North East London NHS
Strategic Health Authority

REPORT OF AN INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF CHANDRAN SUKUMARAN

Distributed by

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Panel Membership

Miss Clare Price	Barrister and Chair of the Inquiry Panel
Dr Alice Parshall	Clinical Director, West London Mental Health NHS Trust
Miss Mary Walker	Independent Social Care Consultant

Summary

1. This Independent Inquiry was established to examine all the circumstances surrounding the care and treatment of Chandran Sukumaran who killed his father, Narayanan Sukumaran, on 2nd November 2001. The Independent Inquiry was jointly commissioned by the North East London Strategic Health Authority and the Social Services Department of the London Borough of Newham, and its terms of reference included a requirement that it have regard to the adequacy of co-ordination, collaboration, communication and organisational understanding between various agencies including both the Metropolitan Police Service and the London Probation Area of the National Probation Service.

2. The Inquiry was also required to prepare an Independent Report including such recommendations as may be appropriate and useful to the services involved and their commissioners and to present it to the Chief Executive of North East London Strategic Health Authority and the Director of Social Services in the London Borough of Newham.

3. Chandran Sukumaran has been diagnosed as suffering from bipolar affective disorder and hypomanic relapse.

4. Chandran was born in Kerala, India on 15th February 1970. His father came to England for an extended visit when he was very young and, whilst his father was away, his mother committed suicide. Chandran remained living in India until 1979 when his father decided that he and his sister should come to live in England. He developed mental health problems at about the age of 15 or 16 years and was admitted to a hospital in India for treatment in his late teens. Since 1990, he has had intermittent contact with psychiatric services in this country and on one further occasion in India. This contact has included a period of in-patient care in Goodmayes Hospital lasting six months between January and July 1991 during which admission he was compulsorily detained for assessment under Section 2 of the Mental Health Act 1983 and for treatment under Section 3. He was admitted to St. Martin's Hospital, Canterbury for about one month in January 1997.

5. In July 1997, Chandran was referred back to the mental health services at East Ham Memorial Hospital where he attended one outpatient appointment and was then discharged from the service following his failure to keep two subsequent appointments.

6. On 28th February 2001 Chandran assaulted a work colleague, kicking him in the face. He pleaded guilty to the offence of assault occasioning actual bodily harm and a Community Punishment and Rehabilitation Order was made in respect of this offence on 12th June 2001. Chandran was subject to the supervision of a probation officer for twelve months.

7. On 12th September 2001, Chandran's cousin made a 999 call saying that Chandran would not allow him entry to the flat where Narayanan Sukumaran was living.

8. On 27th October 2001, Naryanan Sukumaran and two members of his family went to East Ham Police Station to inform the police that Chandran suffered from mental health problems, was not taking medication, was liable to become violent and needed specialist help.

9. On 1st November 2001, Chandran's cousin made a further 999 call saying Chandran had threatened to harm his father and had been violent to people in the past, including having recently kicked a work colleague in the head. Two police officers visited Narayanan Sukumaran's flat and spoke to both Chandran and Naryanan Sukumaran. The police concluded that they had no reason to require Chandran to leave there, and advised that they should be called again if help was needed in the future.

10. On 2nd November 2001, Chandran Sukumaran killed his father. On 15th May 2002 he pleaded not guilty to his murder but guilty to manslaughter, and was made the subject of an Order under Section 37 of the Mental Health Act 1983 with a Restriction Order under Section 41.

11. This Inquiry has therefore investigated (as far as it has been possible) the nature of Chandran's care and treatment over a significant period of time stretching back to when he was a teenager. We have also had to investigate how people with mental health problems can gain access to the services they require and how the various agencies involved responded to requests for help.

12. We have kept in mind throughout the course of this Inquiry that the provision of mental health services within a community setting has changed over the past decade and is continuing to evolve. However, we were not satisfied that the various agencies which come into contact with people with severe and enduring mental illness are working as effectively as they could and should, to ensure timely access to specialist mental health services is available when necessary. We are concerned that further crises will occur unless this issue is addressed, and the need for clearly defined contact points with secondary psychiatric services is identified and acted upon.

13. We also doubt whether carers' assessments are being carried out in all relevant cases as they should, and whether health and social services care is then being provided to meet identified needs. During the course of the Independent Inquiry, we were told that there are resource and training implications relating to the support of carers which are not always easy to resolve. Still, we feel this issue has to be tackled.

14. We have looked at the care and treatment of one service user only, and our conclusions and recommendations are based on the evidence we have heard about him. We believe there are many dedicated, conscientious and hardworking people working at all of the agencies with which the Inquiry has been involved. Nonetheless, a very significant number of Independent Inquiries has been conducted over the past ten years, and we note that the issues which arose for our consideration have been the subject of many of them. In this instance some of the relevant events occurred as recently as 2001, by which time a co-ordinated, collaborative inter-agency response should have been made to them. We cannot emphasize too strongly to the commissioners of this report the need for there to be a sustained and concerted effort to improve access to mental health services and support mechanisms for families and carers if effective care and treatment is to be provided in a community setting.

15. The full text of our recommendations appears at the end of the report. The Inquiry Panel has also incorporated comments and conclusions in bold type throughout the body of the Report. We hope and intend that both our observations and our recommendations will be used as a reference point in the commissioning and provision of psychiatric help and assistance.

16. In outline, we recommend:

- There should be a review of the implementation of Care Programme Approach policies and procedures in the London Borough of Newham with particular emphasis on the rôle and needs of those who care for service users and on the transfer of care between different localities and agencies.

- The quality of the links and interaction between East London and The City Mental Health NHS Trust and the Metropolitan Police Service should be reviewed, with particular attention being paid to the need for there to be a comprehensive referral system to specialist mental health services which works at an operational level on a day-to-day basis.

- East London and the City Mental Health NHS Trust should review with the London Probation Area of the National Probation Service their respective roles in the assessment and management of offenders with severe and enduring mental illness.

- East London and the City Mental Health NHS Trust must implement as a priority its intended system of integrated case records which will be an important step towards providing a comprehensive service.

Acknowledgements

First of all, I wish to thank all of the witnesses who gave evidence to the Independent Inquiry into the Care and Treatment of Chandran Sukumaran. I had no power to compel anyone to attend an interview. I am fully aware that to do so is time-consuming and often burdensome for witnesses. The prospect of attending an interview can give rise to anxiety. Nonetheless, a considerable number of people did attend and they sought to help us, as far as they were able, with our investigation. We learned an immense amount from them without which it would have been almost impossible to conduct a thorough review of the circumstances leading to the sad death of Narayanan Sukumaran. Their evidence also helped us greatly in our understanding of the nature of the relevant services presently available to service users in the part of London with which we were concerned. I am very grateful for their co-operation and for that assistance.

Secondly, I wish to thank Dulara Khatun who has been the manager of the Inquiry throughout. Her hard work, patience, good humour and, at times, considerable persistence have all made a significant contribution to the conduct of the Inquiry.

Thirdly, I am very appreciative of the effort that has gone into the preparation of the interview transcripts and wish to thank Fiona Shipley Transcription Limited for this. The transcripts have been exceptionally useful to the Inquiry Panel both as the Inquiry progressed and in the preparation of this report.

Last, but by no means least, I express my gratitude to my fellow Panel members, Dr Alice Parshall and Miss Mary Walker, for the help and advice which they have given to me during the course of this Independent Inquiry. They have impressive and extensive knowledge and experience in their specialist fields and made many helpful comments and observations for which I am very grateful. They also have great compassion for, and commitment to, those in need of the services with which this report is concerned, and this was inspiring to encounter.

Clare Price
April 2004

Alphabetical list of Witnesses

Name	
Dr Richard William Bamber	Consultant Psychiatrist, East Kent Partnership and Social Care Trust NHS Trust
Angus Cameron	Mental Health Manager, London Probation Area
Dr Joan Feldman	Consultant Psychiatrist, East London and The City Mental Health Trust
Caroline Godleman	Head of Mental Health, Drug and Alcohol Integrated Services, Newham
Inspector Mike Holland	Metropolitan Police Service Mental Health Liaison Officer for Newham
Sulekha Jaykumar	Chandran Sukumaran's sister
Kevin Mullins	Director of Services, Newham Locality, East London and The City Mental Health Trust
Biju Ramkrishnan	Chandran Sukumaran's cousin
Sobhana Ramkrishnan	Chandran Sukumaran's aunt
Dr Frank Röhricht	Consultant Psychiatrist, East London and The City Mental Health Trust
Brian Sanders	Approved Social Worker, London Borough of Newham
Superintendent Roger Smalley	Metropolitan Police Service, Newham
Sonia Stewart	Probation Officer - London Probation Area of the National Probation Service
Chandran Sukumaran	Subject of Independent Inquiry
Sujita Trousdale	Chandran Sukumaran's cousin

Introduction – The Independent Inquiry

1. On 2nd November 2001, Chandran Sukumaran killed his father, Narayanan Sukumaran. On 15th May 2002, he pleaded not guilty to murder but guilty to the manslaughter of his father at The Central Criminal Court. This plea was accepted by the Crown Prosecution Service. His Honour Judge Coombe made an Order under Section 37 of the Mental Health Act 1983 with a Restriction Order under Section 41.

2. Chandran was born in India but came to live in England in 1979. In the later part of the 1980s, he began to experience mental health problems leading initially to admission to a hospital in India and subsequently to admissions to both Goodmayes Hospital in Essex (in 1991) and St. Martin's Hospital, Canterbury (in 1997). The admission to Goodmayes Hospital followed incidents where he had punched his father, was said to have threatened him with a knife and had caused a significant amount of damage to his father's flat and its contents. A diagnosis of bipolar affective disorder was made. At various times from 1991 onwards, appointments were made for him to attend psychiatric outpatient clinics although, far more often than not, he failed to do so.

3. On 20th March 2001, Chandran pleaded guilty at Horseferry Road Magistrates' Court to an offence of assault occasioning actual bodily harm after he had kicked a work colleague in the head. On 12th June 2001, a Community Punishment and Rehabilitation Order was made in respect of this offence.

4. Given Chandran's history of contact with mental health services, East London and The City Mental Health NHS Trust recognised the need for an Internal Inquiry into his care and treatment to be held following the death of his father. Other than in the recommendations at the end of this Independent Inquiry report, East London and The City Mental Health NHS Trust is referred to as "the Trust" throughout this report.

5. The Internal Inquiry met for the first time on 12th March 2002 and held interviews in April and May 2002. The Internal Inquiry Panel prepared a report in May 2002 which concluded that "the prevailing pattern of all the contacts of Mr CS with mental health services was one of very limited engagement, unwillingness to continue with contact once he was well, and no evidence that there was any difference in this regard between Mr CS and the members of his family". A key feature of concern was Chandran's "difficulty in maintaining contact with mental health services, and his constant non-attendance at appointments" although the Internal Inquiry Panel also acknowledged that "particular technical issues relate to the difficulties of following up a patient with bipolar affective disorder (manic depressive psychosis) who is on Lithium, but stable". In addition, the Internal Inquiry Panel concluded that there seemed to be evidence that "the police had been advised by the relatives (and ? father) of Mr CS prior to the index event as to their concerns about Mr CS' behaviour" although, for reasons which the Internal Inquiry Panel recorded it did not know, it understood that those concerns did not appear to have been forwarded to a mental health team.

6. In summary, the Internal Inquiry made four recommendations:-

   a) Consideration should be given to enhancing the resources available to patients presenting with psychotic illnesses in the early stage of those illnesses, either via a formal Early Intervention System or the individual practices of Community Mental Health Teams.

   b) All formal assessments of a patient should be disseminated to the relevant community mental health team for that patient and his/her General Practitioner, and formal liaison should be established by all community mental health teams with the police.

   c) The ready and quick availability of psychiatric assessments should be a priority of community mental health teams with regard to court cases, police contacts, GP surgeries and family homes. Experienced nursing, social or medical staff should be available to make assessments at times when individuals present with active symptoms of mental illness.

   d) Regular agreed communication, co-operation and joint training should be undertaken with the police.

7. Given the circumstances of this case, it was recognised that, in addition to the Internal Inquiry, there had also to be an independent review of Chandran's care and treatment. The National Health Executive Circular *"Guidance on the discharge of mentally disordered people and their continuing care in the community"* HSG (94) 27 states that, if a violent incident occurs involving somebody who has had contact with mental health services, it is important not only to respond to the immediate needs of the patient and others involved but in serious cases also to learn lessons for the future. Paragraph 34 of the circular provides that:

   "In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved."

8. Accordingly, this Independent Inquiry was jointly commissioned by the North East London Strategic Health Authority and the Social Services Department of the London Borough of Newham.

Terms of reference

9. The terms of reference for the Independent Inquiry are dated 27th September 2002 and are as follows:

   1. The Inquiry will examine all the circumstances surrounding the treatment and care of Chandran Sukumaran, and in particular:

   1.1. The quality and scope of his health and social care and any assessment of risk;

   1.2. The appropriateness and quality of any assessment, care plan, treatment or supervision provided, particularly having regard to

1.2.1. His past history
1.2.2. His psychiatric diagnosis
1.2.3. His assessed health and social care needs
1.2.4. Carers' assessments and carers' needs
1.2.5. His ethnic origin, religion and culture
1.2.6. Any risk to his father and other family members
1.2.7. The support needs of his father and other family members
1.2.8. The interaction with the Metropolitan Police Service and the Probation Service;

1.3. The extent to which his care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health including the Care Programme Approach HC (90) 23/LASSL(90)11 and the Discharge Guidance HSG (94) 27 and local operational policies;

1.4. The extent to which his care and treatment plans

1.4.1. Reflected an assessment of risk

1.4.2. Were effectively drawn up, communicated within and beyond mental health services, and monitored

1.4.3. Were complied with by Chandran Sukumaran.

2. The Inquiry will examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care of Chandran Sukumaran or in the provision of services to him, in particular whether all relevant information was effectively passed between the agencies involved and other relevant agencies, and whether such information as was communicated was acted upon adequately.

3. The Inquiry will examine the adequacy of the communication and collaboration between the statutory agencies and any family or informal carers of Chandran Sukumaran.

4. Consideration of the management of risk should consider with equivalent attention the risk to himself and the risk to others presented by Chandran Sukumaran and whether his treatment and care were proportionate.

5. The Inquiry will be held in private.

6. The findings of the Inquiry and any recommendations and ensuing action plans will be made public.

7. The evidence which is submitted to the Inquiry orally or in writing will not be made public by the Inquiry, except as is disclosed within the body of the Inquiry's final report.

8. All witnesses of fact will receive a letter in advance of appearing to give evidence informing them:

   8.1. of the terms of reference, the membership and the procedures adopted by the Inquiry;

   8.2. of the areas and matters to be covered with them;

   8.3. requesting them to provide written statements to form the basis of their evidence to the Inquiry;

   8.4. that when they give oral evidence they may raise any other matter they wished and which they felt might be relevant to the Inquiry;

   8.5. that they may bring with them a friend or relative, members of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of anyone connected with the commissioning of the Report;

   8.6. that it is the witness who will be asked questions and who will be expected to answer;

   8.7. that panel members cannot be cross-examined;

   8.8. that their evidence will be recorded and a copy sent to them afterwards for them to sign and amend if necessary.

9. Witnesses of fact were to be asked to confirm their evidence was true.

10. It is not a principal objective of the Inquiry to seek to blame individuals, although if serious negligence or incompetence is uncovered, the Inquiry should make such findings known and give the individuals concerned the opportunity to respond. Any points of potential criticism will therefore be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given a full opportunity to respond.

    The commissioners reserved the right to refer individual practitioners to the relevant professional bodies where negligence or incompetence is identified.

11. Written representation may be invited from voluntary or other organisations and other interested parties as to present arrangements for persons in similar circumstances as the present Inquiry and as to any recommendations they may have for the future.

    These witnesses may be asked to give oral evidence about their views and recommendations.

12. Anyone else who feels he may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

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

14. The Inquiry will prepare an Independent Report including such recommendations as may be appropriate and useful to the services involved and their commissioners and present it to the Chief Executive of North East London Strategic Health Authority and the Director of Social Services in the London Borough of Newham.

15. The commissioners will invite relevant agencies to respond to the Inquiry report through a joint action plan which will be published together with the Inquiry report.

Procedure

10. As appears above, the procedure to be adopted by the Inquiry was, to some extent, provided for within the terms of reference.

11. The starting point of the investigation into the care and treatment of Chandran Sukumaran was to obtain his consent to the Inquiry Panel using relevant records relating to his care and treatment for its review and for the preparation of this report. We obtained copies of those records which were available and seemed to be relevant to our Inquiry. These included those medical records which could be found, Newham Social Services notes and records held by the Metropolitan Police Service and the London Probation Area of the National Probation Service.

12. From those records and through contact with the Trust, the joint commissioners of this report, the Metropolitan Police Service and the National Probation Service, we then sought to identify those witnesses who we believed to be able to give material information to the Inquiry. The manager of the Inquiry then attempted to make contact with those possible witnesses. She was unable to locate a Dr Nadeem Bhatti who was working at The Market Street Health Group in East Ham, London in 1997. She learned that an employee of the Probation Service who had had some involvement with Chandran's case had died. Dr Alagrajah (who was Chandran's GP in the early 1990s) did not respond to any of the letters sent to him and we subsequently learned that he has retired. However, contact was made with all of the other people who seemed likely to be able to give evidence which was material to the matters the Inquiry Panel had been asked to investigate. They were then invited to attend to give evidence to the Inquiry Panel. Readers of this report will find reference in it to some people who were not asked to attend an interview; the Inquiry Panel has sought to ensure that the evidence it heard was likely to be relevant and proportionate to its terms of reference.

13. Most of the witnesses who gave evidence to the Independent Inquiry came to Aneurin Bevan House, 81 Commercial Road, London E1 or to Hailsham Chambers, 4 Paper Buildings, Temple, London EC4. We visited Chandran at the John Howard Centre which is East London and The City Mental Health Trust's Medium Secure Unit. His sister, Sulekha Jaykumar, preferred not to come to Aneurin Bevan House and we therefore saw her at a different location.

14. Once the Inquiry had heard all of the evidence, a draft report was prepared. The relevant parts of that draft report were forwarded to those agencies and individuals who could be the subject of criticism in the final report. They were all given the opportunity to respond to the possible criticism either in writing or by attending a further interview. The draft report was also provided on a strictly confidential basis to the commissioners of the Independent Inquiry and to the Chief Executives of the Trust and of Newham Primary Care Trust. We received a number of responses to the draft report. The Inquiry Panel then met to consider all of those responses and made amendments to the draft report as a result of them.

15. The conclusions we have reached and the opinions we express in this Report are based on the evidence we have heard and read in the course of our review of the care and treatment of Chandran Sukumaran and on the responses we received to the draft report.

16. Throughout this Inquiry, we have borne in mind that we have been investigating the care and treatment of a patient over a considerable number of years and that the provision of both mental health and social services has changed and developed over that time and, indeed, continues to do so. For some of the time with which we have been concerned, the Care Programme Approach was in its infancy and not fully implemented in many areas of the country. In some instances, we realize that, were similar circumstances to arise now, a different approach might be taken and a different outcome might be achieved. Where appropriate, we have sought to identify the changing nature of the relevant services to the present day. At the end of this report, we set out recommendations which we hope will assist in improving services for people who have mental health needs now and in the future.

Chapter 1 – Chandran Sukumaran's Family Background

1. Our understanding of the background to this tragic incident is based on both the records provided to us and on the evidence we heard from various witnesses. Four members of Chandran's and Narayanan Sukumaran's family gave evidence to the Inquiry. We record here that each one of them was an impressive witness who gave his or her account to us in a calm and dignified manner. They recalled events clearly and gave a straightforward and cogent account of them to the Inquiry Panel. Of the four family members, only Chandran's aunt needed an interpreter to be able to talk to us. It was clear to us that the events we have been asked to investigate gave rise to real concerns for them and that they are very attached to, and anxious about, Chandran. We learned a lot about the family from these witnesses which was not recorded in any of the documentation with which we had been provided at the start of the Inquiry. Our view of the importance of this information will become apparent from later parts of this report.

2. Two members of the Inquiry Panel also spoke to Chandran for a considerable length of time one afternoon. He was willing to talk to us about all aspects of his life, including his illness and the effect which he perceived it to have. He answered every question that we asked him.

3. Chandran was born in Kerala, India on 15th February 1970. He has one sister, Sulekha Jaykumar, who is almost two years older than him. Their father came to England for an extended visit when they were very young and they remained living in India with their mother. We were told that their mother was extremely anxious about a financial problem she had been hiding from her husband and, on learning that he was returning to India, she committed suicide because she was worried about how he would react towards her as a result of this financial difficulty. It appears likely that both of her children were close by when she committed suicide by jumping into a well. We were told that her sister had also previously killed herself.

4. Chandran told the Inquiry that his father was not prepared to talk to him about his mother as he was growing up. Whenever Chandran mentioned her, he was told not to talk about her and that she had made a choice to take her life and leave her children behind. Chandran said he thought her death had "hurt [his father] deep inside".

5. Chandran and his sister initially moved to live with relatives in India whilst their father returned to England. Chandran went to primary school there. However, in 1979, when Chandran was nine years old, their father brought both children to live here also.

6. Chandran and Sulekha Jaykumar went to school together when they first came here. They were at Nelson Primary School in Newham. Chandran went on to Langdon Secondary School in East Ham. Sulekha Jaykumar told us that they found attending school in England difficult because they were being taught in English and struggled at school. Their first language is Malayalam. However, she emphasised that Chandran is a very talented artist, describing him as "really brilliant" at art. Chandran said that he had difficulty learning English and that "academically I wasn't good" although he enjoyed art and considers he had produced a lot of good work over the years.

7. When the family moved to this country in 1979, they went to live at Mr and Mrs Ramkrishnan's house. Narayanan Sukumaran was Mrs Ramkrishnan's uncle. Mr and Mrs Ramkrishnan have three children who are of similar ages to Chandran and Sulekha Jaykumar. The five children got on very well together. Sulekha Jaykumar told us that she and her brother were "so happy" when they lived there. Sujita Trousdale said that her family "welcomed them" and the children "were really pleased that we had two more children to play with. They were part of the family". Biju Ramkrishnan said Chandran was "just a normal kid". Biju Ramkrishnan is a year older than Chandran and he said they used to fight but our clear impression was that this was no more than siblings often do. Indeed, Biju Ramkrishnan kept an eye on Chandran at school and said he was "a happy child". Chandran was described as "a very boisterous child" and "incredibly naughty" but Mrs Ramkrishnan had become a mother figure to both him and his sister and she coped very well with him. Sujita Trousdale said he "was secure, he was well loved" and Chandran said he was happy living with his aunt.

8. Chandran told us that when he was about 15 or 16, he punched a boy who was bullying another child and had smashed up his (Chandran's) artwork. This is the only incident of his having hit somebody or of any other significant aggression for that matter whilst he was young that the Inquiry Panel was told about.

9. It is, however, clear that Chandran's relationship with Narayanan Sukumaran was complicated and sometimes a very unhappy one. Sulekha Jaykumar explained that their father did love them but said he did not display that love to them. He was often angry with them. Whilst she continued to respect her father, she said her brother did not and became angry with him, sometimes saying "I'm going to kill him" when he was young.

10. Sujita Trousdale described Chandran's relationship with his father as "very remote". She said that Narayanan Sukumaran had "minimal contact" with his children and he seems to have kept himself to himself, although she described him as believing "in corporal punishment to the extreme". She told the Inquiry that Narayanan Sukumaran was a violent man who lost his temper quite easily and hit Chandran. Chandran said he was not good at academic work and his father often hit him and told him to go to his room and study. Similarly, Biju Ramkrishnan described Narayanan Sukumaran as being very strict and not showing much love towards his children. He told us that, as children, they had hated him and that Narayanan Sukumaran used to beat the children (including Mr and Mrs Ramkrishnan's) but this did not happen in front of his parents.

11. The living arrangement at the Ramkrishnans' home ended in about 1985 following a dispute between Narayanan Sukumaran and Mr Ramkrishnan about the former's treatment of Biju Ramkrishnan, who told us that Narayanan Sukumaran had beaten him with a tennis racquet after an argument. As a result of this, Mr Ramkrishnan asked Narayanan Sukumaran to move out of his house. Mr and Mrs Ramkrishnan and their children would have liked their cousins to remain living with them but Narayanan Sukumaran insisted that his children had to move out with him. Sujita Trousdale said her father told him not to take the children with him but Narayanan Sukumaran forced them to go and they moved to live in a number of different homes with various friends and relatives. Whilst she thought Sulekha Jaykumar was prepared to go with her father and described her as going "with the flow", she said Chandran begged not to be taken and found the decision "very traumatic". This change of home led to a very unhappy time for both Chandran and his sister. They were unsettled and missed the family life they had had previously. Sulekha Jaykumar said Chandran was very unhappy and that he changed, by which she explained that she thought he became ill. To use her words, she said "After that this disease begin (sic)."

12. Shortly after the move from the Ramkrishnans' house, Sulekha Jaykumar got married. She went to live in India and remained there between about 1985 and 1997 when she returned to England. Her husband stayed in India for a number of years after that.

Comment

There were several adverse elements to Chandran's early years, namely the early loss of his mother when she committed suicide, the subsequent move to live in England, his difficult relationship with his father who was strict and at times abusive, and the disruption of the move from his "foster" family with whom he was happy. Taken together, these elements were such that there was a significant possibility of his developing a vulnerability with regard to progression of his personality and his ability to form attachments.

In our view, these factors are also of very real relevance to Chandran's subsequent killing of his father. We believe they underpin the very powerful and mixed feelings Chandran had towards him. The force of the adversity of his early upbringing was not evident in the subsequent contemporaneous clinical information that we examined.

Chapter 2 – The Onset of Chandran Sukumaran's Illness

1. Sulekha Jaykumar says her brother became unwell from about the age of 15 years. Biju Ramkrishnan explained that he began to talk "about God and just unusual things, which I knew wasn't the Chandran I knew". Chandran described himself as "becoming very hyperactive" and "talking too much". As far as we could ascertain, his family arranged for him to go to India where he was admitted to hospital in the late 1980s, because he was unwell. Little is known about this admission. We have seen no records from the hospital and the family members to whom we spoke knew few details since they were not directly involved. His sister told us that he came to her crying and saying he had lost his life and that, because of the way he was talking and acting, a decision was taken (largely, it seems, by her husband) to have him admitted. It is her understanding that whilst he was an inpatient Chandran was given electro-convulsive therapy and medication - but she did not know which. It is possible this was Lithium Carbonate, which is a name with which his family is familiar. Chandran said this was the medication prescribed. After a while, he appeared to the family to be better again and he insisted on returning to England. He says he decided to stop taking his medication. For a short while, it seems that his relationship with his father improved.

   Comment

   Chandran's first presentation with symptoms of severe and enduring mental health problems was when he was about 15 years old. This is a very young age for the onset of such problems. His symptoms were sufficiently severe for his family subsequently to have arranged for his admission to hospital in India where he received ECT. Yet we found no evidence that the earliness of the onset of the disorder featured conspicuously in the assessment and management of his illness and his prognosis.

2. The first record of Chandran seeking medical help in this country for mental health problems is on 17th April 1990 (he was then 20 years old) when, according to his medical records, he went to his then GP, Dr Alagrajah, saying that "some one did evil for me". He talked of wanting to take revenge on the "family at 32 Hall" who had given him some medication to kill him, and said that he was hearing voices at times. We have been unable to find out whether this was a reference by Chandran to a real family; it is possible he was intending to refer to the Ramkrishnans. On 23rd April 1990, Dr Alagrajah referred him to the London Independent Hospital for a psychiatric assessment where he was seen by a Dr Orton on 26th April 1990. Dr Orton wrote to Dr Alagrajah saying that Chandran:

   > "has either a manic illness, or an early psychosis. He has grandiose ideas of being able to control rainfall, and having a mission to save the poor people of Ethiopia, and talks of hearing "voices" but it is not clear whether these are true hallucinations.
   >
   > What is clear is that he requires sedation, and assessment over a period of time. He has no insight, but from his own and his father's account does not present a threat to himself or others and so admission under a Section of the Mental Health Act is not appropriate at present.

I suggest that he is prescribed tabs Melleril 100mg qds, although he will probably not take them. ... (illegible) wish to ask his catchment area psychiatrist to make a domicillary (sic) visit. You could also ask the Community Psychiatric Nurse to visit and assess him, preferably over several days."

3. After this letter, Dr Alagrajah referred him to Newham General Hospital for a psychiatric appointment. Chandran failed to keep his outpatient appointment on 18th June 1990. On 20th June 1990, Dr Feldman, Consultant Psychiatrist, wrote to Dr Alagrajah saying that the department was very busy and did not "routinely send second appointments". She invited Dr Alagrajah to re-refer him if he thought it was needed.

Comment

Non-attendance at psychiatric outpatients remains a risk area. On the one hand, psychiatry has a higher rate of patients failing to attend outpatient appointments than other specialities and this is seen as an adverse key performance indicator. On the other, it is impracticable assertively to follow up every referral from primary care who does fail to attend. Even with the introduction of full booking, this will remain a live issue. What is clear is that the risk has to be managed in the context of the relationship between primary and secondary care. General Practitioners have a responsibility to target referrals to psychiatric services and to help to identify those patients with high needs, i.e. to assist the secondary services by managing the volume and nature of the work referred. Secondary care has a responsibility to target its services appropriately.

4. On 24th June 1990 Dr Alagrajah prescribed Melleril for the first time for Chandran, recording that this was in accordance with the advice given by Dr Orton. As we have explained in the introduction to our report, Dr Alagrajah did not reply to letters written to him on behalf of the Inquiry. We have therefore not been able to ascertain his views about Chandran's condition at this time and have had to rely on the contents of the notes made about him in his GP records in writing this report.

5. On 23rd July 1990, Dr Alagrajah recorded that Chandran was taking Camcolit (Lithium Carbonate) and that he had had a "manic illness" for six months. As we have observed above, it is possible that Lithium was first prescribed in India. There is no record in Chandran's medical notes of its first being prescribed in this country.

Goodmayes Hospital

6. As far as we were able to ascertain, Chandran's next contact with mental health services was on 7th January 1991. On that day, he was admitted to Rosemary Ward at Goodmayes Hospital, Essex for assessment pursuant to Section 4 of the Mental Health Act 1983. Rosemary Ward is an acute adult psychiatric ward where Dr Feldman acted as the Responsible Medical Officer.

7. On 8th January 1991, Chandran was detained for assessment pursuant to Section 2 of the 1983 Act. His family told us that he and his father were living together in a flat in Corporation Street, London E15. Chandran became violent towards his father, tied him to a chair and appears to have threatened him with a knife. No other family members were present but Sujita Trousdale understands that Chandran told him "I want to see if you have a heart". Chandran also caused a large amount of damage to the flat and its contents.

8. Chandran's recollection of the reason for his admission to Goodmayes Hospital was that he had stopped taking his medication on his return from India and had become very violent because he thought people "were after me - I got delusional thoughts". He explained:-

   "I thought everyone was trying to kill me and things like that and I locked myself in the flat and I started hallucinating. I wasn't sleeping well either. I think I smashed the furniture in the wall. I thought people were moving around...

   "I threatened [my father]. I thought he was someone else, I didn't think he was my father. I made this heart in art class and I asked him, do you have a heart inside you, you don't show any love, that kind of thing. On the report it said I tied him down and said I was going to pull the heart out to see if he has a heart. I don't believe I did that. I chucked him out. I threw the mirror at the wall and I told my father to leave the house and he just walked out of the house. Then the police came down and took me to the police station. They thought my behaviour was very irrational. I had delusional thoughts and they thought I was mentally ill and they took me to Goodmayes Hospital."

9. The Part One discharge summary which is dated 11th January 1991 records, amongst other information, that he:

   "was very well up until about eighteen months ago when he became "high", talking fast and loudly, and occasionally hitting his father. He was sent to India, staying there for three months, and during this time he was admitted to a private hospital. However, when he returned to England he was non-compliant with the medication prescribed for him in India. Subsequently there has been a great deal of friction between him and his father who ... is a very aggressive man and who refuses to allow Chandran to watch television, have regular baths, etc. Over the past month Chandran has become high again, often hitting his father. He has spoken about his father killing his mother who died when Chandran was very young.

   "About two weeks ago Chandran and his father were having a lot of rows which were so distressing to the patient that he called the Police, claiming that his father was going to kill him. Subsequently he was taken to the friend's house, returning to his father's flat a day later. However, the rows continued and Chandran punched his father. It is alleged that at one point he threatened his father with a knife and so his father left the flat and went to stay with a friend, returning to the flat later on in order to get some medication. However, Chandran would not let his father in. For about three days Chandran was living in the flat alone, refusing to answer the telephone or the door. Eventually the Police were called by his neighbours as Chandran was heard to be smashing the flat up. Apparently he had broken many of the windows and some of the furniture, and had strewn paint and rags all over the floor of the kitchen."

Comment

The clinical and discharge information gave a comprehensive account of what was then known about Chandran's condition save that there was, by then, probably a five to six year history of illness, not eighteen months.

10. The differential diagnoses for Chandran's condition were hypomania, schizo-affective illness, schizophrenic illness and drug abuse (although it seems that there was no evidence which was sufficient to confirm the abuse of drugs). Having apparently initially been prescribed Chlorpromazine on a p.r.n. basis, this prescription was changed to 150mgs orally q.d.s.. Dr Feldman told the Inquiry she had no clear recollection of Chandran, that she had several Indian patients with fathers and that she could not remember which couple this was. She added that it was "quite a common scenario of fathers and sons who lived together and fighting".

11. Chandran remained an in-patient at Goodmayes Hospital until 16th July 1991. On 29th January 1991, he smashed six windows in a television room at the hospital and was assessed and detained for treatment under Section 3 of the Mental Health Act 1983. On assessment by an approved social worker, Paul Mahoney, he was described as follows:-

    "to be quite deluded in his conversation making very little sense. He repeated in various fashions that he had discovered the invisible formula which was a cure for aids (sic), prevented glass from smashing (!), helped him be a genetic engineer; gave him abnormal strength because he was surrounded by a special magnetic force.

    "Talked of the devil being after him and preserving eggs in the fridge. Wanted to be a great scientist like Da Vinci and have the attributes of Sherlock Holmes. Claimed he could fly through space though he hasn't tried this yet.

    "Chandran appeared co-operative in taking medication, but was very keen to go home saying he missed his dad, regretted his behaviour, but he was not ill. Asked about the damage at home including the destruction of the cooker and fridge, he said he connected all the wires up because his powers make him resistant to electricity and pain."

12. His diagnosis on discharge was bipolar affective disorder and hypomanic relapse. The following description of his mental state and treatment is contained in the Part Two discharge summary dated 19th July 1991which was signed by Dr Levi, Dr Feldman's then Registrar.

    "At the beginning of February he was extremely disinhibited singing "rock and roll", with the grandiose delusion that he had the cure for AIDS, he was extremely restless, jumping round the ward, dancing, and his mood was clearly elated. He exhibited mild pressure of speech and flight of ideas. Initially he was tranquilised with Haloperidol 20mgs q.d.s. and Lorazepam 4mgs t.d.s., both via the intramuscular route, and then switching to the oral route, gradually reducing both drugs and stopping them.

    "Initially he was treated with the mood stabilizer Carbamazepine, but this was gradually phased out and instead he was put on Lithium Carbonate since he did not appear to respond to Carbamazepine. In addition he was switched from Haloperidol to Chlorpromazine because the latter appeared more effective. The combination of Lithium Carbonate with gradually reducing doses of Chlorpromazine appeared to be the holding combination for him with regard to pharmacological therapy. Eventually he was established on Lithium Carbonate 800mgs nocte and his Chlorpromazine was gradually phased out. Unfortunately he was given notice to quit his flat while an inpatient and his accommodation is somewhat in the air.

    "By the time of discharge he was free from any affective or psychotic symptoms and after periods of gradually increasing leave he was very settled. "

13. Chandran's medication on discharge was Lithium Carbonate 800mgs nocte. His proposed treatment plan was:

a) To be followed up in the outpatient clinic at Newham General Hospital by Dr Littlejohn (a Psychiatric Registrar) about two months later when his Lithium Carbonate was to be regularly reviewed with serial serum Lithium levels to ensure that the Lithium level was within the therapeutic range.

b) A Section 117 meeting had been planned for 15th October 1991.

c) Referral to the Community Psychiatric Nurses' (CPN) team at the Lord Lister Health Centre for support.

d) Lithium Carbonate treatment for at least two years.

e) A Social Worker with the Mental Health Team was to keep in touch with both Chandran and his father with regard to their housing situation and to ensure that they both got appropriate representation for a pending Court appearance.

f) Encouragement to re-attend his art course at St Martin's College.

The Treatment Plan

Outpatient review

14. On his discharge from Goodmayes Hospital, Chandran seems to have gone to live briefly with the Ramkrishnans. He then returned to the flat in Corporation Street and lived there with his father.

15. He did not attend an outpatient appointment on 16th September 1991, which had been arranged in accordance with the treatment plan on discharge from Goodmayes Hospital.

16. On 20th September 1991, Dr Littlejohn wrote to a Peter Williams at the Homeless Persons Unit supporting an application by Chandran for assistance with his housing needs. Dr Littlejohn recorded:

> "Mr Sukumaran had a long admission to Goodmayes Hospital ... He made an excellent recovery and was free of any symptoms when he left hospital. Unfortunately, his mental illness tends to recur and he is quite likely to have serious breakdowns in the future. ...
> "Mr Sukumaran junior remains vulnerable to stress and in need of continued assistance from your department."

17. On 28th January 1992, Dr Feldman saw Chandran Sukumaran (and his uncle) for half an hour. She had been asked to prepare a report expressing an opinion as to whether he was well enough to give instructions to his solicitors in relation to a claim for personal injuries arising out of an accident on 2nd August 1987. She reported as follows:

"On examination Mr. Sukumaran presented as polite and courteous. His mood was normal, as was his talk. He told us that he had been taking his Lithium regularly and was well aware of the consequences if he did not. He gave us a clear account of the reason for his presence at the ward round and understood perfectly that he was in the process of settling a claim for his personal injuries which he seemed to think was very acceptable to him. He seemed to comprehend perfectly the his (sic) situation in life, the details of his illness and the requisites for further progress with his health and career. He had insight into the nature of the illness that he had suffered.

"In my opinion, at the present time there is no evidence of mental disorder. Mr. Sukumaran seems quite capable of giving instructions to his Lawyers and is well aware of what is happening around him and his situation."

18. On 27th March 1992, Chandran did not attend an outpatients appointment. Dr Feldman wrote to Dr Alagrajah saying that he had not attended the outpatients' clinic and would not automatically be sent a second appointment. She added the following postscript to her letter:

"This man is on Lithium and needs to have his Lithium Carbonate blood level checked routinely. I will try to persuade him to come to outpatients but failing this I wonder whether you could make sure that his Lithium levels are within normal limits. He needs his blood level to be checked at least every 3 months."

19. On the same day, Dr Feldman also wrote to Chandran saying she was sorry not to have seen him at her outpatients' clinic and explaining the need for his Lithium level to be checked. She said he should contact either her or his GP. During the course of 1992, Dr Alagrajah appears to have prescribed Camcolit (Lithium Carbonate) 400mg on 24th February 1992, 30th March 1992, 11th May 1992 and 9th December 1992. As we have already explained, Dr Alagrajah did not respond to the Inquiry Panel's request that he give evidence. There is no note in Chandran's GP records that he was, in fact, seen on these occasions when the prescriptions were made but we have been unable to clarify whether this is the case with Dr Alagrajah. The only pathology report relating to Litihum levels to be found in his GP records is dated much later on 11th July 1997 and we have been unable to ascertain whether Chandran's Lithium levels were checked during 1992.

Comment

Looking at the GP records which record only the issuing of repeat prescriptions and no information about Chandran's condition at all, it is possible that Lithium Carbonate was prescribed on occasions without his in fact having been seen by Dr Alagrajah. We do not think we can make a definitive finding about this without having had the benefit of hearing evidence from Dr Alagrajah. However, we observe here that it is not satisfactory, in our view, to manage a patient with relapsing bipolar affective disorder by issuing repeat prescriptions without any examination of, or discussion with, the patient. It is important that a GP plays an active rôle in managing the patient's condition which may best be done by remaining in direct contact with him/her but should at the least ensure that the patient's condition is being managed within a proper framework of care.

20. On 15th April 1992, Dr Feldman wrote to the Homeless Persons Unit at the London Borough of Newham in the following terms:

> "Chandran Sukumaran suffers from manic depressive psychoses (sic). Provided he takes his Lithium, which acts as a prophylactic, he is perfectly well at all times. However, if he fails to comply then he has quite severe breakdowns which require hospital medication. To this end we are treating with Lithium Carbonate, which he should take daily. He should have a Lithium level assessment done every three months and I am finding it very hard to persuade him to attend outpatients for this to be done. His prognosis depends on whether he complies with medication and whether he can set up a stable life style in the community. It is essential that he has a resonable (sic) home environment as part of his successful rehabilitation in the community."

21. On 23rd June 1992, Chandran did go to see Dr Feldman. In her letter to Dr Alagrajah, she expressed her amazement that he had come to see her. He was taking 800mg of Lithium Carbonate but insisting he wanted this dosage reduced to 400mg. Dr Feldman agreed to this reduction, considering it was better than his not taking any medication. He then failed to attend appointments on 25th September 1992 and 1st December 1992. After the second occasion, he was not sent another appointment.

22. Dr Feldman said that the policy at that time was to give patients two outpatient appointments. If the patient failed to attend both appointments, he/she was referred back to the relevant GP with a letter inviting the GP to re-refer the patient if necessary.

23. Dr Feldman also said that it was very much left to general practitioners to take on board the advice given in a patient's Discharge Summary and to act on it. Talking of the service in the early 1990s, she said:

> "There was no what I call running after people. It was a fragmented service where people did the most minimalist things and you were lucky if they even received an appointment. I wouldn't have said it was a robust service. ... It was the lack of resources and the lack of togetherness and the lack of morale and all the things that Cinderella services have, which we were."

24. Chandran told us that he went to some of his outpatient appointments and then stopped going to them. His explanation for doing this was he was:

> "so young and they kept putting injections into me. It was loads of medication and I just swallowed it. I had a lot of side effects and I didn't like the side effects. ... I never understood my illness and no one explained it to me."

Comment

The nature of the care Chandran describes himself as receiving is characteristic of an over-stretched traditional service at that time. Chandran did not feel he was a partner in his care package or recovery.

25. Dr Feldman had no further involvement in Chandran's care and treatment after he was discharged in December 1992.

Involvement of a Community Psychiatric Nurse

26. We have not been able to find any evidence that Chandran had any contact with a Community Psychiatric Nurse following his discharge from Goodmayes Hospital.

Involvement of a Social Worker

27. A social worker did become involved in his care. The reference in his follow-up plan on discharge from Goodmayes Hospital to a pending Court appearance appears to refer to possible possession proceedings by the London Borough of Newham. The accommodation in Corporation Street was only temporary accommodation. Newham served a Notice to Quit after Narayanan Sukumaran refused two offers of alternative accommodation in November 1990 and was deemed to be intentionally homeless. It is suggested in the documents we have seen from the Social Services department that he did not understand he was only living in temporary accommodation nor that he would only be made two offers of alternative accommodation before being served with Notice to Quit. He was keen to remain living in the flat even though Chandran had caused extensive damage to the flat prior to his admission to Goodmayes Hospital, including flooding, so that the cooker, fridge, carpets and some furniture had to be removed. Narayanan Sukumaran made an application to the DSS Social Fund for a loan to enable him to replace those items as he wanted to stay there.

28. Both a Councillor Goodman and Graham Bull (who was appointed to be Chandran's social worker in about November 1991) wrote letters in support of the Sukumarans being able to continue living in the flat. In his letter dated 4th December 1991 to the Director of Social Services, Graham Bull emphasised Narayanan and Chandran Sukumaran's "extreme vulnerability on account of their health".

29. On 7th January 1992, Graham Bull discussed their housing situation with a John Aldridge at the Homeless Persons Unit and they agreed that John Aldridge would take over negotiations with the Housing Department. Graham Bull ceased to be involved in Chandran's care in February 1992 when the case was closed because Chandran had "settled down after leaving hospital ... and ... found a work placement" (c.f. Social Services Closure Summary dated 24th February 1992). His mental state was said to be well and he was taking his medication.

Comment

(1) The purpose of the Care Programme Approach is to ensure the support of mentally ill people in the community. It was then in its infancy (having only been introduced in Health Circular (90) 23/Local Authority Social Services Letter (90)11) and, in many places across the country, it has taken a considerable amount of time for it to be implemented. Even in areas where its implementation is advanced, it remains a fact that the GP rarely participates (e.g. by attending CPA meetings) other than by receiving information. It was abundantly apparent from Dr Feldman's evidence that she had misgivings about the effectiveness of the service in her catchment area at that time.

The treatment plan made for Chandran was an adequate one but there were no mechanisms then in place for monitoring a patient's progress against the plan in terms of patient or indeed service accordance, which is plainly not a sufficient response. The practical effect of this was that when Chandran failed to attend outpatient appointments, his relationship with the psychiatric service ceased. Thus, Chandran's contact with Social Services ended in February 1992 and effectively ended with the specialist psychiatric services in June 1992. On 23rd June 1992, he went to see Dr Feldman in her outpatient clinic but he did not keep his subsequent appointments. He appears to have maintained some contact with his GP surgery because he was issued repeat prescriptions but, as we have already explained, it is possible that he did not in fact have any direct interaction with a doctor there.

(2) We could find no evidence of any consideration being given by anyone involved in Chandran's care as to the difficult relationship which existed between him and his father. The serious nature of his attack on his father and the undesirability of the two trying effectively to act as co-carers were not issues which were confronted. In our view, it is possible that this was because the situation was not viewed as unusual. In saying this, we have in mind Dr Feldman's observation that it was quite a common scenario for her to encounter fathers and sons living together and fighting.

(3) In addition, we found no evidence that the nature of Chandran's illness, including the potential for recurrence, and advice as to how to manage his illness and how to access help in the event of a recurrence, was discussed with any member of Chandran's family or with Chandran himself. To the extent that no key carer for Chandran was identified, there was some practical difficulty to giving such advice. However, any such difficulty was by no means insuperable. The practical routes for return to the mental health services (other than via a GP) could and should have been made clearer to a family member and, indeed, to Chandran himself.

30. Sujita Trousdale and Biju Ramkrishnan gave evidence that Chandran was well for a long time after his admission to Goodmayes Hospital. He did various jobs which were described to us as "odd jobs", for example working in shops, and was also studying. He studied at Newham College of Further Education gaining a BTEC First Diploma and National Diploma in Art and Design. He also became involved with the "Guardian Angels" and patrolled the underground and streets in the West End of London with them. He had a considerable amount of contact with various members of the Ramkrishnan family who understood that he was continuing to be prescribed Lithium Carbonate. In fact, looking at his GP records, it appears unlikely that he was prescribed Lithium Carbonate after 3rd September 1993. On 3rd July 1995, it was noted in his GP records that "Now he is free from psychiatric problems".

Chapter 3 – Chandran Sukumaran’s Move to Canterbury

1. Narayanan Sukumaran returned to India for a significant period of time in the mid-1990s and, in September 1995, Chandran began a degree course at Canterbury Christ Church University College. He was studying Art and Design and Sports Science. However, he gave up this course within a year. He says he “started getting ill” and he gave up the course because it was “stressing him out.”

2. Sujita Trousdale told us that Chandran again caused damage to the flat in Corporation Street in about February 1996. She said the police telephoned her to tell her that he had damaged the flat and that they (i.e. the police) could not find him. He returned to Canterbury. Sujita Trousdale and Mrs Ramkrishnan went to see how he was and thought that he was unwell. He did not make any threats but was talking about Mrs Ramkrishnan saying that she was the devil, which was the type of comment he made when he was unwell. Sujita Trousdale explained to us that they know when they made this trip because it was the day of the Canary Wharf bombing. She said she “begged him to take his Lithium and he refused to”. He would not go back to London with them, insisting he was fine and there was nothing wrong with him. His family members did not agree. Sujita Trousdale claimed she telephoned Dr Alagrajah but he refused to do anything. We have been unable to discuss this alleged conversation with him. Sujita Trousdale said she sought help from a number of organisations who advised her that he needed to take his Lithium Carbonate but could not offer any further help.

   Comment

   Although the family understood that Chandran was being prescribed Lithium Carbonate at this time, this was not in fact so.

3. On 23rd February 1996, Chandran visited his GP in Canterbury (having registered there in about November 1995) complaining of fever especially at night. We did not consider that it was necessary for the purposes of this Inquiry to ask this GP to attend for an interview and the information we have recorded in the following paragraphs is derived from Chandran’s medical records.

4. Following the examination on 23rd February 1996, the GP’s impression was recorded as being “? Manic symptoms. Thoughts erratic. ? physical (chest) illness.”

5. On 25th March 1996, Chandran again visited the GP to discuss a blood test result and the GP records show that he said that all of his family had been murdered in India and that he had been brought up by foster parents who were Hindus. He expressed a belief that he was Christian.

6. On 9th April 1996, he told the GP that he had written to the Indian Embassy to discover the circumstances of his parents’ death. He complained of a reduced sleep pattern but reported that his appetite was all right. His thoughts were recorded as being “ordered” and his speech “OK”. The impression recorded by the GP was that his anxiety was related to his parents. He was advised that he was not ill and did not require treatment.

7. On 12th June 1996, Chandran attended the GP requesting a head scan. According to the record of this visit, he complained of having suffered headaches for 7-8 years which worsened on reading or concentrating. He said the pain was confined to his forehead and described it as "thumping" and "pulsating". His vision was not affected. He experienced slight nausea at times. He said he had had a skull x-ray before with no abnormality being detected. He also claimed he had been previously denied a CT scan by a doctor in India. Chandran was referred for a CT scan to exclude any "vascular malformation". On 19th June 1996, a CT scan was reported by Dr R.Simmonds as follows:-

   "The ventricles are symmetrical and undisplaced. No focal abnormality identified before or after contrast."

8. The result of the CT scan was discussed with Chandran on 3rd July 1996, when he was told that no abnormality had been detected and he was reassured. He said he had problems concentrating and with his memory and appears to have said he had "learning difficulty". According to the records, his GP advised him that a "lot of it is anxiety" and noted that he "feels better knowing there's nothing wrong organically".

Chapter 4 – Admission to St. Martin's Hospital Canterbury

1. On 4th January 1997, Chandran was admitted to Anselm Ward at St. Martin's Hospital via the Kent & Canterbury Hospital Accident & Emergency Department. He had been working part-time in a restaurant and his employer accompanied him to the hospital. According to the record of his psychiatric assessment on admission, he had been ill since before Christmas 1996 when he was described as having become "paranoid, accusing staff of being possessed by devil, irritable+". On Christmas Day, he had an argument with his employer.

2. Sujita Trousdale told us that Chandran also threatened Mrs Ramkrishnan shortly before New Year's Eve 1996, possibly threatening to kill her. The circumstances surrounding this incident were as follows. Narayanan Sukumaran had left some money with Mrs Ramkrishnan for safekeeping before he went to India. This money was intended to meet Chandran's education and living expenses and she had given him a considerable amount of money which he had spent. Chandran then went to London in December 1996 and asked her for more money. Mrs Ramkrishnan said she would give it to him the next month. On being told this, Chandran destroyed a large number of Mrs Ramkrishnan's devotional artefacts. He then forced her to sit on the stairs and would not allow her to answer the telephone. He tried to force her to go into the sitting room but Mrs Ramkrishnan thought he was going to try to get a knife and refused to move from the stairs. Chandran told the Inquiry Panel that he smashed his aunt's picture of a saint and told her she was evil. He said he was not going to hit her but his aunt became frightened and went into a corner. At about this time, her other daughter, Sindhu, came to the house and intervened. We were told that Mrs Ramkrishnan did not want to tell the police about this incident and no other member of Chandran's family did so. Dr Bamber, the Consultant Psychiatrist in charge of Chandran's care at St. Martin's Hospital, told us that his service was not made aware of this incident either. He told the Inquiry Panel that the assessment of the team at St Martin's was that the only violence had been to his friend's property and they did not assess Chandran as being violent either to himself or others.

3. In very early January 1997, Chandran went into his flatmates' rooms and appears to have destroyed their possessions. This was the incident to which Dr Bamber was referring when he said his team was only aware of violence towards a friend's property. When Chandran was examined before admission to St. Martin's Hospital, he gave the following explanation:

   > "I thought my flatmates were members of IRA, and were making bombs, so I broke into their rooms and destroyed their stuff. I haven't slept for 5/7 (5 days). I'm frightened to go back to my flat."

4. He gave a similar description to the Inquiry Panel although he said he messed up the flat but did not destroy his flatmates' belongings.

5. There is no evidence that Chandran was being prescribed Lithium Carbonate at this time. As we have observed above, we can find no record of this medication being prescribed after 3rd September 1993 although his family believed that it was being prescribed. Their understanding was that there were, however, times when he did not in fact take it. Biju Ramkrishnan said of his time at Canterbury:

"I think the reason why he used to get into that state was he couldn't handle stress, and when he went to study and started the course, because of the stress of studying and so on, he stopped taking his medication and he went back into his mental state."

6. The information recorded in respect of Chandran's mental state examination included the following:

   "Appearance and behaviour (violence)
   small Asian man, co-operative, laughing and smiling (in incongruent mood).

   Speech
   ↑rate + vol (volume), pressured

   Mood
   Hypomanic

   Suicidal
   Has had thoughts of killing himself. Nil now

   Delusions
   Friends members of IRA (illegible)

   Hallucinations
   Denies any"

7. A decision was taken to admit Chandran and he was initially prescribed Procyclidine 5mg three times a day and Haloperidol 5mg twice daily. He complained of side effects from the Haloperidol and his prescription was therefore changed to Olanzapine 10mgs once a day. According to the discharge summary dated 26th February 1997, "he became more high" when given Olanzapine so his medication was again changed to Haloperidol 5mgs tds.

8. Dr Bamber explained to us that he requested a copy of Chandran's medical records relating to his admission to Goodmayes Hospital but they never arrived at St Martin's Hospital. He did not know why this had happened but assumed that they had been delayed in medical records. He said that he did not know anything about Chandran's earlier history of mental illness other than that he had been an in-patient at Goodmayes Hospital for three months, which he had learned from Chandran himself. To the Inquiry, Dr Bamber described this episode of illness in Canterbury in the following terms:

   "At the time it was an isolated short-lived discrete episode and the major symptoms settled very quickly. The mood settled more slowly but there was never any problem with co-operation and it was in every way a routine case."

9. Chandran was discharged from St Martin's Hospital on 31st January 1997. He attended hospital as a day patient for a week and then decided to return to London. Initially, he went to stay with Mr and Mrs Ramkrishnan. There was no contact between St. Martin's Hospital and the Ramkrishnans even though the latter were to provide Chandran with accommodation and support after discharge.

10. On 26th February 1997, a Discharge Summary was written by Dr Sarah Evans, Dr Bamber's Senior House Officer, to a Dr Alleright whose address was given as The Surgery, Burgess Road, East Ham, London. Dr Bamber said that he assumed the GP's name was given to Dr Evans by Chandran or his cousins. We had hoped to interview this GP as part of our investigation but the enquiries made on our behalf revealed that the North East London Strategic Health Authority had no record on its database of a GP with this name and, although there is a GP surgery at 27 Burgess Road, we learned that there has not been a Dr Alleright working there. One possibility that has occurred to us is that this was in fact intended to be a letter to Dr Alagrajah but we doubt whether that is right. The Discharge Summary was not in Chandran's GP records. We only found it in the records we received from Canterbury & Thanet Community Healthcare Trust.

11. The Summary recorded a diagnosis of bipolar affective disorder, medication on discharge of Haloperidol 3mgs tds "to reduce to 1.5 mgs tds after 5 days and then to be reviewed and stopped as appropriate" and Procyclidine 5mgs tds and ended with the following request:

    > "We also discussed with him before discharge about starting Lithium and I should be grateful if when he registers with you, you would refer him to the local psychiatrist for consideration of Lithium therapy."

12. In fact, Chandran registered as a new patient at The Market Street Health Group, 52 Market Street, East Ham, London. On 18th February 1997, he attended the surgery where it was noted that he had been in St Martin's Hospital. This was recorded as being a psychiatric hospital. His diagnosis was "manic depressive psychosis". His medication was recorded as being Procyclidine and Haloperidol. He was described as not being known to Social Services. We do not know where this information came from, possibly from Chandran himself. It does not seem to us that it can have come from the Discharge Summary since that is dated 26th February 1997, i.e. eight days later, and the Discharge Summary was not filed in his GP records.

13. On 20th February 1997, Chandran was seen again at the surgery and was said to be going to India on 23rd February 1997. A note was made "Needs to see psychiatrist". However, we have seen no evidence of a referral at this time. Chandran went to India with Mrs Ramkrishnan and was there for about five months. There, he again appears to have had contact with a psychiatrist. Chandran told us he had not worked or done anything and he felt a failure here. Sujita Trousdale suggested that he should stay in India because it was easier for the family to find somebody to look after him there whereas, in England, everybody who might have looked after him was working. Nonetheless, Chandran did return to England.

    Comment

    The above chronology of events demonstrates that Chandran gradually became ill over a number of months necessitating in-patient admission in January 1997. In other words, that relapse was insidious and took place over a number of months, probably from February 1996, with blunted insight being an early feature but with a prodrome of Chandran knowing something was going on in his head and looking for a medical explanation for this. By January 1997, a potentially fatal drama had unfolded at his aunt's house although Mrs Ramkrishnan did not want to tell the police about it, despite being advised to do so by other family members.

By then, there was a history of illness extending back almost ten years with, as we assess the history, three major relapses. We do not consider this information was fully available to those caring for Chandran at St. Martin's Hospital. This was partly because his earlier notes did not arrive at the hospital so neither the fact of the admission to hospital in India nor his subsequent non-compliance with his medication regime, nor the full extent of his earlier admission to Goodmayes Hospital and the background leading up to it were known. It was also in part because, as far as we can ascertain, there was no discussion between any member of Chandran's family and the staff at St Martin's Hospital about his illness nor about the plans for him on discharge. Although we do not know whether Mrs Ramkrishnan would have spoken about the incident involving her in any event, given her unwillingness to report it to the police, we do know other family members were prepared to speak about Chandran's illness because they have spoken to us about it. Additionally, when we spoke to Chandran, his present social worker told us that a lot of relevant information about him had now been learned from the family.

Thereafter, in our view, the proper conclusion following this sequence of events is that the aftercare planned for Chandran, namely the consideration by a psychiatrist of the indication for an ongoing mood stabilizer, was not worked through fully at that stage. In real terms, nothing for or against the use of ongoing mood stabilizers was communicated to the new GP in London by staff at St. Martin's Hospital because of the error in the GP's name and address. By the same token, it also seems likely that a copy of Dr Evans' Discharge Summary was not sought by the general practice with which he registered in London although the practice was aware he had been admitted to St Martin's Hospital. We think this is likely because there was no copy of it in the GP records with which we were provided.

It will be seen later in this chapter that Chandran was in fact referred back to secondary care but this did not come about as a result of Dr Evans' request that there should be a referral to psychiatric services. On that subsequent referral, a copy of the Discharge Summary was not sought. We consider that Caroline Godleman rightly accepted in the course of her evidence that it should have been.

The outcome of this failure to communicate was that detailed information about the Canterbury admission and the plan for discharge was never amalgamated with Chandran's medical notes in London. Similarly, his family had no information about the admission and the discharge plan. This period of in-patient care was therefore isolated from other information and, whilst it was known that Chandran had been admitted to St. Martin's Hospital, the reasons for that admission and details of it appear to have been largely unknown, as was Dr Evans' request for a referral to a local psychiatrist.

In those circumstances, there was no actual transfer of Chandran's care as anticipated by the CPA and an opportunity to provide him with continuity of care on discharge from St Martin's Hospital was lost.

14. On 25th June 1997, we believe that Chandran saw Dr Bhatti (a locum GP at The Market Street Surgery). We wished to interview Dr Bhatti but, when enquiries were made on our behalf, we were told that he could not be found. The note in Chandran's records for the consultation on 25th June 1997 reads:

> "H/O (history of) manic/depressive psychosis.
>
> Taking Li (Lithium) Carbonate 400 mg nocte. Clonazepam tablets 0.5mg nocte.
>
> Would like to ↓(decrease) medication. Lost to follow up.
> → Recontact hospital to recommence follow up.
>
> → Concerns re employment prospects."

15. As far as we can ascertain from Chandran's medical records, Dr Bhatti wrote a letter addressed to "Consultant Psychiatrist" at the East Ham Memorial Hospital on 7th July 1997 asking for an outpatient appointment for him. In that letter, Dr Bhatti explained that Chandran seemed to be "lost to follow up" and that he (i.e. Dr Bhatti) was "not exactly sure how his Lithium is being monitored". Dr Bhatti recorded that Chandran appeared:

> "to have been last seen at Newham General Hospital by Dr Feldman in 1992 but has had an instance at the beginning of the year where he was admitted to Canterbury Hospital via the A&E Department where he apparently had been suffering a breakdown and appeared to be hypermanic. He was discharged on 31st of January with a prescription of Haloperidol 5mgs qds and Procyclidine 5mgs tds. He, other than this, feels that he is now much better and he would like to begin decreasing his medication. I feel this is inappropriate and would be grateful for your opinion and further management."

16. Dr Bhatti appears also to have arranged a blood test to check Chandran's Lithium level.

Comment

The Lithium Carbonate and Clonazepam recorded in Dr Bhatti's note of the consultation on 25th June 1997 were not prescribed on Chandran's discharge from St. Martin's Hospital. As is recorded above, he was prescribed Haloperidol 5mgs qds and Procyclidine 3mgs tds which was to reduce to 1.5mgs and then to be reviewed, not Haloperidol 5mgs tds and Procyclidine 5mgs tds as Dr Bhatti understood.

Dr Evans' request that he be referred "to the local psychiatrist for consideration of Lithium therapy" had also of course not been acted upon because it had been sent to an unidentifiable GP at a practice where Chandran had not registered.

We believe it is likely that Chandran was prescribed Lithium Carbonate and Clonazepam whilst in India (he told us he was given medication by a private psychiatrist there) although we have not seen any evidence confirming what he was prescribed.

It is a matter of very real concern to us that he was apparently taking this medication, particularly Lithium Carbonate, without its being monitored and without it being clear as to why his medication had been changed since his discharge from St Martin's Hospital and who had prescribed it. Dr Bhatti seems also to have been anxious about the situation then prevailing.

We are also concerned that it seems that accurate information as to the amount of medication prescribed for Chandran on discharge from St. Martin's Hospital was not available.

17. On 6th August 1997, Dr SK Ted-Aggrey (locum Senior House Officer to Dr PK Reddy, Consultant Psychiatrist) wrote to The Market Street Surgery saying that Chandran had not attended a psychiatric follow-up appointment on 23rd July 1997 and that another appointment had not been sent because the Psychiatry Clinics were very busy. If the patient required another appointment, the GP was advised to contact the Department of Psychiatry to arrange one.

18. We were surprised to find this letter because, according to the outpatient records with which we were supplied, Chandran did attend an outpatient appointment on 23rd July 1997. In his notes, it is recorded that he had his first breakdown at about 18-20 years of age, he had been admitted to Goodmayes Hospital in 1991 and had relapsed whilst in Canterbury as a full-time student. He had been admitted to St Martin's Hospital at the end of January 1997. His mental state was described as "appropriately dressed, speech & fairly good rapport". The plan was to discontinue the Clonazepam he was taking and to continue with Priadel 400mg nocte which had been prescribed by "a private doctor". He was to be seen in 2 months.

19. On 27th August 1997, he went to the offices of the Community Mental Health Team East apparently with a letter from his GP saying he had a housing problem. A letter was written by a Mark Howard (a duty worker with the CMHT) to the Homeless Persons Unit saying that it was not conventional for such a problem to be dealt with by that team as this was primarily a problem for mainstream social services. Chandran was described as appearing:

    "relatively well at present" but "there is enough evidence to suggest a significant measure of vulnerability from his Psychiatric history".

20. Whatever the housing problem may have been in August 1997, we learned that Chandran lived with the Ramkrishnans for about a year after he returned from India and he told us he had, at some point, rented a property.

21. Chandran did not attend an appointment on 25th September 1997 nor on 2nd April 1998 when he was discharged from the outpatients clinic and "very poor attendance" was noted.

Comment

(1) We were surprised that the letter should have been sent to Chandran's GP saying he did not attend the July 1997 appointment when he did. Furthermore, we could not find any evidence that the fact Chandran had visited the offices of the CMHT-East with a letter from his GP in August 1997 was considered before he was discharged from the outpatients' clinic.

(2) Dr Bhatti tried to re-engage Chandran with the psychiatric service, apparently perceiving a need for its specialist opinion and management. Unfortunately, the system then operated meant that, in practice, if a patient did not attend two outpatient appointments, there was unlikely to be any review or follow-up to find out why the patient had failed to attend or how he/she was, as happened here following Chandran's non-attendance in April 1998.

There may, of course, be occasions when a patient does not attend an outpatient appointment precisely because he/she is unwell but has no insight or recognition of that fact and is consequently in need of help. In this case, the system ought to have picked up on the issues we have identified, i.e. the absence of any discharge summary from St. Martin's Hospital and thus the absence of any details about that admission, the discrepancy in Chandran's prescribed medication over the past months and absence of any explanation for that discrepancy, and the fact of his visit to the CMHT-East.

(3) As noted previously, the unsatisfactory nature of a system which discharges patients who fail to attend outpatient appointments without any assessment of the patient and any consideration of whether it is appropriate to do so is now recognised by the Trust. The Inquiry Panel was told that this no longer happens. Now, if a service user fails to attend two outpatient appointments, a Consultant Psychiatrist reviews his/her medical records and decides what the service's response should be. We welcome this modification to practice but stress that it must be maintained.

22. It appears that a reasonably lengthy period of stability in many aspects of Chandran's daily life began at around this time and this may explain why he did not attend the two outpatient appointments in September 1997 and April 1998. We learned that he found employment with W.H. Smith. It is hard to be precise as to when exactly he started this work but he told us that he worked as a shop assistant at various stores. His father had returned to England and he spent quite a lot of time helping him, for example by doing his shopping, cooking for him and ensuring that he attended medical appointments. Chandran said that he was getting on very well with his father at this time.

23. From what we have seen in the records we have, and heard from various witnesses, it appears that there was a considerable period of time (about three to four years) following his discharge from St. Martin's Hospital and subsequent contact with a psychiatrist in India when, on the face of it, Chandran seemed to be reasonably well and to be managing his daily activities. As we have set out above, he had stable employment and he was helping his father.

24. Thus, in many respects, this was a period in which Chandran appeared to be managing his life and to be settled in stable employment. Sujita Trousdale described visiting him in 1998 and regarding him as "happy, content". One of the documents we have seen is a reference dated 12th February 2001 written by a W.H. Smith store manager which described his work as being "of an acceptable standard" and Chandran as being "a punctual member of staff with a very good sickness record".

25. However, according to his sister's recollection, he started to become unwell again in 1999 and it was clear from what we were told by his family that he was then often violent or aggressive. Sulekha Jaykumar told us that he hit her and kicked her down on the floor and, she believes, tried to break her neck on one occasion. Sujita Trousdale said Chandran hurt Sulekha Jaykumar but she refused to report the incidents of violence. On the other hand, Chandran told us he did not hit his sister.

26. Similarly, Chandran denied having hit his brother-in-law. Yet Sulekha Jaykumar said that he had hit her husband and Sujita Trousdale said he was very violent towards him and had "attacked him a couple of times". Sulekha Jaykumar also told us that Chandran had hit her daughter and that, particularly after that, she was very afraid of him. Her description to the Inquiry Panel was "I'm so scared, he's so violent."

27. On 15th November 1999, it was recorded in his GP notes that he was using natural remedies for manic depression. He was taking Ginseng, Vitamin C and garlic tablets and it was noted that he been working for two years and was now a manager.

Comment

Although Chandran was managing his daily life in many respects, the significant episodes of violent behaviour particularly towards his sister from 1999 onwards suggest a long slow prodrome to florid illness again. From what his family say, they recognised he was ill but did not have sufficient information to know how to gain help for him.

Chapter 5 – Relevant Events in 2001

1. By 2001, Chandran was living in a housing association flat on his own. Sulekha Jaykumar lived in a different flat with Narayanan Sukumaran, her daughter and her husband when he came to England from India. She was largely responsible for caring for her father who was, by then, elderly and physically frail but Chandran appears to have visited their flat regularly.

2. On 28th February 2001, Chandran went to work at W.H. Smith at Blackfriars Railway Station at about 5pm. Narayanan Sukumaran had been in hospital and Chandran wanted to have some time off to look after his father. He says his request was refused and he was angry and frustrated at having to go to work. Whilst at work, Chandran attacked a work colleague kicking him in the face with sufficient force that the colleague had to have root canal treatment to two of his teeth. Chandran claims that he felt under considerable stress because of his father's condition and that he was provoked by his colleague at work and the attack then ensued.

3. An independent witness to the attack described Chandran and his colleague arguing whilst he was in the shop. Whilst this witness was paying for his purchase, he saw Chandran hit his colleague around the head several times. There was then a short period of time when Chandran walked away and carried on serving the witness who said that he then saw Chandran kick his colleague in the face whilst the latter was bending over to get something out of a lower cupboard. Chandran lost his job as a result of this incident.

4. In the view of the Inquiry Panel, the nature of the attack, namely hitting somebody around the head several times and then kicking him in the head with sufficient force that the victim needed to undergo root canal treatment, was serious.

5. On 20th March 2001, Chandran pleaded guilty at Horseferry Road Magistrates' Court to an offence of assault occasioning actual bodily harm. The Court wished to have a pre-sentence report and psychiatric report before sentencing him and the case was therefore adjourned for those reports to be prepared.

6. On 10th April 2001, a Probation Officer, Gill Lewis, wrote to Dr Röhricht telling him that Chandran had pleaded guilty to the offence of common assault, that this had involved his kicking a fellow employee in the head who had had to have root canal treatment to two teeth, that he had previous mental health problems and had been an inpatient at Goodmayes Hospital but was unable to remember the dates of the admission. She added that she had met Chandran and was

   "of the opinion that he does not present as a danger to you or any of your staff".

7. There is a manuscript note on the letter to Dr Röhricht which reads:

   "Frank. This patient was last seen by Dr Feldman in June 1992. He DNA'd (did not attend) in 7/97, 9/97 and was discharged in 4/98 for poor attendance."

   As we have explained, we believe Chandran was seen in July 1997 in the outpatients clinic and as well by the CMHT in August 1997.

8. Dr Röhricht explained that he saw his primary rôle as being to provide an expert opinion for the Court as to Chandran's mental health at the time he saw him. The only information he had when he prepared his report was that contained in Chandran's outpatient file and that which Chandran himself gave him. He explained that the only reason for his seeing Chandran was because the Probation Service was aware that Chandran had a past history of mental illness "and wanted to exclude that the offence was driven by mental health features". Nonetheless, at the end of his interview with Chandran, he offered to put him in contact with mental health services with a view to monitoring his mental state but Chandran declined this. Dr Röhricht did not himself refer Chandran to the CMHT. Dr Röhricht told the Inquiry Panel that Chandran did not present any delusions of a persecutory nature, did not talk about voice hearing experiences of a command nature, took full responsibility for what he had done and seemed to have been stable for long periods of time without any intervention and without any maintenance therapy.

9. In his report dated 11th June 2001, he summarised his opinion as follows:

> "In summary I can say that I could not elicit any symptoms/evidence of a current mental disorder. Mr Sukumaran is quite capable of giving a coherent account of himself and his personal view on the index offences was that it very much a resulted (sic) from provocative behaviour of the other employee.
>
> "Nevertheless there is sufficient evidence that Mr Sukumaran suffered in the past from Affective Disorder with hypomanic or manic episodes and it is difficult to retrospectively establish if this condition might have caused him to react inappropriately in response to the argument with his colleague. He was certainly going through a distressing time, due to the fact that his father was seriously ill."

10. Dr Röhricht said he had no supplementary background about Chandran to assist him with assessing his past dangerousness other than that contained in his outpatient records which, in his opinion, did not disclose anything significant. He was aware that Chandran had damaged his father's flat before his admission to Goodmayes Hospital (which had, of course, been more than ten years earlier) but concluded that alone did not weigh heavily in the balance given Chandran expressed very real concern about his father's illness at the time of the offence and that he appeared to have been stable for long periods of time.

11. The Inquiry Panel heard that, in making this referral, the Probation Service thought they were referring Chandran back into catchment psychiatric services and that they were triggering a forensic psychiatric assessment with fuller information-gathering as part of that assessment. We do not think Dr Röhricht considered he was providing a forensic report (indeed, he is a general, not forensic, psychiatrist).

12. There is clearly a discrepancy between the two as to their expectation of the nature of a psychiatrist's input in preparing reports for sentencing purposes. Caroline Godleman told the Inquiry Panel that she thought the links between the Trust and the Probation Service needed to be improved. It was her hope that a request for a psychiatric report to assist the Court would trigger consideration of the case by the CMHT but that was not the practice in 2001. We were not reassured that it would happen now either.

Comment

(1) It was apparent from the evidence both of the professionals to whom we spoke and of Chandran's family that Chandran frequently presents as articulate, lucid and well orientated. As it appears from that part of his report we have quoted above, Dr Röhricht found him to be so when he interviewed him. However, the other evidence which we have set out in detail in this Report tends to suggest strongly that he was not always as well as he presented. Dr Röhricht's testimony to the Inquiry Panel was that this characteristic was not known to him when he assessed him. Had he had information which revealed a profile of a violent nature, he would have initiated a referral to the CMHT even though the primary purpose of his report was to assist the Court when sentencing Chandran. Dr R^hricht did not pursue further information-gathering nor seek to speak with, for example, a relative for collateral information. He did not have the pre-sentence report.

(2) Thus, an opportunity for Chandran to re-engage with mental health services was again lost. In making this observation, we have borne in mind that there was some conflict in Dr Röhricht's rôle on this occasion. We consider there is confusion in the perspective and rôle of a psychiatrist preparing reports in circumstances such as these, separate from their catchment duties. The Trust must clarify this issue.

13. A Pre-Sentence Report (as defined in Section 3(5) of the Criminal Justice Act 1991) was prepared by Andrea Hedley. This concluded that Chandran was under extreme stress at the time of his offence because his father was unwell and that he was possibly provoked by his victim. She was of the opinion that members of the public were not at risk from Chandran and that the risk of self harm was low.

14. On 12th June 2001, a Community Punishment and Rehabilitation Order was made in respect of this offence. This was to remain in force until 11th June 2002. Chandran was required to do 80 hours community service, which he completed on various dates between 21st August 2001 and 20th October 2001.

15. Sujita Trousdale told the Inquiry that she saw a report of Chandran's conviction in the Newham Recorder. She said she telephoned the police to ask whether they were aware that Chandran had a history of psychiatric illness and was advised to speak to the Probation Service. The police have no record of this telephone call and were unable to assist the Inquiry any further with any advice that may have been given. It was explained to us on behalf of the police that they have Computer Aided Despatch messages (CAD messages) but they only keep a record of 999 calls. No record would have been kept of the call unless it necessitated some police action. Sujita Trousdale said she did not manage to speak to Chandran's probation officer. She said she either did not get through to the office when she rang or, if the telephone was answered, she felt the situation was too sensitive simply to leave a message.

16. As far as the London Probation Area of the National Probation Service is concerned, we were told that they would expect to make contact with an individual who was expressing concern about an offender but, in this case, this did not happen. Chandran was, however, seen on a regular basis from June 2001 onwards by members of the Probation Service. His original probation officer left on 7th September 2001 and his case was then transferred to Sonia Stewart.

She saw him on three occasions and told the Inquiry Panel that there was nothing to indicate he posed a risk to his family. He arrived for his appointments on time, he engaged with Ms Stewart, he was articulate, his behaviour was positive and he completed his community service. Ms Stewart felt that Chandran's relationship with his father needed to be explored particularly because he appeared to feel unable to meet the criteria expected by his father, but did not have an opportunity to do so in the time she worked with him before he killed his father.

17. Having lost his job at WH Smith, Chandran applied for a lot of jobs but failed to find employment. He wondered whether there was anything else he could do and decided to begin studying again. He enrolled on a one year course at Tower Hamlets College. He told us that this was to study creative computer and graphic design.

18. Chandran started his course but said that, at half term in October 2001, he went to his flat and became very lonely. He explained that he had problems dealing with his entitlement to benefits and felt he was unable to live on the money he was receiving. He described to us becoming "stressed out", saying that he was eating only bread and baked beans, was unable to sleep and started hallucinating. He said that he started seeing things and people moving around in his flat and "started reading a spiritual book to get rid of the devil". His account of his condition at the time included that he "thought someone was sticking daggers" into him and woke up thinking a vampire had bitten him during the night. He thought the man upstairs was the devil and told the Inquiry Panel how he set fire to some white spirits in his sitting room because he thought the devil did not like fire. Biju Ramkrishnan told us that there were smoke marks caused by this fire in the sitting room. Chandran painted his flat in strange colours. His sister described it vividly as changing "into like a devil house. Painting everywhere, ceiling, floor, bed sheet, wall" and said that the neighbours reported to her that he was making a lot of noise.

19. Chandran told us that he went to see a GP at about the end of October 2001 asking for sleeping tablets but he was told he was fine and it would be better if he had a natural sleep. There is no record of a consultation with a GP at this time in Chandran's notes and we have therefore not been able to discover any more information about the visit he says he made.

Chapter 6 – The Metropolitan Police Service

1. Chandran's family had become increasingly concerned about his behaviour. Biju Ramkrishn said that, from about the time of his conviction, he seemed to be becoming ill again and, whilst Mrs Ramkrishnan, Sulekha Jaykumar (and very possibly Narayanan Sukumaran) had been reluctant to report incidents of violence or possible violence, this was not so for other family members as 2001 progressed.

2. From the records supplied to us by the Metropolitan Police Service, we learned that one of his family made a 999 call on 12th September 2001. According to the CAD message for this call, the informant was described as wanting to visit his uncle who had heart trouble but his son was refusing him entry to the property. The police rang the number of the flat and tried to speak to somebody who answered the telephone but did not speak English. We assume that this was Narayanan Sukumaran. No disturbance was heard in the background so that the police left a message on the answerphone of their informant advising "them to contact us if they still require our assistance". The police made a further telephone call to the property and Narayanan Sukumaran appears to have answered that call. Again, no disturbance was heard in the background.

3. On the same day, Chandran assaulted Gopalan Jaykumar, his brother-in-law. We understand this assault to have involved Chandran twisting his arm and wrist.

4. On Saturday 27th October 2001, Narayanan Sukumaran went to East Ham Police Station accompanied by Sulekha Jaykumar, Gopalan Jaykumar and their daughter. Narayanan Sukumaran did not want the police to be told that Chandran had done anything wrong but he was concerned about his son and wanted medical help for him. It appears that the family spoke to a police officer for about half an hour. However, no police record of this visit was kept and Superintendent Smalley told the Inquiry Panel that the police had been unable to identify the police officer to whom the family spoke. The description of the officer given to the police did not match the officer on duty on the front desk who, we were told, had no recollection of talking to the family in any event.

5. The family handed two documents to the police officer: a copy of the Court record of Chandran's conviction for the assault in W.H. Smith (which, of course, showed that he was subject to the supervision of a Probation Officer) and a letter written by Gopalan Jaykumar on Narayanan Sukumaran's behalf. This letter was about Chandran and contained the following:-

   "I have to inform you about my son ... he is a mentaly (sic) person.

   "Now he is not taking medication so his condition is very bad and at any time he can become violent.

   "I am 78 years old and I am scared when he visit (sic) my house. I am a patient with two times By Pass surgery. I can't even manage alone to do my needs. My daughter and family ... are coming regularly and helping me. But he is threatening them also. My humble request is I need Police help to admit my son in Hospital for immediate medication for his better health. My another request is this report has to be confidential .... "

6. According to the family, the police officer treated them politely but he did not offer them any practical assistance or advice as to how or from whom they might seek help. Sujita Trousdale told the Inquiry Panel that nothing was done to help those family members who went to the police station. The family's understanding of that advice they did receive was that it was "advice about going to the Council at the Town Hall". Superintendent Smalley told the Inquiry Panel that he would "surmise that [the] advice would be to contact the local GP and/or the mental health authority through the local authority". If that were the case, he considered this advice to be correct.

7. Superintendent Smalley told the Inquiry that, if the family had concerns about Chandran, they had an obligation to make contact with the relevant authority. The family say, in effect, that was the purpose of their visit to the police station. They were trying to seek help for Chandran but did not know with whom they should be making contact. Inspector Holland elaborated on this issue when he spoke to us. He told us that, in a situation such as this, the police officer concerned has to decide whether there is an immediate risk of harm. If not, he then has to consider the nature of any future risk and should give advice to relatives and make an independent referral to the mental health service, if that is appropriate.

Comment

(1) We have found it impossible to ascertain the precise nature of the advice given to the family, particularly without being able to identify or talk to the police officer involved. However, even if advice was in fact given in the terms suggested by Superintendent Smalley, it is apparent that that advice was not clearly or sufficiently explained to the family so that they understood anything beyond that it was a matter to take up with the Council at the Town Hall (which strikes us as an unspecific understanding of the steps they needed to take to gain help for Chandran, for example to trigger a Mental Health Act assessment). They do not appear to have been left with the understanding that they should contact Chandran's GP (assuming they knew with which GP he was then registered) or the mental health authority via the local authority.

(2) It also appears that they were not given any specific contact details of anyone to whom they could turn at the local authority, e.g. a telephone number which would enable them to gain out-of-hours access to the Emergency Duty Team given this was a Saturday.

8. For her part, Sonia Stewart told the Inquiry Panel that she knew nothing about the letter until we asked her about it. She said she would like to think the information about the letter and the family's visit to the police would have been shared with her by the police and described herself as being "taken aback" by the letter and the fact that the information contained in it was not passed on to her. She regarded the police and the Probation Service as working as a multi-agency organisation and would have expected to see the letter or to be told about it. She said she would have taken the information to her line manager and would have expected it to trigger a risk assessment by the Probation Service, particularly bearing in mind the fact that Chandran's conviction was for an offence of violence. At that stage, if there were a need for mental health input, she would have expected that to be identified and acted upon.

9. The Metropolitan Police Service does not agree that there was any procedural reason for it to communicate with the Probation Service. The police say that Chandran Sukumaran was not in breach of the Community Punishment and Rehabilitation Order made on 12th June 2001. Further, they point out that there is evidence that the family did not want to get Chandran into trouble, and that involving his probation officer might have been perceived as doing just that. The letter handed to the police contained a request that "this report has to be confidential".

10. Caroline Godleman said that if somebody at Newham Council had been contacted, she would have expected that person then to make contact with the Community Mental Health Team (CMHT). She has duty staff available including a clinical medical officer (Section 12 approved), approved social worker and a nurse.

11. Caroline Godleman was keen to emphasize to the Inquiry Panel that she considers there to be good links between the Trust and the police. She told us the Trust works closely with the Public Protection Unit and the Domestic Violence Unit and has regular mental health liaison meetings.

12. We accept significant effort has been put into working towards an integrated service, particularly at a senior level. However the fact remains that, on this occasion, there was no contact with either the Emergency Duty Team or the Domestic Violence Unit nor was there recourse to the Adult Protection Procedures.

Comment

(1) In this case, we know that the police did not themselves forward information about the family's concerns on to any other agency. We do not know, in the absence of having been able to talk to the relevant officer, the precise nature of the information he elicited from the family about Chandran's behaviour and illness and the nature of any judgment he formed based on that information. Any attempt to form a view as to his opinion would be no more than speculation. However, we take the view that information that a person with mental health problems is not taking his medication and at times becomes violent or threatening (all of which was in the letter handed to the police) is such that the police should have referred the matter to the mental health services, whether by direct contact with the CMHT or the Domestic Violence Unit, or had recourse to Adult Protection Procedures.

(2) We believe this would have been the right course of action but, at the least, it seems to us that the police ought to have provided relevant contact details to the family if they were to be left to get in touch with the mental health services themselves, or ensured that the family fully understood how to gain help for Chandran.

(3) Had the police taken appropriate steps, it is likely the CMHT would have been contacted either directly or indirectly, and Caroline Godleman told us that there would then have been a CMHT response. The CMHT's response would have included talking to Chandran's family and a member of the team would have been sent out to do an assessment. The CMHT would have picked up the duty to do an assessment.

(4) The police and the Probation Service hold different views as to whether the probation service should also have been informed of the family's concern about Chandran's current state of mental health. We do not think this Inquiry has heard sufficient evidence to decide whether one view is correct or not. Still, it is possible that situations may arise where the effective delivery of care to mentally disordered offenders and the safety of the public may require communication between the police and the probation service even in the absence of, for example, a breach of a Community Punishment and Rehabilitation Order and we are of the opinion that this is an issue which could usefully be reviewed.

(5) As will be apparent to readers of this Report, a particularly striking feature of this Inquiry has been the inability of Chandran's family members, who were articulate and aware of those periods when he was unwell, to gain access to help for him. If they found it difficult to know where to go to get help for him, we could not help but wonder about the difficulties other people might encounter. This is an issue which, in our view, has to be addressed by all of the agencies involved in this case and with which we deal in greater detail later in this report.

13. On 1st November 2001, the sister of Sujita Trousdale and Biju Ramkrishnan made a 999 call at 21.27 hours. The police records show that the caller said her

> "cousin Chandran aged 31 with mental problems is at his father's house and is refusing to let inft [informant] in. Father is 80 years old Sukumaran. Male threatened to harm his father and inft blvds [believes] that he will do so ... For info. male has been violet (sic) to people tin (sic) the past and has recently kicked a colleague at work in the head."

14. Two police officers, PC Robert Larkey and PC Alan Mitchell went round to the property in response to that call. Chandran opened the door to the police officers and Narayanan Sukumaran was standing behind him. PC Mitchell spoke to Narayanan Sukumaran and asked him whether he was all right, to which he replied "Yes, yes". PC Mitchell formed the impression that Narayanan Sukumaran understood sufficient English to talk to him and asked him out of earshot of Chandran whether he wanted the police to get his son to leave the property. Narayanan Sukumaran said he did not. He asked whether his son was in trouble and said he did not want him to leave. He said Chandran had not threatened him.

15. PC Mitchell then joined PC Larkey who was talking to Chandran. In a statement, PC Mitchell described Chandran's behaviour as "odd" and said that "he appeared to be very hyper and was unable to relax. However, he was lucid and speaking clearly, putting his point across without apparent difficulty". The police officers asked Chandran whether he was known to the police and he told them he had assaulted a work colleague. PC Mitchell made some enquiries which confirmed that information was correct and that Chandran was not wanted or missing from East Ham Memorial Hospital. PC Larkey asked Chandran if he had ever been in hospital and Chandran said he "went in a mental hospital in Bournemouth for a few days and left". PC Larkey asked him whether he needed any tablets and he said that he did not but sometimes took walks in the country to clear his head..

16. The police officers discussed the situation and concluded that they had no reason to require Chandran to leave the property. They then left, advising Chandran and his father that they could call the police if they required help in the future.

Comment

(1) Chandran's probation officer was not informed that the police had been called to the property although the police were aware of his conviction and one of the police officers (although not a trained mental health professional) thought his behaviour was "odd". Again, the police say that there was no reason to communicate with the probation service and no breach of any guidance or protocol in not doing so. As we have observed above, we consider that the issue of communication about mentally disordered offenders between the two services should be reviewed.

(2) No link was made between this request for help via the 999 call and the family's request for help at East Ham Police Station only six days earlier.

17. On 2nd November 2001, the same two police officers were contacted when they were starting their tour of duty at 9pm and asked to identify Chandran. Narayanan Sukumaran had been found dead and there was information to suggest that Chandran had killed his father. They went to Forest Gate Police Station where they identified Chandran as the man they had spoken to on the previous evening.

18. Narayanan Sukumaran's body had been found at about 8pm by some of his family members. He was covered with a sheet. He had sustained extensive external and internal injuries which were said in the pathology report to be "consistent with having been caused by repeated blows onto face such as punches, stamps from a shod foot and/or stroke or kicks". The cause of death was given as cardiac failure, ischaemic heart disease and severe facial injuries.

19. Chandran told us he was not "feeling right" that day and he got into an argument with his father. He described what happened to the Inquiry Panel:

> "I started seeing faces and my father was laughing. Everything I said he was laughing at me - I thought maybe the devil was playing tricks with my mind. I kept coming forward and I hit him. I was frightened and he went down and hit the television. I saw him standing and I was still seeing faces and I put the bed sheet over him. I thought maybe the devil was my father. He was standing there strong and then I walked out of the house. I thought the devil was in there and I could run away. "

20. When he was told of Narayanan Sukumaran's death, Biju Ramkrishnan went to Chandran's flat. He found Chandran there and called the police. He said that Chandran "wasn't in the right state of mind" and, when the police did not arrive immediately, he decided to drive him to the police station.

21. Chandran was arrested by PC Lomas at 21.40 hours on 2nd November 2001 at Forest Gate Police Station on suspicion of having murdered his father. The police learned that he had mental health problems and a Forensic Medical Examiner ("FME"), Selladurai Shanmugadasan, examined him at about 21.30 hours on 2nd November 2001. At that time, Dr Shanmugadasan found no evidence of hallucination and decided that he was fit to be detained and interviewed in the presence of an Appropriate Adult.

22. Newham Social Services Department was therefore contacted and a support worker, Philomena Omeku, was the Appropriate Adult who arrived. She was present whilst Chandran was interviewed from 17.40 hours on 3rd November 2001. At the end of her shift, an Approved Social Worker, Brian Sanders, who was the emergency duty social worker for Newham, took over as the Appropriate Adult. He told the Inquiry that Chandran was articulate and orientated. However, when the police asked Chandran about his father, he was very confused and could not remember his father as his father, but said it was a beast he had seen. Brian Sanders formed the opinion that he was mentally unwell at that time although he could not, of course, express any opinion as to how he had appeared earlier, and he quite properly did not seek to do so when he spoke to the Inquiry Panel.

23. Chandran was subsequently charged with the murder of Narayanan Sukumaran and remanded in custody at HM Prison Pentonville. There he was noticed to be behaving in a bizarre fashion and was said to have "been talking rubbish to officers". He was admitted to the prison hospital wing. On 13th November 2001, he attempted to assault three other inmates. When asked why he had done this, he said it was to get attention. Both Dr Whittle (Consultant Forensic Psychiatrist) and another doctor decided that he needed to be transferred to the John Howard Centre under Section 48 Mental Health Act 1983. So far as is relevant for this Report, Section 48 provides:

> "(1) If in the case of a person to whom this section applies the Secretary of State is satisfied by the same reports as are required for the purposes of Section 47 above [i.e. reports from at least two registered medical practitioners] that that person is suffering from mental illness or severe mental impairment of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and that he is in urgent need of such treatment, the Secretary of State shall have the same power of giving a transfer direction [i.e. a direction that that person be removed to and detained in a hospital] in respect of him under that section as if he were serving a sentence of imprisonment.
>
> "(2) This section applies to the following persons, that is to say - ...
>
> "(b) persons remanded in custody by a magistrates' court ..."

24. Chandran was transferred from Pentonville Prison to Belmarsh Prison and remained there until he was admitted to the John Howard Centre on 20th December 2001.

Comment

One issue which arose for consideration was whether an Approved Social Worker should go to the police station when a person who has or might have mental health problems is arrested in relation to a serious crime. That this matter arose for our consideration is not a criticism of either the FME or the support worker who first attended the police station as the Appropriate Adult. The Inquiry Panel decided it did not need to invite them to give evidence and we have formed no conclusion or recommendation relating to any matter connected with them. We understand, however, that the policy has changed in Newham and an Approved Social Worker would go to the police station where a suspect with mental health problems were detained for a serious crime. This is a change which we support. In this regard, the Inquiry Panel has kept in mind the problems that the Trust has faced for a number of years in trying to recruit forensic psychiatrists.

Chapter 7 – Discussion

1. It was clear to the Inquiry Panel throughout the course of this Independent Inquiry that there was a lot of relevant information about Chandran's behaviour, his ability to manage his daily affairs and possible trigger factors or stressors for his illness which would have been readily available to professionals had appropriate systems or mechanisms been in operation. The Inquiry Panel considers there was much which was not known about Chandran but which should have been known and that, as a result, nobody got to grips with the extent of his illness or its management before he killed Narayanan Sukumaran.

2. We were struck by the fragmentation of the available services. Throughout this Report, we have highlighted instances where there was insufficient collaboration or co-ordination between different agencies or between the various parts of the mental health services involved in Chandran's care and treatment. Increasing globalization and current social mobility trends will mean that such fragmentation becomes a growing problem unless there are systems and procedures in place to address it. We do not consider that the Care Programme Approach on its own can provide an answer to this problem. Indeed, the Inquiry Panel is of the view that there is a risk that the CPA may create a false sense of security in that agencies who encounter an individual who is not "their" client but is subject to the CPA may be lulled into thinking the individual is not their responsibility and their input is, therefore, lessened or extinguished. This should not be so and, in our view, effective inter-agency working and comprehensive information-sharing are essential to the delivery of specialist services to vulnerable people.

3. Two issues which are linked arose very clearly and early on in the course of this Independent Inquiry, namely:

   - Access to mental health services, both for service users and for their families.
   - The risk assessment and management of the mentally unwell by those providing mental health services, the police and the London Probation Service.

4. We are conscious that these issues are not new ones and have featured prominently in other Independent Inquiries. The External Reference Group which examined and validated the evidence underpinning the Mental Health National Service Framework developed ten guiding values and principles to help shape decisions on service delivery. Those principles included that people with mental health problems can expect that services will be accessible so that help can be obtained when and where it is needed and will be well co-ordinated between all staff and agencies. Standard three specifically addresses access to services by providing:-

   "Any individual with a common mental health problem should:

   • be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care

   • be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services."

5. It was clear that information about Chandran was available from different sources and yet not collated adequately so as to provide a complete picture. His medical records were held in a number of different locations and much relevant information about him was not known to any professional involved in his care at all. If the information about a service user is of a poor quality or incomplete, there is a very real possibility that important information will not be available to those who need it and that risks which might be managed will be missed. An incomplete assessment of the risk of violence to others may provide false reassurance to family and friends or, on the other hand, unfairly and inaccurately label a service user as violent.

6. The following list demonstrates the nature of the information which ought to have been gathered from various sources and assimilated and ought, in our view, to have informed the decisions as to whether Chandran needed access to mental health services and whether help was needed for his family.

6.1 His childhood which had in many respects been very troubled. For example, we have described earlier in this report how his mother and his aunt had committed suicide in India.

6.2 The nature of his relationship with his father who was often violent towards Chandran.

6.3 Some understanding as to the reason for his admission to hospital in India in the later part of the 1980s when he was still very young. Although the Inquiry Panel doubts whether much information about the detail of this admission would have been learned, Chandran's family were able to provide some relevant facts.

6.4 The psychiatric assessment by Dr Orton in April 1990 including Dr Orton's view that Chandran needed psychiatric assessment over a period of time. Such an assessment did not take place because Chandran was discharged from the psychiatric outpatient clinic when he failed to attend the appointments he was sent.

6.5 His inpatient admission to Goodmayes Hospital in January 1991 which included his detention under Section 3 of the Mental Health Act 1983. This admission was preceded by Chandran's being frequently violent towards his father, allegedly threatening him with a knife and destroying windows and furniture at the flat they shared.

6.6 His subsequent failure to attend outpatient appointments at any time other than on 28th January 1992 (when the purpose of his visit to Dr Feldman was for a report dealing with his capacity to give instructions to solicitors in relation to a personal injury claim) and on 23rd June 1992 and 23rd July 1997. In total, he missed seven outpatient appointments, i.e. on 18th June 1990, 16th September 1991 (i.e. immediately following his discharge as an in-patient from Goodmayes Hospital), 27th March 1992, 25th September 1992, 1st December 1992 and in September 1997 and April 1998.

6.7 The lack of any adequate monitoring of the Lithium Carbonate prescribed on his discharge from Goodmayes Hospital.

6.8 The damage he caused again to the flat in Corporation Street in 1996.

6.9 The incident involving Mrs Ramkrishnan in December 1996 when he had destroyed her devotional artefacts and led her to believe he was going to get a knife with which to threaten her.

6.10 The damage he caused to his flatmates' possessions in early January 1997.

6.11 His in-patient admission to St. Martin's Hospital in January 1997 and the reasons for this admission. Allied to this was Dr Evans' request that he be referred to a psychiatrist in Newham for consideration of Lithium therapy, which was not acted upon.

6.12 The discrepancy between the medication prescribed on discharge from St Martin's Hospital in January 1997, i.e. Haloperidol and Procyclidine, as compared to the medication recorded by Dr Bhatti on 25th June 1997, i.e. Priadel (Lithium Carbonate) and Clonazepam, which ought to have revealed that Chandran had had further contact with a psychiatrist (in India) since his discharge from St. Martin's Hospital.

6.13 From 1999 onwards, the violence which Chandran used towards his sister and subsequently his brother-in-law and, also, possibly his niece.

6.14 The assault at work in February 2001 which involved Chandran hitting his victim on the head several times and then kicking his head.

6.15 The assault in September 2001 on Gopalan Jaykumar.

6.16 His family's increasing concern about his condition, as evidenced by Sujita Trousdale's call to the police following the report of Chandran's conviction in the *Newham Recorder*, her attempts to contact his probation officer and the 999 calls made on 12th September and 1st November 2001.

6.17 His family's visit to East Ham Police Station on 27th October 2001 with a letter which contained information that:

- Chandran suffered from mental illness (the nature of his illness was undefined in the letter but the fact of it was clearly apparent);
- he was believed by his family to have been prescribed medication but not to be taking it;
- he was liable to become violent at any time;
- his father was scared when Chandran visited his house; and
- his father believed he needed admission to hospital.

Access to psychiatric services

7. We recognise that particular stigma is often attached to mental illness throughout the community at large. In the Asian community, we understand that the manifestation of such stigma may be particularly complex in relation to male family members where the family may wish to contain the difficulties presented by mental illness.

8. In Chandran's case, however, we consider that his family realized his difficulties required external formal medical help. They recognised that he became violent when he was ill and, although they had tried on occasions to manage his illness by sending him to India, they also acknowledged that it progressed beyond a stage where they were able to help him. When they sought help for him, the "system" did not operate as it should have done to provide access to help.

We believe that appropriate CPA planning ought to ensure that relatives of patients are not left in a situation where they simply turn to the police for help, but that they know the action they need to take to respond to a crisis and what to expect of the professionals who will be involved[1]. We have concluded that the promotion of both patients' and carers' awareness of how to get help from the mental health services (including the right to request a Mental Health Act assessment) should be a priority for the Mental Health Trust.

9. In this Report, we have specified those occasions upon which we believe an opportunity to re-engage Chandran with the mental health services was lost. First, in 1997 following his discharge from St. Martin's Hospital when there was no adequate transfer of care from that hospital to his GP because of the mix-up over his GP's name. Secondly, despite Chandran's attendance at the Psychiatric Outpatients' Clinic in July 1997, he was subsequently discharged because of his non-attendance at two appointments in September 1997 and April 1998. In our view, instead of being discharged from specialist psychiatric services, a thorough risk assessment of Chandran's mental health should have been conducted, which ought to have flagged up the past violent and potentially violent incidents and ought to have identified the need for a plan to manage his illness.

10. Thirdly, Chandran's condition deteriorated from 1999 onwards such that, looking at the Eligibility Criteria for a Service from the CMHT provided to us by the Trust, he appears to have been eligible to receive help from the CMHT. Given the evidence of the family, he had by then a history of violent behaviour due to mental health problems (although no criminal conviction until 2001). As Dr Röhricht said, a history of that nature would have initiated a referral to the CMHT had he been made aware of it when he saw Chandran on 25th May 2001. In our view, had his family known whom they should contact when Chandran's condition deteriorated and been reassured that it was not in any way a betrayal of Chandran to seek help for him, it is likely that his increasingly violent behaviour would have been flagged up and he would have been eligible for help from the CMHT.

11. Fourthly, there was such an opportunity for psychiatric intervention when Chandran's family went to the police later in 2001. Dr Röhricht remarked to us that a family does not usually go to the police on the first occasion of violence: there is normally a history of violent or threatening behaviour. This was so in Chandran's case and we agree with Dr Röhricht's observation.

The Rôle and Response of the Metropolitan Police Service

12. As we have set out in this Report, Chandran's sister and aunt were reluctant to report to the police incidents when he had been violent or had threatened violence, and did not do so. The same appears to have been true for Narayanan Sukumaran who does not seem to have informed the police of Chandran's violence towards him at any time until the letter was taken to East Ham Police Station on 27th October 2001.

[1] C.f. Standard four of the Mental Health National Service Framework, the aim of which is "to ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible."

13. We believe that the information in the letter handed to the police on 27th October 2001 and the fact that three family members had gone into the Police Station with it, were such that their concerns should have been acted upon by the police and help sought for Chandran and his family. We wish to emphasise that reports of violence or possible violence by a person with mental health problems must be treated seriously.

14. The police are not trained as mental health professionals but, as happened here, for somebody who is worried about possible violence by a patient, assistance will often be sought at the police station. It is also true that officers on the front desk of a police station will encounter many enquiries on many different subjects and have many different forms to complete. We suggest that the problem is how to resolve that tension so as to seek to ensure that appropriate referrals are made on to relevant agencies for those who are in need of help. There must be joint working between the police and mental health services. It is not sufficient, in our opinion, to "divert" the mentally ill offender towards mental health services without parallel careful consideration being given to proper community protection issues.

15. **The Protection of Vulnerable Adults from Abuse**
The Department of Health issued Circular HSC 2000/07: LAC (2000) 7 in March 2000 requiring Social Service Departments to ensure that local multi-agency codes of practice were developed and implemented by 31st October 2001. The co-ordination rôle fell to Social Services Departments but "No Secrets" (also issued by the Department of Health) emphasised the responsibility on agencies receiving a complaint or allegation of abuse to inform other agencies of the nature of the complaint or allegation and of the action taken in relation to it[2]. We suggest that, given the age and physical frailty of Narayanan Sukumaran, appropriate use of this procedure could have provided a means of help for Chandran's family at this critical point.

16. We have already observed that we do not know what judgment the police officer reached in this case when he spoke to Chandran's family members on 27th October 2001, although the letter handed over suggested strongly that Chandran presented a risk to his father's safety and well-being.

17. It is clear from what we have said that we do not think sufficient steps had been taken in the past to ensure that Chandran and his family knew where to go for help when he relapsed. However, in our view, the documentation handed over was such that it was not a sufficient response at that time simply to leave his family to look elsewhere for help.

18. In addition, in what was an increasingly critical situation, a further opportunity was lost during the visit made to Chandran and his father by the police officers on 1st November, for intervention through referral to the Social Services Department for investigation under the Adult Protection Procedures.

19. The police should have taken steps to initiate an assertive police/mental health collaborative intervention. There were a number of ways that the police could have and should have arranged access to the mental health services for Chandran, e.g. through contact with Social Services or via direct contact with the CMHT. Unfortunately, none of this happened.

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[2] C.f. Section 6, para 6.13

20. Thus, there had been three calls for help made within a period of seven weeks. This fact was missed by the police when there ought to have been systems and procedures in place to ensure it was not.

21. Had the police fully appreciated at that time the need to provide access to help for the family and access for Chandran to a psychiatric assessment for management of his mental health problems, we have concluded that the need for a re-assessment of Chandran's condition would have emerged and the information which we have learned in the course of this Inquiry should have become apparent.

22. Other Independent Inquiries have highlighted the need for there to be clearly defined routes and mechanisms to ensure access to specialist mental health services is available when it is needed. This must include sound operational links between the police, the mental health services and Social Services.

Risk Assessment

23. Further, the issue of risk assessment crops up as a regular theme in a number of Independent Inquiry reports, which have stressed the need for comprehensive risk assessments on many occasions. In Chandran's case, a formal risk assessment was never carried out. We are of the view that a psychiatric outpatients' clinic with an assertive component is likely to operate effectively only if the volume and nature of its work is managed via primary care. Further, we think that the need for outpatient "monitoring" during periods of remission seems to decrease if patients and carers know how and in what circumstances to come back to secondary care. On the other hand, there is an expanding volume of psychiatric work which makes it increasingly difficult to find time and expertise to carry out risk assessments.

24. Nonetheless, we wish to emphasise once again that risk assessments must be thoroughly conducted, always include a detailed independent account of the patient's mental state from a family member or friend, must note all reports of violence (whether resulting in a criminal conviction or not) and must include consideration of key relationships. In the course of this Inquiry, significant doubts were expressed to us about the usefulness of a risk assessment which simply involves putting ticks in boxes without there being an ongoing assessment of a patient and the identification of possible triggers for a crisis. We agree with those views and stress that medical history-taking must be thorough and ongoing. In Chandran's case, a thorough clinical history was not taken throughout his care. Further, having threatened his father before his admission to Goodmayes Hospital, Chandran lived for a brief period following discharge with the Ramkrishnans, and then returned to live with his father with no assessment of the risk this may have posed to Narayanan Sukumaran having been carried out. This was key risk information which was never highlighted.

25. Material contained in the CPA procedure is intended to inform current needs-based care planning. It is, however, no substitute for in-depth clinical judgment. The challenge for contemporary practice is to balance both the gathering of information and the effective procedural programming of care so as to maintain good practice in both, particularly where resources are stretched.

26. We recognise the truth in the Royal College of Psychiatrists' Report 53 *"Assessment and clinical management of risk of harm to other people"* that:

    "Risk cannot be eliminated; it can be rigorously assessed and managed, but outcomes cannot be guaranteed."

27. We also recognise that we can only approach the question of whether Naryanan Sukumaran's death was preventable with hindsight. Still, we have concluded, that had there been a clearly defined route for the family to gain access to help for Chandran and had the need for a risk assessment been recognised, much more would have become apparent about his mental health at the time. We believe it would have revealed that Chandran posed a risk to Narayanan Sukumaran at that time of being violent towards him.

28. We have also come to the conclusion that, with appropriate intervention by the mental health services when the family expressed their concerns about his condition to the police, the outcome could not be guaranteed but there was a very real possibility that this homicide would have been prevented.

Chapter 8 – Recommendations

1. We appreciate that Chandran first became ill in the 1980s and that his first admission to hospital in this country occurred at a time when the CPA was very much in its infancy. The past twelve or thirteen years have seen significant changes in the management of those with severe and enduring mental illness and especially in the management of risk. We realise that some aspects of Chandran's care and treatment would now be approached differently: for example no decision to discharge him from the Psychiatric Outpatients' Clinic would now be made automatically following non-attendance at appointments. The appropriateness of that course of action would first be considered by a Consultant Psychiatrist who then has a number of options, e.g. to contact a service user's GP or to refer the case to the CMHT or to the Assertive Outreach Team. Further, there is now a single point of entry to the services via the CMHT. We have sought to keep those changes in mind in making the recommendations we make in this Report.

2. At the same time, many of the relevant events occurred between the later part of the 1990s and 2001, a time when we believe that all local agencies, including the police, should have fully understood the need to identify those people who require timely access to specialist mental health services and should have known how to access those services. We are not confident that the systems in place in Newham at present meet those needs. We share the concerns expressed by the Commission for Health Improvement (CHI) in its February 2003 Clinical Governance Review of East London and The City Mental Health Trust about clinical risk management within the Trust, and agree with CHI that the Trust needs to undertake a thorough review of the systems and processes it has in place to manage all aspects of clinical risk.

3. Furthermore, current clinical practice is predicated upon the active role of patients. They should be provided with information about their illness and be partners in the management of it. In the event that Chandran had been able to engage with such opportunities, he may have been able to facilitate some of his own access to services.

4. Newham's residents are from diverse ethnic backgrounds, and have different cultural needs. A wide variety of languages is spoken. Service users and their families are often unsure how to gain access to services to meet their needs. It is a considerable challenge for the CMHTs there to meet the varied mental health needs of that community. Local health and social care communities need to ensure that advice and help is consistent. The population of the borough as a whole must have confidence in the mental health services available, and service users and their carers must have the requisite knowledge to obtain the help they need. It is our hope that the recommendations we make will highlight those areas in which changes or further work are needed in order to improve equal and consistent access to those services for all members of the multi-racial community in Newham.

5. The criteria below upon which the Care Programme Approach is based must be fully appreciated and implemented although, as we have already observed, the CPA alone is not sufficient. There must be effective inter-agency collaboration to ensure that those in need of psychiatric services do not slip through the net. There must be:

- systematic arrangements for assessing the health and social care needs of people accepted by specialist psychiatric services;
- the formulation of a care plan which addresses the identified health and social care needs;
- the appointment of a key worker to keep in close touch with patients and monitor care;
- regular review and, if need be, agreed changes to the care plan.[3]

Recommendations

(1) East London and The City Mental Health NHS Trust and the London Borough of Newham should as soon as possible review closely the quality of their implementation of Care Programme Approach policies and procedures. They should ensure those policies reflect fully the importance of identifying those people who require timely access to specialist psychiatric services and promote links between organisations to facilitate access to those services.

In particular, that review must investigate the following wide-ranging issues identified by this Inquiry:

- the promotion of a culture of user-led service packages;
- the extent to which comprehensive assessments of service users' circumstances (including their family situation) are in practice carried out;
- the extent and adequacy of support for the families of the mentally ill and of any programme of education and advice for them;
- the extent and adequacy of publicised information about the mental health services available in the London Borough of Newham;
- the implementation of risk assessment procedures;
- the transfer of the care of patients with severe and enduring mental illness to and from East London and The City Mental Health Trust, including between primary and secondary care.

(2) East London and the City Mental Health NHS Trust and Newham Primary Care Trust must engage in continued development of the primary/secondary care interface for the management of people with severe and enduring mental illness, with the clear understanding that their management is a joint and several responsibility.

(3) The results of the review recommended at (1) above should be taken into account when Newham Primary Care Trust and East London and the City Mental Health NHS Trust are considering the commissioning and provision of an Early Intervention Scheme and a Crisis Resolution Scheme.

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[3] ***Building Bridges*** *A guide to arrangements for interagency working for the care and protection of severly mentally ill people DOH 1995,* para 1.3.5.

(4) East London and the City Mental Health NHS Trust and the London Borough of Newham should review the extent to which they have now implemented recommendation 6 in *The Report of an Independent Inquiry into the Care and Treatment of SH* (July 2002), namely that they should ensure their compliance at the earliest date with the involvement of carers in CPA assessment, care and treatment plans, in accordance with Standard 6 of the National Health Service Framework for Mental Health.

(5) East London and the City Mental Health NHS Trust and the London Borough of Newham as part of such a review should carry out an audit of those carers' assessments which have been undertaken since that Report was published.

(6) East London and the City Mental Health NHS Trust should review the quality of its interaction with the Metropolitan Police Service, giving particular consideration to whether further training is required to assist the police in the recognition and management of the signs and symptoms of severe and enduring mental illness and possible relapses.

(7) The London Borough of Newham Social Services Department in conjunction with East London and the City Mental Health NHS Trust and the Metropolitan Police should review the implementation of Adult Protection Procedures to ensure that front line staff are aware of their duties and responsibilities to protect vulnerable adults.

(8) East London and the City Mental Health NHS Trust and the London Borough of Newham should consider with the Metropolitan Police Service whether psychiatric liaison nurses should be employed to work in police stations within the borough, as presently happens at some locations throughout the country.

(9) East London and the City Mental Health NHS Trust should review with the London Probation Area of the National Probation Service their respective roles in the assessment and management of offenders with severe and enduring mental illness.

(10) The review recommended at (9) above should include looking at single entry points for psychiatric reports, with particular reference to the co-operative venture involving the Probation Service which gives an access route for Community Court reports into Southwark Mental Health Services.

(11) The reviews which are carried out by East London and the City Mental Health NHS Trust, the Metropolitan Police Service and the London Probation Area of the National Probation Service should include an investigation of the quality of communication of information about mentally disordered offenders between these services, and guidance as to the circumstances in which such communication may be needed.

(12) East London and the City Mental Health NHS Trust must implement as a priority its intended system of integrated case records which will be an important step towards providing a comprehensive service.

(13) East London and the City Mental Health NHS Trust should review its practice on obtaining case notes when there has been a transfer of care from a different mental health trust and, if necessary, carry out an audit to assess the efficacy of its practice.