that you would have urged depot medication, and indeed perhaps have advised the Home Office to consider recall if he resisted it in the community?
A Yes, that has been part of my thinking. Certainly he needed to be on depot and I think I can say very explicitly, to reduce the risk to an acceptable level, he has to be on depot.

3.51 When we interviewed Dr Richard Duffett, PH's RMO immediately prior to the homicide, he told us that he was never approached by the police for his views on a prosecution of the offence committed on 6 December 1999. Initially he received only a third or fourth-hand account of the incident, which was to the general effect that PH had pushed a woman in the street. Described in those terms it would not have appeared particularly worrying. The further information, which Dr Duffett did not apparently have, that PH had dragged his victim along the ground, suggests that at least for a while he may have harboured some distinctly dark intentions. We put to Dr Duffett the information about the incident we had received from the police and asked him what he would have like to have happened:

Q If the police had got in touch with you to say "we would like to tell you everything we know about this, because, as his consultant, your views on what we do may be rather important", if they had done that

and given you their version of events, how do you think you would have responded?

A Whatever they said, I would have been keen for a prosecution as the only thing that was likely to give us a handle on him at that time in the community. Particularly in my referral to the forensic service, I would have highlighted my concerns about abductions and the other incident with him holding visitors in his flat. Action had been taken on visiting him carefully, but this attempt to abduct a woman in the street is a more serious concern. It would have made me extra keen that he be prosecuted.

Q If he had been prosecuted and you had been asked for your opinion on disposal, what do you think you would have recommended to the court?

A I would have recommended going down the forensic line.

Q Leading to a Section 37 or what?

A I would have opted for a Section 37/41.

3.52 Dr Duffett went on to explain the probable consequences of a prosecution:

> "He had continually disengaged from treatment in the community and, if he had been convicted, I would definitely have been looking for a longer term secure placement which generally we do not obtain for patients who have not gone through the criminal justice system as it is extremely difficult to do so in practice. That would have allowed a structured discharge probably to a hostel, it would have allowed him to have depot medication started, and he probably having very little choice as to whether he remained on it, and to continue to be seen in the community."

3.53 We were struck by the remarkable difference that criminal prosecutions might have made to the course of PH's career as a patient. Whilst all these witnesses were aware of the offences and PH's antecedents, with the exception of the full details of the assault on 6 December 1999, their management of PH as a patient would have been transformed if he had been subject to criminal process, and acquired a hospital order, probably with a restriction order. They would then have expected a significantly longer period in secure conditions under depot medication, and a fully structured discharge afterwards. Two forensic psychiatrists, and Dr Duffett as a general psychiatrist, felt that the risk posed by PH was sufficiently high to place him in the elite category of patients from whom the public need to be protected from 'serious harm' – the criterion for the imposition of a section 41 restriction order.

3.54 We should make clear, as police witnesses made clear to us, that the local police force's decision would be to refer the case to the Crown Prosecution Service. The CPS would make the final decision. But if the evidence were sufficient to convict, as it would have been in both the cases we have considered, the CPS would surely have proceeded,

particularly if a forensic psychiatrist had urged a restriction order to ensure public protection.

3.55 Dr Duffett reminded us that on 20 August 1999 he had written to Inspector Faulkner, the Police Mental Health Liaison Officer at Forest Gate, in the following terms:

> "PH is a man who is well known to the psychiatric services with serious mental illness. He is currently also known to the police in the area as he has had a number of charges in the past following physical assaults on women (usually punching, hitting, and on one occasion holding 2 CPNs hostage). He is currently out of touch with the mental health services despite our best efforts and we have some concerns regarding his mental health. If he is picked up and suspected to be suffering from a mental illness by police officers we would be happy to see him on a Section 136. However, should he commit an offence we would be happy to see him whilst on remand."

3.56 The officers investigating the offence of 6 December 1999 were unaware of this letter. It was not entered into police computer intelligence, perhaps because it was not a request for immediate police action. Its tenor was "we stand ready" not "help us to find him".

3.57 Dr Duffett did not find out about the arrest until PH had been admitted under a section 3. He told us that he was very disappointed that there had been no prosecution, though within the timescale to which he was referring the delay was no bar to criminal process.

3.58 His next written report was on 21 February 2000, when he prepared a report for a Tribunal Hearing, though in the event PH withdrew his application. PH was enjoying unescorted leave and knew he would shortly be discharged home. In that report the only comment Dr Duffett made on the recent offence was:

> "P was admitted on section 3 from the police station where he had been accused of assaulting a woman. Prior to his admission CMHT had had reports of his deteriorating health but had been unable to establish face to face contact"

In his summary he wrote:

> "He tends to be very guarded about his symptoms and he usually only comes to the attention of the police and psychiatric services following assaults on women, which indeed resulted in his current admission"

3.59 At some date before writing this report Dr Duffett would have been aware that PH's assault on 6 December 1999 was more disturbing than he had previously thought. The incident was more fully described by his SHO in a letter to Dr Lucas dated 24 December 1999. And his

team member Tom Leahy's report, written five days before Dr Duffett's report, had said:

> "On the 6th of December 1999 he was accused of dragging a female along the pavement near to where he lived. He was arrested by police but the charges appear to have been dropped. He maintains that he accidentally bumped into her."

3.60 This filled in an important piece of information. It should have alerted Dr Duffett to the increased risk that PH represented. It also exposes an obvious contradiction in his approach, favouring a much stricter regime if he had been prosecuted, but essentially a repetition of the past pattern of discharge in the absence of a prosecution.

3.61 Thus the future treatment plan, save for the fact that it was to be enshrined in a section 25 structure, was essentially a replication of past treatment plans, which had all proved inadequate to prevent deterioration.

3.62 The moment at which the risk posed by a patient to an individual or the public becomes unacceptable is often not easy to define. But Tom Leahy's recommendation "As all PH's violence and aggressive behaviour has been towards females in the past, he should only be worked with male staff in the community" shows that the psychiatric service was taking protection measures for its own staff. The risk assessment implicitly accepted that he would deteriorate and offend against women in the future, at least as seriously as he had done in the past, and possibly more seriously. We agree with the views expressed by Dr Lucas, Dr Boast and Dr Duffett in their evidence to us that the risk posed by PH was at a level that absolutely required depot medication. If he had absented from treatment, we think that very energetic steps to locate him would have been appropriate.

3.63 How, therefore, did it come about that the police opted for 'diversion' and not prosecution on December 1999?

**The police decision not to prosecute**

3.64 Detective Chief Inspector Davidge, from Forest Gate Police Station, was not in post prior to 1998, and so could not assist on the decisions taken in 1995, but he was involved in and aware of the investigation of the assault on 6 December 1999, and the decisions made. He told us that by reason of the nature of the offence – the woman had not suffered "horrendous injuries of any sort" – it was decided to deal with it under Rule 12 of the Home Office Rules. This Rule allows a senior police officer or the CPS to decide not to prosecute where there is deemed to be no point in so doing, in circumstances where the evidence is clear and corroborated, in other words where they are satisfied that the offender did the act. That was the decision in this

case, suggesting that the police were confident that there was evidence to convict.

3.65 Although the victim had not suffered serious or horrendous injuries, she was 'distraught' when the police spoke to her. She had a large swelling and bruise developing on her hip, redness to the wrists, and a sore shoulder, injuries quite sufficient to support a charge of 'actual bodily harm'. She was extremely frightened that her assailant would attack her again, and had gone to stay at her mother's.

3.66 The decision to apply Rule 12 is the more surprising in view of other information available to the police. First, on the day of his arrest PH's father had contacted the CID to tell them that his son had been to his house that morning and made threats to kill an Irish woman in Stratford. PH appeared to be hearing voices from the police instructing him to take action against this woman. Secondly, when the police arrested PH in his flat "Two large knives were found on the arms of his armchair". PH was obviously showing obvious signs of mental illness and was taken to the police station.

3.67 The victim and her father were visited and advised of the progress of the investigation and the outcome, namely a decision not to prosecute but the accused's admission to hospital under section 2 of the Act. They were described by DCI Davidge as "highly delighted". It was certainly not suggested to us, however, that either the victim or her father were asking that there be no prosecution. If anything, the contrary was the case. Detective Constable Stout told us that the victim's family were quite angry, and there were 'certain indications' that they wanted to take the law in their own hands. They may well have been even more delighted if PH had been prosecuted, with the form of disposal suggest by Dr Boast, Dr Lucas and Dr Duffett.

3.68 DCI Davidge initially suggested to us that the same decision would be reached today. He was unrepentant about the police decision, and the fact that it was taken without discussion with PH's RMO. He defended it thus:

> "No I didn't talk to anyone. My decision not to progress this any further was, as I see it, that the point of putting someone into the criminal justice system is normally so that they can get a point of entry into psychiatric help. If we can get them there by way of an immediate assessment, then I see that – and I particularly saw it then – as a way of shortcutting the system and not having to go through a point where the court, with the benefit of a psychiatric report, then puts someone into the system. It is my belief that the psychiatric report that will come out of a court asking for that order will not be any different from one where somebody is detained under a 28 day order. I don't see how it can be."

3.69 On further questioning however he was ready to accept that a psychiatric viewpoint should be carefully considered, even heeded:

Q Supposing that during those 10 days [between offence and arrest] the medical team had been consulted and had said, “From a therapeutic viewpoint we would wish to see his behaviour prosecuted in this case.” Would that have changed your attitude? Would you in that case have decided not to divert?
A Indeed, because I felt that they were the people to give me the best advice and had I had that advice, I would have taken it.
Q That means that the views of the psychiatrist will be very influential in the police decision one way or the other? If you accept that the psychiatric view, presumably properly, would have been that significant, should it not follow that you should seek it rather than merely respect it if it is passed on to you?
A The answer is probably ‘yes’. However I know that then – and things are only gradually changing – medical confidence was a big barrier to discussions between police and the medical professionals.

3.70 DCI Davidge recognised that our Inquiry Report would be likely to address the issue of “joined up thinking”. It makes no sense to recognise the significance that psychiatric advice may have on a decision to prosecute, but to take no active steps to seek it. We do not think that medical confidentiality is an inhibition in this context. But it also makes no sense for psychiatrists to fail to communicate with the police if the latter’s decisions may have decisive influence on their management of difficult patients. If liaison were better developed, it would hardly be necessary to point this out.

3.71 Patients like PH may commit offences anywhere in the country. Local liaison between police and psychiatric services will assist when an offence is committed locally and both services are directly involved. Often, however, the decision to prosecute or divert may be made at some geographical distance from the mental health team who have been managing the patient. Our recommendation therefore goes beyond urging merely good local liaison. We think that all police establishments need to recognise that prosecution may be a necessary response to an offence, whether or not the victim is (to use the customary phrase) anxious to ‘press charges’.

3.72 In the course of our interviews with the police and the key psychiatrists involved in PH’s care, the positions they had adopted showed some signs of movement. The police witnesses recognised the value of psychiatric opinion, despite initially appearing certain that they had been correct to divert without taking any external advice. Psychiatric witnesses envisaged a wholly different therapeutic approach if criminal process had been pursued, and, we think, came to see the significance of criminal process in sharper focus.

3.73 At the start of our Inquiry, on the basis of the written reports in PH's case, Dr Philip Lucas had appeared to be a lone voice urging that any future offending should be prosecuted. After eliciting the views of other psychiatrists involved in his care he was shown to be far from alone. It is therefore a matter of serious regret that the opportunity to put his approach into practice was missed in December 1999, the one further occasion after Dr Lucas's report when it could have been applied prior to the homicide. It may have been the process of questioning that elicited this previously unappreciated psychiatric consensus on this issue. When we sought psychiatric opinions on the proper form of disposal for the offences of 1995 and 1999, we were conscious that the process of hindsight might have made them more resolute. The proposition that PH should have received a restriction order implies an assessment of risk of a very high order. If, as appears to have been common ground, it could only reliably be mitigated by resort to depot medication, it is hard to understand the relatively brief period of detention after a section 3 admission was instituted on 19 December 1999, without any further trial of depot medication during detention, let alone the early concession to PH that he could once more resist depot.

3.74 For our part, we fully endorse the view that PH should have been prosecuted both in 1995 and 1999, and we think it would have been proper to urge a hospital order with a restriction order on both occasions. One might debate whether a court would in fact have imposed a restriction order in 1995, but by 1999 we think that he gave rise to grave concern, and we think that if psychiatric opinion had urged the highest level of caution the court would have agreed. Women were obviously particularly at risk. It was unrealistic to regard the gravity of his past aggression and violence up to December 1999 as indicating the limit of his future potential. We cannot seriously imagine that a criminal court would have rejected this analysis when considering disposal after conviction.

3.75 If PH had received a hospital and restriction order following his assault on 6 December 1999, he would probably have been required to accept depot medication on a long-term basis when discharged. It is highly likely that he would have come under the care of a forensic psychiatrist following conviction, and been placed in a medium secure unit. He would surely have spent considerably longer in such a unit than he did on any of his admissions in the 1990s, not least to see whether a period on depot medication produced benefits to his mental health, which he would himself recognise as essential for the future. He would very likely have been discharged to a hostel rather than his own flat, so that he could be closely supervised.

3.76 It is true that a single default, for example a missed out-patient appointment for a depot injection, would not by itself have permitted the Home Secretary to recall him to hospital. However we have little doubt that attempts to locate him would have been far more strenuous, and

that the threshold for re-admission by way of recall would have been met long before he became acutely psychotic.

3.77 We conclude this part of our Report by stressing how powerful perceptions appear to have been. Even where the nature of the past aggressive conduct displayed by a patient is not in dispute, a wholly different mode of treatment is contemplated by mental health professionals if it has been prosecuted to conviction and marked by a hospital and restriction order. It is too easy to seek to justify this by reference to the possible unwillingness of ASWs or Tribunals to support resolute management. If RMOs believe that, notwithstanding the absence of criminal process and/or section 37/41 orders, a patient presents high risk, they have a duty to argue this energetically. Dr Duffett's report to the MHRT in January 2000 made no attempt to do so. The critically important message is that risk should be more important than legal status.

3.78 When patients have psychiatric histories as lengthy as PH's their clinical records become voluminous, and the process of mastering the detail can be daunting. It is not uncommon for patients with chronic or recurrent psychosis to have several volumes of case notes. In these cases we strongly recommend that teams follow the example of some forensic units, and prepare accurate and succinct 'cumulative clinical summaries'. These may take hours to prepare, but this is a tiny fraction of the time caring for these patients. These summaries enable staff members to get abreast of the clinical problem quickly, and reduce the danger that significant events are forgotten, devalued or doubted altogether. This is one of the most important contributions junior staff can make, and is also a valuable training exercise.

3.79 The foregoing discussion touches on an issue that has provoked considerable legal and psychiatric debate in the past has been whether it is permissible under current legislation to re-section a patient at the point at which he/she refuses medication. The report of the "Committee of Inquiry into the events leading up to and surrounding the fatal incident at the Edith Morgan Centre, Torbay on September 1 1993" analysed the question of "sectionability" and suggested that "there is probably no legal impediment to the re-admission of a [revolving door] patient..."at the point of loss of insight when he refuses further medication." The Committee criticised the view that it was necessary as a matter of law to wait for the patient to deteriorate, or as they put it, "to wait for the psychosis to ripen". Some resistance to this view emerged in medico-legal circles, but the latest volume of Jones' 'Mental Health Act Manual' provides the following analysis, which we think is sound and correct:

> "It is suggested that the following approach should be taken by those involved in the assessment of a "revolving door" patient who has ceased to take medication for his mental disorder:

(1) A withdrawal from medication is a significant, but not a determining factor in the assessment;
(2) The role of the professionals involved in the assessment is to assess the patient's response to the withdrawal and to identify the reason for his decision to cease taking medication; and
(3) Although it would not be possible to determine that the provisions of section 2(2) (a) or 3(2) (a) are satisfied solely on the ground that the patient has ceased to take medication, an evaluation of the patient's history, and, in particular of his reaction to withdrawal from medication in the past, could lead to a decision that the "nature" of his mental disorder justifies an application being made in respect of him."

3.80 Current law, under a supervised discharge, does not permit the imposition of medication on a patient unless he is once more 'sectioned' under either section 2 or 3 of the Act. If the terms of the recently published "Draft Mental Health Bill" are implemented, that will change. A 'clinical supervisor' of a Part 2 patient (i.e. a patient in the community receiving treatment under a care plan approved by a Tribunal) will be able to administer treatment set out in the care plan without necessarily restoring him/her to in-patient status.

3.81 Such a power might well have been appropriate to PH's circumstances, particularly if there had been a determination to establish him on depot medication. For the reasons discussed earlier, re-admission to hospital as an in-patient might be difficult to defend if he had merely missed an appointment for a depot injection, and was still presenting as relatively well. Moreover the very existence of the power might have a beneficial effect on clinical practice. Of course it is also necessary that a more analytic approach should be taken to considerations of risk, but a current barrier to implementing such an approach would be removed.

**Multi-Agency Public Protection Panels (MAPPP)**

3.82 The management of this case would probably be different today, because of the advent of Multi-Agency Public Protection Panels. The multi-agency public protection arrangements (MAPPA) grew out of the closer working relationship which developed between the police and probation in the late 1990s. Sections 67 & 68 of the Criminal Justice and Court Services Act (2000) placed these arrangements on a statutory footing and the Criminal Justice Act (2003) strengthened them further.

3.83 The law requires the police, prison and probation services locally to establish arrangements for assessing and managing the risks posed by sexual and violent offenders. The arrangements are to be reviewed and monitored, with annual reports on their operation. The focus is on three groups of offenders: registered sex offenders; violent offenders and sexual offenders who are not required to register; and any other offender considered to pose a risk of serious harm to the public.

Serious harm is defined as harm which is life threatening or traumatic and from which recovery, whether physical or psychological, is likely to be difficult or impossible.

3.84 The aim of such Panels is public protection, and their inclusion of several agencies recognises that risk to the public is rarely a straightforward medical matter. In PH's case, discussions at a MAPPP meeting would have increased the chances of better cooperation between agencies and, in particular, between health and the police. The MAPPA are meant to ensure that decisions on whether to prosecute are informed by the perspectives of agencies other than the police, and that such decisions take account of wider concerns, rather than being determined solely by the current offence.

3.85 It seems likely that a case such as PH would come to the notice of the local MAPPP. There had been several referrals to forensic mental health services, and there had been police involvement that did not lead to prosecution.

3.86 The involvement of a Multi-Agency Public Protection Panel would not have guaranteed a different outcome. It grants no new legal powers and cannot compensate for the limitations of mental health law. However, the MAPPP would be likely to improve communication between agencies, which was problematic in this case and has been identified as an important issue in many other homicide inquiries.

3.87 We note that PH would probably fall within the group of patients eligible for the Community Treatment Order set out in the Mental Health Bill. An order of this type would serve the important function of sending a clear message to mental health services that they can and should detain patients who present a risk of violence, solely because of failure to comply with treatment in the community. Such an Order would also signal a new national determination that patients who have behaved violently while mentally ill should not be allowed to relapse as a result of reluctance to comply with medication.

**Standardised or structured risk assessment**

3.88 There is a debate within the UK about the place of standardised or structured violence risk assessment, as an alternative to unstructured or clinical risk assessment. This debate is less advanced here than in some other countries. For example, in Canada it is routine for all forensic patients to undergo a structured assessment of risk and a structured assessment of psychopathy or personality disorder. This approach has been adopted by some forensic services in England, including the Reaside clinic in Birmingham, but it is still the exception rather than the rule.

3.89 The scientific evidence derived mainly from studies in North America, shows that structured clinical assessment is superior to clinical risk

assessment. The most famous study to support this conclusion was the MacArthur study of violence risk assessment, based on about 1,000 general psychiatric patients followed up for one year after discharge. The single best predictor of violence following discharge was a simple, structured measure of psychopathy, the Psychopathy Checklist – Screening Version (PCL-SV). It seems that most of this predictive effect derived from a careful, systematic description of previous violence, rather than from the identification of psychopathic personality traits, which were rare in this sample of general psychiatric patients.

3.90 PH was never assessed using this tool. Had he been assessed, he would have scored in the moderately high range, even though his main problem was mental illness rather than psychopathy. This information would have been useful in reinforcing the clinical impression of increased violence risk.

3.91 One of the most widely used tools for structured clinical judgment in violence risk assessment is the HCR-20. The initials refer to Historical, Clinical and Risk management factors relevant to violence risk, and the scale has 20 Items. They are made up of ten Historical items, concerned with past events of violence, personality disturbance and antisocial behaviour; five Clinical items, concerned with present mental state, insight and compliance; and five Risk management items, concerned with likely circumstances in the future, including stressors, destabilisers and non-cooperation with services. The orientation towards the future, and pro-active management of risk, is reinforced in the final section of the HCR-20, in which the team is asked to discuss feared scenarios of violence in the future, analysing them in terms of what factors make the violence more likely, and what factors are likely to be protective.

3.92 PH had several risk assessments during the course of his contact with services. In most cases, the risks were implicit in the reports, rather than being spelled out. A more formal, structured clinical approach would have encouraged teams to be more open about the risk of violence and to formulate plans for managing those risks. It is much more difficult to persist with an over-optimistic management plan when the risks of failure have been explored and recorded.

3.93 As with the PCL-SV, this assessment was never carried out and we cannot give definitive ratings. He would probably have scored positively on 7 of the 10 Historical items; 5 of the 5 Clinical items; and 4 of the 5 Risk Management items. These results suggest a high risk of violence not adequately addressed by the management plans.

3.94 The HCR-20 is perhaps more illuminating when one moves on to consider likely scenarios of violence. For example, an assessment following the attack on a female stranger in December 1999 would have had to include the possibility of further acts of serious, unprovoked violence against strangers. Women would have been

identified as a specific victim category. Such an assessment would have identified, as factors increasing the risk, signs of a relapse in mental illness and non-compliance with treatment.

3.95 A similar approach following the hostage incident would have identified a risk of serious threatened or actual violence to staff and, in particular, to female staff. It can be argued that the team were aware of this risk anyway, as evidenced by warnings about female staff dealing with PH, but they seem never to have explored the implications for other women. When the assault on a stranger and the hostage incident are considered, together with other instances, it is impossible to escape the conclusion that there was a general risk to all women with whom PH had contact.

3.96 If the potential risks had been stated explicitly, as part of a structured risk assessment, they would have forced a reconsideration of the management plans. Steps were taken to protect female staff but, in respect of the danger to strangers and to other women who may have contact with PH, there was no risk management plan because the risk was never discussed. This was a serious and important omission.

3.97 The failure to spell out the risk to women had serious ramifications when, on 2nd March 2000, Mimi Spence noted that PH had a girlfriend. The team did not investigate further, as they should have done. A structured risk assessment, identifying the general risk to women, would have compelled further investigation of PH's relationship with his girlfriend.

3.98 Leaving aside the specific issue of his girlfriend, it seems likely that, had the risks been spelled out, it may have been decided at several points that continued outpatient treatment of a non-compliant patient did not adequately address the risks of serious violence. There had been many warnings of the risk of serious violence. The management plans were not an adequate response to those risks.

3.99 We recommend that there should be a structured assessment of risk whenever there is a transfer of care between forensic and general teams, and preferably at every CPA meeting.

**The relationship between general and forensic services**

3.100 PH was assessed by forensic services on several occasions, although most of his treatment was within general services. The situation may have been different if the Tribunal that rejected PH's application for discharge from the John Howard Centre in early 1997 had not recommended his transfer back to a general ward. In our view this recommendation was not based on a rational analysis of the patient's care needs. It was an unhelpful recommendation and served to cut short an attempt to administer long term depot medication that could have made a crucial difference to the outcome in this case.

3.101 There was little continuity in the forensic assessments but, despite the different clinicians involved, there was considerable consistency in the assessments and advice. We argue elsewhere for a more explicit and structured risk assessment but the main risks and possibilities for management were identified.

3.102 We are concerned that some of the forensic advice was not realistic, in that one would not have expected a general psychiatric team to be able to implement the suggested treatment. Much was made of the need for depot medication, yet everyone knew that the team would be unlikely to gain his compliance with depot in the community.

3.103 The fundamental problem appears to be that those advising on management of the risks are not the ones required to manage them in the longer term. We therefore recommend much closer involvement of forensic services in the management of patients who present a continuing high risk of violence in the community. If those giving advice are to be involved in implementing that advice, it is more likely that the advice will be practical.

**The final discharge**

3.104 Dr Duffett inherited a serious problem. The advice of forensic psychiatrists was consistent in stating that there was a high risk of violence, and that the most important measure in reducing that risk was depot medication. This advice was not easy to follow, as both forensic and general services agreed that PH was unlikely to comply voluntarily with depot medication.

3.105 Forensic and general services also shared the view that the law and practice did not readily allow doctors to force medication on an unwilling patient who was not subject to a restriction order. They agreed also that it was impractical to use the Mental Health Act to admit a patient compulsorily because of non-compliance alone, in the absence of other evidence of relapse. None of the witnesses we interviewed had ever managed an unrestricted patient in that way, and none believed that it would have been easy to persuade a Tribunal to accept it. We note that there is authoritative legal advice to the contrary, most notably from the “Falling Shadow” Inquiry, but we accept that the views expressed by our witnesses are probably representative of most mental health services.

3.106 Faced with this dilemma, Dr Duffett persisted with a strategy adopted by his predecessors, to encourage compliance with oral medication and to attempt to increase the patient’s confidence in services and thereby increase his co-operation. As the forensic advice was unequivocal that such an approach would not adequately address the risk of violence, this strategy amounted to little more than hoping for the best.

3.107 In our view it was not an adequate strategy. As the months and years passed, with no improvement in compliance and with no apparent diminution of the risk of violence, it became harder to defend. PH was not becoming more co-operative, and his involvement with services was not improving.

3.108 In 1998 and 1999 PH attacked women who were strangers to him. The most serious incident was on 6 December 1999, but in October 1998 PH had self-reported an attack on a woman earlier in 1998. Even though the only evidence relating to this incident was the patient's self-report, it had to be taken into account in any clinical assessment of risk of violence. There was no obvious reason to doubt PH's account. There were also unprovoked attacks in 1998 on a member of staff in the A & E Department of King George Hospital, and again at Goodmayes Hospital.

3.109 Attacks on strangers are generally regarded as an indicator of increased risk of violence overall. They are significant because of the lack of any relationship between or tensions that could in other cases mitigate the seriousness of the assault, and they are particularly significant indicators of risk when there is no possible 'provocation'. Unprovoked assaults on strangers suggest that anyone is at risk of violence. There is no possibility of controlling the risk by restricting access to particular potential victims or classes of people, or by warnings, because the victim could be anyone. The only reasonable course of action is to alter the patient's mental state since nothing else, short of detention, will reduce the risk.

3.110 We are entirely sympathetic to the view that PH should have been prosecuted after the December 1999 assault. The fact remains that he was not prosecuted and the management plan remained essentially unchanged.

3.111 We accept that the case was challenging, but the risks were clear. There should have been energetic discussion with forensic services about future safe management, involving detention in hospital with depot medication, and a realistic discharge plan at a future date that at long last acknowledged the impracticability of seeking compliance with oral medication.

3.112 We are critical of Dr Duffett's report prepared for a Mental Health Review Tribunal in February 2000, which failed to spell out the risks of violence. If an RMO's report so understates the risks posed, ASWs or Tribunals lack vital guidance as to the significance of their decisions. The report had no practical effect because the Tribunal did not take place, but it cannot be dismissed simply because the Tribunal was never held. It was set to form part of PH's medical record, and if events had not taken the particular tragic turn that they did, it would have contributed to the long-term management of the case. It also

indicates that Dr Duffett did not at the relevant time, appreciate the magnitude of the risk that his patient posed.

3.113 We are concerned that part of the justification of the management plan, given to us by witnesses, was the high baseline of violence in this part of east London. It was argued that serious assaults are so common as to be almost unremarkable in the locality. Even if true, it is emphatically not an adequate reason to fail to confront the risk violence in this case. Depot anti-psychotic medication would very likely have significantly reduced or abolished the risk of violence. Moreover mental health teams should not assume that the community afflicted by violence tolerates it, or that opposition to violence is a result of bigotry or prejudice against people with mental illness. This is particularly so if the violence is serious, as in this case. We do not think that any community accepts the risk of unprovoked physical assault on strangers, and we are quite sure that, if a forum existed to test this, the response would have been unambiguous. The team did have access to the views of PH's family. We have no doubt that PH's mother, for example, would have been strongly in favour of far more assertive management to deal with the violence risk. There is no suggestion that she ever minimised it, or found it in any way acceptable.

3.114 We were handicapped by an inability to track down the notes of PH's final stay at Runwell Hospital between 20 December 1999 and 7 February 2000. Without those notes it was not possible to trace the course of PH's treatment there. Dr Acharya could not recall PH's case without the assistance of the contemporary notes. We accept that during this final admission to Runwell Hospital PH was stabilised on oral medication, but no attempt was made to institute depot medication.

3.115 By the time Dr Duffett received PH back at Goodmayes on 7 February 2000, the opportunity to initiate a regime of depot medication had effectively been missed. PH was moving into insecure ward conditions, and could not be relied upon to stay. The move to lesser security implied that he would soon no longer require detention, and would certainly have conveyed that expectation to PH himself, and probably also, if one had been held, to a Tribunal. If he had been prosecuted it is very likely that he would have been placed in secure conditions with an expectation of staying there for at the very least several months. Even as a civil patient, either at Runwell Hospital or the John Howard Centre, the treatment strategy could and should have been resolved upon and adopted. On the basis of Dr Obomanu's report (25 January 2000) Dr Duffett would have been entirely justified in arguing for PH's continued detention in medium security rather than a transfer back to Goodmayes Hospital, so that the proposed treatment strategy could be implemented. Setting up a 'supervised discharge' was the best that could be done once the opportunity had been missed, but it was unlikely to change PH's long-standing tendency to become non-compliant.

3.116 There was a clear failure to institute an effective treatment programme, but it should not be seen merely as a feature of the final few months before the offence on 20 April 2000. It dated back earlier as the risk revealed by PH's behaviour steadily increased without an effective response. Dr Feldman, Dr Bashir and Dr Duffett were all given advice from the forensic service that they could not realistically implement without a far more significant contribution from local secure units.

3.117 Local psychiatric services, general and forensic, must in the future pursue a far more assertive approach to the care of any patient like PH before he reached such a stage, so that a psychiatrist in Dr Duffett's position would not have to start from the point he did.

## CHAPTER 4

## SS's PSYCHIATRIC HISTORY

4.1 SS was born to Jamaican parents in Forest Gate, East London, on November 6 1967. Her father was a carpenter, born around 1932, and her mother was born around 1937. Her mother and father divorced when she was an infant, her mother leaving the home when she was nine months old. Her mother has lived since 1969 in New York, and remarried in 1987. She was brought up by her father until she was 15.

4.2 She had three sisters and two brothers.

4.3 As a child she was reported to be shy and reserved, and was subject to some bullying and teasing. She left school at 15, with no qualifications. She worked for 6 months in a C & A store on a cash register, but this employment was terminated. In 1991 it was stated that she had not worked since then, but there is a later reference to her work as a cleaner and evening work at Tesco's.

4.4 In 1982, when she was 15 years old, she went to live in a hostel because of communications problems with her father. A year later she moved to New York to live with her mother, but this did not work out and she moved to a sister who was also living in the USA.

4.5 SS's first psychiatric episode occurred in 1985 when she was 18 years old in New York She is described as having stripped off and run naked in the street, and having become abusive and distressed when attempts were made to retrieve her. Another account describes her as having attacked her mother, biting her legs. A diagnosis of manic depressive psychosis was made.

4.6 By August 1986 she had returned to Britain, and lived first in a hostel, and then with a sister. Her hobbies were roller-skating, discos and music.

<u>Events of 1987</u>

4.7 From June 19 until August 18 1987, when she was 20 years old, she was admitted to Guy's Hospital, London, initially under section 4 of the Mental Health Act, and then under section 2. This was the second episode of her illness that resulted in admission. Two weeks beforehand she had been living in a hostel, where she had wrecked a room, and written swear words on the walls. She moved to her sister's, where she stopped eating and talking, and would not leave the room. She had not been seen to drink anything. On admission she was unable to answer any questions. She was mute and avoided eye

contact. She required intravenous transfusion. She described auditory hallucinations telling her she should not eat or drink. The diagnosis reached was bi-polar affective disorder. She was treated with neuroleptics, then lithium carbonate, and improved steadily.

Events of 1988

4.8 From March 29 to August 12 1988 she was admitted to Goodmayes Hospital under Dr Margo with what were described as "all the features of hypomanic illness" (Episode 3). She displayed considerable aggression towards her family. She was secluded for a few days, and then transferred to Hackney Secure Unit for a month. With treatment she became more stable and was discharged to the Roy Dennison Hostel. Initially she received Redeptin injections but discontinued these because of weight gain.

Events of 1989

4.9 SS remained an out-patient throughout 1989, but defaulted from care at the end of the year and was referred back to Dr Feldman at Goodmayes Hospital.

Events of 1990

4.10 SS was admitted briefly to Goodmayes Hospital on 25 May 1990 (Episode 4). She had not been taking medication. She recovered quickly, and on discharge was receiving Carbamazepine and haloperidol.

4.11 She defaulted from follow-up and medication in October, but was seen again on November 19 and advised to take Carbamazepine. In December 17 a pregnancy was diagnosed. She stopped her medication when she became pregnant.

Events of 1991

4.12 She had a miscarriage on January 18 1991, at eight or nine weeks gestation, and shortly afterwards on January 22 was admitted to Goodmayes Hospital, where she remained until May 3 1991 (Episode 5). She had been "going high" during the weekend before admission, and had lacerated her hand smashing windows at home. She was extremely elated with pressure of speech when admitted and required sedation. She was placed under section 3 of the Mental Health Act on 30 January, and treated with Clopenthixol, later Carbamazepine and Redeptin. A diagnosis of hypomania was made. She was "very settled, and free from affective and psychotic symptoms" when she was discharged. She appears to have remained stable for the remainder of 1991.

Events of 1992

4.13 SS remained psychiatrically well on Carbamazepine but it seems to have caused her to gain weight. At the end of 1992 her general practitioner reduced the dose to help her lose weight.

Events of 1993

4.14 From 27 May to July 16 1993 she was admitted to hospital (Episode 6) with a diagnosis of mania. Her general practitioner had referred her to psychiatric out-patients, where she was extremely agitated and requested admission. She had been sleeping for only two hours a night for two months, and was unwell and emotional with mood swings. She spent much of her time attending prayer meetings and bible classes. On admission she was pacing, shouting, crying and threatening. She was treated with haloperidol and chlorpromazine and settled quickly. A diagnosis of manic depressive psychosis was made, and she was discharged on lithium and Paroxetine.

4.15 On 28 October she was complaining of nausea and diarrhoea, and had stopped taking lithium. She was low and tearful. She was admitted to Goodmayes Hospital (Episode 7), and stayed until 18 January 1994. Her mood was labile and at times depressed, and at other times smiling and cheerful. She was treated with lithium and chlorpromazine.

Events of 1994

4.16 In November 1994 she was admitted to Rosemary Ward at Goodmayes once more (Episode 8), but there are no details of this episode.

Events of 1995

4.17 On June 15 she was seen by Dr Feakins, a trainee psychiatrist. She was disinhibited and irritable, and at different times shouting, crying, laughing, and swearing. She had pressure of speech and flight of ideas. She had been deteriorating for two months, and her sleep had been reduced to two hours a night.

4.18 From June 17 to September 1 she was admitted to Goodmayes Hospital (Episode 9) under section 3 of the Mental Health Act. The diagnosis was bipolar affective disorder, currently manic without psychotic symptoms. The police had brought her to the hospital after she had smashed up her flat. Muteness alternated with agitation and over-activity. Voices were telling her to kill someone. She had lost faith in lithium, and so Flupenthixol injections were started at her request.

4.19 She gradually settled on Droperidol and Flupenthixol, and although initially resisting she agreed to resume lithium.

4.20 On 20 September she referred herself, feeling depressed and unable to cope. She had discontinued lithium two weeks earlier, but was persuaded to take it again. However within the month she had stopped all medication except Flupenthixol.

Events of 1996

4.21 A domiciliary visit on July 4 found her tearful, low-spirited and withdrawn. She had felt much worse during the previous two months. Life was hard for her and everything was an effort. Her energy, concentration and appetite were poor, but she had not managed to lose weight. She had had thoughts of cutting herself.

4.22 From 5 July to August 2 she was admitted to Goodmayes (Episode 10) with depression. Though co-operative and well-mannered, she had reduced motor activity, and she was having recurrent violent thoughts of killing herself. She was treated with lithium carbonate and her mood gradually came under control.

Events of 1997

4.23 She discontinued lithium in March 1997 because she felt well. A CPA meeting was held on June 3. She was not attending to have her lithium checked and she was not responding to messages left at home.

4.24 From June 11 to July 25 1997 she was admitted to Goodmayes Hospital (Episode 11). The police had taken her to East Ham Memorial Hospital because she was warning people in the street about some imminent danger. She was arrested when knocking and kicking at a door. Her sleep had been poor for one week, with only 30 minutes a night. She felt full of energy. She said that thoughts were racing through her mind, and she believed that something dangerous was going to happen. She rapidly settled on treatment with lithium and haloperidol. Clopenthixol depot injections were started and she was discharged on Clopixol 200 mg every two weeks.

4.25 On June 19 she was assigned a social worker called Petrona Hogan.

4.26 On September 22 she attended out-patient clinic complaining of low spirits for the previous two months. She had discontinued all medication except the depot injections. Once again she was not taking the lithium prescribed.

4.27 On 21 October she failed to attend a CPA meeting. Her CPN, Nazeema Khodabukus, said that she could not be found at home. She had not attended for her depot injections.

Events of 1998

4.28 On 21 January 1998 SS attended a CPA meeting with her father. She had felt sad and stressed for two months, and suffered from insomnia. She was very worried about her weight gain. She had not taken her oral medication and was not regular with her injections.

4.29 In February she failed to attend an out-patient clinic. In April there was a telephone call from her social worker Petrona Hogan, who was aware of her non-compliance. She was prescribed Citalopram, but was now refusing depot injections because of extra-pyramidal side effects and weight gain.

4.30 On May 12 she attended a CPA meeting with her father. The meeting was called as an emergency because of concern about her medication. Her weight had increased to 16 stones. She often felt depressed and was very self-conscious. She was now living with her father. She was sleeping a lot during the day time. She wanted to discontinue her injections.

4.31 She missed two out-patient appointments in August, but attended in September. She appeared well, but was sometimes “paranoid about people”. Her Clopenthixol injections were reduced to 100 mg/month and Olanzepine from 5 – 10 mg/day.

4.32 In November, having previously agreed to have depot injections, she again refused them because of weight gain, drowsiness, lack of concentration and low mood. Her CPN was now Christine McArdle.

4.33 On 16 December Dr Reddy, Christine McArdle and Albert Semantia (CPN) visited her at home. It was agreed to stop her depot injections.

Events of 1999

4.34 In January she failed to attend an out-patient clinic, but on 5 February she attended a CPA meeting with Albert Semantia. She had felt better since starting Sulpiride. It later emerged that she only took Sulpiride for two weeks.

4.35 On 24 February 1999 she burst into the general practice consulting room, extremely agitated. She was referred to Newham General Hospital A & E Department, where she complained of insomnia, and a fear of ghosts. She had kept her father awake during the night. Her symptoms had developed during the previous week. She was admitted to Goodmayes Hospital (Episode 12). On admission she was verbally aggressive and threatened patients and staff. She was elated and showed pressure of speech. She believed she had special talents with singing and drawing. She was treated with Quetiapine.

4.36 On April 2, during a period of home leave, she knocked on the door of a house and asked the price of their BMW car. When asked to inquire elsewhere, she felt insulted and smashed the car's lights and mirror and attacked passers by and their cars. She broke one car window because the owner was white and had a white dog. Back in hospital she slapped one patient on the face, and threatened another with a knife. On April 3 she was transferred to Runwell Hospital under Section 2 of the Mental Health Act (Episode 13). There she showed considerable improvement in her mental state, took part in ward-based activities and complied with her medication. She was transferred back to Goodmayes Hospital on 20 April. On 22 April a Mental Health Review Tribunal declined to order her discharge. Her improvement continued and she was granted leave on 30 April to run until 18 May, when it was planned to discharge her. However she never returned from the leave, and her father, with whom she had had an argument, denied all knowledge of her whereabouts. She was discharged in her absence on June 1 1999.

4.37 In June 1999 her keyworker Albert Semantia agreed a plan with her, whereby:

- he would visit her weekly;
- she would ring him in an emergency;
- she would get her medication from the practice, and take it regularly;
- she would see a psychiatrist if she was deteriorating and
- she would be honest with him about her symptoms.

4.38 There is reference to SS having met a "new man" in September 1999. It is possible that that was when she and PH met, though (see para 2.119) when Mimi Spence visited and assessed PH on 2 March 2000 she recorded that PH had had a girlfriend he had been seeing for about 14 months. The dates do not match. We are unable to be sure when they first met and when they first became intimate.

<u>Events of 2000</u>

4.39 On 25 January 2000 Dr San, her general practitioner, wrote to inform the Community Mental Health Team that SS had had a positive pregnancy test, her LMP (last menstrual period) being 10 November 1999. SS had refused medication since December, and remained off medication thereafter.

4.40 On March 1 2000 Albert Semantia invited SS to a CPA meeting. She told him "in confidence" at that meeting that PH was the father.

4.41 On 2 March Albert Semantia spoke to her on the telephone. She was hostile and irritable. She declined any further contacts, and did not answer when he visited the next day.

4.42 On March 6 Dr Duffett attended a CPA meeting. Albert Semantia said that the team were concerned about her mental state during the pregnancy. Dr Duffett wrote to Dr Velupillai that day as follows:

"A CPA meeting was held for SS which her key worker, Albert Semantia attended, although SS unfortunately failed to attend.

I understand from Albert that since her discharge from Rosemary Ward in the middle of 1999 she has been doing relatively well. I understand that recently it has been confirmed that she is pregnant, which in the short term is likely to have a protector affect in her bipolar affective disorder. However around the time of the birth of the child later this year risk of relapse will be around 50%. I have arranged a further review on 31st May when it will probably be important to start planning for this possibility".

4.43 On March 12 or 14 Albert Semantia visited SS at home, with Dr Gomez (senior clinical medical officer) present as a bystander. She was uncommunicative, and said she was fine and did not require any visits or medication. She indicated that she would give the baby up.

4.44 On April 5 she visited Unit I and was pleasant and friendly. She had decided to keep the baby, but did not want any support. She told Janice Strachan point blank that she would not work with anybody except Albert Semantia, who told her that he would be on holiday for 4 weeks, and that he was handing his case over to Siew Tin P'ng, his supervisor.

4.45 On April 10 SS was admitted to the obstetric unit, and because of premature rupture of the membranes and infection, she was "advised to terminate the pregnancy or have labour induced". Her father saw her just before the birth. Until then none of her family knew that she was pregnant.

**The birth**

4.46 On Tuesday April 11 in Newham General Hospital she gave birth to a boy weighing only 0.63 kg (or 1 lb 6oz). The baby was said to be 22-24 weeks gestation, according to her LMP, but more probably 27 weeks.

4.47 The baby was flown to the Royal London Neonatal Care ward, where he was ventilated.

4.48 Her sister Sheila, who visited her immediately after the birth, told us that she always knew when SS was becoming unstable. She found her smoking two hours after the birth, telling other mothers that the doctors had tried to kill the baby. Sheila thought that SS herself knew that she was becoming unstable. She told Maggie Clarke, the ward

sister, that SS was bipolar and needed medication because she was "going off".

4.49 On 12 April Sheila found her worse:

> "She was really high now. She was talking and boasting. You could see that the nurses were fed up with her. "

4.50 Sheila told Maggie Clarke again that she needed her medication, and she responded that they would need to set up a mental health assessment. Sheila felt that there was a lack of proper urgency:

> "You do not have time for that. You need to get the doctors here now, or contact Rosemary Ward at Goodmayes Hospital, because that's the ward for Newham."

4.51 An assessment was set up for the 14 April. Sheila felt that this was not quick enough, but it had been decided that a full team should come to assess her.

4.52 Sister Clarke found her "more hyper and manic" on 13 April, with labile mood, talking a lot and hyperactive. That evening, before she could be assessed, SS left the ward at 7 p.m. and did not return that night. She was due to visit her baby that evening with her partner, but did not turn up.

4.53 On 14 April the CMHT learned of the developments at the hospital. Siew Tin P'ng (CPN) was contacted by Cathy Newcombe, acting manager of the CMHT, and in turn notified the Emergency Duty Team (EDT) and asked them to conduct an assessment. Ali Cotton, social worker at the Royal London, was contacted. Arrangements were made such that if SS attempted to remove the baby, the CMHT and Child Protection Team (CPT) would be informed. Her general practitioner and the CPT were informed.

4.54 At the request of Janice Strachan (duty social worker) a team of three went to her home and her father's home, but she could not be found. A telephone call to PH failed to get any response. Her whereabouts could not be established.

4.55 On 15 April Mr Sunder Singh, approved social worker (ASW) from the EDT, contacted SS's father, but he refused to discuss his daughter's problems. The maternity ward staff gave him Sheila's number, who told her that she was sleeping in her own flat, sedated after taking some unused medication.

4.56 Sheila believes that SS visited her son at the Royal London Hospital on either the 16 or 17 April, and she certainly visited again on 18 April. Siew Tin P'ng managed to make telephone contact with SS that day, and said that she wanted to meet, but SS refused the request, saying

that there were no problems, and that she would only see Albert Semantia when he returned from leave.

4.57 At 10.30 p.m. on 18 April SS was arrested and taken to Plaistow Police Station. According to the Combined Arrest Referral Scheme Assessment Form, she had "smashed her neighbour's flat" because this person had closed her door in her face. She had apparently pulled out a gas meter and used the cabling or part of the casing to break several windows. She tried to hit policemen with a metal rod and broke several windows. It was necessary to overpower her with riot shields. She was charged with affray. On arrival at the police station she was shouting and screaming, crying and very angry. She spent the night in the police cells. At midnight she requested medication, having flushed her supply down the toilet. At 1 a.m. she was violently kicking the cell door and shouting. At 2 a.m. she was still banging on the cell door.

4.58 Les Barron, ASW with the EDT, attended the police station at 2.40 a.m. on 19 April, because the police wanted a responsible adult to be present when she was charged. He spent about 15-30 minutes with her. She was initially very hostile but he and the custody officer managed to placate her. She denied to him that she had done anything wrong and indicated that a great wrong had been done to her. Once she had calmed down he remembers her conversing with him quite normally. He thought it sounded as though she had been suffering a psychiatric breakdown, but "she didn't apparently show any very apparent symptoms of mental illness at the time I saw her". He was not asked to conduct an assessment.

4.59 Shortly before 8 a.m. on 19 April Vicky Rodriguez, a forensic mental health nurse working for the (now disbanded) Combined Arrest Referral Scheme (CARS), visited SS in her cell. When Ms Rodriguez attended the police station SS's case was referred to her by the custody sergeant, who felt that her behaviour the previous night indicated mental health concerns. She was told about the offence the previous evening, and talked to SS for about 10-15 minutes. Initially SS was aggressive in tone, but Ms Rodriguez was able to elicit that she had recently given birth at 24 weeks gestation, and that she had a diagnosis of bi-polar affective disorder with delusions. She notified Siew Tin P'ng, and advised a full assessment. She completed a "Brief Psychiatric Rating Scale", mostly with low ratings, except for agitation and disturbed thinking. She felt that she needed to be in an environment where she could be assessed and stabilised. She was contacted by Petrona Hogan (social worker), and told her that in her view she needed an assessment and hospital admission. Her typed report was faxed to the CMHT at 10.10 a.m.

4.60 At around 2 p.m. on 19 April Janice Strachan (ASW), Dr Sullman (GP) and Dr Kamal Gomez (psychiatrist), with Petrona Hogan also present, attended Stratford Magistrates Court to conduct an assessment. All

four professionals agreed that she was not “sectionable”. The ASW Report Form noted:

> “She was relaxed, coherent, and able to express herself clearly and remembered the incident which led to her detention and gave her own account in that she felt she was provoked to respond in the way she did. She said she was tired but happy about the birth, only she was feeling unhappy that the baby was taken into the Royal London Hospital and she was left on her own with no attention and decided to leave. However she was looking forward to being reunited with baby and PH. She did not think she was mentally unwell but said that she had an infection on her tongue, which hurt and was still bleeding and itching and asked for attention. She agreed to go back to outpatients for follow up.
>
> All professionals … agreed that she was not sectionable, but could benefit from treatment and encouraged to be admitted as a voluntary in-patient. Initially she agreed but later refused.”

4.61 The team told the clerk to the Court that their view was that SS should go into hospital informally. During that day, however, the Court had received a number of communications from PH requesting that she return to his flat. At the hearing of her case, after representations from SS’s solicitor, the Court made residence at PH’s address a condition of bail. When the assessment team queried this with the clerk after the hearing, he simply replied, “Oh well, it’s done”.

4.62 After the hearing SS walked back to Unit 1 with Ms Hogan and Ms Strachan, and told them of her plans to meet PH and attend a Jehovah’s Witness meeting that evening. She was calm and apparently stable, laughing and joking. When they reached the office SS waved them goodbye and left.

4.63 That evening, according to PH’s mother, PH and SS visited his brother’s flat, where SS broke windows and a fish tank, flooding the room with water. PH took her back to his flat.

4.64 On 20 April 2004, probably around 6 a.m., PH ran a sword through her body 30 times. Afterwards he contacted the police to inform them that he had just killed her.

## CHAPTER 5

## ISSUES ARISING FROM THE CARE AND TREATMENT OF SS

5.1 The issues arising in SS's case can best be considered by posing the following questions:

- What was the lifetime diagnosis of SS's psychiatric illness?
- What were the risks of psychiatric illness after the birth?
- Were appropriate steps taken to reduce this risk?
- Did SS develop a psychiatric illness after her son was born?
- Did the assessment team have access to the information required to make this diagnosis?
- What was the purpose of the assessment interview? Did it fulfil its purpose?
- What went wrong? What safeguards would have reduced the risks?

### What was the lifetime diagnosis of SS's psychiatric illness?

5.2 The narrative history of SS's illness shows that she suffered from between 12-14 episodes of mental illness during her life that necessitated hospital admission. For ease of reference we have tabulated these episodes in Table A.

| Date | Admission |
|---|---|
| 1985 | SS admitted to psychiatric hospital in new York. Diagnosis: manic depressive psychosis |
| June – August 1987 | Admitted to Guy's Hospital |
| March – August 1998 | Admitted to Goodmayes Hospital. Including transfer to John Howard Medium Secure Unit for 1 month |
| May 1990 | Admitted to Goodmayes Hospital |
| January – May 1991 | Admitted to Goodmayes Hospital. Diagnosis: hypomania |
| May – July 1993 | Admitted to hospital |
| October 1993-January 1994 | Admitted to Goodmayes Hospital |
| November 1994 | Admitted to Goodmayes Hospital |
| June – September 1995 | Admitted to Goodmayes Hospital |
| July – August 1996 | Admitted to Goodmayes Hospital |
| June – July 1997 | Admitted to Goodmayes Hospital |
| February – June 1999 | Admitted to Goodmayes. Transferred to Runwell Psychiatric Intensive Care Unit. Transferred to Goodmayes Hospital and discharged in her absence June 1st 1999 |

5.3 There can be no doubt in our view that the proper diagnosis was one of manic depressive psychosis of considerable severity, with onset at around 17-18 years of age. The episode in 1987, when she required intravenous fluids, was very severe. It is most unusual for fluids to be required in a psychiatric setting. Mania was the diagnosis at the time of her first hospital admission in New York in 1985, and it remained the diagnosis for most of her later hospital admissions. In some episodes delusions and auditory hallucinations were present. She spent a total of 22 months in hospital, or 13% of her life since the age of 18.

5.4 The Panel was at pains to obtain information about SS's premorbid personality, and particularly about any tendency to violence when she was not ill. We obtained information from several family members and professional staff. It is true that she had difficulty in maintaining satisfactory relationships and failed to comply or cooperate fully with professional staff, but all our sources agreed that she was not by nature an aggressive person.

**What were the risks of psychiatric illness after the birth of her child on 11 April 2000?**

5.5 The high risk of psychiatric illness after childbirth was adumbrated by Hippocrates 2,500 years ago, and there are now over 2,000 works published on the subject. It has been known for at least 35 years that women with a history of manic depressive psychosis are at greatly increased risk after childbirth (see e.g. Motherhood and Mental Health, Oxford University Press 1996, Brockington I.F. pages 216-219).

5.6 The risk for this category of women is around 20%, compared with an incidence in the general population of one in a thousand. However in view of the severity of SS's illness, and the fact that she had previously had an episode in early 1991 which occurred post-termination, the risk in SS's case was higher. Dr Duffett's estimate of a 50% risk was an entirely sensible one.

5.7 An episode post-childbirth was likely to be manic in form, with its onset in the first 2 weeks after childbirth. Lithium, administered immediately after delivery, would have reduced the risk of occurrence. A postpartum psychosis carries a slightly increased risk to the baby, and a small risk of suicide.

**Were appropriate steps taken to reduce this risk?**

5.8 When Dr Duffett became aware of the pregnancy he sent a warning letter to SS's General Practitioner on March 6 2000 which pointed out the high risk of postpartum psychosis. A copy of this letter was sent to

Albert Semantia, her care co-ordinator. There is no evidence that the GP alerted obstetric services.

5.9 The baby was born at least three months prematurely, and, as it turned out, at a time when both Dr Duffett and Albert Semantia were on leave. If the birth had not been so premature, there would have been greater pre-birth planning. Dr Duffett had arranged a further review on 31 May 2000, because he recognised that it would be important to plan for the possibility of relapse. In evidence to us Albert Semantia was sure that there would have been further preparation after he returned from leave.

5.10 In this case there was also a specific element of child protection. The 1989 Children Act was followed in the 1990s by a plethora of guidance to ensure its effective implementation. The 1991 guidance entitled "Working Together under the Children Act" was replaced in 1999 by further guidance "Working Together to Protect Children". This set out how all agencies should work together to promote the welfare of children and protect them from abuse and neglect. It formed the basis of detailed guidance issued by all Area Child Protection Committees. It set out the responsibility of mental services and emphasized the need for close collaboration and liaison between adult mental health and children's services. Whilst it recognized that mental illness in a parent does not necessarily have an adverse impact on a child (or unborn child) it stressed that it is essential for adult mental health staff to assess the implications for children and for the parent's capacity to parent.

5.11 In view of the wide range of risks associated with SS's pregnancy – the risk of relapse after delivery or termination, the risks of pharmaceutical treatment during pregnancy - and the risks to the unborn child, planning discussions became urgent as soon as pregnancy was diagnosed. They should have included the general practitioner, a member of the obstetric team, a social worker and if possible a member of her family. Given the severity of SS's mental illness, the involvement of child protection services would have been very likely. The agenda would have included the possible involvement of a specialist in the psychiatry of childbirth, treatment and prophylaxis during pregnancy and immediately after the birth, and vital social issues including SS's parenting capacity. We think it inevitable that the identity of the father would have been sought and that at this stage Albert Semantia would have disclosed PH's name. With PH revealed to be the father, the involvement of the Social Services child protection services would have been mandatory and we do not doubt that it would have occurred. Had a referral been made to the Social Services Department at an earlier stage and a pre-birth planning meeting taken place involving obstetrics staff, it is probable that the response to SS's treatment post-birth would have been very different. In the event both the obstetrics team and the adult mental health team were completely unprepared for such a premature birth.

5.12 We fully accept that the psychiatric team had no reason to expect such a premature birth. We realize that only six weeks had elapsed between the CPA meeting on March 1 2000 and delivery on 11 April and that the decision to convene a planning meeting at the end of May was influenced to some extent by the planned leave of key members of staff in the ensuing weeks. In such an unusual case it would be unfair to criticize but wise to learn from this experience that, in patients with this degree of risk, pre birth planning meetings need to occur as soon a possible after pregnancy is diagnosed.

5.13 We are mindful that the management of this case would be different today following publication in 2003 of the *London Child Protection Procedures (Edition 2)*. This offers clear and explicit guidance which stipulates that a referral to the Social Service Department must be made where agencies or individuals anticipate that prospective parents may need support services to care for their baby or that the baby may be at risk of significant harm (this includes potential risk to an unborn child). Delay must be avoided to provide time for planning and assessment, to make initial approaches to the parents, to give them time to contribute their own ideas and solutions, and provide early support. Among the circumstances requiring pre-birth assessment is a degree of parental mental illness likely to have a significant impact on the baby's safety or development. Not all women with a history of major mental illness meet this threshold, but SS, with 12 hospital admissions, more than 22 months spent in psychiatric hospital, and a diagnosis of manic depressive psychosis (with its known risk of post partum relapse) clearly *did* meet them.

5.14 Albert Semantia was given information “in confidence” by SS that PH was the father of her baby. We know that Albert Semantia did not find this an easy confidence to maintain and in the circumstances should have taken the opportunity to share it with his supervisor and to seek clarification about disclosure. His reluctance to share the information explicitly with other members of the CMHT was misguided. Guidance issued by the Department of Health acknowledges the position taken by Albert Semantia in his evidence to the Panel that information should not normally be disclosed without the consent of an individual but it stresses that “the law permits the disclosure of information necessary to safeguard a child or children in the public interest – that is, the public interest of child protection may override the public interest of confidence”. In this matter of crucial importance to the welfare of the mother and her unborn child we would have expected Albert Semantia to have informed the CPA meeting on the 6 March so that an urgent assessment of the risks posed to SS and her unborn child could have been undertaken.

**Did SS develop a psychiatric illness after her son was born?**

5.15 We think there is overwhelming evidence that SS suffered from typical puerperal mania after the birth of her son.

5.16 Her sister Sheila noted the onset of “mental instability” with manic behaviour and the delusion that the baby would be killed, on the day of delivery (11 April 2000).

5.17 Sister Maggie Clarke on the following day thought she was very manic: “her mood was very labile, talking a lot, very hyperactive sort of behaviour”, and she noticed an increase in severity the day after.

5.18 On the fourth day (Friday 14 April) her brother noticed over-talkativeness. She took medication that day, and slept a lot. It is not known how she was on the following two days.

5.19 On 18 April 2000 she was arrested following a violent incident. It was established by Vicky Rodriguez that she was acting on the delusion that her neighbour was stealing her gas and electricity. She was not a violent person when she was well. The violence that she showed on that day was typical of the violence she had shown in previous episodes of mania. Vicky Rodriguez noted agitation and disturbed thinking when she interviewed her nine days (19 April) after the birth.

5.20 At the assessment the same afternoon, Petrona Hogan noted her restlessness, and Dr Sullman noted her loquacity, ideas of persecution (that people on the estate were against her) and positive mood.

5.21 That evening there was a further episode of violence at PH’s brother’s flat.

5.22 There were some unusual features however. Onset appears to have been very soon after delivery. Onset is usually between the third and fourteenth day. Nevertheless onset as early as the date of delivery has been reported. Her pregnancy was of very short duration, but again episodes have been reported in such circumstances (see Motherhood and Mental Health page 223).

5.23 We are also aware that she appeared comparatively normal to the assessment team when they interviewed her during the early afternoon of 19 April 2000. We do not think this refutes the diagnosis in any way. Symptoms can wax and wane and she may have taken some of unused medication that she still had.

**Did the assessment team have access to the information required to make this diagnosis?**

5.24 The only source of information available to us, but not the assessment team, was the account that we received from SS’s sister Sheila.

5.25 Her psychiatric notes were kept at the CMHT base, and could have been consulted. The views of Sister Maggie Clarke were communicated directly to the CMHT, and this led to the involvement of

Siew Tin P'ng and Mr Sunder Singh. The latter's report was faxed to the CMHT on Monday April 17 2000. The police records and the constabulary themselves were available to give details of the behaviour which was the subject of criminal charge. Vicky Rodriguez's observations were faxed to the CMHT shortly after 10 a.m. on Wednesday 19 April 2000. Dr Sullman brought the general practice notes to the assessment interview. These notes contained summaries of past admissions. Dr Sullman noticed abnormalities in her behaviour during the assessment interview. Petrona Hogan was available to advise on SS's non-violent pre-morbid personality.

5.26 The information that the assessment team could have gathered was therefore quite sufficient but, as will be seen, the team failed to make efforts to obtain all this information.

**What was the purpose of the assessment interview? Did it fulfil its purpose?**

5.27 The essential purposes of the assessment interview should have been to establish a diagnosis, to consider the risks involved in allowing the patient to remain at large, and if so indicated, to offer care or invoke the Mental Health Act.

5.28 The process of establishing a diagnosis cannot be based merely upon the patient's presentation at interview. Patients can simulate and dissimulate. There may be variations in a clinical state during an episode. And the history may have a vital effect on the assessment. Information should therefore be recruited from all available sources.

5.29 The risks involved were of different kinds. SS was facing charges that were likely to be a stressful experience. She might be a risk to herself, whether from self-harm or suicidal activity. In view of her violence the day before, she might present a risk of violence to others, particularly if she was experiencing delusions about other people. In a puerperal psychosis there is a small risk to the infant, whom she was likely to visit. In a manic illness there is a risk of sexual exploitation, and she might also be at risk of violence from others.

5.30 The assessment team consisted of (social worker), Janice Strachan (ASW), Dr Gomez (psychiatrist), and Dr Sullman (general practitioner), with Petrona Hogan in attendance.

5.31 Unlike the other members of the team, Petrona Hogan had known SS before the meeting, having attended CPA meetings as far back as June 1997. She had got to know her fairly well, and had been her care co-ordinator until about December 1998, when Albert Semantia had taken over her responsibilities. When SS was well, Ms Hogan described her as a "gorgeous lovely young woman", but somebody whose mental state was very fragile.

5.32 Petrona Hogan had been asked to attend the assessment meeting to "shadow" Janice Strachan. She was aware that SS had recently given birth. She was not given any records before attending, but assumed that Janice Strachan would have all the information. In interview with us Petrona Hogan said that she felt that SS needed some time to "cool out and rest". Though the team reached the conclusion that she was not "sectionable", Ms Hogan had asked her if she was prepared to return as a voluntary patient to Goodmayes, and SS had said that she would. She passed this on to the clerk to the court before the hearing started, and had therefore expected that after the hearing SS would accompany them back to the office, and proceed to Goodmayes by taxi. She assumed that the court would make residence at Goodmayes a condition of bail. She was therefore very surprised when the court made PH's flat the bail address, but in conversation with SS afterwards realised that she had changed her mind, and wanted to go to her boyfriend.

5.33 During the interview, which Ms Hogan remembers as having lasted about 45 minutes, SS had been calm and able to answer questions. She thought that she "appeared well, but logically one would know she's not very well". She did not herself know the full details of the alleged offence, but gathered the impression that the police had gone "over the top". At the time she thought that the Team's conclusion that SS was not "sectionable" had been right.

5.34 Janice Strachan had had no prior contact with SS but as the ASW on rota she had been called to assess her at court. She assured us the team had access to the clinical file, and a "window of opportunity" to read it, but she was not at all certain that Dr Gomez had the file with her at court. She could not recall having read Dr Duffett's letter of 6 March warning of the risk of relapse. She wrote after the interview that SS had been "relaxed, coherent, able to express herself clearly". SS had given her side of the incident the previous day, which suggested that the police had been heavy-handed, but she told us that she did not have the opportunity to check this out with the police themselves. In interview with us, the principal "risk" which she felt arose was in connection with housing. She felt that the "least restrictive alternative" should be chosen, and in her view she did not feel that she should be sectioned.

5.35 Dr Sullman had no prior acquaintance with SS, having only recently joined the practice. He had had 8 weeks of psychiatric teaching at Dundee medical school. He recalls having read her general practice file but could not specifically remember the letter from Dr Duffett. He met SS and the assessment team in the cells, and, as he put it to us, he was thinking "shall I section this patient or not?" Dr Gomez asked the standard psychiatric questions. SS was very talkative, and with hindsight and experience he wondered if that did not reflect mania. He also felt that she displayed "features of paranoid beliefs". She was "happy, on a wave, and standing 10 feet tall". He knew that childbirth

carried a high risk of depression and "could destabilise schizophrenics". He thought the risks were to herself or neighbours, not the baby, who was in special care. He thought she had an argumentative and provocative and difficult personality, but he decided at the time, and still felt in interview with us that she was not sectionable:

"I was malleable, happy to play No. 2 but did not disagree with Dr Gomez. My role in that room is to find out if she was sectionable, and if she had enough psychiatric care and support. There are so many people with mental illness. The core question I kept asking myself again and again was whether we had to take her liberty away. I did not think it was necessary for her to be in hospital. The system is overloaded, so we try our best to do things in the community".

5.36 He remembers being told that she was on medication, and was set for an out-patient appointment the following day. "We were fairly sure she would co-operate". However if he had known that she would not co-operate he said that his view would have changed – "the treatment would have to be imposed upon her. I could not release her as a loose cannon".

5.37 The fourth member of the team, Dr Kamala Gomez, was a senior clinical medical officer attached to the mental health team. She had been approved under Section 12 of the Mental Health Act since July 1998, and as the psychiatric member of the team she should have played the leading role in deciding on diagnosis and prognosis. She had no prior knowledge of SS, and had been approached just minutes before 2 pm. She told us that normally she would read the case notes, but on this occasion it appears that she did not:

> "I was asked to do the mental state examination to see if she could go home. I felt pulled. People were bleeping. Normally I would take the records, but at that time I went because no other person was available. They dragged me along saying "Please do this".

5.38 In interview with us, Dr Gomez said that she did not recall any discussion with Janice Strachan about the case as they walked to the court. She also said that did not know that SS had had manic depression, or that she had been admitted to hospital having recently given birth. (We could not reconcile this with the evidence of other witnesses present, and are sure that this was a failure of recollection). When we asked her if awareness of these facts would have affected her assessment she said: "I would still have been doing the same – looking for depression, psychosis".

Q What was your diagnosis of this young lady, Dr Gomez?
A In retrospect?
Q When you saw her at the court what diagnosis did you make? What was wrong with her?

A I didn't make a diagnosis.
Q You mean you diagnosed her as being an entirely normal person?
A Yes, at that time.

5.39 Dr Gomez appeared to regard her task as being to assess the immediate presentation of the patient. Her answers to us became increasingly surprising:

Q Are you really saying that it is possible to do a Mental Health Act assessment on a patient in a police station, who is arrested for a violent incident less than 24 hours before you saw her? Can you really do an adequate mental health assessment without knowing something about the incident, without mentioning the incident?
A No, you can't, but in these circumstances you are so pushed.
Q You are saying you didn't ask her about the incident because you didn't have time to even say "Why are you here? Why did the police arrest you?"
A No I didn't ask. I've said this before, I did the mental state at that present time, but I didn't know the history.

5.40 In a letter written subsequently by Dr Gomez on 19 May 2000, she wrote that SS's neat congruous appearance, her posture and movements, did not suggest the possibility of (sic) physical illness. She found her talkative, but understood that this was her normal presentation. She found no evidence of elation, depression, delusions or hallucinations. Her content of conversation revolved around her baby and her boyfriend. She thought her well orientated in time and place and her attention and concentration were good. Unsurprisingly, therefore, she did not think she was sectionable. Yet Dr Sullman, who agreed with the ultimate conclusion, had written on the following day "she was talkative and excited. She displayed features of personality disorder, paranoid beliefs and some mania…."

**What went wrong? What safeguards would have reduced the risks?**

5.41 In our view the assessment team that attended court that day failed to carry out a proper assessment. The primary responsibility for this failure must rest with Dr Gomez. As the section 12 psychiatrist it fell to her to establish the facts that would enable her to make a diagnosis, to assess the risks, and to decide on SS's future care. She should have equipped herself with the full clinical notes and acquainted herself with the psychiatric history. She clearly should have tried to establish the content of the allegations against SS, because such an event obviously called for psychiatric interpretation.

5.42 Although all four members of the assessment team shared the view that SS was not sectionable, we have little doubt that if the psychiatrist had conducted a proper assessment the issues would have appeared very differently to the other members present. Most importantly, it should have been apparent to the psychiatrist, and hence to the team,

that SS had relapsed as Dr Duffett had predicted she might, that she was suffering from puerperal mania, and that this was the overwhelmingly probable cause of the very disturbed behaviour the previous day. This in turn should have underlined the imperative of re-establishing SS on medication. Such a conclusion would have pointed to the need for hospital admission.

5.43 SS had indicated before the hearing in court that she would go to Goodmayes voluntarily. If the team had firmly decided on the need for admission, but been told by SS that she was content to be admitted voluntarily, the team would have been presented with a dilemma. However we feel that in view of the history since 11 April, voluntary admission was a risk that it was not safe to take. Her co-operation could not be relied upon, and repetition of further disturbed behaviour was an ever-present risk until she was re-established on medication. The team did not of course know at that stage that her behaviour the same evening would again become disturbed.

5.44 We are aware that a number of unfortunate circumstances came together at that time. The absence of both Albert Semantia and Dr Duffett on leave meant that the assessment lacked anybody with in-depth and recent familiarity with SS's case. She managed to present well at interview, and led the team to believe that the police may have over-reacted the previous day. Once the Court was aware that the team did not intend to invoke the Mental Health Act, it accepted PH's address as the bail address with no awareness of the background, or of the view of at least some of the team members that SS needed in-patient care.

5.45 The assessment team had no reason to anticipate PH's extreme violence the following night. We have concentrated on the care she received in the light of her condition and her needs at the time. We find a clear failure to establish the correct diagnosis on 19 April 2000, as a direct result of which SS was not given the treatment she required.

## CHAPTER 6

## THE PERSPECTIVES OF PH'S AND SS'S FAMILY

### PH's Family

6.1 During the course of PH's illness, the professionals with whom he came into contact changed throughout. A constant point of reference was his family and we feel it important to relate their feelings and views about his care and treatment.

6.2 It was PH's father who in 1989 initiated PH's first contact with mental health services. He took his son to Goodmayes Hospital following an episode at work when PH started banging his head against scaffolding and complaining that something was wrong with his head. In the years that followed his family and particularly his mother, initiated and remained in contact with mental health services, attending CPA meetings both with him and frequently when he was absent. She was usually the first person to detect signs of deterioration and to communicate her concerns to relevant professionals.

6.3 She told us that as far back as 1989 she was concerned by his deteriorating health, and described how she would see his mood change "he would go black and become very aggressive and start smashing things up". Very early on his parents felt that he did have insight into his illness, was desperate for help, and took the tablets prescribed, perhaps the only time when he was compliant with medication. When asked if there was a time between 1990 and 1995 when she was confident that he was taking his medication, she replied "No. Only the first time, the Anafranil. After that I don't think P was taking anything. He had gone completely haywire and didn't know what was going on. I don't think he was ever in hospital long enough to be well enough to understand he was ill, except when he was in Hackney and then he was secure".

6.4 For a few months in 1997 PH's family confirmed that he was compliant with medication. This followed his discharge from Goodmayes, when as described in Chapter 2 of this report both his mother and a forensic CPN Nigel Ryan were involved in the supervision of PH's medication. His mother confirmed that for a few weeks, between May and August 1997, he would come to her on a daily basis and she would watch him take his medication. This was the most successful period of compliance. When he suddenly stopped coming she confirmed that she immediately notified Nigel Ryan and by the beginning of 1998 both she and Nigel Ryan confirmed that he had begun to deteriorate once more.

6.5 In 1998 she was no longer involved in the systematic monitoring of his medication because she felt that he was becoming paranoid towards her. However she told the professionals involved with his care and treatment that she wished to know what was happening to him. In July of that year she wrote to Dr Feldman expressing real concern about her son. Later in 1998, when PH was in Runwell, she confirmed to us that she did not attend the mental health review tribunal because she was "frightened of him at that time". When asked if he had ever attacked her, she said, "No. He would threaten me but he never did. The worse he ever did was he pushed me against the door once. He never attacked me. He threatened he would stab me once."

6.6 By 1999, following his remand in custody in February and his transfer to Runwell, she told us "I did get in touch with the doctor at Runwell and I was saying that he is so sick could you explain to the court that he is very ill, and could you get a section to hold him?" As described in Chapter 2 he was transferred back to Goodmayes but absconded on arrival.

6.7 During 1999 she continued to express her concerns. She told the Inquiry panel that she was "terrified to walk along the street with him" because "he would make remarks and look stroppily and barge into people". She told us she had written to Dr Duffett telling him she was "petrified that he was delusional and thinking people were after him. It really terrified me when he said one specific woman" (this referred to an incident referred to in Para 2.110 of this report when he threatened to kill an Irish woman). She thought it was a real risk, and this had prompted her to go to the police.

6.8 During the early part of 2000 when PH was in hospital the family continued to keep in touch with him and with mental health services. His mother visited him in Runwell but not in Goodmayes because "I was too nervous of him at this time". He did however visit the family home on day release from Goodmayes. When asked by us if she thought he was better than in December 1999 (when she had been so worried) she replied "He was definitely better than he was when going in, but he was still showing signs of being paranoid. Certain things concerned me and I phoned the ward and told them".

6.9 She was invited to the discharge planning meeting but did not attend because she felt that she did not want to "get on the wrong side of him". When she phoned to send her apologies she mentioned that she still had concerns.

6.10 Following his discharge in early April 2000 he continued to have contact with his parents. She told us that she had visited him on the day of the killing and had been pleased with his progress. She spent some 2-3 hours in his company, and although she told us that he still had delusions she was quite happy with his general demeanour and

had no thoughts that he was relapsing. In fact she had returned home and told her husband that she was pleased with his progress.

6.11 PH's parents said that they had been unaware of his relationship with SS and pregnancy until after the killing. There had been no sign of co-habitation when she visited his flat.

**Issues arising from the evidence of PH's parents**

*Did the services involved with PH have sufficient regard to whether his family were acting as carers, and did they consider whether they had needs arising from his illness?*

6.12 In their evidence to us PH's parents demonstrated how concerned they had been for their son's mental health, of their involvement with him and of their many attempts to ensure that PH received the care they felt he needed. They had numerous contacts with staff of community mental health services and we asked them for their views about the support they had received.

6.13 Despite one successful partnership with a CPN, in her evidence to the Panel PH's mother shared some of her frustrations about the professionals with whom she came into contact. There were times, she said, when "I didn't get any help anywhere. I would phone them up and tell them what was happening but there was never any action taken". She said that she was passed from pillar to post with no continuity. She felt that professional staff did not see her as a key person although when she was involved in supervising PH's medication he was well.

6.14 In mid 1999 at a time when Mrs H was expressing real concerns about PH's deteriorating health she was told by Janice Strachan, a social worker, that "we are taking his name off the computer" at a time when "we were going through hell". Mrs H said that she felt that the CMHT and the Social Services Department did not take her concerns seriously and that they probably thought she was an over-anxious mother. In view of the family's concern and their perception that they were not being taken seriously she approached the National Schizophrenia Fellowship (NSF) for advice. She told us that the NSF wrote to Deborah Cameron then Director of Social Services for Newham, but the letter was never acknowledged. "P was completely psychotic now and he told us that he knew who was behind the conspiracy and that she was evil, a neighbour of his. We were very frightened. P was targeting her house, throwing bricks etc. I think the police were called a couple of times. I wrote to Dr Duffett, who had taken over from Dr Bashir. He answered my letter and said that things were being done to see P about this time".

6.15 Given the level of anxiety being experienced by the family during this time, the lack of response from the Social Services Department was

clearly unsatisfactory. The Carers Recognition and Services Act 1995 gave a clear entitlement for carers to have their own needs assessment and to receive support from services in their own right. Although PH's mother frequently attended CPA meetings, participated at times in his treatment plan and cooperated in a number of ways in his care, there is little evidence to suggest that the CMHT saw her as a carer or key person in PH's life. This may reflect a dilemma faced by staff keen not to breach patient confidentiality, but as a consequence she and her husband felt unsupported and frustrated during much of his illness. According to her the only person who really established contact was the forensic CPN Nigel Ryan. She told us, "It was such a relief to me that someone was phoning and saying to me: how is he?"

*Given the increasing risk of violence towards women, was sufficient thought given to the risk PH might pose towards his mother?*

6.16 Despite the findings of the National Confidential Inquiry into Suicide and Homicide published in 1999 relating to the risks to family members, members of the CMHT never considered the potential risk to Mrs H. This was clearly unsatisfactory and emphasises the deficiencies in risk management outlined elsewhere in this report.

*What were the parents' views about the care PH received?*

6.17 In all their evidence to us PH's parents gave a clear indication that they would have favoured far more assertive management to deal with the risk of violence. They themselves took what steps they could to alert mental health professionals and the police. They regretted that it had not been possible for PH to remain in a secure setting, and expressed relief when Section 25 of the Mental Health Act (as opposed to a simple discharge) was used in March 2000.

6.18 They thought PH needed a long enough spell in a secure hospital to enable him to "understand his illness". Only then, after such a spell, did they feel that he would be compliant with his medication, and his symptoms kept under control.

**The perspectives of SS's family**

6.19 The family of SS was in touch with her during her lengthy illness. At times she lived with her father, although during her final pregnancy there was less contact and her father was unaware that she was pregnant.

6.20 The Panel interviewed SS's father, her two brothers, together with a friend of the family and a relative by marriage. On a separate occasion Professor Brockington met a sister of SS, who had not wished to attend a meeting with the whole Panel.

6.21 SS's brothers told us that they had seen her briefly after she had given birth and that one of her brothers had collected SS and taken her home from hospital at her request. He told us that he thought SS was very excited but was unclear whether that was because she had just given birth or because she was becoming ill again. Her other brother saw her briefly about two days before she died but did not have a long enough exchange with her to notice if she was unwell. He stressed that SS usually knew herself when she was becoming ill and SS's friend told us that she had asked at the hospital to be put back on medication but that this had not happened.

6.22 The family stressed that she was normally a very "happy-go-lucky" person and her father told us that he had not been aware of any episodes during her illness when she had been violent. Her brother said that usually, if there were problems with SS at her flat, one of her neighbours would get in touch with her father. They thought that the police knew that she had a history of mental ill health.

6.23 After the arrest a neighbour telephoned her father and told him that a neighbour of SS had telephoned the police, and that she had been "manhandled like an animal and chained in the back of a police van". However no-one in the family was *officially* informed that she had been arrested and taken to court. They were not informed that she had been bailed to PH's flat, and indeed had not heard his name at all.

6.24 The family all expressed concern that she had been bailed to PH's flat and were seeking answers as to why this happened.

6.25 SS's father also told the Panel that communication with professionals after his daughter's death was very insensitive and should have been handled with more care, bearing in mind their needs at that time.

6.26 Their principal concerns were that:

- she should not have been discharged from hospital;
- the police did not inform her father (her next-of-kin) of her arrest;
- she should not have been bailed to the home of someone who was mentally ill with a history of violence;
- there was a long delay in informing her father of her death, and the circumstances in which it occurred, and
- the family had been given little information.

6.27 Her sister Sheila, who herself worked for social services, had been the member of the family closest to SS. She recalled that when well, she was 'pleasant, bubbly and intelligent' and functioned well, she was never violent except when ill. She was fully aware of SS's bipolar disorder, and always knew when she was becoming ill. We have referred to Sheila's involvement in Chapter 4 (Para 4.45 – 4.55).

6.28 She gave Professor Brockington her views about what had gone wrong:

- PH was known to be very ill and dangerous, and should not have been out of hospital;
- there was delay in assessing her sister and giving her medication;
- staff failed to heed Sheila's warnings about the urgency of giving her medication;
- the family were not informed that she was arrested, and
- after her sister's death the family were involved in 'battles' to get access to SS's son, and later help in caring for him.

6.29 In summary she said: "My personal opinion is that it was a whole mess-up, and Social Services and Mental Health caused my sister's death".

**The family's concerns**

6.30 The Panel share many of these concerns expressed by SS's family. We are very critical about the treatment PH had been receiving, and the failure properly to assess the risk he posed to others, particularly women. It is therefore a matter of great concern that SS should have been bailed with a condition to be in his flat; especially bearing in mind the recommendation of Dr Obomanu that professionals should not visit PH alone.

6.31 SS should have been psychiatrically assessed much earlier after giving birth, by deliberate pre-planning, and closely cared for thereafter. An early return to treatment could have mitigated the relapse of which she was always at high risk. The incident that led to her arrest and appearance in court therefore ought never to have happened at all. Even after it happened the severity of her illness was missed when it should have been apparent.

6.32 If her need for urgent treatment had been recognised but she had been resistant, it might well been necessary to invoke the Mental Health Act. Depending on the form of order, her father's consent might then have been needed by the Approved Social Worker. However except with juveniles, no obligation is placed on the police when arresting or charging a person to notify next-of-kin. There is a difference between the approaches, though save where the Mental Health Act stipulates otherwise, psychiatric staff require an adult patient's consent before passing on information even to close family.

6.33 If after giving birth she had received the close and determined psychiatric care and treatment we have indicated, the likelihood is surely that the family would have become closely involved with her full agreement, particularly with her baby so recently born. Indeed we have set out our view that pre-birth planning should have started as

soon as her CMHT became aware of the pregnancy, at the beginning of March. Though she had been reticent about the pregnancy, such pre-birth planning would have encouraged her to grapple with all the long-term considerations. This would almost inevitably have involved those closest to her in the family.

## CHAPTER 7

## POLICING AND MENTAL HEALTH

7.1 In Chapter 3 we explored the implications of the failure to prosecute PH when he offended. It is our view that if he had been prosecuted, the likelihood is that he would have been placed under a hospital order, and probably a restriction order. Thereafter he would probably have been treated far more assertively. Many previous homicide inquiries have similarly regretted that the police failed to prosecute the individual into whose care and treatment they were inquiring before the fateful index offence.

7.2 In June 2004 the Metropolitan Police Authority (MPA) set up a joint review with the NHS on Policing and Mental Health. One of the issues with which the review dealt was the question of prosecution. The joint review report Policing and Mental Health was published at the end of October 2005.

7.3 We warmly welcome the review's report and its conclusions. It acknowledges that some of its conclusions have been influenced by previous reports on homicides.

7.4 Paragraph 71 of the report deals with the question of "Charging", and we reproduce much of the text in the following paragraphs

### Charging

7.5 The review report states

> 'A decision about whether a person should be charged for a crime they are alleged to have committed is generally made on the basis of two tests. Firstly the weight of the evidence, and secondly on whether it is in the public interest to proceed. The CPS code of practice states that decisions to prosecute also consider the impact it could have on the person's mental state. Their guidance refers to the Home Office circular 66/90, which suggests other avenues such as diversion to hospital or support in the community should be considered. However the guidance also states that if the offence is part of a pattern of behaviour, prosecution may be appropriate as a way of ensuring the patient accepts responsibility for their actions.
>
> Analysis from homicide enquiries has shown there is often a history of offending behaviour, which has not been addressed. Research also indicates that the charging thresholds are much higher for those with mental illness, indicating that there is some reluctance to charge individuals who have a mental illness.

We heard evidence from a number of sources about whether action should be taken against mentally ill people who have offended. Professor Genevra Richardson (Professor of Public Law at Queen Mary College London) suggested that a starting point could be that the individual concerned has a right to be treated in the same way as everybody else, which presumes that they will be taken through the criminal justice system. She also suggested that there is a need to establish a record of what happened. Our reference group endorsed this position, noting that having the full facts could enhance the care and treatment received by the individual concerned. This supports the view of a consultant forensic psychiatrist, who told us that risk assessment can only be as good as the information available.

There are further considerations for example offending behaviour is not necessarily a direct result of mental illness and therefore should not be treated as such. Also, victims should be able to see that justice is being served.

We identified early on that the willingness (or lack of) of police officers to take forward allegations of assault against staff or patients who are in in-patient care was an issue. DAC Brian Paddick told the project board that the MPS (Metropolitan Police Service) is developing a range of protocols in order to address this point.

At her presentation to the project board Gail Miller told us about the approach being developed by the South London and Maudsley NHS Trust. She explained that the NHS has a zero tolerance towards assaults against staff, and that this is undermined if police are not prepared to press charges against the perpetrators. Her multi-pronged approach includes agreement of a charging policy with local police. This policy challenges the assumption that patients aren't capable and responsible for their actions. She has also worked with police colleagues to develop a fact file on how the police work with guidance on what to do and who to contact in particular circumstances. It is notable also that she is realistic about the practicability of zero tolerance and suggested that each case should be decided on its merits.

Dr Guite's work recommends that local protocols should be agreed between the police, probation services, the Crown Prosecution Service (CPS) and NHS and social care agencies. It also outlines what the policy should cover. The project proposes the establishment of criminal justice officers in each PCT to provide co-ordination between agencies. The project board endorses this work approach."

7.6 The joint review Panel makes two principal recommendations on this aspect of their report:

*R15 If someone with mental health support commits an offence, it should be followed up through the criminal justice system. At the same time, it is important their mental health needs should be assessed and addressed appropriately, which may involve diversion to the mental health system.*

*R17 As part of their approach to reducing violence on mental health wards, Trusts should adopt the approach taken by the Southwark police and the Maudsley in developing a prosecution policy and educating staff about how to deal with the police should the need arise*".

7.7 We hope that the Mental Health and Policing joint review report will be widely read within the Trust. Its analysis and conclusions go well beyond the issue on which we have concentrated here. We fully endorse the recommendations it makes, in particular that there should be a marked change of practice, with a significant re-setting of the threshold for charging decisions.

7.8 With this clear signal that the Metropolitan Police Authority wishes to see change, the time must be right to adopt the practice initiated by the South London and Maudsley NHS Trust and Southwark Police as soon as possible.

7.9 We recognise of course that not all incidents of offending, violent or otherwise, occur on local police territory, but a substantial proportion do. It is certainly to be hoped that other forces will follow the approach taken by the Metropolitan Police.

# CHAPTER 8

# RECOMMENDATIONS

## Risk Assessment and Management

1 We recommend that there should be a written record of a structured clinical assessment of violence risk whenever there is a transfer of care between mental health teams.

2 We recommend that the Trust should introduce a structured clinical assessment of risk as part of every CPA meeting in every patient with a history of violence.

3 We recommend the Royal College of Psychiatrists should review its guidance to psychiatrists on the management of violence risk, to take into account recent developments in structured risk assessment.

4 We recommend that the Trust should introduce a policy of involving families and carers in violence risk management, and their views should form part of the CPA documentation

## Co-operation and co-ordination between general and forensic services

5 We recommend that the PCT should commission a comprehensive forensic outreach service.

6 We recommend that the forensic outreach service should offer a full range of services from advice to general psychiatry teams, to full care in the community of patients who present a sufficient risk of serious violence.

## Liaison with the police and the decision to prosecute

We are greatly encouraged by the approach taken in the Metropolitan Police Authority's recent "Joint Review on Policing and Mental Health" (October 2005) on the question of prosecution (see Chapter 7 above).

7 We recommend that the Trust follow the approach pioneered by the South London and Maudsley NHS Trust with the Southwark Police. This process should amongst other things aim at agreement on a charging policy, as in Southwark, but it would have far wider objectives falling outside the scope of our report.

## Mental Health Assessments

8 We recommend that the Trust should write to all staff involved in mental health care reminding them of the principles to be applied when assessing patients for possible detention under the Mental Health Act 1983, namely:

- they should make all reasonable attempts to obtain relevant written records, and information from all other available sources;
- they should review all available records, and consider all other information prior to the interview;
- they should take all reasonable steps to ensure that they are briefed on the background events leading to the assessment request; and
- the assessment should consider risks of self-harm, violence to others, harm from others, including sexual exploitation, and inappropriate prosecution for acts committed while seriously mentally ill.

9 We recommend that trust clinical governance procedures and medical appraisals should make explicit reference to competence and performance in Mental Health assessments including those at court and in other settings outside hospital.

The interview on 19 April 2000 highlighted the need for improved ASW training particularly about post-puerperal illness. The Panel recognises that the training of ASWs nationally has substantially altered since this date, with a rigorous competency framework and an accreditation scheme now in place. We were assured that since this date ASW training in the borough has been updated and the content includes issues concerning risks to children and post puerperal illness. The Trust and Social Services Department may wish to satisfy themselves further by auditing practice in this area, and ensuring that services are resourced adequately to fulfil this function comprehensively.

**Pre-birth Planning and Protocols**

When a woman with a history of severe or recurrent psychiatric illness becomes pregnant, a pre-birth planning meeting is necessary, and should be arranged as soon as possible. It is vital to establish the risk of relapse after delivery or termination, treatment and prevention during pregnancy and after childbirth, and risks to the mother and unborn child. The meeting should include the patient's general practitioner, a member of the obstetric team, a social worker, and if possible a member of the patient's family. This would ensure that the obstetric team were aware that a woman in their care was at risk of childbirth related psychiatric illness, the mental health team could be informed of the birth, and the newly-delivered mother given treatment and protection without delay.

10 We recommend that the Trust should ensure the adoption of a pre-birth protocol based on the London Child Protection Guidelines, familiarity with which should be part of core competency for all staff of community mental health services.

11 The Trust Director with responsibility for safeguarding children and the named Child Protection Nurse should ensure that policy imperatives and guidance on pre-birth and post-natal care of women with a history of mental illness are disseminated in a relevant and timely manner.

**Documentation: Cumulative Clinical Summaries**

We have referred in the context of PH's case, to the difficulties faced by mental health teams when clinical records are very lengthy. We urged the preparation of "cumulative clinical summaries", and the point applies just as much to SS's case as to PH's. We set out our reasoning at 3.77, and repeat it here:

> "When patients have psychiatric histories as lengthy as PH's their clinical records become voluminous, and the process of mastering the detail can be daunting. It is not uncommon for patients with chronic or recurrent psychosis to have several volumes of case notes. In these cases we strongly recommend that teams follow the example of some forensic units, and prepare accurate and succinct 'cumulative clinical summaries', and thereafter keep them up to date. These may take hours to prepare, but this is a tiny fraction of the time caring for these patients. These summaries enable staff members to get abreast of the clinical problem quickly, and reduce the danger that significant events are forgotten, devalued or doubted altogether. This is one of the most important contributions junior staff can make, and is also a valuable training exercise".

We recognise that hard-pressed teams, even if they acknowledge the future saving of time and improvement of quality of patient care, are deterred from adopting this approach due to short-term time pressure.

12 We recommend the adoption of Cumulative Clinical Summaries and that the Trust embark on a consultation process with mental health teams to establish a timetable to implement this approach, taking full account of the additional human resource implications in the short-term.

The Panel experienced a great deal of difficulty in obtaining a complete set of all records, which were held in different teams and on different sites. The Panel are mindful that during the time under consideration CPA policies and procedures were not in most cases well integrated with the Care Management responsibilities of the Social Services Departments. In 1999 "Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach" brought about procedures for the integration of CPA and Care Management known as the 'Integrated Care Management Approach', but at the time under review these arrangements were not fully implemented. The Panel heard evidence that "integrated notes is still a difficulty the service is struggling with".

13 The Panel experienced a great deal of difficulty in obtaining a complete set of all records, which were held in different teams on different sites. We recommend that the Trust undertake regular audit to ensure the effective implementation of an integrated care records system.

**Confidentiality**

We fully acknowledge that confidentiality is a difficult issue. Guidance from professional bodies is usually expressed in general terms, leaving much room for uncertainty in its application to specific cases.

14 The Trust needs to ensure that its' staff have clear guidance, with illustrative examples. In any event better inter-agency liaison – we specifically recommend close liaison with the local police – absolutely requires clear thinking about the permissible extent and limits of mutual disclosure. We can do no better than to reproduce Recommendations 25-27 of the MPA/NHS Joint Review Mental Health and Policing:

"*R25 There should be a clear policy statement from a pan-London alliance that confidentiality will be respected, information will only be shared when it is either in the best interests of the individual or there is concern for public protection and information will only be used for the purposes for which it is being shared. We recommend that there will be regular data cleansing in recognition that people's mental health status can change and improve. Systems and processes will need to be developed to achieve this.*

*R26 There is a need to clarify the legal framework, for example using case studies, making it easier for practitioners to understand the circumstances within which information can be shared.*

*R27 Where possible (and we recognise that this isn't always possible), the individuals should be told that information is being sought from/shared with other agencies. The reasons for this should also be explained."*

## GLOSSARY

| | |
|---|---|
| ASW | Approved Social Worker |
| CFSMS | Counter Fraud Security Management Service |
| CMHT | Community Mental Health Team |
| CPA | Care Programme Approach |
| CPN | Community Psychiatric Nurse |
| CPS | Crown Prosecution Service |
| CRAM | Clinical Risk Assessment and Management Tool |
| ELCMHT | East London and The City Mental Health Trust |
| GP | General Practitioner |
| HCR-20 | Historical, Clinical Risk assessment tool |
| MAPA | Managing Actual and Potential Aggression training |
| MAPPP | Multi-Agency Public Protection Panels |
| MDO | Mentally Disordered Offenders |
| MPA | Metropolitan Police Authority |
| MHRT | Mental Health Review Tribunal |
| PCT | Primary Care Trust |
| PCL-SV | Psychopathy Checklist – Screening Version |
| RMO | Responsible Medical Officer |

**INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH**
**JOINT ACTION PLAN**

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| **Risk Assessment and Management** | | | | |
| There should be written record of structured clinical assessment of risk of violence whenever there is transfer of care between mental health teams<br><br>The Trust should introduce a structured clinical assessment of risk as part of every CPA meeting in every patient with history of violence | Structured risk assessment is included in the current document set and it is required as part of the Care Programme Approach (CPA) of all those on enhanced and standard CPA. ELCMHT uses the Clinical Risk Assessment and Management Tool (CRAM) 1 & 2.<br>• Clinical Risk Assessment Policy ratified by the Trust Board<br>• In Newham a management tool for use in supervision is in place and has been independently audited<br>• Trust-wide documentation audits are on-going<br>• Managing Actual and Potential Aggression (MAPA) mandatory training programme is in place for all clinical staff<br>• Actions arising from external audit of supervision includes establishment of a group of team managers who meet each month and are responsible for monitoring performance and taking action relating to staff competency issues and problem-solving | 1. CPA documentation Review Report and Action Plan to be endorsed by Trust Board<br>2. Implementation to be audited on a six-monthly basis<br>3. All staff to have completed mandatory CRAM training as part of rolling programme<br>4. Internal re-audit of management supervision practices to be completed in Newham by May 2006 and rolled out across Trust as part of audit programme | East London and The City Mental Health Trust | 1. May 2006<br>2. On-going<br>3. On-going<br>4. On-going |

**INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH**
**JOINT ACTION PLAN**

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| The Royal College of Psychiatrists should review its guidance to psychiatrists on the management of violence, to take into account recent developments in structured risk assessment | The Royal College of Psychiatrists issued Safety of Psychiatrists Council Report CR134 in January 2006. The new guidance builds on existing guidance published in 1999 Safety for Trainees in Psychiatry (CR78). | East London and The City Mental Health Trust should review its policies and procedures against the recommendations in CR134 Safety for Psychiatrists and amend where indicated. | East London and The City Mental Health Trust | 2006 |
| The Trust should introduce a policy of involving families and carers in violence risk management and their views should form part of CPA documentation | ELCMHT fully supports this recommendation and the Trust's CPA Policy identifies the importance of the views of families and carers<br>1. Where appropriate (taking into account user's views and the safety of others) this is part of the systematic assessment particularly where family members have information to share or are potentially at risk<br>2. Carers have a right to an assessment of their needs and these are done across all parts of the Trust. In 2005-06 47 carers assessments were conducted in Newham | 1. Continued implementation of rolling programme of mandatory training of all trust staff involved in CPA process<br>2. Carers audit planned for summer 2006 involving representatives of the ELCMHT Carers Group | East London and The City Mental Health Trust | 1. On-going<br>2. June 2006 |

**INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH**
**JOINT ACTION PLAN**

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| **Co-operation and co-ordination between general and forensic services** | | | | |
| The PCT should commission a comprehensive forensic outreach service | This has been achieved.<br>A Consultant Forensic Psychiatrist works closely with community mental health teams and is able to offer advice on complex cases. There are also two Forensic Community Psychiatric Nurses located with the community teams providing specialist support to complex cases in the community | The ELCMHT Community Services Review will assess the impact of the Forensic Outreach Service, suggesting new models across the Trust where necessary | Newham Primary Care Trust<br>East London and The City Mental Health Trust | May 2006 |
| The forensic outreach service should offer a full range of services from advice to general psychiatric teams to full care in the community of patients who present sufficient risk of serious violence | | | | |
| **Liaison with the police and the decision to prosecute** | | | | |
| The Trust should follow the approach pioneered by the South London and Maudsley NHS Trust with Southwark Police. This process should amongst other things aim at agreement on charging policy | There are a number of liaison meetings with Newham Police at various levels.<br>• The Borough Director for Newham is a member of the Crime and Disorder Reduction Partnership Board<br>• Consultant Forensic Psychiatry and a senior manager attend the Multi Agency Public Protection Arrangement (MAPPA) meetings<br>• Mentally Disordered Offenders Group (MDO) feeds in to the MAPPA meeting and acts as a filter to significantly high risk cases | Consolidate work across the Trust taking account of local protocols | East London and The City Mental Health Trust/Metropolitan Police | Sept 2006 |

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| | • ELCMHT works with the Counter Fraud and Security Management Service (CFSMS) around the management of security in the NHS. CFSMS and the Legal Protection Unit work with the Police and the Crown Prosecution Service to apply criminal and civil actions | | | |
| **Mental Health Assessments** | | | | |
| The Trust should write to all staff involved in mental health care reminding them of the principles to be applied when assessing patients for possible detention under the Mental Health Act 1983 | The crucial people involved in patient assessments are Approved Social Workers (ASWs). ELCMHT's Practice and Development Manager has responsibility for setting standards and ensuring competence of ASWs.<br>• All ASWs have a handbook of local guidance which states the legislative framework code of practice, Mental Health Act Policies and Procedures Handbook<br>• There is a clear warranting and a 3-year re-warranting procedure in place for all ASWs<br>• All ASWs have refresher training at least twice a year and often more frequently<br>• The ASWs Forum meets every six weeks<br>• Trust-wide ASW training in place<br>• A rolling programme of Mental Health Act training is available for all staff | Audit of compliance with mandatory training programmes | East London and The City Mental Health Trust | On-going |

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| | • Annual Appraisal and Personal Development Plans are in place for all staff<br>• Section 12 Approved Doctors are subject to an annual revalidation process | | | |
| The Trust clinical governance procedures and medical appraisals should make explicit reference to competence and performance in mental Health assessments including those at court and in other settings outside hospital | Competence and performance issues regarding medical staff are taken forward by the Clinical and Medical Director via appraisals and personal development plans<br>• ASWs and Community Psychiatric Nurses (CPNs) are supervised by their line managers<br>• There is a clear warranting and re-warranting process in place for all ASWs<br>• A Mental Health Law Steering Group chaired by the Mental Health Act Practice and Development Manager has been established<br>• Annual appraisals and personal development plans are linked to the Knowledge and Skills Framework (KSF)<br>• A monthly Reflective Practice group is held to enable staff to hold peer reviews of complex cases<br>• An externally audited supervision management tool is in place across the trust | Action plan to be developed in response to re-audit of supervision practice | East London and The City Mental Health Trust | May 2006 |

**INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH**
**JOINT ACTION PLAN**

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| **Pre-birth planning and Protocols** | | | | |
| The Trust should ensure the adoption of a pre-birth protocol based on the London Child Protection Guidelines, familiarity with which should be part of the core competency of community mental health staff | A pre-birth planning protocol has been incorporated into the ELCMHT Safeguarding Children Policies. Since 2004 all new ELCMHT staff attend a Safeguarding Children course as part of their induction programme, an additional programme of mandatory training is in place for all clinical and non-clinical staff | • ELCMHT to agree and implement an updated Pre-Birth Planning Policy and training programme<br>• Training programme to be held twice yearly from 2006<br>• ELCMHT Women's Strategy Group to agree costed perinatal service model<br>• A comprehensive Safeguarding Children Policy and Implementation Plan will be presented the ELCMHT Board in May 2006 and monitored through Trust rolling audit programme<br>• A comprehensive Policy and Implementation Plan for the Care of Pregnant Women and Unborn Children will be taken to the ELCMHT Board in September 2006 and monitored through the Trust's rolling audit programme | East London and The City Mental Health Trust | 1. Dec 2006<br>2. June 2006<br>3. May 2006<br>4. Sept 2006 |

**INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH**
**JOINT ACTION PLAN**

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| The Trust Director with responsibility for safeguarding children and the named Child Protection Nurse should ensure that policy imperatives and guidance on pre-birth and post-natal care of women with a history of mental illness are disseminated in a relevant and timely manner. | ELCMHT has created a Safeguarding Children Team (SCT) accountable to the Safeguarding Children Committee of the Board. Each borough has a named Psychiatrist responsible for this area.<br>The SCT provides<br>• Advice, guidance, training and support and runs the Trust's training programme<br>• Represents the Trust on local Safeguarding Children Boards<br>• Has set up and electronic information folder available to all staff via a shared network drive<br>• Is alerted to all serious incidents involving children and pregnant women through the Trust's Serious Incidents Policy and reporting system, providing advice and contributions to investigations | 1. Comprehensive Safeguarding Children information, guidance and policy packs to be given to all wards and community teams<br>2. All packs to be regularly updated by SCT<br>3. Comprehensive training to be provided to all link workers, wards and teams<br>4. ELCMHT in partnership with local statutory agencies will agree and implement a Domestic Violence Policy<br>5. Director of Nursing to provide sessional training to Senior Managers on Safeguarding Children with a focus on domestic violence and perinatal issues | East London and The City Mental Health Trust | 1. Oct 2006<br>2. On-going<br>3. On-going<br>4. June 2006<br>5. May 2006 |

**INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH**
**JOINT ACTION PLAN**

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| **Documentation: Cumulative Clinical Summaries** | | | | |
| The Trust should introduce Cumulative Clinical Summaries embark on a consultation process with mental health teams to establish a timetable to implement this approach taking full account of the additional human resources implications for this in the short term | ELCMHT's electronic CPA system Sepia enables the production of cumulative clinical histories of patients. Consideration is being given to making this available as part of the new national electronic patient records system (RiO) for mental health being developed through the Connecting for Health programme | Audit compliance with Sepia system | East London and The City Mental Health Trust | May 2006 |
| The Panel experienced a great deal of difficulty in obtaining a complete set of all records, which were held by different teams and on different sites. We recommend the Trust undertake regular audit to ensure the effective implementation of an integrated care records system | • Integrated records system in place across the trust<br>• Record Management Policy and Records Keeping Standards in place<br>• Clinical Negligence System for Trusts (CNST) Level 1 assessment on new standards for mental health trusts record ELCMHT 100% compliance<br>• Trust-wide records audits across all teams undertaken on a rolling programme | 1. Continuous scrutiny through CNST process<br>2. The Clinical Records Management Action Plan to be updated following CNST review | East London and The City Mental Health Trust | 1. On-going<br>2. Sept 2006 |

**INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PH**
**JOINT ACTION PLAN**

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| **Confidentiality** | | | | |
| We can do no better than reproduce Recommendations 25-27 of the Joint NHS/MPS Review:<br>• There should be a clear policy statement from a pan-London alliance that confidentiality will be respected, information will only be shared when it is either in the best interest of the individual or there is concern for public protection and information will only be used fore the purposes for which it is being shared. We recommend that there be regular data cleansing in recognition of people's mental health status can change and improve.<br>• Systems and processes will need to be developed to achieve this.<br>• There is a need to clarify the legal framework, for example using case studies, making it easier for practitioners to understand the circumstances within which information can be shared.<br>• Where possible the individuals should be told that information is being sought from/shared with other agencies. The reasons for this should also be explained. | <u>ELCMHT response</u><br>• Information-sharing Protocol in place ratified by the NE London Caldicott Group<br>• Training materials in place<br>• Patient information leaflet disseminated on induction and widely available<br>• Half-day mandatory information governance training in place as part of induction programme and for existing staff<br>• Clear decision-making flowchart available<br>• Permission to share information form in use and retained in case notes<br>• Record keeping policy contains section on consent and confidentiality<br>• Records management training mandatory on induction<br>• Borough Director meets the Borough Commander through the Crime and Disorder Reduction Partnership Board. Other meetings are held including MAPPA and MDO meetings where individuals can be discussed within the information sharing protocol and in the interests the of the service | <u>ELCMHT Action</u><br>1. Audit of compliance against all policies and attendance at mandatory training part of Trust's rolling audit programme<br>2. Audit of all relevant documentation included in rolling audit programme<br><br><u>London-Wide Action</u><br>1. Conference to launch Review Report<br>2. Implementation team to look at disparity across London between current guidance resulting from the memorandum of understanding between police and health services, Bichard recommendations, and MAPPP processes<br>3. Action plan underpinning delivery of Review recommendations to be agreed | East London and The City Mental Health Trust<br><br>MPS/NHS Review Implementation Board | 1. On-going<br>2. On-going<br><br><u>London-wide</u><br>1. May 2006 |

| Recommendation | Action taken to date | Further Action | Responsible | Date |
|---|---|---|---|---|
| | user and public safety<br>• Legal framework training included in mandatory induction training and in training for existing staff | | | |