REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF DENNIS FOSKETT

Commissioned by North East London Strategic Health Authority and published by its successor organisation NHS London

CONTENTS

GLOSSARY

CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CST	Community Support Team
ECHR	European Convention on Human Rights (1950)
GP	General Practitioner
MDO	Mentally Disordered Offender
MDT	Multi Disciplinary Team
MHA	Mental Health Act 1983
OCD	Obsessive Compulsive Disorder
OT	Occupational Therapy
PCT	Primary Care Trust
SW	Social Worker
UK	United Kingdom

PREFACE

THE INQUIRY PROCESS AND APPROACH

Introduction

1. This report sets out the findings and recommendations of an Inquiry into the care and treatment of Dennis Foskett following the homicide by him of his partner PC on 23 July 2003. The Inquiry was commissioned by the North East London Strategic Health Authority, and established in October 2004[1] under NHS Executive Guidance (HSG (94)27)[2]. The Inquiry has been funded and supported by the Newham Primary Care Trust and Barnet Primary Care Trust who are responsible for providing the relevant services.

2. At the time of the homicide, Mr Foskett was not subject to any formal monitoring or supervision by mental health services, having been absolutely discharged from liability to detention in hospital under sections 37 and 41 of the Mental Health Act 1983 (hospital and restriction orders) in April 1995. He was being seen on an informal basis by Professor Jeremy Coid, consultant forensic psychiatrist, based in Hackney, East London. Mr Foskett was originally a resident of the London Borough of Newham and in 1985 committed two homicides – his wife and his general practitioner – for which he was made subject to the above-mentioned Mental Health Act orders and treated at Goodmayes Hospital, Essex, until he was conditionally discharged in November 1992, taking up residence in Barnet, initially in Lyndhurst Hostel, a supported hostel. Mr Foskett met PC at Goodmayes Hospital in 1987.

3. Membership of the Inquiry Panel comprised Ms Aswini Weereratne, barrister, Doughty Street Chambers, London, Ms Angela Greatley, Chief Executive of the Sainsbury Centre for Mental Health and Dr James Anderson, consultant forensic psychiatrist, The Bracton Centre, London.

4. There have now been in excess of one hundred inquiries after a homicide by a person under the care of mental health services and, as here, the majority have

[1] Membership of the Inquiry Panel was finalised in November 2004.
[2] Amended on 15 June 2005. "Independent investigations of adverse events in mental health services, published by the Department of Health." Available on www.doh.gov.uk.

been commissioned in compliance with HSG (94)27. There are no prescribed procedures to be followed by such inquiries, which have no statutory powers or status and are not subject to the Tribunals and Inquiries Act 1992. Until recently, the sole guiding principle has been the concept of "fairness", recognised by the common law of England and Wales. Each independent inquiry has therefore to prescribe its own procedure.

5. The amended guidance published in June 2005 by the Department of Health recommends a process such as 'root cause analysis' to facilitate openness, learning lessons and creating change, suggesting a new methodology for conducting homicide inquiries. This system was previewed as looking beyond human error to systemic contributions to any poor practice identified. At its heart it is a radical change of culture requiring mistakes to be seen in a 'positive light as a source of learning, instead of condemned as signs of personal incompetence.'[3]

6. We are aware of, and have considered, the many criticisms that have been published of the process used in homicide inquiries.[4] We acknowledge that there have been difficulties in devising a robust process that fulfils all the aims of an inquiry while avoiding the criticisms of hindsight bias or the development of a 'blame culture'. We had already set out procedures and commenced our Inquiry by the time the amended guidance was published. In any event, we did not consider the alternative of a root cause analysis method to be appropriate in this Inquiry because the active involvement of services with Mr Foskett ceased in 1998. Services have since undergone change and individuals involved have moved on, some were untraceable. Further, the longitudinal nature of Mr Foskett's care, spanning over a period of eighteen years made such an approach impractical. The approach adopted by this Inquiry is set out more fully below.

7. Since October 2000 it has also been necessary to consider the requirements of the European Convention on Human Rights as applied in the UK courts pursuant to the Human Rights Act 1998. Of particular relevance to homicide inquiries is

[3] Munro, E. (2004).
[4] See for example, Munro above, Eldergill, (1999); Szmukler, G. (2000); Reiss D. (2001)

Article 2 (the right to life), and the associated investigative process that is required when a death has occurred to protect and promote the right to life in the future. This change has been recognised in the amendment to HSG (94)27.

8. Not every death at the hands of a person in the care of specialist mental health services may, or will be, the responsibility of an agent of the State such that Article 2 is engaged or breached, nevertheless the investigation process developed in that context is imbued with standards and principles that usefully guide every independent homicide inquiry. In essence these require that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny, and involve the next of kin to an appropriate extent.

Terms of reference

9. The aims of an independent inquiry as set out in the amended NHS guidance are openness, learning lessons and creating change. This incorporates the aims of minimizing the risk of future similar deaths and assuaging the anxieties of the public. These are reflected in the Inquiry's terms of reference which are set out in Appendix B.

10. At the request of the Inquiry Panel an additional term was added to the Terms of Reference that allowed the Inquiry to fulfil its obligations fully. This allowed the inquiry "To consider such other matters relating to the issues arising in the course of the Inquiry as the public interest may require". As a result the Inquiry was able to call for the records of PC and to consider the joint needs of the couple to the extent that was relevant to Mr Foskett's own care.

Procedure

11. The procedure adopted by the Inquiry is at Appendix C and the list of witnesses is at Appendix D.

12. As with the majority of homicide inquiries, this Inquiry heard evidence in private. The procedures were designed to mitigate any unfairness this may result in where, for example, witnesses could not hear the evidence of others which was relevant to them. All witnesses had the opportunity to be accompanied by a legal representative or other person and to comment on conflicts in evidence which

emerged through the course of the hearings that were relevant to findings of fact and comments likely to be made by the Inquiry in the final report. The element of public scrutiny has also been preserved by the publication of the final report in its entirety.

13. All witnesses were sent copies of the terms of reference and procedures. They were informed of the particular areas for questioning identified by the Inquiry and given the opportunity to raise any other matters of relevance to the Inquiry. All witnesses had the opportunity to peruse available documentation relating to their interaction with either Mr Foskett or PC. In some cases documentation only came to light during the interview or as a result of it. In those circumstances, the witness was sent additional documentation and invited to comment upon it.

14. In this way, and through oral questioning of those witnesses who attended for interview, the aim of the Inquiry was to understand as well as possible the thinking of the individual practitioner when he or she was actually involved with Mr Foskett and what factors influenced their thinking and decision-making.

15. The procedures ensured that the Inquiry was undertaken with expedition and allowed for candour in evidence which a public hearing is likely to have inhibited.

16. The independence of the process has been a paramount concern of the Inquiry Panel and safe guarded by the Panel membership who have not had any interests in the services under review during the Inquiry process. It should be noted that Ms Greatley accepted a position as a Non-Executive Director on the Board of the Barnet, Enfield and Haringey NHS Mental Health Trust in February 2006 after the majority of the Inquiry's business had been concluded.

17. The family of PC was contacted by the Inquiry, but declined to participate. The Panel met and interviewed Mr Foskett at Camlet Lodge, Chase Farm Hospital on 14 April 2005.

Approach of the Inquiry

18. A homicide inquiry has the dual aims of highlighting practice issues that need to be changed and promoting the accountability of public services and professionals

to those in their care and the public at large. Achieving these aims requires the openness and co-operation of those who had responsibility for the patient.

19. The oral hearings were kept as informal as possible, but the Inquiry Panel was acutely aware of the stress that is experienced by individuals and agencies while an Inquiry is under way. However, a thorough examination of the events leading up to and surrounding the incident in question is essential in fulfilling these aims. It is not easy to conceive of how this can be achieved in a way that does not engender some sense of blame. Whether in a private interview or in a group exercise, the process of accounting for one's actions when something has gone wrong is a stressful one. In theory there should be no perception of blame and a non-punitive approach would be the best in encouraging openness. In reality the change in culture whereby mistakes are seen as positive learning experiences is radical indeed and one requiring a significant shift in human nature.

20. However, the Inquiry is firm in its view that attaching "blame" or finding "scapegoats" is not a positive way forward and we have striven to make our conclusions as reasonable and balanced as possible. In finalising our report we have tried to be constructive in our criticisms and offer praise where in our opinion it is due. It has not been our mission to find individuals to blame.

21. The history of Mr Foskett's care stretching back beyond 1985 when he committed two homicides which brought him into contact with specialist services, has meant that the Inquiry has had to deal with a long period of care and management in order to come to a good understanding of the decisions made in relation to him. As a result, service issues have not been to the fore except in the latter period leading up to the killing of PC.

22. We are also only too aware that some tragic incidents are unavoidable and we do not wish to perpetuate a culture which believes otherwise. As a society we must learn to understand that serious adverse incidents will sometimes happen, and it is not always necessary or productive to find someone to blame as long as lessons are learnt along the way.

23. Although mental health professionals must be accountable for good practice, they cannot ultimately be expected to carry complete responsibility for the actions

of their patients. There is a limit to the control and influence which it is possible for them to achieve over any individual. It would also be wrong to overlook the right of a patient to refuse interventions by the services.

24. We have endeavoured during our deliberations to come to conclusions without the benefit of hindsight and to consider the standards of practice that would have prevailed at the relevant time.

25. The practice of individual practitioners has been judged by reference to that of a reasonable and responsible body of practitioners in the relevant field. To assist in that process, additional expert evidence was sought, where it was considered necessary. We have throughout applied the standard of proof used in civil law, namely, a balance of probabilities.

26. The issue of hindsight bias is indeed a difficult one in any situation of inquiry where the outcome is known. This in itself makes the legitimate process of asking searching questions a critical one which inevitably links every action to that outcome. The issue of causation is one that is familiar to lawyers, also known as the 'but for' test, it is intended to enable clear lines of accountability to be established. Clearly the application of the 'but for' test relies on the exercise of reasonable judgments. In this regard relevant expert evidence and the expertise of panel members is important to ensure the application of reasonable standards.

27. It is crucial that employees are fully supported by those employing them at the time of the relevant incident through to the conclusion of legal proceedings and any Inquiry. Legal services are only one form of support. A full debriefing, counselling and a timely internal review are also relevant.

28. The Inquiry has treated all evidence, written and oral, including Mr Foskett's records, as being received in confidence. We have considered its relevance to the terms of reference, and in using and disclosing information within the report the Inquiry have weighed the public interest against confidentiality, and whether disclosing confidential information is proportionate to the legitimate aims of the Inquiry. The evidence provided to the Inquiry will remain confidential save to the

extent that it is set out or referred to in the text of the report. This report contains the unanimous findings and conclusions of this Inquiry Panel.

29. The Inquiry Panel has endeavoured to deal with matters as expeditiously as possible, but inevitably delays have been incurred, most of which have been completely outside the Panel's control. Hearings took place at Doughty Street Chambers, London, on nine days between 14 April and 16 September 2005 including on 7 July when bombings in London took place. Additionally, due to the timescale and the fact that some practitioners had moved to different areas, the process of tracing witnesses took some time.

Documentation

30. We received the written consent of Mr Foskett for disclosure of his medical and other relevant records to the Inquiry. Although the homicide occurred in 2003 and there was a serious untoward incident report published on 7 October 2003, records were provided to the Inquiry in a piecemeal fashion. It is incumbent on the commissioning authority to ensure as soon as it becomes known that an independent inquiry will be established, to secure all relevant documentation from all agencies in the interests of speed and efficiency of the Inquiry process.

31. The Inquiry, with Mr Foskett's consent, also had access to the statements and material gathered by the police during their investigation into the homicide. This was of particular importance in identifying friends and family who could enlarge on Mr Foskett's activities and behaviour in the community and offered the Inquiry a point of balance to evidence otherwise solely provided by practitioners and agencies.

Acknowledgements

32. We would like to offer our sympathies to the family and friends of PC.

33. We would like to thank all those contacted by the Inquiry for their co-operation and patience. In particular we would like to note that Dr Joan Feldman, consultant psychiatrist, who was responsible for Mr Foskett's care for the majority of his time at Goodmayes Hospital and until 1992, died in November 2005. She had been ill for some time and we are grateful that she allowed Ms Weereratne

to visit her on 27 May 2005 to take evidence from her. We would like to express our condolences to her family and friends.

34. We must also thank Wordwave for producing transcripts of the hearings and Doughty Street Chambers for hosting the hearings. We owe thanks to Alasdair McKenzie, barrister at Doughty Street Chambers, for his research into some of the issues considered in this report.

Chapter 1

INTRODUCTION

Issues and relevant services

1. Sometime during 27 July 2003 Dennis Foskett, aged sixty, killed PC his long-term partner, whom he had met at Goodmayes Hospital, Goodmayes, Essex, in about November 1987. Mr Foskett called the emergency services at 1.02 a.m. on 28 July saying that he had killed his 'wife' and taken an overdose. The police found PC with multiple lacerations to her head and neck; she had bled to death and had been dead for some time. Mr Foskett remains amnesic of the details of this event which is the trigger for this Inquiry. He was suffering from severe depression.

2. At the time that Mr Foskett and PC met, he was an inpatient at Goodmayes hospital under sections 37 and 41 of the Mental Health Act 1983 ('MHA'), having killed his wife Margaret and their general practitioner, Dr Eva Glickman, on 17 May 1985. He was then aged forty two. He was diagnosed as suffering from severe depression at the time. Chapter Two summarises Mr Foskett's early history and the events leading to these killings of which he is similarly amnesic. PC also suffered severe mental health problems and was an inpatient at Goodmayes Hospital when they met. These details are relevant to Mr Foskett's care and are set out in Chapter Five.

3. Following the double homicide in 1985 and having spent a period on remand at HMP Brixton, he pleaded guilty to two counts of manslaughter on the grounds of diminished responsibility at the Central Criminal Court, London. On the advice of two consultant psychiatrists he was made the subject of a MHA disposal. In a controversial decision, the judge accepted the evidence of the two psychiatrists that Mr Foskett was no danger to the public unless the depression recurred and directed that he be treated at a local hospital rather than under conditions of high security. The depression had receded and was well controlled by medication with which Mr Foskett was completely

compliant. Mr Foskett's early history and offences in 1985 are set out in more detail in Chapter Three.

4. Mr Foskett was treated and assessed by clinicians at Goodmayes Hospital under the supervision of the Home Office, including the Advisory Board on Restricted Patients. This period is considered in detail in Chapter Four. He was conditionally discharged by the Home Secretary in November 1992 and discharged to Lyndhurst Hostel, Barnet on 26 March 1993. Shortly after this, outpatient psychiatric supervision switched from Goodmayes and Dr Joan Feldman, to Dr (now Professor) Jeremy Coid based at Hackney Hospital, East London. Mr Foskett was also being seen by a social worker from the East Newham CMHT. Issues relevant to his conditional discharge and the provision of after care services for Mr Foskett are considered at Chapter Six.

5. On 11 April 1995 Mr Foskett was absolutely discharged by a Mental Health Review Tribunal. Professor Coid offered him continuing support and unsuccessful attempts were made to transfer his care to the local Barnet community support team, and then the mentally disordered offenders team. Mr Foskett accepted continued input from a social worker in that team until early 1998. After that time he was seen only by Prof Coid on a bi-annual basis. The decision to absolutely discharge Mr Foskett and the arrangements for supervising him are considered at Chapters Seven and Eight. Mr Foskett gained his own independent accommodation in October 1996, from which time he and PC were effectively co-habiting, dividing their time between their two homes. This period and the events leading to PC's death are described in Chapter Nine.

6. A chronology of key events is provided at Appendix A.

Issues

7. The issues that arose for investigation were focused as follows:

- The appropriateness of a local hospital placement and the need for conditions of greater security (Chapter Three)

- Assessment and treatment at Goodmayes Hospital focusing on personality, index offence, psychology and couple therapy (Chapter Four)

- Discharge planning and after care under conditional discharge (Chapter Six)

- Absolute discharge and its implications for long term care (Chapter Seven)

- The role of services following absolute discharge and the use of CPA principles, including the need for joint assessments of Mr Foskett and PC (Chapters Eight and Nine).

Relevant services

8. Goodmayes Hospital, Goodmayes, Essex: Since April 2001 part of the North East London Mental Health NHS Trust covering Barking and Dagenham, Havering, Redbridge and Waltham Forest, and Brentwood in Essex, a population of approximately one million people and providing beds for patients from Newham, such as Mr Foskett and PC. This is one of two mental health trusts under the auspices of the North East London Strategic Health Authority (formerly East London and The City Health Authority), the other being East London and The City NHS Mental Health Trust covering the heart of east London.

9. Newham East Community Mental Health Team, joint health and social services care, is the responsibility of the East London and The City NHS Mental Health Trust. Mr Foskett was subject to their supervision on conditional discharge to Lyndhurst Hostel, Finchley, Barnet. PC was referred to them on three occasions in 2002 and 2003.

10. Professor Coid, consultant forensic psychiatrist, was based at the time in question at the Hackney Hospital also part of the East London and The City NHS Mental Health NHS Trust.

11. The East Ham Memorial Hospital, Forest Gate and Newham General Hospital, Plaistow is where PC was seen as an outpatient from 1998

onwards. These services were part of the Newham Community Health Services NHS Trust and Newham Healthcare NHS Trust respectively.

12. The Barnet Community Support Team (CST) and the Barnet Mentally Disordered Offenders Team (MDO) are both part of the Barnet, Enfield and Haringey NHS Trust established in April 2001 and formerly three Trusts: the Barnet Community Healthcare, Enfield Community Care, and the Haringey Healthcare NHS Trusts.

13. The Secretary of State for Health is currently considering proposals for a single London wide strategic health authority.

14. By way of summary all Newham and East London services mentioned above are commissioned by Newham Primary Care Trust. All Barnet services are commissioned by Barnet Primary Care Trust.

15. A map showing the area covered by these services is at Appendix H.

Care Programme Approach

16. Mr Foskett was an inpatient at Goodmayes Hospital at a time before the advent of the Care Programme Approach ('CPA') which was introduced in 1990 as a national framework for the care of people with mental health needs.[5] National implementation was patchy and by 1994 the Audit Commission reported that many districts had failed to implement CPA.[6] As a result, this Inquiry has not been concerned with issues of CPA at Goodmayes Hospital during his admission between 1985 and 1992.

17. Care planning and after care for Mr Foskett at the time of his discharge from Goodmayes Hospital fell for consideration under section 117 MHA.

18. The main service issue arising in relation to Mr Foskett's care for consideration and one that engaged CPA implementation, was that of the involvement of Barnet mental health services and more specifically, the

[5] See *Caring for People*, DoH, White Paper (1989) and *The Care Programme Approach for People with a Mental Illness Referred to Specialist Mental Health Services,* (1990).
[6] *Finding a Place: A Review of Mental Health Services for Adults,* (1994).

community support team (and later the mentally disordered offenders team) when Mr Foskett was living in independent accommodation in Barnet. This was allied to the issue of psychiatric supervision provided by Professor Jeremy Coid, based in Hackney and the provision of services from unconnected bodies in different service areas.

19. A potential service issue in relation to the care of PC relates to her referrals to the Newham East CMHT which appear not to have taken place.

Chapter 2

EARLY HISTORY

Introduction

There are few original records surviving from prior to 1985. This Inquiry has not uncovered any significant facts that were not known about at the time of the 1985 homicides or thereafter. What follows is taken from the court papers relating to 1985, the psychiatric reports of the time and interviews conducted by the Inquiry panel with Dennis Foskett, his brother and Prof Jeremy Coid who had responsibility for Mr Foskett's care between 1993 and 2003. Prof Coid had previously also assessed him as an inpatient at Goodmayes.

Family and early life

1. Dennis Foskett was born on 15 April 1943 and was the youngest of two sons. His family is described as a 'good' one in various documents. His father died of cancer at the age of fifty five. He also had Parkinson's disease. His mother who was seventy six in 1985 died in 2004. She was cared for largely by Dennis Foskett's older brother who lived with her until she died. Dennis Foskett was born with a hare lip which was operated on when he was a few months old. He had a nasal bone graft at the age of thirteen. He left school at fifteen and a half.

2. Mr Foskett was bullied at school and was a nervous child. His description now is of serious abusive behaviour towards him by children at his school. He was humiliated and spat on due to his hare lip. He also says that he was sexually assaulted. The extent and severity of the bullying he experienced does not seem to have emerged until some time after the 1985 homicides. He met his wife, Margaret, when he was sent to another school where he was not bullied, aged around fourteen. He was an average pupil, but left school at sixteen without any qualifications and was until 1985 always employed. His first employment was as an apprentice blacksmith for British Rail and then various jobs including labouring, hospital portering, as a stoker in a hospital boiler room and as a crane driver. His last occupation was as a hospital porter at Hackney Hospital, London.

Psychiatric history

3. There is said to be a history of mental illness on both sides of the family details of which are unclear. Dennis Foskett, however, has a long history of mental illness and first developed problems during his adolescence, aged about fifteen. This was his first diagnosis of depression following a bout of 'flu. Thereafter he developed a significant illness which manifested itself on at least another three occasions prior to 1985. In March 1970 he was admitted to hospital for ten days following another round of bad 'flu about two months previously. It is noted that Mr Foskett thought that he was going to die and became very depressed with suicidal thoughts. As a result, he lost his job. He had been married for six years by this time. It was recorded that during the course of his depression he had often felt 'extremely aggressive towards other people, but realises that this feeling is irrational'. He was treated with amitryptiline. This appears to have been his second episode of depression.

4. There was another hospital referral to Goodmayes Hospital in 1979 and again to the East Ham Memorial Hospital in 1981. The records of these admissions are not now available but they are referred to in a Home Office document of 1990. Subsequent to the 1985 homicides, Dr D.K Hirst, consultant psychiatrist, in his recommendation to the sentencing court commented that he had 'no doubt from reading case notes of his treatment at Goodmayes Hospital, that he is a man of considerable vulnerability in respect of his personality, prone to anxiety, and responding less robustly to stress than is normal.' He responded to anti depressant medication and remained well for the three years leading to 1985.

5. Later accounts of this episode of illness indicate that he was experiencing very severe depersonalisation i.e. a change in self awareness such that the person feels unreal, and was having increasing difficulty coping with his job. He had feelings that he was being watched, was frequently crying and stressed by the feeling that he had to cope with his wife Margaret who

suffered from epilepsy, see below. There is no evidence whatsoever that he was ever in fact aggressive or violent in any way prior to the offences in 1985.

Marriage to Margaret

6. Dennis Foskett married Margaret when he was 21 years old. They met at secondary school as teenagers aged thirteen, a time which appears to have marked a turning point in his life, as from around that time he escaped the bullying that had characterised his early schooling. For all intents and purposes they had been happily married for 22 years at the time of the killing and a 'devoted couple'. There is no evidence of any domestic or other violence.

7. Margaret was epileptic, a fact that was known to Mr Foskett prior to their marriage. Mr Foskett has described 'walking on eggshells' around her for fear of bringing on an epileptic fit. This meant that he was careful to avoid any disagreements and was unable to share his worries with her for fear of causing her to have an epileptic fit because this had happened once following a serious argument. He told the Inquiry Panel that he could not remember what it was about. Mr Foskett says that he more or less took over the household chores and there is a suggestion that he was doing the housework in an obsessive fashion in the weeks before the offence and when he was suffering from depression.

8. The couple did not have any children. Margaret had a miscarriage once which upset her a great deal and caused her to have some fits. Nevertheless, in Mr Foskett's view they remained close. He used to worry about what would happen to a baby if she should have a fit while caring for it while he was at work.

9. Subsequent to the 1985 offences there was focus on the nature of his relationship with Margaret which revealed that he remained passive within it, controlling and internalising the stress resulting from the way in which he cared for her in order to prevent her from having fits. Even so it was never doubted that he did genuinely love her.

Chapter 3

1985 OFFENCES

Introduction

On 17 May 1985 Dennis Foskett killed his wife Margaret and their general practitioner of many years, Dr Eva Glickman. He was forty two years old and suffering from severe depression at the time. He pleaded guilty to two counts of manslaughter on the grounds of diminished responsibility and on 22 November 1985 was made the subject of a hospital order with restrictions unlimited in time, under sections 37 and 41 of the Mental Health Act 1983. Controversially, the judge directed that Mr Foskett be treated in a local psychiatric hospital, Goodmayes, situated in the London Borough of Redbridge in North East London, rather than a high secure hospital. The serious untoward incident report of 7 October 2003 concluded that Mr Foskett should have been placed in high security. The Inquiry Panel considered the following issues:

a. The role of any adverse reaction to medication in the homicides in 1985, and

b. the appropriateness of the court disposal to a local hospital.

Evidence on these issues was obtained from the Home Office, Mental Health Unit, the Department of Health, Broadmoor and Rampton Special Hospitals, Professor David Healy, North Wales Department of Psychological Medicine, and Dr Jackie Craissati, consultant clinical and forensic psychologist, the Bracton Centre.

Depression and homicides

1. Mr Foskett's depression in April/May 1985 was precipitated by a bout of 'flu a month or so earlier. Mr Foskett says that he and his wife recognised that he was ill. He lost weight and interest in life and developed a belief that he was being watched, including by his work colleagues. He became more anxious and nervous than normal and became concerned about his performance at work. Mr Foskett recalls experiencing auditory hallucinations. He went to see Dr Eva Glickman, his general practitioner, at her surgery. She prescribed mianserin (Bolvidon), a tricyclic anti-depressant known on occasion to aggravate psychotic symptoms, such as feelings of persecution. Mr Foskett reported feeling worse, reckless and agitated. His

feelings of paranoia did not improve. His work colleagues had in fact encouraged him to go to the casualty department of Hackney Hospital, where he worked and he says that he did so.

2. Mr Foskett has never been able to provide a coherent account of what happened on 17 May. He was, and remains, almost totally amnesic of the killings. What is known is that Mrs Foskett called Dr Glickman and requested a home visit. This may have been up to a week after Mr Foskett started on mianserin. Dr Glickman left her surgery at around 6.45 p.m. and at 7.10 p.m. Mr Foskett was seen by a neighbour outside his house holding a hammer and shouting for help saying that he had killed his wife. He was very distressed and attempting to swallow a large number of pills. The bodies of the two women were discovered in the house.

3. He has since expressed strong feelings of remorse for both killings. He was unable to understand why he had killed two people for whom he had the highest regard and affection. In particular, he is recorded as talking about the loss to the doctor's family. He also found it difficult to believe that he could have committed such an horrific act. Later there was some question over whether he had distanced himself from the killings. Assessment of these offences is considered in more detail in the next chapter.

Court disposal: local psychiatric hospital

4. The decision to send Mr Foskett to a local psychiatric hospital was controversial and resulted in the local MP writing to the Secretary of State to complain about it. The Daily Mail newspaper ran a campaign against Mr Foskett expressing concerns at his being placed in an open hospital. A photographer used lies to gain admittance into Goodmayes Hospital with the result that a photograph of Mr Foskett in hospital was published in the Daily Mail. In addition, there was a letter from a member of the public complaining in similar terms. The matter was aired in the House Commons on 24 February 1986 by the member of parliament for Ilford, North, from which it is clear that members of the public as well as hospital staff had aired their concerns about the placement. The point was made that six months was not a sufficient period of time in which to assess a person's suitability for a local psychiatric hospital. The Parliamentary response referred to the availability of three concurring psychiatric

opinions which are discussed further below and that the decision was ultimately that of the court with which the Government could not interfere.

5. The fact that these killings were brutal must not be underestimated. However, it has never been doubted that Mr Foskett committed them while he was acutely and severely mentally ill and suffering an abnormality of mind which substantially diminished his responsibility for his actions, hence the acceptance by the court of a plea of diminished responsibility (s. 2 Homicide 1957). There was also consensus that this is a recurring rather than a chronic illness. The court had available to it evidence from three consultant psychiatrists, Drs PLG Gallwey, D Hirst and P Bowden, the latter had seen Mr Foskett at HMP Brixton. There is no transcript of the sentencing hearing now available, so the judge's remarks and reasoning are not known. Dr Gallwey, consultant psychiatrist, then a senior lecturer in psychiatry at St George's Hospital, Tooting, reported that Mr Foskett was clearly agitated and depressed when he saw him on two occasions, a fortnight apart, in September 1985. He notes that he was better on the second visit.

6. Dr Gallwey identified paranoia as a new feature of Mr Foskett's illness and expressed his view that the offence arose not only directly from the illness, but also from the fact he was being inadequately treated with mianserin. He attributed this to two factors, first that Mr Foskett was slow to see his doctor and, second, that he did not tell her of his paranoid feelings. This second was also a feature of his presentation in 2003 shortly before killing PC when he had been unable to tell Prof Jeremy Coid, who later supervised him, how seriously unwell he had become (Chapter Nine). In Dr Gallwey's view, an understanding of the seriousness of the illness and its deteriorating nature was likely to have led to a hospital admission.

7. A hospital order under section 37 of the MHA was recommended. Dr K Hirst, then a consultant psychiatrist from Goodmayes Hospital, had offered Mr Foskett a bed. Dr Gallwey's view was that Mr Foskett did not need to be treated under conditions of special security because he was unlikely to '*be a danger to others provided he is adequately treated for his recurrent psychiatric illnesses. Certainly while he is under treatment ….I would not think there would be any risk of him absconding or becoming a management problem. I would anticipate that he would get better from this particular attack and the important thing is to ensure that he is properly followed*

up psychiatrically during his periods of remission so that any relapse is identified speedily and full treatment initiated early on.' He added '*I would consider that a Restriction Order without limit of time under Section 41 of the Mental Health Act would be perfectly adequate in ensuring that Mr Foskett's illness does not overtake him again with such dreadfully tragic results.'*

8. Dr Hirst noted that even though Mr Foskett's presenting illness had ameliorated by the time he saw him, he still showed permanent signs of an anxiety prone and highly dependent personality. As for risk, he said that Mr Foskett was not then a danger to the general public and would only present such a danger if his mental illness was to recur. For this reason he recommended a placement at an open hospital and offered Mr Foskett a bed at Goodmayes hospital. He had explained to Mr Foskett that this was likely to occur under a restriction order and the effect that would have on his obtaining leave of absence from the hospital. Subject to a continuation of his relatively good mental health, he envisaged offering outpatient supervision of '*an intense nature, with a view to monitoring his mental state extremely carefully in the belief that this would enable the psychiatric services to identify the start of any further episode of depressive illness which would clearly require immediate treatment……adequate supervision would ensure that any recurrence of his serious mental illness would receive immediate treatment.'* In an earlier letter to Dr P Bowden at HMP Brixton, Dr Hirst had referred to the 'woeful situation' in North East London regarding access to secure accommodation and that there was no access to any. The requirement is that one of the two recommending doctors must give evidence at court if a restriction order is to be made.

9. On 22 November 1985 a judge at the Central Criminal Court in London, directed that Mr Foskett, who had pleaded guilty to two counts of manslaughter, be detained under sections 37 and 41 of the Mental Health Act 1983 at Goodmayes Hospital, Redbridge.

COMMENT

Adverse reaction to medication

10. Professor David Healy of the North Wales Department of Psychological Medicine, is one of the few experts in the UK researching the links between anti-depressant

medication and violence. His evidence indicated the inconclusive nature of this research currently. As far as depression and homicide is concerned, his evidence was that while in general there are 'grounds to believe that antidepressants can precipitate acts of violence up to and including homicide', there have been only a very few reports making the link in relation to a variety of anti depressants over the past 40 years. Links between anti-depressant medication and violence are not universally accepted by the medical and scientific communities. Again in general, he said that the more severe the mood disorder, the greater the likelihood that the disorder rather than its treatment led to the violence. It is not doubted that Mr Foskett exhibited a severe degree of disorder at the time of these two homicides and when he killed PC in 2003, but there is no reliable evidence that his illness was caused by improper drug prescription.

11. In relation to the killing in 2003, Mr Foskett had been treated with Amitryptiline [and lithium] for many years without any recorded problems. This allows for a fairly conclusive opinion that it is highly unlikely that medication contributed to Mr Foskett's actions in July 2003. This would be so even if there were some grounds to implicate mianserin in the 1985 killings. These grounds might include the fact that he had started treatment relatively recently and had reported adverse effects to this treatment. However, the level of any contribution, if any, of mianserin is impossible to determine.

Appropriateness of court disposal and level of security

12. Section 37 MHA empowers a court to sentence an offender to a period in hospital instead of prison or other penal disposal. There are thus, in broad terms, two models of sentencing: the justice model and the treatment model. The former draws upon the links between the crime and the sentence and cannot try to provide explanations of the offender's behaviour. In contrast, the latter emphasises the personal characteristics of the offender, especially his psychological condition and the benefits of treatment, while also seeking to offer protection to the public. A hospital order is intended to be in lieu of punishment.[7] There has been a protracted debate as to the

[7] *R v Birch (1989)* and *R v Morris* [1961] under the MHA 1959.

merits of this system,[8] which it is inappropriate to rehearse in this report which will focus only on those issues relevant to Dennis Foskett.

13. The relevant legal criteria for admission to hospital under section 37(2) are that the: *" (a) court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental illness……and that… (i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment …;"*

14. In this case these criteria were clearly met; the court had the requisite recommendations of two psychiatrists and the availability of a hospital bed (section 37(4)). In addition, the court had to *'be of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender and to other available methods of dealing with him, that <u>the most suitable method of disposing of the case</u> is by means of an order under this section.*' (Section 37(2)(b) emphasis added.) This implies that the court must take account of what is likely to happen to the offender, including the level of security offered by the hospital he will be detained in and that he may (in the absence of a restriction order) be released without punishment, or reference back to the court, once doctors, or a Mental Health Review Tribunal, assess him to be well enough to be discharged from hospital. Imposing a hospital order which would not provide an adequate level of security would by definition not be the 'most suitable method' of disposal. Indeed a judge is entitled to disagree with the assessments of the doctors before him/her that an offender could be dealt with safely at a less secure local hospital.[9]

15. The power to impose a restriction order arises once a hospital order has been made and supported by the oral testimony of at least one doctor. It can only be made by the Crown Court and allows the court to impose additional safeguards to protect the public. The order achieves this by restricting the patient's discharge, transfer or leave of absence for a specified, or more usually, unlimited period without the consent of the Secretary of State (section 41(3)). An order may be made where it appears to the court '*necessary for the protection of the public from serious harm*'

[8] See for example Hoggett (1996), Bean (1986) and the Butler Report (1975)
[9] *R v Morris [1961]*

and '*having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large.*' (section 41(1)).

16. The issue for the court was the seriousness of the harm he would inflict, not just on the public in general, but on any identifiable category persons or a single person, if he did in fact re-offend. This involves a prediction of future serious harm and not simply future re-offending. On this test a restriction order was, in our view, proper. In Mr Foskett's case the relevant identifiable category would have been women in close contact with Mr Foskett, and the killing of Dr Glickman might have widened the ambit of this definition beyond partners and family.[10] We do not know which of the psychiatrists provided evidence to the court for this purpose. On the face of Dr Gallwey's report he does not address the section 41 test of 'serious harm'. However, Dr Hirst's report does address this issue by reference to the general public, which strictly conforms to the wording of the statute.

17. But the position may not be so clear cut, and in *Courtney,*[11] the Court of Appeal quashed a restriction order imposed on a man of good character, who had killed his wife while undergoing treatment for depression, because there was no medical evidence that he was a danger to the public at large. He was assessed as presenting a low risk of re-offending, even though he had committed a serious offence. However, a court would have to be sure of its ground not to impose a restriction order in such as case. The Court of Appeal has also stated that in cases of crimes of violence or where there is a history of mental disorder involving violent behaviour, there would have to be compelling reasons not to impose a restriction order.[12] While it is not possible to conclude definitively that the Court of Appeal would have overturned the restriction order in this case, there was no appeal, and what might have happened had Mr Foskett only been subject to a hospital order is a matter of speculation which this report cannot pursue. It is clear, however, that while in 1986 Mr Foskett may have entertained the possibility of a successful appeal against the restriction order, today such an appeal is highly unlikely to succeed.

18. It is clear that there is no express power for the court to insist on a particular hospital place to be made available for an offender in respect of whom a hospital order is

[10] *R v Birch* (above)
[11] *[1988] Crim LR*
[12] *R v Gardiner (1967)*

being made. In this case, the court accepted that Mr Foskett could be managed and treated in an open hospital and there is no evidence to suggest that this was an irrational decision. The imposition of the restriction order shifted the nature of the disposal from one that was intended to be in the interests of the patient to one that focused on public safety. A patient subject to such an order is likely to be detained for much longer in hospital than one who is not.[13] However, it makes no requirements as to the level of security in which a patient must be detained and this remains a matter for the judge.

19. Dr Hirst raised the issue of the 'woeful' availability of secure accommodation. Section 4 of the NHS Act 1977 requires the Secretary of State to provide Special Hospitals for the detention of mentally disordered individuals '*who in his opinion require treatment under conditions of high security on account of their dangerous, violent or criminal propensities.*' There are three such hospitals in England: Broadmoor, Rampton and Ashworth. The current Broadmoor admissions policy identifies three main admission requirements: the presence of a recognisable mental disorder, liability to detention under the MHA and risk to others. As to the latter, it states that '*care and observation at Broadmoor Hospital can only be justified when the highest level of security is required and no lesser degree of security will provide a reasonable safeguard to the public. It is an unacceptable infringement of a patient's rights to detain them in a higher level of security than they require.*' This is in accordance with the National Service Framework for Mental Health which states (amongst other things) that an appropriate hospital bed is one that is in the least restrictive environment consistent with the need to protect the service user. High security at Broadmoor is thus for those patients who would present a *'grave and immediate risk to the public and who could not be safely contained within the security available at a medium secure unit.'* These criteria are little changed from those available in 1991, save for the requirement that the patient present a 'grave danger' to the public with no reference to 'immediate'. Prior to that admissions were handled by a central admissions panel at the Department of Health.

20. The impetus for medium secure units is usually accredited to the Glancy Report (1974) and the Butler Report (1975). The first 'interim secure unit' opened is said to

[13] *R v Birch* (above)

be one in Norfolk in 1980.[14] However, their development was slow. This was a time before the availability of regional (now medium) secure units.

21. The notion of detention in the 'least restrictive' environment is contained in the Mental Health Act 1983 Code of Practice 'Guiding Principles'. It is not, however, incorporated into the statutory criteria, nor is it a requirement of article 5(1)(e) of the European Convention on Human Rights (1950) which governs the lawful detention of persons of unsound mind.[15] It is, however, contained in the UN Principles for the Protection of Persons with Mental Illness (1991) and the Council of Europe Recommendation (2004)10 and we endorse its use in the Special Hospital admissions criteria and the provision of compulsion generally.

22. There is no doubt in our minds that given Mr Foskett's presentation and on the evidence before the court that a hospital order was the most suitable method of dealing with his case. It is of course, highly unusual, though not completely unheard of even in contemporary practice, for someone who has committed a homicide to be sent to a local hospital.

23. On the criteria pertaining since 1991 Mr Foskett would not have justified detention in a high secure hospital. Further, given that he was identified as presenting a low risk of serious harm, we consider that the open hospital disposal was probably appropriate at that time with the safeguards offered by the restriction order. We are clear that he did not satisfy the criteria for high security and was not a management risk and so more suited to the local hospital environment in terms of the risk he presented. Even now, and following the killing of PC in 2003, he has been assessed as being suitable for medium security.

24. The question for the future regarding Mr Foskett's long term supervision needs was appreciated at this time. The third killing took place eight years after Mr Foskett was absolutely discharged from detention under the MHA and eighteen years after the first two killings. There had been no recurrence of the illness in that time. The key issue that this case raises is: what is the proper course of supervision of an otherwise asymptomatic or compliant person over a long period of time?

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[14] http://www.nmhct.nhs.uk/Forensic/forensic_psychiatry_&_regional_secure_units.htm (22/2/2006)

[15] *Winterwerp v Netherlands* (1979); *Ashingdane v UK* (1985)

Chapter 4

GOODMAYES HOSPITAL

The Advisory Board

1985-1993

Introduction

Dennis Foskett was transferred from HMP Brixton to Goodmayes Hospital, Essex on 17 December 1985 under sections 37 and 41 of the Mental Health Act 1983 (MHA). He was admitted to Rosemary Ward, an acute general psychiatric ward under the care of Dr V Minas, locum consultant psychiatrist. In May 1988 he was transferred to Magnolia Ward, a continuing care ward. After Dr Minas left his post in December 1988, Mr Foskett was transferred to the care of Dr Joan Feldman, consultant psychiatrist. He was briefly under the care of Dr David Abrahamson from 31 October 1992 until 13 May 1993 (after he had been conditionally discharged) when he reverted to the care of Dr Feldman.

Goodmayes Hospital, situated in the London Borough of Redbridge, was managed at that time by the Redbridge Health Authority and provided inpatient treatment to the residents of several London boroughs, including Newham in which Mr and Mrs Foskett had been resident for many years. PC was also a resident of Newham and received inpatient treatment at Goodmayes Hospital as discussed in Chapter Five.

Goodmayes Hospital was a general psychiatric hospital originally built as one of a number of Victorian asylums on the periphery of London. In 1985, it still had a large number of wards, both short stay and long stay, accommodating over 1000 patients. Most care would have been provided by psychiatric and nursing staff with occupational therapy, but limited availability of psychological services and social work services. Certainly the model of psychiatric care at that time in general psychiatric services was different to now in that consultant psychiatrists were often responsible for large numbers of inpatients, there was less multidisciplinary input to patient assessment and management, and less individualised care planning and management. This was a time

before the introduction of the care programme approach,[16] although Mr Foskett was subject to the after care arrangements of section 117 of the MHA on conditional discharge in 1993.

Acute psychiatric wards, such as Rosemary Ward where Mr Foskett was originally admitted, would have had responsibility for a wide variety of patients with differing psychiatric conditions including acute and chronic schizophrenia, bipolar affective disorder (manic depression), depressive illness of varying severity, anxiety disorders, obsessive compulsive disorders, personality disorders and disorders associated with substance abuse.

Such wards would have experience of managing patients who were violent and some experience of managing patients who had been through the criminal justice system. However, it would have been unusual for such wards to have managed patients who had committed homicide. The specialist skills and facilities of forensic psychiatric services that are now available to general psychiatric services, were not readily available at that time. There was no dedicated forensic psychiatric service available to Goodmayes Hospital in 1985, which could advise on the management of patients such as Mr Foskett.

However, being subject to a restriction order (section 41 of the MHA) meant that his progress was closely monitored by the Mental Health Unit (then C3 Division) of the Home Office, who additionally referred his case to the Advisory Board on Restricted Patients (since abolished). Dr Feldman also sought guidance from Dr Paul Bowden, consultant forensic psychiatrist who had assessed Mr Foskett while he was at HMP Brixton and later Dr Jeremy Coid (now Professor), also a consultant forensic psychiatrist. She also referred to Dr Stuart Checkley on the question of maintaining Mr Foskett on a prescription of lithium carbonate with Amitryptiline prophylactically.

This chapter summarises Mr Foskett's eight year admission to Goodmayes Hospital. It then elaborates issues which the Panel considered significant to a full understanding of his risk assessment and risk management, particularly in relation to PC, whom he had met while she was an inpatient at Goodmayes Hospital in 1987. These include:

- Assessment of his personality.

[16] See Chapter Six for more on the care programme approach.

- Assessment of the index offence.
- Psychology input.
- Assessment of the couple.

Overview of Goodmayes Hospital admission

1. Following Mr Foskett's admission to Rosemary Ward, he was described as settling comfortably on the ward and proved himself a "model patient". He was diagnosed as having been suffering a psychotic depressive illness at the time of the index offence and in the earlier part of his detention while remanded in custody at HMP Brixton. However, by the time of his admission to the ward, he was considered to have some residual symptoms of depression, but not to be profoundly depressed. He remained on anti-depressant medication i.e. Amitryptiline 50 mg in the morning and 100 mg at night. It was also noted that he appeared to deny the reality of his wife's death at times stating that he believed she was at home, at others that she was reincarnated. However, over time, this changed and he did acknowledge his responsibility for the killing of his wife and Dr Glickman.

2. During this early period Mr Foskett's treatment was largely by way of medication which was clearly seen as the key to averting any danger he might have posed. This is apparent from the first annual statutory report to the Home Office from Dr Minas.[17] Mr Foskett was noted to be very reliable with regard to medication, with good insight, but unrealistic as to the circumstances of his crime. He was initially maintained on Amitryptiline, a tri-cyclic anti-depressant, as stated above. In July 1989, lithium carbonate, a mood stabiliser was introduced at 400 mgs at night and regular blood checks for monitoring lithium levels were introduced.[18] The Amitryptiline was to be reduced once the lithium was at a therapeutic level to a maintenance dose of 50 mgs a day.

[17] A statutory requirement under the MHA is that the responsible medical officer of a patient subject to a restriction order report annually to the Secretary of State on the patient's progress. Section 41(6) MHA.
[18] This is due to the existence of a narrow therapeutic/toxic ratio. Three monthly blood checks were recommended then and now.

3. He also received individual and group therapy from nursing staff. The nursing notes contain many references to his mental state and feelings about his wife. He was noted to be 'playing the good patient' and to have 'some insight without understanding illness'. Mr Foskett also found it very difficult to participate in group therapy for fear of revealing his index offences to other patients. He eventually told two other patients in July 1987.

4. From about December 1987, he commenced art therapy twice a week with Lore Woodroffe and Terry Molloy, and also had a weekly session of psycho drama at this time, with Terry Molloy. These therapists are noted to have participated in ward round discussions regarding Mr Foskett. Later in May 1990 he was referred to the East Ham Centre, for relaxation, yoga and living skills training. The provision of psychological input is discussed further below.

5. Although Mr Foskett expressed his dislike of being on an acute ward with very disturbed patients, he was reluctant to move to Magnolia ward, a continuing care ward. However, he was persuaded to do so in May 1988, but remained unsettled, not eating, sleeping or mixing with other patients for a whole month. He was deeply ashamed of being in the hospital at all and was hoping for a discharge sooner than later. This sense of shame and unwillingness to reveal his index offences to agencies and professionals came to the fore at the time of his absolute discharge in 1995 and thereafter. It manifested as a resistance to supervision by local forensic psychiatric services (see Chapter Eight).

6. From autumn 1988, Mr Foskett had occasional escorted day leave and this increased over the early part of 1989. By this time, he had formed a relationship with PC who had been a patient on Rosemary Ward from November 1987 until January 1988. At this time in her life she had been diagnosed as suffering personality and social problems with reactive depression. In December 1989, he started occasional overnight leave to his mother's home. All of these passed uneventfully and were successful. By June 1990, he was spending four nights a week at his mother's home.

7. In May 1989, a Mental Health Review Tribunal considered his case and concluded that he should not be discharged. The decision referred to his

exemplary behaviour and good progress, but focused on the need for careful and detailed counselling regarding the relationship with another 'disabled patient' i.e. PC. An independent report prepared by Dr Paul Bowden, the consultant psychiatrist who had seen him while he was at HMP Brixton, recommended a further two years at Goodmayes. He also recommended close monitoring of the relationship with PC because of the difficulty Mr Foskett had in coping with his wife's epilepsy when he was unwell. He said that the couple needed to be seen together regularly. From around this time there were notes that Mr Foskett and PC should be seen together as a couple and the progress of this is discussed in more detail below.

8. By the end of 1989, the statutory report to the Home Office noted that Mr Foskett saw himself as 'special' within the ward and that PC had expressed some ambiguity about the future of their relationship that he was unaware of. Dr Feldman elaborated on Mr Foskett's feeling of being 'special' in evidence to the Panel as being somewhat narcissistic and that he thought he was better than the other patients. She also described how she felt scared of him and somewhat out of her depth. This resulted in her seeking advice over specific matters from initially Dr Bowden, and then later Dr Coid, both experienced forensic psychiatrists.

9. In January 1990, two members of C3 Division, the Home Office (now the Mental Health Unit, Home Office) attended a case conference at Goodmayes Hospital to discuss Mr Foskett's possible conditional discharge.

10. The Home Office officials had a number of concerns about a conditional discharge at that time: his admission to Goodmayes Hospital had provoked criticism in both the local and national press, and there was anxiety that his conditional discharge might reactivate it. There was concern about his relationship with PC because at that stage she appeared ambivalent about it, and it was also felt that if the relationship was to continue, couple counselling was imperative. Mr Foskett expressed real remorse for the killing of his wife, but there was concern that he had not appeared to have done so towards the other victim, Dr Glickman. Mr Foskett was perceived as a "model" patient, which it was considered necessitated additional caution in his exposure to stresses in his

rehabilitation. There was concern recorded that he was effectively keeping his head down and doing what was required of him to be discharged to a flat i.e. into independent accommodation. Also at that time, there had been an attempt to encourage Mr Foskett to give up his relationship with PC. However, this was unsuccessful and it rapidly became clear that he had been seeing her secretly while on weekend leave.

11. By December 1990, however, the Home Office recommended a conditional discharge, but referred its ongoing concerns to the Advisory Board on Restricted Patients.[19]

12. Their report in February 1991, was very critical:

"Treatment in a special hospital might have been expected in this case but, instead, he had been sent to a local hospital, told that he was not responsible for the killings and that all he had to do to secure release into the community was to sit tight for two years. The Board therefore felt that the case had been mismanaged and that it was premature and unsafe to conditionally discharge him in view of his un-redressed personality problems, the stress of this current relationship, his lack of insight into his condition and the political element involved."

13. As a result of the Advisory Board Report, Dr Feldman and the Home Office agreed that Professor Jeremy Coid (then Dr Jeremy Coid, consultant in forensic psychiatry to the North East Thames Regional Health Authority based at Hackney Hospital, and Senior Lecturer in Forensic Psychiatry to the Medical College of St Bartholomew's Hospital, University of London), should assess Mr Foskett with a view to advising the clinical team on future management.

14. Professor Coid reported on his assessment in March 1991 and provided a very full report. He did not view the situation as negatively as the Advisory Board. In

[19] The Advisory Board was set up following the report of Sir Carl Aarvold in January 1973 to provide the Home Secretary with independent advice to assist with decisions about the discharge or transfer between hospitals of a small number of patients who are subject to special restrictions and whose potential risk to public safety is thought to be particularly difficult to assess. Referral to the board was by the civil servant involved in the case, the minister or exceptionally, the Responsible Medical Officer. The board has since been abolished.

particular, he did not think that the case had been mismanaged as they had done, because cases of homicide by depressed patients 'are amongst the most difficult to manage as they are almost invariably highly complex.' Prof Coid's opinion is dealt with in more detail below see under 'Assessment of Index Offence'.

15. In the light of Professor Coid's more positive assessment, Dr Feldman contacted the Home Office to seek their support to work towards Mr Foskett's conditional discharge. This was agreed subject to the provisos Professor Coid had made.

16. Mr Foskett was assessed again on behalf of the Advisory Board in April 1992 and reassessed by Professor Coid in October 1992. Professor Coid supported Mr Foskett's proposed conditional discharge to Lyndhurst Hostel, Barnet. The Advisory Board supported his conditional discharge, but stipulated that this should be subject to Mr Foskett being supervised by a forensic psychiatrist. Professor Coid stated that this would be difficult given his own limited resources at that time, but did agree to see him at most every four weeks in his outpatient clinic. He could not provide any community psychiatric nurse follow-up.

17. Mr Foskett was granted conditional discharge by the Home Office to Lyndhurst Hostel in November 1992. This is dealt with in more detail in Chapter Six.

Assessment of personality

18. At the time of Mr Foskett's admission to Goodmayes Hospital in December 1985, there was limited information about his personality and development. The available information was provided by the three assessments by consultant psychiatrists[20] while he was remanded in custody to HMP Brixton. Thus, it was known that Mr Foskett was born in Northampton, to where his mother had been evacuated during the war. He was afflicted with a hare lip and in consequence has suffered from chronic infections of his sinuses throughout his life. He grew up in East London and missed a great deal of schooling because of illness. He was a nervous child who was bullied a lot at school. He tended to be clinging and over dependent on his parents. He married in 1964 to Margaret who he had

[20] Dr P Bowden, Dr P Gallwey and Dr D Hirst.

known since childhood and who had frequent epileptic fits. They were childless and lived in rented accommodation. For most of his adult life Mr Foskett worked for British Rail, but for the last three years he had been employed as a night porter at Hackney Hospital. It was noted that although his illness had recovered somewhat while he was in prison, he showed 'permanent features of an anxiety prone and highly dependent personality.'[21]

19. Mr Foskett had been previously admitted to Goodmayes Hospital, and the Panel has had access to what is now available of those records, although the full notes relating to previous contact are not available. In a letter dated 16 March 1970, a consultant psychiatrist noted:

"His previous personality, he has always been a worrier, but a cheerful man who usually makes everybody laugh. … He has been married for nearly six years and is very happy, although they have not yet been able to have the children they want. He has a good work record, but is obviously disappointed that he lost his job as a chargehand and because of his attack of flu.

During the course of his depression, he has often felt extremely aggressive towards other people but realises that this feeling is irrational. During the last few days he has been feeling very trembly."

20. At admission, Mr Foskett was not subject to a formal psychological assessment of personality, as would be standard practice in a forensic psychiatric hospital now. Nonetheless, a composite understanding of his personality was established through his contact with the different disciplines during the course of his seven and a half year admission. The nursing team inevitably had most direct contact with him. He quickly established a reputation as "a model patient". This was based on the fact that he was friendly and helpful and "eager to please". He was helpful to staff and other patients and undertook various chores in the ward and the hospital. However, it was also noted that he found it difficult to express his feelings and, for example, as noted above, for a long time he was unable to reveal why he had been admitted to hospital to other patients. He said that this

[21] Dr D. Hirst report of 7 November 1985.

was because of anxiety that he would be rejected by them and subject to hostility.

It was shortly after this, in November 1987, that Mr Foskett developed a relationship with PC while she too was an inpatient on Rosemary Ward. This developed rapidly to the extent that he declared in January 1988 that he was intending to get married to her "as soon as possible" and caused concern to the clinical team. These concerns were discussed with Mr Foskett in terms of the need to think through the consequences and implications of a future permanent relationship. He seemed to understand the point being made and had indicated that he would discuss it with PC.

21. However, the relationship persisted, although at various periods it was noted that the relationship was discouraged and Mr Foskett told Professor Coid in March 1991 that he would reduce contact with PC. At one point in October 1990 there was concern noted that he was visiting her secretly during his weekend leave.

22. There were other incidents to suggest that while Mr Foskett was superficially compliant he could also be deceitful. In August 1991, Mr Foskett bought himself a car without telling staff and parked it outside the hospital. The nursing team found out and after some delay so did Dr Feldman. She expressed her concern that he had not informed her, but eventually agreed to his using it to visit his mother and PC. When the car was stolen and subsequently found in Brixton, South London, Dr Feldman expressly stated that he was not allowed to recover it himself. However, the following day he did so, claiming later that he had misunderstood Dr Feldman's instructions. When the Panel interviewed Mr Foskett he was still unable to see that he had gone against Dr Feldman's instructions, thereby causing her to be angry and annoyed.

23. Mr Foskett had most individual assessments of his personality through art therapy which was part of the Occupational Therapy Department. He saw Terry Molloy, art therapist on a weekly individual basis from early 1989 to the summer of 1991. Mr Molloy's opinions were thoughtful and well documented. He noted a "*tightly controlled personality that in dealing with peer group members and therapists could tolerate little deviation from preconceived and somewhat sterile*

interactions. Even when he did allow himself to acknowledge and accept a degree of independent thought on the part of another, he would soon incorporate this into his own line of thinking, convince himself this had always been in his mind in the first place and strive to avoid future stress by attempting to anticipate and pre-empt the future thoughts and actions of the other person. He was also very resistant to change and even minor alterations in pre-planned arrangements caused him great stress – such stress was usually concealed by the aforementioned process of false acceptance and historical distortion. This narrow encapsulated and sterile psychic world was reflected in the repetitive and predictable nature of his art work – rather banal landscapes with constantly repeated elements."

24. By January 1992, within a group setting, some positive steps had been taken in that he noted important apparent shifts in Mr Foskett's thinking, such as would allow him to handle personal relationships in a more adequate fashion leading to a reduction in daily stresses. These were shifts in his understanding of his relationship with his wife, which he had previously viewed as 'perfect' and was now more inclined to accept had negative and overly dependent aspects to it. He was also expressing greater tolerance of other people's separate existence outside of his control, enabling him to express his own opinions, ideas and emotions. Mr Molloy's view is that as a result he was less likely to form a relationship with the same degree of 'pathological enmeshment' as before. He recognised, however, the need for a high level of monitoring and support in this area, which apparently Mr Foskett also recognised and expressed.

25. Importantly, and in concert with the opinion of Dr Coid in March 1991, Mr Molloy also took the view that given Mr Foskett's age, it was unrealistic to expect major changes in his overall pattern of thinking within the available treatment facilities.

26. In evidence to the Panel Mr Molloy summarised his opinion of Mr Foskett: "*I think I essentially saw him as an extremely vulnerable person who almost could not cope with the everyday frustrations of life. The way he did it was just by being very compliant, very meek, he was very meekly dressed, he would always do exactly what he was told. And in a sense, that was the way he got through life."*

27. In Professor Coid's assessment of March 1991, he too commented on an 'over controlled personality'. In his statement to the Panel of 4 May 2005 he said, however, that he did not think Mr Foskett had a formal psychiatric personality disorder. He restated this in his evidence:

"*I was aware that other people had considered him to have a personality disorder but I could not see that in him myself. I was aware that there were certain traits, he had been somewhat neurotic, he had had certain problems since childhood. He had been bullied, he had a degree of under-confidence.*

There was a concern at one point about PC when he was in Goodmayes. He had not been fully open, I think, that they had got into quite a close relationship while in Goodmayes before the staff had been aware of that."

28. The social work department at Goodmayes Hospital were involved relatively late in Mr Foskett's admission, but also made comments on his personality. Graham Bull, social worker commented on concerns over his 'model' behaviour in his home circumstances' report of 7 September 1990:

"In the short time I have known him he strikes me as an engaging, interesting person and also a fairly compliant person. When I asked if I could speak to his mother and brother in private, while his brother questioned this, Mr Foskett was only too eager to please, and immediately got up and went out of the room. Sometimes it seems as if a lot of energy has to go into this "pleasing for others" way of being in the world, while resentment, anger, annoyances are not shown. Keeping up this pleasing and helpful behaviour while living in the daily world outside the hospital must have some effect on him, even if an unknown effect to him. … It would be necessary, I feel, for Mr Foskett to stay in contact with professional staff – with a social worker, and perhaps his therapist, which he himself suggested would be a good idea."

COMMENT

29. The Panel felt that it was regrettable that a more formal detailed psychological analysis of Mr Foskett's personality had not been part of his assessment (see below). However, it is clear that available resources were deployed with the

result that the team did have a reasonably good understanding of Mr Foskett's personality. This did inform their understanding of the index offence and his potential risk in relation to future relationships particularly PC. The key features of his personality that were recognised were:

- He was not overtly aggressive or violent but tended to suppress his feelings.
- He could be controlling of others.
- He had a low threshold for changes to routine and differences of opinion that were outside his control, all of which caused him considerable stress.
- He was eager to please, over-compliant and a model patient yet could be deceitful.
- He had a tendency to form relationships with vulnerable women and appeared to "need to be needed".
- That he felt embarrassed and unable to reveal to others what he had done to be in hospital.

30. The Panel agree that Mr Foskett is unlikely to have a formal personality disorder within accepted definitions (as defined in ICD10 or DSM IV) within which personality disorder is defined as a 'severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption' (ICD10). This would not apply to Mr Foskett who in the normal way appeared to function satisfactorily, particularly in that he had the ability to establish and maintain social and intimate relationships and maintain work. Underlying vulnerabilities in his personality only became manifest in the context of severe depressive illness.

Assessment of index offence

31. The consensus of the three psychiatrists who had assessed Mr Foskett in HMP Brixton was that his offence was a direct consequence of his mental illness. They allude to his history of recurrent depression which had previously been

triggered by flu-like illness, as it was on this occasion. They also indicated that there were features of his personality that appeared to make him vulnerable, in that he was anxious and a worrier. They described his mental illness variously as 'depression with distinct paranoid features' and with suggestions of hypomanic episodes, or 'depressive psychosis', or a severe depressive illness with paranoid delusions.

32. They all also mentioned Mr Foskett's amnesia which made it difficult to understand precisely why he had become violent on this occasion. There was an issue over his dissatisfaction with Dr Glickman over her prescription of mianserin (see Chapter Three). His only memories of her were that she had been a good general practitioner. However, he did describe feeling worse on the tablets she had given him. The police at the time postulated that he was so enraged that she was persisting with medication that had not helped him that this caused him to attack and kill her and that when his wife intervened; he continued his attack on her. He only stopped his attack when they both lay motionless on the floor.

33. During the early part of Mr Foskett's admission, this understanding of the index offence was not reviewed. He remained amnesic of the offence and his clinical management appeared to focus on the medical treatment of his depressive illness and his initial denial of his wife's death. Once the reality of his actions had been accepted, he was given supportive counselling to deal with his grief. It remained the case that he was seen as acknowledging this at an intellectual level, but not fully grasping it at an emotional level. This was seen as partly a psychological defence on his part, but also a consequence of his perception that he was not responsible for his actions because he was mentally ill at the time. It was also noted that he did not appear to express the same level of remorse towards the killing of Dr Glickman as he did his wife, although this changed over time.

34. When Dr Feldman took over Mr Foskett's care she, by her own admission, felt out of her depth in dealing with a patient who had committed double homicide. She sought the support of outside experts including Dr Stewart Checkley, consultant psychiatrist, Maudsley Hospital to advise on the management of Mr Foskett's medication, and Dr Paul Bowden, consultant forensic psychiatrist,

Maudsley Hospital, who had assessed him at HMP Brixton and further assessed him on 13 February 1989 in relation to a Mental Health Review Tribunal. Later she also sought the advice of Professor Coid regarding the incident with the car (above). Dr Feldman told the Panel that she was heavily reliant also on Dr Bowden to guide her through the process in relation to a restricted patient. It was her understanding that there was a strict timetable when it came to discharging a restricted patient of which the Home Office was in control.

35. There was accruing evidence that Mr Foskett's relationship with his wife may have put stresses on him that had not previously been recognised. Recognising this and being aware that Mr Foskett had developed a relationship with PC, Dr Bowden stated in his report for the tribunal:

"In addition the relationship with P will need to be looked at closely. Mr Foskett's late wife was epileptic and I understand that her illness was a great strain on Mr Foskett, particularly when he was not well himself. Mr Foskett and PC will need to be seen together on many occasions so that their individual needs and expectations can be explored. Mr Foskett presents very well the front of kindliness and all is well and this needs to be challenged, particularly in the relationship with P so that tensions and stresses are not covered up……. Mr Foskett has no memory of his intentions at the time of the killings. Given his psychosis at the time this is not an uncommon finding and my experience is that it would not be helpful to look for meanings which depended on a unique set of prevailing circumstances, perceptions and feelings, many of which were not rational."

36. As a result of this opinion and the decision of the Mental Health Review Tribunal in May 1989, the issue of couple therapy arose and efforts were made to engage Mr Foskett and PC in the same. These efforts were re-doubled following the review of Mr Foskett's case sought by the Home Office from the Advisory Board on Restricted Patients in February 1991 and Prof Coid's report of March 1991. Prof Coid formulated his understanding of the index offence in his report of 19 March 1991.

37. In relation to the four documented episodes of depression experienced by Mr Foskett, Prof Coid identified the increasing severity in the degree of illness with the appearance of psychotic features and agitation. Importantly, he also noted the rapid progression of symptoms to a severe state in the most recent episode indicating the need for supervision in the future. He expressed the hope that these would be controlled by medication even in the face of further stress.

38. He also highlighted the additional difficulty posed by Mr Foskett's amnesia of the offences: a primary defence mechanism that also prevented progress in terms of remorse and coming to terms with what he had actually done. Ideally, this should have been worked on at a very early stage, but this would have required considerable therapeutic input from an experienced clinician. It was clear that what was ideally required was intensive individual psychological work, the resources for which were not available at Goodmayes Hospital. Prof Coid questioned whether it was worth trying to dismantle his amnesia at this stage in 1991, given the attendant risks in the form of potential relapse of his psychotic depression.

39. He did, however, praise the progress Mr Foskett had made in a group setting and the limited insight he had gained into his relationship with his wife. He referred to limitation in insight also regarding the relationship with PC, in respect of whom Mr Foskett had said he would limit his association, but there was concern that he was possibly meeting her covertly.

40. Professor Coid also commented on Mr Foskett's over-controlled personality, extreme passivity, and compliance "even in the face of what must have been frustrating circumstances". This was illustrated by his inability to assert himself within his relationship with his wife. In his view, it was unrealistic to expect any major change in his over controlled personality at this late stage in his life. Mr Foskett was to be expected to form relationships with women and, unless it was to be a condition of discharge that he should not do so, then the only proper management was close supervision and limiting the nature of such relationships. In particular, that he should not cohabit and the clinical team should do their best to be aware of the nature and circumstances of such relationships.

41. He concluded that:

> *"disinhibition resulting from his severe, agitated and psychotic depression was the primary factor in the index offence. This was combined with the factors of long-term repressed feelings of irritation and hostility towards his wife that had never been vented in a normal manner. These may well have emerged explosively following the final precipitant of being told to persevere with medication by his G.P., a preparation in which he had no faith, and which he at the time believed was making him worse. Although such a form of stress would seem trivial, in Mr Foskett's disturbed and agitated mental state, and with a progressively distorting view of reality, it may well have combined with these other factors to produce the final homicidal outburst. If this view of the index offence is correct then assessment of further dangerousness must hinge primarily on the risk of further relapse of the underlying condition. Secondly the presence of ongoing and potentially long-term frustrating factors that he is again repressing and concealing from others (and indeed himself). Thirdly, whether there are likely to be sudden precipitating stressful factors which would occur in the context of a further depressive episode."* (emphasis added).

42. Thus, Professor Coid identified additional issues related to Mr Foskett's continuing amnesia, his longstanding over-controlled personality and extreme passivity, particularly in the context of frustrations within a relationship, as a result of which he noted the importance of close supervision of his relationships with women. Even so, Professor Coid stated that in his opinion the broad aims of management so far had been "along the right lines", and the most important risk factors for further relapse and the possibility of additional stresses were being properly addressed.

43. This understanding of the index offence, Dr Feldman found helpful. It did support her focussing her management of Mr Foskett on maintaining his depressive illness in remission, and exploring Mr Foskett's psychology, particularly with regard to his relationship with PC.

COMMENT

44. Professor Coid's assessment provided much reassurance and guidance to the clinical team. While he endorsed their approach in broad terms, he noted the complexity of the case and he also underlined the key areas of concern regarding the amnesia, personality, and relationships with women. He also noted that Mr Foskett's depression had deteriorated rapidly on this last occasion, a feature that repeated itself in 2003 when it is clear that he must have deteriorated very rapidly and probably in a matter of days prior to the killing of PC. His was the first coherent attempt to draw together a formulation of Mr Foskett's problems. This analysis remained relevant from here on and was a useful benchmark from which to assess his progress and future needs.

45. The Panel considered that Dr Feldman's team did have a reasonable understanding of the interplay between Mr Foskett's mental illness, his underlying personality and the index offence – in as much as this was possible given his persisting amnesia for the offence and his state of mind at the time. Persisting amnesia is a well recognised phenomenon in perpetrators of homicide. The frequency in different studies varies between 20-40%; it is more commonly seen in those who have a history of psychiatric disorder, alcohol problems and 'crimes of passion'. It is also commoner when the victim is female and/or married to the offender, and the weapon is a blunt instrument. Many of these factors do apply to Mr Foskett and therefore it is unlikely that his persisting amnesia of his offences is wilful on his part.[22]

46. Depression as a cause of homicide is relatively unusual within reported literature – paranoid schizophrenia being the mental illness particularly associated with homicide, as well as features such as drug or alcohol dependence.[23] When it occurs, as Professor Coid stated in his report of March 1991 'cases of homicide by depressed patients are amongst the most difficult to manage as they are almost invariably highly complex.' This may in part be due to the fact that there may be little or no previous history of violence prior to the offence and that there

[22] Pyszora et al, (2003).
[23] See key findings: homicide published by National Confidential Inquiry at www.national-confidential-inquiry.ac.uk

are no particular symptoms that distinguish homicidal depression from other cases of severe depression. That Mr Foskett's depression had been severe was clear – at the time he was extremely distressed and had developed psychotic features. But the latter were not in themselves indicative that he was going to act violently. Professor Coid's analysis of how Mr Foskett's over-controlled personality, extreme passivity, and compliance interacted with the depression to cause homicidal rage is, we believe, the key to understanding the index offence.

47. Within the parameters of what was known and what could have been known as set out above, the Panel is of the opinion that the focus of assessment and treatment on controlling Mr Foskett's depressive illness through medication, and improving his understanding of the likely dynamics of his relationship with his wife and with PC through counselling and therapy were appropriate at this stage. What follows next is a consideration of how successfully the latter was carried out.

48. Mr Foskett did not have a formal risk assessment undertaken while at Goodmayes, but it was the clear opinion of all those consultant psychiatrists assessing him at the outset and later, Professor Coid, that his risk of serious violent re-offending was very low.

49. Jackie Craissati, principal clinical psychologist and head of forensic clinical psychology services at The Bracton Centre, a medium secure unit, was asked by the Panel to rate Mr Foskett's risk according to standardised risk assessment scales available today. In written evidence, she confirmed the assessments made by reference to various validated psychological profile testing tools[24] currently available to assess the risk of violent offending. She said that nothing in his profile suggested that Mr Foskett would have posed a significant risk of future violence, as compared to perpetrators of other homicides or mentally disordered offenders. However, the combination of factors including unresolved personality problems, occurrence of extreme stress within his relationship and the recurrence of his depressive illness are the key features in his homicidal outbursts.

[24] Violence Risk Appraisal Guide (VRAG), HCR 20 and PCL-R.

50. We would add that co-habiting with a vulnerable, mentally ill woman was also identified by both Drs Bowden and Coid as increasing Mr Foskett's risk profile, requiring close monitoring and supervision.

51. Mr Foskett simply would not have ticked the right boxes when it came to formal risk assessment measures. This does not represent any error or shortcoming in the process, but serves to underline the fact that some events are difficult to predict, and that prediction is dependent upon assessment and treatment, followed by supervision and monitoring and continuing assessment. This process is critically dependent on sound judgment and information.

Psychology input and couple therapy

52. Apart from the counselling and therapy provided by the nursing staff and the occupational and art therapy departments as discussed earlier, the psychology service to Goodmayes Hospital was provided by Redbridge Health Authority (based at the hospital) and Newham Health Authority. From the outset of Mr Foskett's involvement with PC, there was concern about the implications of this relationship. It was following Dr Paul Bowden's assessment in February 1989 (above) for the purposes of a Mental Health Review Tribunal, that attempts were first made to provide couple therapy for Mr Foskett and PC. These concerns were then re-iterated by the Home Office, the Advisory Board on Restricted Patients and Prof Coid in 1991.

53. Dr Feldman said in evidence that she should have had a family and couple service available to her from Newham and, as Mr Foskett came from Newham, she wrote initially to both the family therapy centre at the East Ham Centre, Forest Gate on 4 May 1989 and the Mental Health Team, Family Therapy Unit, East Ham on 8 May 1989. These were in fact part of the same service. In her letter of 4 May, she outlined the facts relating to PC's own difficulties – that she had a personality disorder and obsessional neurosis and was a very difficult person. She would have known this from her own knowledge of PC as her patient. Mr Foskett attended the East Ham Centre on 27 June 1989, but PC did not do so and no further appointment was offered because the service was being restructured.

54. Further unsuccessful attempts were made by Dr Feldman to secure couple therapy from Newham. She then turned to the head of the Redbridge service which provided a psychology service to inpatients at Goodmayes Hospital. He arranged for the couple to be seen by Janice Hiller, at that time principal clinical psychologist with an interest in couple work, now head of the sexual health service specialising in couples and psychosexual work. It was she who discovered for the first time that the couple was having a sexual relationship.

55. Ms Hiller in evidence stated that the service operated under some pressure: there were perhaps twelve psychologists providing a service to somewhere between one and two thousand inpatients. They also provided some services to local general practitioners. The service covered adults, children and adolescents, neuropsychology and the elderly. There was no specific forensic psychology service. Magnolia Ward, Goodmayes Hospital did not have a psychologist dedicated to it.

56. Dr Feldman said in evidence that her priority was for Mr Foskett and PC to be assessed as a couple, to find out how they operated together, whether there was anything the clinical team could work on and help with management. She complained that to the local services Mr Foskett was just a man with 'ordinary depression' and, therefore, not a priority.

57. There is no referral letter from Dr Feldman to Ms Hiller in which she sets out what it is she is seeking from the referral. Ms Hiller said that she knew the background and had a sense of what was sought. In the event, PC failed to attend any appointments with Ms Hiller in 1990. She did see Mr Foskett on two occasions and following the second, Ms Hiller commented in a letter of 4 July 1990 to Dr Feldman:

"*This really is the basis of their relationship: she has good intentions but seems incapacitated by her rituals to move forward in her life. Apparently she will not allow Dennis into her home (believing it to be contaminated) and threatens to stop seeing him if he tries to go there.*

Dennis wants to believe that P will make an effort to change, but all indications are that she will not manage to alter her way of life. In speculation about P, she

sounds like someone who needs to keep certain areas of her life separate in order to survive, and living with a man could be beyond her scope. I did suggest this to him and he seemed to understand, but I am sure he will need help to come to terms with this possible loss." (emphasis added).

58. Ms Hiller subsequently saw them on 28 October 1991, 13 January 1992, 2 April 1992, and 27 July 1992.

59. In April 1991, Dr Feldman had written to Ms Hiller stating that the views of the Home Office were that the couple was not to co-habit and that counselling was to be in that context. However, in May the ward progress summary stated that a decision as to whether they could co-habit rested on their assessment in couple counselling. Ms Hiller was emphatic in evidence that she was not asked to discourage the relationship, or to discuss with them that they needed to separate. She told the Panel in evidence that she would not have thought it her role, nor that she would have had the authority to say to them that they could not be together or live together. However, she said she would have asked them how things would work between them given PC's difficulties and she clearly expressed reservations regarding the relationship in correspondence to Dr Feldman. She did not feel that it was her role to pursue that, but left it to the clinical team, but she told the Panel that whilst not saying so expressly, she was questioning the appropriateness of them being together.

60. There were subsequently further difficulties arranging to see them both, but following the impetus from the Home Office and Professor Coid's report, Ms Hiller saw them together on 1 July 1991. Ms Hiller commented in her letter of 12 July 1991:

"*Dennis described Pas very different from his wife as P will discuss or even argue with him, whereas his wife agreed with everything he said, and was altogether a very quiet person. … I felt there was an element of fantasy about how their life together would be. It seems that their relationship can work while Dennis is in hospital and P lives with her mother (they meet every day at his mother's). However if they were running a home together, P's disturbance could well cause serious difficulties. It seems they are living on a hope that cannot be*

*fulfilled and the query is whether facing them with the truth would be more beneficial than letting them live the hope.***"** (emphasis added).

61. Dr Feldman's response to Ms Hiller indicated the strong feelings of the Home Office regarding the need for the effect of the relationship on Mr Foskett to be worked out before he could be discharged from hospital. Ms Hiller was urged to continue her work with the couple, although she had expressed her view that there was no necessity for couple therapy, citing increasing waiting lists.

62. Ms Hiller's notes include much background information about PC and her physical and psychological disorders. She told the Panel that she was trying to understand the nature of the relationship and *'could see that she had a very disturbed background and was struggling enormously with managing her life and the fact she could not and she was retreating in her OCD behaviour.*' She said that there were not any issues between them for her to work on. They were reporting their lifestyle and he was coping with her problems. There was no tension or hostility between them. Her overall impression was that: *"while I was seeing them the relationship, clearly, was both supportive to both of them and was helping them both. Despite their enormous psychological, psychiatric and physical problems they were both getting something from the relationship, it was nourishing and rewarding in some way."*

63. When asked whether it was in any way her role to assess how Mr Foskett could cope given PC's quite extreme difficulties, Ms Hiller replied: "*I have to say I was not asked to do that, no and I would have known that there was a psychiatric team who were working on that aspect of him on his own. So that was not my remit."*

64. It was not Ms Hiller's practice at the time to attend ward rounds, instead she supplied letters for use by the clinical team and it was not the norm to go to case conferences, which she said were very time consuming. She was unable to attend a meeting with the Home Office which took place on a Wednesday as she worked part-time and not on a Wednesday.

COMMENT

65. The possible role that psychology services generally might have provided while Mr Foskett was an inpatient, was considered in detail by the Panel in relation to the general input, and focused on issues surrounding his personality and offending and couple counselling. Nowadays, specialist forensic psychology is an important component of the provision available to individuals like Mr Foskett. The question arises as to the quality of the psychology service provided to Mr Foskett during the period of his admission to Goodmayes Hospital and how the issues raised in the case were dealt with. Once again, the Panel turned to Dr Jackie Craissati, head of forensic clinical psychology services at the Bracton Centre.

66. She described the development of psychology services at this time. It was a period of time when psychologists were establishing their role within the NHS and their status as independent clinical practitioners. They tended to focus on their own 'uni-disciplinary' therapy service within which long waiting lists were not uncommon. She described conflicts in practice between psychologists and psychiatrists, as they learned to work together causing frustrations on both sides. The Panel did not consider it helpful, at this distance in time, to delve deeply into the precise issues around the provision of psychological therapy at Goodmayes Hospital in this period. It is now a completely different service. There were clear difficulties relating to boundary and resource issues experienced by Dr Feldman, and the correspondence reveals the attendant frustrations on both sides. This fits with the general description provided by Dr Craissati.

67. The psychology input actually achieved was probably reasonable, especially when one considers the totality of input including ward-based, occupational and art therapies that Mr Foskett used. Couple therapy was pursued and ultimately obtained by Dr Feldman, and Ms Hiller made efforts to accommodate PC's needs by altering the time and place of appointments to assist her to attend. It is important to acknowledge that PC's own obstructive behaviour and failure to attend appointments contributed to the limited appointments actually attended by them as a couple.

68. Dr Craissati also described a lack of psychologists at the high secure level which in any event did not work in a fully integrated fashion at that time. The service was uneven and difficult to access. In her view, there is no reason to assume that a greater level of psychological input would have been achieved had Mr Foskett been detained in a high secure hospital. In the 1980s forensic psychology skills were still developing and probably less consistent in their standards than today.

69. The most identifiable gap in psychological assessment is probably the lack of a clear developmental and interpersonal history before Professor Coid's report of March 1991. This would have assisted an understanding of his personality. The observations of Mr Molloy, art therapist, Ms Hiller and the social worker, Graham Bull, were helpful, but they were not pulled together in a coherent formulation.

70. While this may have allowed for a deeper analysis of Mr Foskett's offending behaviour, the Panel is of the view, that a sufficient understanding of it had been reached by the time of his conditional discharge to make this an appropriate course of action. Further, that Dr Feldman had made use of all the resources available to her.

71. It is highly speculative now to consider whether such an assessment and formulation would have significantly altered the risk assessment of Mr Foskett. Actuarial measures would have placed him in a relatively low category of future violence risk. Amnesia of the offences is not a significant risk factor unlike, for example, hostility towards women, which Mr Foskett did not display. The main issue for a low risk, over-controlled individual is the dilemma over future management and in this case, the management of an intimate relationship and the appropriate level of follow-up into the future. Living as a couple was going to be the most high risk factor, although in the short term and following conditional discharge to a supported hostel this was not going to be an immediate factor.

72. There was a clear gap between what was expected of couple therapy, as envisaged by Dr Bowden, the Home Office and Professor Coid, and expressed by Dr Feldman, and what Ms Hiller understood as her remit or was able to provide. Dr Craissati highlighted this in evidence and differentiated between

systemically focussed couple therapy – dealing with interpersonal conflicts in the here and now (which was Ms Hiller's area of expertise) – and what was required in this case which was keeping PC safe, a role which did not necessarily require any specific psychological input, but could have been fulfilled by the multi-disciplinary team.

73. It is clear that there were negative and positive aspects to the relationship. What was needed was that their awareness of their own individual vulnerability was raised. They needed to be helped to develop coping strategies and to overcome any resistance they felt to services and the help offered. That also required PC to be an active participant in Mr Foskett's aftercare, fully informed of his vulnerability and her own and actively monitoring his wellbeing. Her capacity to do this was not evaluated. If it had been, her inability to fulfil this role and the extent of her own difficulties might have been appreciated.

74. Ms Hiller did outline the likely difficulties for them living as a couple as a result of PC's illness in her assessment of July 1991. In doing so, she laid the foundation for ongoing work by the whole team and did what was required of her. It was this that needed to be further explored with the couple and to remain at the forefront of future supervision. Unfortunately, it remained unaddressed and untested prior to Mr Foskett's absolute discharge in April 1995 and became impossible to address formally thereafter because of his resistance by then to the involvement of too many professionals and supervision by the local Barnet community team. This now seems such an obvious failing, that it is difficult to say that it should not have been a clearly identified need at the time. This issue is considered again in the context of care planning in Chapter Six and in relation to the absolute discharge in Chapter Seven.

75. As it was, Mr Foskett appeared to, and probably did in fact, cope quite well with PC's needs over a long period and indeed his 'need to be needed' clearly allowed him to tolerate the demands that PC's illness imposed on him without complaint. However, as her own condition deteriorated in 2003, she recognised that she was 'making him ill', but neither of them recognised the possible implications of this, and by this time there was no external support or supervision of the relationship to intervene and ameliorate the risk.

CONCLUSION

76. Mr Foskett was not a problem to manage in a local psychiatric hospital and the public's concerns at his placement (see Chapter Three) in fact proved groundless. The role of the Home Office under the restriction order and the use of the Advisory Board on Restricted Patients also provided a counter-balance to the concerns regarding the open hospital that kept to the fore issues of public protection.

77. Mr Foskett remained under assessment and treatment at Goodmayes for eight years in which time he received as much assessment and input as was available. Drs Bowden and Coid provided reassurance and guidance to Dr Feldman in the face of her acknowledged trepidation and inexperience with restricted patients. The input of the Home Office and the reference to the Advisory Board, equally, meant that perceived shortcomings in the assessment process were raised prior to conditional discharge. These referred explicitly to personality and relationship issues.

78. These shortcomings were largely addressed by Prof Coid in his report of March 1991 in which he provided an analysis of issues that had not been addressed, namely, amnesia, and those involving an over-controlled and passive personality which required monitoring particularly in the context of Mr Foskett's relationship with a vulnerable woman. He provided a risk assessment based primarily on the need to keep Mr Foskett's depressive illness under control to prevent a relapse, but which also outlined his tendency to repress ongoing and potentially frustrating factors e.g. within the relationship, that he might conceal from others or himself, the presence of any such factors, especially should they occur in the context of a further episode of depression.

79. As a result, a good working understanding was reached of Mr Foskett's personality, the index offences and the likely effect of a stressful relationship. What was lacking, however, was a more specific understanding of PC herself and the likely stresses that this relationship would bring to bear upon Mr Foskett, whether or not they lived together, with a view to planning a strategy of support and management for the future. The couple therapy on offer was not suited to a

full analysis of the relationship and its likely problems, but laid the foundations for further work by the whole team which could have been pursued while he was subject to conditional discharge. PC's own mental health problems were known to Dr Feldman and to Ms Hiller.

80. A joint assessment between Mr Foskett's and PC's care teams should today probably be automatic. In 1991/2 this could easily have been achieved because of Dr Feldman's dual role, and it was clinically indicated for the future management of the case. Dr Feldman referred PC to the Maudsley Hospital for specialist help with her behavioural problems in around late 1991. The issue highlights the need for good communication and cross team work, especially in a case such as this where both parties were heavily reliant on mental health services. The threshold for sharing information should have been low because it was needed in order to keep the couple safe due to Mr Foskett's history of homicide. Furthermore, as time passed, periodic re-assessments of the risks posed within the couple should have been jointly assessed. Opportunities for joint assessment existed right up to the point of absolute discharge in 1995 and beyond (Chapter Seven).

81. Much reliance came to be placed on Mr Foskett's actual compliance with medication and attendance at outpatient appointments when issues around absolute discharge and subsequent supervision arose. That he was compliant became an axiomatic feature of his presentation, treated as being synonymous with a high degree of insight into his illness and the risks he posed. In our opinion, this notion needed to be challenged and questioned more rigorously as part of a periodic review of risk. There is little evidence to suggest that he was sufficiently challenged, especially around the time of his absolute discharge. The evidence does suggest the development of a somewhat false reassurance on the part of the care team based on the fact that Mr Foskett was easy to manage and was eager to please, which cannot be justified.

82. Looking at features of his personality as identified during his time at Goodmayes, there is a question to be raised as to how much was understood in relation to his apparent compliance and his true insight into himself, his illness and the risks it posed. It is now apparent that they were not coterminous. We find that this

discrepancy was recognised at the time he was in Goodmayes, but was somehow lost over time. These were features of his personality that were unlikely to change but needed to remain in the forefront of risk assessment into the future. These features were:

a. That he found it difficult to acknowledge that he had committed two homicides to others in his therapeutic group and was eager to limit those who were told, to the extent that later he resisted this information being passed on to appropriate housing authorities who were be responsible for finding him independent accommodation (Chapter Eight).

b. He was noted to consider himself 'special' and Dr Feldman clearly did not trust his over compliant behaviour, added to which he had demonstrated that he was capable of being deceitful.

c. He was a 'model' patient, and the Advisory Board were concerned that this should be challenged. He had found it difficult to tell Dr Glickman of his paranoid symptoms and later in 2003 similarly he had been unable to tell Prof Coid that he was very ill and wanted admission to hospital. It is now apparent that this is likely to have been a manifestation of his over-compliant personality – his need to be seen to be the 'model' patient.

d. Aspects of his personality were also important with regard to his relationship with PC and his inability to bring to light any real difficulties he was facing within it.

83. In addition, Mr Foskett was noted to have limited insight into his relationship with his wife and then PC.

84. After his absolute discharge, he successfully resisted supervision by the Barnet Mentally Disordered Offenders Team, on the basis that he no longer required specialist team involvement or input from too many professionals. This again may reflect his sense of shame and a desire simply to forget the past.

85. In the event, what happened on conditional discharge was that issues around Mr Foskett's personality and that of couple assessment, receded into the

background, never to be re-addressed. Mr Foskett's apparent wellbeing and his apparent ability to cope with PC over a long period of time offered ungrounded reassurance that all was well and would remain so.

86. Risk issues must remain to the fore in the care of long term patients to enable them to live safely in the community, as much as to safeguard those at risk. This is a difficult practice issue, but it clearly depends on a rigorous analysis of risk at the outset. Today actuarial tools would be used to assist clinical judgment and are certainly likely to highlight the relationship issue as a major ongoing supervision need. Clear risk assessment and management plans are now expected to be routinely carried out for patients such as Mr Foskett. We identify the following as important features of risk plans:

- They must be periodically reviewed and re-formulated if they are not to lose value and currency in the long term.

- They provide the best basis for long-term supervision for all involved in an individual's aftercare.

- They highlight high risk scenarios. Where low frequency, but high impact events are at issue, maintaining vigilance over high risk scenarios must be maintained, if necessary over long periods of time. This necessitates ensuring that the appropriate configuration of aftercare exists, and is maintained.

Chapter Five

PC

Introduction

Dennis Foskett met PC (dob 12 July 1953) in late 1987 while they were both inpatients at Goodmayes Hospital. PC was a resident of the London Borough of Newham. Mr Foskett was undergoing treatment following the homicides of his wife and GP in May 1985 (see Chapter Four). It is clear that PC had severe mental health problems of her own throughout her life, and that these were at times, quite disabling. She was a patient of Dr J Feldman, who was also responsible for Mr Foskett at Goodmayes, and who referred PC to the Maudsley Hospital, Denmark Hill, South London, for treatment for severe obsessive compulsive disorder at the end of 1991. This coincided with the time that arrangements were being made to conditionally discharge Mr Foskett. There followed numerous referrals to the Maudsley Hospital for behavioural therapy and by the time of her death in 2003 she had been receiving counselling from Jonathan Ash as an outpatient since 1999. She was also being seen by the Newham community services as an outpatient over this period of time. She was last seen by these services in July 2003 when her mental state had deteriorated significantly.

The Inquiry panel recognised the importance of understanding PC's own mental health needs and the impact of them on Mr Foskett. This was clearly relevant in the light of the fact that he had killed two women and that his wife, who had epilepsy had placed a considerable strain on Mr Foskett who was her carer. It became clear to us that he had become PC's main carer, helping her cope with her obsessive routines and taking her to her various appointments. However, those responsible for supervising Mr Foskett did not know the extent of the care he provided for PC.

Consequently, we sought and reviewed a selection of PC's medical records. We interviewed her general practitioner, Dr Chang, her therapist at the Maudsley, Jonathan Ash and the consultant in charge of the Newham service used by PC, Dr Waterdrinker. Both Mr Foskett and PC had been heavily reliant on mental health services. There had been some brief early overlap in these, and the Inquiry sought also to establish

a. The extent and severity of PC's illness,

b. what problems this posed for Mr Foskett, and

c. what, if any, mutual understanding the services had of the problems of the person they were not directly dealing with.

The Inquiry made contact with PC's father who expressed his wish not to be involved with this process.

Early history and mental health: summary

1. PC's recorded psychiatric history stretches back to 1974 when she was noted to be suffering from depression (aged 21). Later records summarise her family background and refer to the cruelty of her mother, that she spent some time in a children's home and became pregnant when aged about 18. Her daughter was later given up for adoption and PC lost contact with her. She suffered post natal depression which appears to have triggered or contributed to a life long depressive illness. She had once worked in a dry cleaning business, but does not appear to have worked throughout her relationship with Mr Foskett. There is reported to be a strong history of mental illness in her family.

2. Jonathan Ash, her behavioural therapist at the Maudsley from 1999 recalls a history in which PC's parents had separated. She was said to be wayward at school, out drinking at night and her pregnancy at 18 may well fit with that description. She was also a 'loner' and did not have a particularly good childhood. All of this contributed to her low self esteem and overall anxiety. She attempted to cover this up by being assertive and 'bolshy'. This was described by Mr Foskett, and accepted by those responsible for him, as constituting a significant difference between PC and his wife Margaret, which allowed them to have a more open and less strained relationship.

3. In late 1987, she was admitted to Goodmayes Hospital, into the care of Dr Feldman, with a diagnosis of 'neurotic depression'. Personality and social problems with reactive depression were also referred to. The records note a poor and damaged relationship with her mother and in December PC took an overdose of paracetamol. She was unhappy and depressed and had suicidal ideas. It was at this time that she met Mr Foskett and in January 1988 it was recorded that they had become engaged. During this admission her mother refused to have PC back at home and it was the prospect of discharge from

hospital that caused her to overdose on paracetamol. She was allowed to stay for an extra week until arrangements for accommodation were made.

4. The available notes indicate that PC remained under the care of Dr Feldman after her discharge from hospital, although she failed to attend outpatient appointments on numerous occasions. She was referred for the first time to the Maudsley Hospital in connection with her obsessive symptoms disorder in late 1991. There is a letter to Dr Feldman in May 1992 from the Maudsley which documents PC's long history of severe problems and demonstrates that they were aware of Mr Foskett's history. It mentioned that her boyfriend is on a restriction order following the killing of his wife and general practitioner. There are no details of the offence. It diagnosed obsessive compulsive disorder (OCD) and probably a borderline personality disorder or schizophrenia. She was to be placed on a waiting list for admission. This letter appears in PC's notes, but although there is a manuscript note that it should be placed on Mr Foskett's file and copied to his general practitioner, it does not appear in those records.

5. This first referral to the Maudsley coincided with plans to conditionally discharge Mr Foskett from Goodmayes. In fact, PC was admitted to the Maudsley at the beginning of November 1992 and Mr Foskett was granted a conditional discharge by the Home Secretary on 27 November 1992, although he did not in fact move out of hospital into Lyndhurst Hostel until March 1993. There is no reference to the extent and severity of PC's condition in Mr Foskett's notes or assessments.

6. In February 1993, Dr Feldman received a letter from the Maudsley which appears on PC's notes. It stated that she had made progress with her obsessive rituals, that she had a sustained exacerbation of depression while in the unit and was 'clearly an extremely vulnerable woman…..very reluctant to accept any treatment'. This is followed in the notes by an undated letter from PC in which she says that Mr Foskett has had to bathe her and that she would not be seeing a community psychiatric nurse. As Mr Foskett had yet to leave Goodmayes, it is likely that PC's reference to him bathing her must significantly post date this letter from the Maudsley. In our view, this letter probably relates to events in 1998, three years after Mr Foskett's absolute discharge from liability to detention under

the Mental Health Act 1983, when there was an attempt by the Newham CMHT to engage PC at the request of the Maudsley.

7. PC was re- referred to the Maudsley by her GP, Dr Chang in March 1993. The Maudsley provided advice on how PC should address her phobia of hospitals so that she could be referred to a gynaecologist for problems of menorrhagia and fibroids. By April 1993, in a letter to Dr Feldman, the Maudsley's assessment was that PC had made a 40% improvement. They identified remaining problems as including the avoidance of 'saliva and social' (*sic*). She continued to count to herself and to have urges to shock or harm others throughout the day. However, by August she was again severely depressed and anxious and questioning her relationship with Mr Foskett. She was taking Amitryptiline and Phenelzine (MAOI) for depression, Danozol for menorrhagia and Nifedipine for hypertension. By the end of 1993, PC had been offered six sessions of therapy with a chartered psychologist and had attended only three. In a letter to Dr Chang, it was concluded that there was a need for couple therapy and that she needed specialist help in dealing with 'her altered feelings about the relationship….to prevent the build up of frustration and its possible consequences in either partner.' The letter finished by saying that they were not able to help any longer and that longer term help provided more locally would be appropriate.

8. There was never any referral for couple therapy, but in December 1994 Dr Chang referred PC back to the Maudsley because she was experiencing intrusive thoughts about harming other people and problems with rituals. It is not clear what the precise response to the referral was, but later in 1995 several sessions of behavioural therapy are noted with moderate progress made. She was then discharged.

9. The next referral to the Maudsley was made by Dr Chang in June 1997. She had been on Fluoxetine (Prozac) which was not working. There is an assessment letter which detailed suicidal ideation, but with no intent. Her medication was changed to Venlafaxine (SSRI) and Promethazine (anti histamine). She was asked to see her GP regularly for review and a referral to the local psychiatric service was advised if her depression worsened.

Mental health from 1998 to 2003

10. From January 1998 to July 2003, PC was seen regularly at the East Ham Memorial Hospital (later relocated to the Newham Centre for Mental Health), part of the Newham community mental health services, as an outpatient. She was referred for depression following the death of her mother in December 1997 (she and Mr Foskett had found her mother dead at home). She was taking Fluoxetine which had previously been prescribed by her general practitioner. She was seen by several locum consultant psychiatrists, latterly by Dr Waterdrinker, and by a senior occupational therapist who noted her reluctance to attend group therapy. PC refused behavioural therapy at the Maudsley at this time due to her depression.

11. In May 1998, two members of the Newham East CMHT, a social worker and a CPN, visited PC to assess her needs. PC refused to allow any home visit and said that she could not attend an appointment. She only wanted to see a psychiatrist regarding medication. It seems possible that the letter in the notes referred to in paragraph 6 above relates to this attempt to engage PC with the local CMHT (but see below also). The psychiatrist noted that Mr Foskett was helpful and supportive. Later in the year it was noted that her OCD put a strain on her relationship with Mr Foskett.

12. The Newham CMHT closed this case in June that year because PC was being seen by a psychiatrist in the outpatients department and so did not need to be seen by a psychiatrist in the CMHT as well. The plan was that she continue to be seen by a psychiatrist in outpatients. She was never formally allocated a key worker or care co-ordinator, other than the psychiatrist, or made the subject of services from the Newham East Community Mental Health Team. She was referred to the CMHT in June 2003 and then a month or so later in July, a few days before she was killed, she was assessed and allocated to the CMHT after presenting herself in outpatients in a distressed state, but this allocation was not fully processed prior to her death.

13. The records available to the Panel indicate that PC was subject to a standard care programme approach which was limited to letters to the general practitioner with updates on appointments and ongoing issues. By this time, it is clear that

Mr Foskett was playing a key role in her care and was seen as supportive and caring by those responsible for PC. The notes also show that her care and treatment was discussed with him.

14. The notes do indicate that PC attended a relaxation course and had individual sessions of psychology, attending only when Mr Foskett could take her. We have no specific notes for these sessions and she was discharged from the latter due to service changes. She was noted to be increasingly depressed. She continued being seen at the Maudsley behavioural therapy unit as an outpatient, and there was contact between the Maudsley and Newham. In late 1999, PC's problems were identified as an enduring grief reaction following her mother's death and a morbid jealousy of the relationship between Mr Foskett and his mother. She was described as a 46 year old woman with a history of OCD since her late teenage years 'involving physical or mental rituals to neutralise intrusive thoughts and images of violence and contamination…..possible psychotic symptoms were also identified at the time and a diagnosis of schizophrenia was considered but was not borne out….' A history of insulin dependent diabetes and hypertension was also noted. A continuous experience of low moods since first suffering depression post-natally at age eighteen was noted, followed by about five periods of severe depression brought on by negative events such as the death of her mother. Further inpatient treatment at the Maudsley was planned, but conditional on an improvement in her depression.

15. In July 2000 a letter to Jonathan Ash outlined the reasons why PC's admission to the behavioural unit was delayed. This was because of slow progress due to traumatic life events and variable compliance from her current partner which was not explained. It also mentioned physical health problems. PC suffered from hypertension, diabetes, breast cysts. In May 2001, a letter from a Newham consultant psychiatrist to Dr Chang stated that therapy at the Maudsley must stop because PC reacted with severe anxiety.

16. During this time, PC was being seen regularly by Jonathan Ash, a clinical nurse specialist specialising in cognitive behavioural therapy, then based at the inpatient unit at the Bethlem Hospital in South London. She is recorded as having moderate to severe depression with obsessive compulsive disorder and

psychotic symptoms. In evidence to the Inquiry, Mr Ash described PC's complex presentation including borderline personality disorder, obsessive compulsive personality disorder and an avoidant personality disorder with paranoid features. This was in addition to depression and OCD. In his assessment she had three main areas of obsessional behaviour: the first was a contamination fear particularly related to insects, which was dated back to when she was very young living with her parents and there was an infestation of maggots in their laundry. As a result, she had to check that the fridge door was shut so that no flies could get in, she could not leave washing in the basket for more than a few hours and she constantly had the washing machine working. Bed sheets had to be done every day. Secondly, she felt she smelt sweaty and so had rituals around deodorants, putting massive amounts on daily. Thirdly, she was a perfectionist and her house was immaculate. Everything was in its place and cleaning was done everyday. PC was thus a woman with a high degree of obsessional behaviour, who managed to remain in the community and to keep functioning. In Mr Ash's view this was largely due to Mr Foskett's patient and supportive caring of her. He took her to appointments and waited for her. Mr Foskett told us that when she was ill, he cleaned her flat for her, although not always to her satisfaction. He was doing this in July 2003 when they were both unwell.

17. She was seen on some occasions with Mr Foskett both at Newham and the Maudsley. In July 2002, Mr Ash wrote to the consultant in Newham requesting that he review PC and advising of the need for a community psychiatric nurse (CPN) to monitor her mood. A referral was duly made in August to the community mental health team (CMHT) for allocation of a key worker for ongoing support and monitoring because she was due to begin intensive work with her therapist and would need CPN support. It was logged on 3 September 2002.

18. For reasons we have not been able to ascertain, there was never any contact made with PC by the CMHT at this time. A more robust local policy had been introduced in mid 2001 ensuring an integrated CPA and care management process. The aim was to provide a thorough assessment of needs for users of specialist mental health services, whether in the community or as an inpatient. PC fell squarely within this policy. She had a longstanding and severe mental illness and was being seen by specialist services on an outpatient basis. This

policy had a section devoted to the needs and assessment of carers. The CMHT operational policy outlines as one object a rapid response to referrals. Thus, the outcome of this referral, assuming some co-operation by PC, should have been a full assessment of her and Mr Foskett's needs. She was subject only to a standard CPA as before.

19. She did continue seeing Mr Ash. It is clear that PC remained quite unwell. She was depressed and anxious and expressing suicidal thoughts in early 2003. In May she was also having problems of severe breast pain and was being seen by her GP for this and also her high blood pressure. She tried unsuccessfully to bring forward an appointment with Dr Waterdrinker and was seen on 27 June when she attended with Mr Foskett and reported that she was finishing with her therapist at the Maudsley and that her panic attacks were returning. It was noted that she did not invite anyone to her home because of severe contamination issues and that she was on a cocktail of drugs. She was noted not to look overtly depressed but severely debilitated and low. She was referred to the CMHT for assessment, but the process of allocation had not taken place by the time she re-presented on 22 July (below). Dr Waterdrinker had no recollections of this meeting apart from what was written in the records, but was able to tell the Inquiry that she realised that PC needed more support locally now that her therapy was ending, and was not otherwise going to get it.

July 2003

20. 4 July 2003 was an occasion when Mr Ash saw PC and Mr Foskett together. He recorded that they were arguing a lot and Mr Foskett was not sleeping properly; he was preoccupied with his physical health and concerns regarding the effect of cannabis smoke from the flat below his on his mental health. Mr Ash says he advised him to see his consultant and was aware that he had an appointment coming up in July. He formed the opinion that Mr Foskett had to put up with a lot from PC, but he remained with her because he cared a great deal for her. On occasions, Mr Foskett had telephoned Mr Ash for advice when PC was unwell e.g. not getting out of bed. The last such occasion was around December 2002 or January 2003. Mr Ash tried to reassure Mr Foskett that it was for her to make the effort and not for him to force her to get out of bed.

21. Mr Ash saw PC again on 9 and 15 July when she was depressed. She was worried about Mr Foskett and whether she was making him ill and also that the pressure of dealing with Mr Foskett had caught up with her. She talked about death, but not about killing herself and about the fear of being lonely. She failed to attend her next appointment on 23 July which he said was unusual and either she or Mr Foskett would normally telephone to say that they were not going to come. Mr Ash told the Inquiry that PC regularly had lows and this was one which had gone on for longer than the average of 2-3 days. She had been doing well until the end of June and this seems to be borne out by the available notes.

22. Although Mr Ash was aware of Mr Foskett's history from the records held by the Maudsley, there was never any contact with any services responsible for him. Mr Foskett was not in fact the formal responsibility of any service from the time of his absolute discharge in 1995.

23. On 22 July, the day after Mr Foskett was seen for the last time by Professor Coid before the homicide, PC telephoned the CMHT in a distressed state. She said that she had taken an overdose at the weekend and was suicidal. She was afraid that if she did not see someone she would do the job properly. A referral was opened and she was seen that day by Dr Waterdrinker and a social worker. Dr Waterdrinker told us that the process of being seen and speaking to someone calmed PC down. Although the letter to the GP noted that she would be allocated to the CMHT East at the next meeting, Dr Waterdrinker assured us that by the process of being seen by her and a social worker that day, she was in fact accepted by the team, would be referred to the day hospital and reviewed again in outpatients in October. She could have been seen at the Day Hospital within 24 hours depending on what the referral said, but the letter was not typed up until 29 July and faxed to the Day Hospital on 31 July. The key worker could have been allocated within the week at the next meeting of the CMHT.

24. Dr Waterdrinker told us that any urgency went out the situation once they had seen PC, and she left with many support telephone numbers that she could have used. PC did not talk about Mr Foskett in a caring role with respect to her. Their living arrangements would have formed a part of the care programme approach

(CPA) process. Even had she known about Mr Foskett's background, she does not think she is likely to have acted differently.

25. Mr Ash told us that the work undertaken at the Maudsley related to PC and her problems. There was no consideration of any risk that Mr Foskett might pose to her. However, there would have been consideration of risk posed to Mr Foskett by PC because severe obsessive compulsive disorder can involve physical violence or emotional abuse by the sufferer. As for the nature of their relationship, Mr Ash speculated that life would have been uncertain for Mr Foskett when PC was particularly ill. From day-to-day he would not know what was going to happen: if he was staying at PC's flat or not, or whether or not she would be in a low mood and not able to perform her frantic cleaning rituals. Once the rituals were going, however, life would be more likely to be stable for several days at a time.

Liaison between services

26. We heard that the Maudsley took referrals for specialist treatment from local CMHTs who remained responsible for the general mental health care of the patient and focal point for contact. As follow-up was in the local community, their role in this was limited, although follow-up contact points were provided to individuals. With regard to medication, they offered guidance and advice on this, but prescription was left either to the CMHT or the GP.

27. Their patients were normally subject to what was then standard CPA, requiring only a discharge letter. Outpatients were not subject to CPA at all, although the practice was still to keep in contact with the local team and to provide a discharge letter at the conclusion of treatment.

28. In PC's case, the local team was advised to allocate a CPN in 2002 but, as noted above, this did not happen. At this time also, the Maudsley wrote to the Newham consultant with advice regarding PC's medication and in particular alerting him to the fact that the medication she was taking for breast pain, Danazol, was associated with depression. She was never seen by that team, but did have regular contact with various consultants attached to it on an outpatient basis. In the years between 1998 and 2003, she was seen by at least four different

consultants from Newham, the last being Dr Waterdrinker. As a result, she was not subject to anything other than standard CPA in Newham either. PC could not be compelled to comply with an assessment or referral to the CMHT, and no formal compulsion under the MHA was indicated.

29. We have not seen any correspondence from Newham to the Maudsley responding to the above. Information was, however, passed on to Dr Chang, PC's GP. Dr Chang told us that he relied on the fact that PC was being seen at the Maudsley and by local consultants and that it was not his role to interfere with their work. PC always presented an acceptable front to him, usually saying she was 'fine' when asked how she was. He never felt the need to initiate contact with the CMHT. He dealt primarily with her physical health problems, of which there were many. He did, however, refer her to the Maudsley on at least two occasions. One in 1994 followed her reporting thoughts of harming others.

30. Mr Ash did not know that Mr Foskett was being seen by Prof Coid specifically, although he said he was aware that he was being monitored. His concerns about Mr Foskett were of a general nature, had they been more specific he would have attempted to find out who was monitoring him, possibly through PC and made contact with them. As it was, he advised Mr Foskett to see his consultant, gave him literature on sleep and also suggested that he bring forward his forthcoming appointment if necessary.

COMMENT

31. PC was an extremely vulnerable and psychologically damaged woman. She had a multitude of serious mental and physical illnesses throughout her life. Her mental illness took the form of a debilitating obsessive compulsive disorder, together with depression. Although both of these fluctuated in intensity over time, she was never without them. She was also assessed as having a borderline personality disorder which made her prone to sudden mood swings. She had received inpatient treatment for depression and OCD. She was in receipt of long term treatment with anti-depressant medication of various types and underwent a considerable amount of behavioural therapy at the specialist units at the Maudsley and Bethlem Hospitals in South London. There is little doubt that her disorder fell within the definition of severe mental illness, and

would certainly have done so from about 1998 onwards when she was being seen regularly as an outpatient at the Bethlem Hospital and in Newham.

32. However, we have seen no evidence that PC was ever the subject of full assessment and care planning by services responsible for her. Two referrals to the CMHT, the first in August 2002 and the second in June 2003, do not appear to have been acted upon. There is a good chance that had either of these been appropriately acted upon that the extent of the couple's difficulties over this period would have become known to at least her carers. This raises questions as to the implementation of the new CPA policies put in place in mid 2001 and the functioning of the East Newham CMHT which this Inquiry cannot investigate. It is our view that there should be a review into why these referrals were not followed up. There was no CPA following her inpatient admissions to the Maudsley/Bethlem which was on the other side of London from where she lived. At the same time, she was clearly very resistant to home visits and had resisted the CMHT previously. This was part and parcel of her very severe OCD.

33. Furthermore, in order to target resources and to maintain consistency, the CPA is delivered at two levels according to need: standard or enhanced. We heard that PC was on the standard level of the CPA. This level is appropriate for someone requiring the support of only one agency, who poses no danger to self or others and who will not be at high risk if they lose contact with services.[25] Whilst this may have been appropriate for PC for some of the period after her discharge from Goodmayes, her mental health problems became more severe and complex later, as did her co-morbid physical health problems. The definition for standard CPA does not seem appropriate to Ms. Cole's condition in 2002 and 2003. It is the Panel's view that the definitions for levels of CPA should be reviewed in the Trust with further consideration given to the inclusion criteria for someone with complex mental health problems.

34. Concerns regarding the relationship with PC had been at the forefront of opinion of the Advisory Board on Restricted Patients in 1991 to whom the Home Office referred Mr Foskett's case when considering his conditional discharge from hospital, and they were raised in the first report from Dr Jeremy Coid in March

[25] *National Service Framework* 1999

1991. It was also the concern of a Mental Health Review Tribunal and an independent psychiatric opinion from Dr Paul Bowden in 1989. Consideration was given to requiring Mr Foskett to end the relationship, or for there to be some form of couple therapy (see Chapter Four).

35. Mr Foskett was known by those seeing PC to be an important part of her life, and the person on whom she relied to bring her to appointments. He was even consulted about her care by the psychiatrist in the Newham outpatients department.

36. Mr Ash provided a graphic illustration of how PC's OCD is likely to have affected her daily functioning and Mr Foskett. He said that life would have been unpredictable for Mr Foskett, but that he obviously cared a great deal for PC and so he remained with her. Mr Foskett had clearly mentioned the stress it placed on him at an outpatient's appointment in Newham. Later in July 2003, PC had said that she thought she may have been making him ill. Through this all, however, it was probably Mr Foskett's support and care that helped PC to function as well as she did and to remain in her own home without any greater intervention by services.

37. In the Panel's opinion, a full assessment of PC and Mr Foskett as her carer should have been carried out under existing policies in Newham at some point after 1998, and definitely in 2002 and 2003, when referrals to the CMHT were made. There is no evidence that any such assessment was attempted. Had they been carried out, it is likely that the extent of Mr Foskett's role would have been fully addressed. It is hoped that this would have involved an assessment of his own background, which would have revealed that he was once again in a vulnerable situation which posed a risk to his own mental health and to PC's well being, even though he had apparently been coping well.

38. Further, as discussed in Chapters Seven and Eight, an inter-agency joint assessment of the couple's needs should have been carried out prior to Mr Foskett's absolute discharge, and then again by Barnet services and Prof Coid with PC's carers around the time the Mr Foskett moved into independent living with a view to co-habiting with PC and periodically thereafter.

39. As discussed in the next chapter, the fact of PC's debilitating illness was known to those responsible for Mr Foskett at the time of his conditional discharge, and to Dr Feldman in particular. Dr Feldman was for a number of years responsible for both Mr Foskett and PC. Yet this was not a factor that was reflected in his subsequent care plans for special supervision, nor was there at any time any formal consideration of PC's own mental disorder and its likely impact on Mr Foskett or any joint assessment of their needs at this time.

40. This is especially surprising in view of the analysis of the index offences provided by Prof Coid in 1991 and Mr Foskett's caring role for his wife who had epilepsy. It is our view, that if PC's daily functioning and needs were understood, this is very likely to have revealed the extent to which she relied on Mr Foskett to assist her daily functioning, and from a time not long after he was conditionally discharged.

41. In summary, an analysis of PC's care and needs reveals two important issues that may, if dealt with differently, have affected the ultimate outcome and prevented PC's death. Firstly, that Newham CMHT failed to respond to a referral to them in August 2002 and were slow to respond to a second referral in June 2003. Also the referral/allocation on 22 July 2003 seems to have gone astray and was not put into action for one week. The second issue relates to the failure of Mr Foskett's team to assess the daily reality of his relationship with PC and to find out more about her mental disorder.

42. This Inquiry's Terms of Reference have not permitted an in-depth consideration of PC's care and treatment that would have allowed more specific and detailed recommendations to be made. In the circumstances, we make the following recommendation only.

RECOMMENDATION 1 (see Chapter Nine)

East London and The City Mental Health NHS Trust (now incorporating Newham community mental health services) should, 1) review the implementation of its CPA policy with a view to establishing the reasons why the referrals of PC to the East Newham CMHT in 2002 and 2003 did not occur and/or were delayed, 2) review the definitions and inclusion criteria of standard and enhanced CPA.

RECOMMENDATION 2 (See Chapter Nine)

Barnet, Enfield and Haringey, and East London and The City Mental Health NHS Trusts, should review the implementation of CPA policy to ensure compliance with current guidance relating to the needs of carers.

Chapter Six

CARE PLANNING AND CONDITIONAL DISCHARGE
Lyndhurst Hostel

1992-1995

Introduction

A warrant conditionally discharging Dennis Foskett was issued by the Home Secretary on 27 November 1992 pursuant to section 42(2) of the Mental Health Act 1983 (MHA). This was twenty two months after the Advisory Board on Restricted Patients advised against his conditional discharge. In that time, he had been seen and assessed twice by Dr (now Professor) Jeremy Coid, consultant forensic psychiatrist, East London, was continuing with art therapy in Newham and yoga and relaxation classes at the East Ham Centre which was also going to help with plans for future employment. He was seen again by a psychiatrist from the Advisory Board.

Mr Foskett and PC were seen by Janice Hiller, principal clinical psychologist, for couple therapy, and in May 1992 PC was assessed at the Maudsley Hospital and placed on a waiting list for admission for treatment for obsessive compulsive disorder. She was also noted probably to have borderline personality disorder or schizophrenia at this time, although the latter was later discounted. The admission took place on 2 November 1992.

Mr Foskett's accommodation had been troublesome to finalise, but Lyndhurst Psychiatric Residential Care Home (to be referred to as Lyndhurst in this report), North Finchley, in the London Borough of Barnet, was identified as a possibility by May 1991. There had earlier been a suggestion by Dr David Abrahamson, consultant psychiatrist and leader of the Goodmayes rehabilitation team, of a move to a group home to prepare him for hostel life. The Secretary of State agreed in principle to a transfer to Lyndhurst prior to conditional discharge in August 1992 and sought a further view from Professor Coid. Mr Foskett was accepted at Lyndhurst by October 1991, and proposals for payment including from the London Borough of Newham were in place by November. The place

was not available until Christmas leading to Mr Foskett's discharge and ultimately, although the warrant was signed in November, the place at Lyndhurst did not become available until 26 March 1993, which is when he finally moved out of Goodmayes Hospital. There had been difficulty identifying a suitable hostel within Newham, the area in which he had previously resided.

This chapter summarises care planning for Mr Foskett in the period leading up to and following his conditional discharge to Lyndhurst, and bearing in mind the risk factors identified by Prof Coid in 1991 which are considered in Chapter Four. After discharge he was supervised by social workers from Newham social services department, Graham Bull and later Khadija Patel. The Inquiry was unable to locate either social worker to give evidence to it. The social services records of this period are missing. This has meant that Newham social services involvement with Mr Foskett has been reviewed through the few available notes contained in the records of other agencies for this period. This is the inevitable consequence of an Inquiry into events dating back over ten years. Newham Health Authority retained responsibility for his after care under section 117 MHA at this stage. The care programme approach had been introduced in 1991 but had been poorly implemented nationally. It was not until about 1995 that the London Borough of Barnet accepted responsibility to provide services for him, and Mr Foskett left Lyndhurst for independent accommodation on 13 October 1996 (Chapter Eight). He had by this time been absolutely discharged from liability to be detained in hospital under the MHA (see Chapter Seven).

Care planning pre conditional discharge

1. Following the intervention of the Advisory Board on Restricted Patients and Professor Coid in 1991, efforts were focused on conditionally discharging Mr Foskett from Goodmayes Hospital. Professor Coid identified future dangerousness to depend primarily on relapse of the underlying condition and the identification of long term frustrating factors with which Mr Foskett would have to cope. The latter was concerned with issues around his relationship with his wife and now PC.

2. As noted in Chapter Four, couple therapy did not fully address the concerns regarding the future of Mr Foskett and PC and how he would cope with the

stresses placed on him by her debilitating mental disorder. Ms Hiller, principal clinical psychologist attached to Goodmayes Hospital, did see them for a brief time as a couple. She identified positive and negative aspects to the relationship and expressed concerns should they live together due to PC's problems. In April 1992, she said that at each meeting Mr Foskett talked of the differences between his relationship with his wife Margaret and with PC. The former involved him caring for his wife without any sharing or communication, whereas with PC he said he could be open and discuss whatever came up.

3. In January 1992, Dr Feldman wrote a positive report to the Home Office. She did alert them to a problem she had encountered with Mr Foskett in relation to his ownership of a car and his use of it while on unescorted leave without her knowledge. This had arisen in August 1991 and she had referred to the Home Office and to Professor Coid as to how to deal with it. Nevertheless, her report was based on Mr Molloy's detailed work on Mr Foskett's personality problems and an optimism about the relationship with PC based on Ms Hiller's work. She also reported at this point that the hospital managers were still against discharge following on from earlier problems with negative publicity when Mr Foskett was first sent to Goodmayes Hospital (Chapter Three).

4. On 2 June 1992, the Advisory Board provided its second decision now supporting conditional discharge and on 22 July 1992, Dr Feldman reported back to the Home Office the results of a large multi-disciplinary meeting attended by a long list of those then involved in Mr Foskett's care (but not Ms Hiller who worked part time) and those who would become responsible for him. The letter was copied to Goodmayes Hospital management, and representatives from Barnet and Lyndhurst and Mr Foskett and his brother. Professor Coid was not invited. By this time funding for Lyndhurst had been finalised by Newham Health Authority and a place available at Christmas identified, which could not be held for him much beyond that time.

5. Lyndhurst hostel provided 24 hour staffing cover with ten staff, two on night duty and Mr and Mrs Scott, the proprietors, on call. The Scotts were both mental health nurses by profession with experience of psychotherapy and patients with drug and alcohol problems, three or four of the other staff at that time would have

had mental health qualifications, but the rest would have been unqualified. In evidence the Scotts described a system of care planning that they used and which was evident in the notes provided to the Inquiry. At that time most of their clients were from out of borough sources. It opened in 1985 as a mental health residential care home, but by this time had developed into a unit that specifically took patients under a restriction order of the MHA.

6. The letter of July set out the short, medium and long term plans for Mr Foskett that were agreed with him. The plan included re-admission to Goodmayes Hospital should that become necessary. This was a detailed plan and included Dr Abrahamson taking over his care from 31 October 1992 as he was then taking over Magnolia ward. Monitoring of the relationship was a key component.

7. The short term plan was for discharge to Lyndhurst under the care of Mr Bernard Scott. Prior to his taking up residence, Mr Foskett was to familiarise himself with the hostel and its residence by having a meal there once every three weeks initially. The Lyndhurst care team would formulate a care plan to incorporate a monitoring mechanism for the time he would spend in Newham with his family and PC who, it was noted, was to enter the Maudsley as an inpatient on 31 July 1992[26] to deal with her OCD. The relationship was to be monitored and discussed at every care plan meeting. Mr Foskett's weekly programme was set out, including sessions at the East Ham Centre. Arrangements for medication to be monitored by a new general practitioner, Dr Brett. Care plan meetings were to be held monthly with the social worker, Graham Bull visiting weekly, diminishing to fortnightly, then monthly.

8. The medium term plan included the development of local contacts for rehabilitation and work experience.

9. For the long term, Mr Foskett had expressed a wish to return to Newham to live independently. It was agreed that independent living was the object of the exercise, but the location had yet to be finalised. His relationship with PC was to continue to be monitored 'especially in the light of her treatment at the Maudsley Hospital for her obsessive compulsive neurosis.' Couple therapy was not

[26] Her records indicate that she probably in fact did so on 2 November 1992.

envisaged because Ms Hiller could see no reason for it, but it was stated that 'we will continue to address the issue, everybody being aware of any possible developments.'

10. Professor Coid's assessment, requested by the Home Office, is contained in a letter of 22 October 1992. He noted a slow but steady progress. He mentioned PC and her OCD and attendant rituals. He knew that she was attending the Maudsley Hospital. He was happy with the move to Lyndhurst which he was familiar with due to another patient. He also felt that due to the local adverse publicity Mr Foskett had received in Newham, the relocation to Barnet had an advantage.

11. However, importantly, he outlined the dilemma he found himself in arising as a result of the Advisory Board's advice that Mr Foskett should be supervised by a forensic psychiatrist. This normally assumes that the individual concerned had adequate resources to provide the support and backup necessary. He advised of his own lack of resources in that respect and complained of the lack of any unit locally to which he could admit Mr Foskett, and that there were not sufficient staff to provide the 'important community service' that these patients require. Admission, if that was to be required, would have to be back at Goodmayes Hospital, because his own facilities were overloaded and he said that private hospitals had long waiting lists. He emphasised that a shortage of medical staff within the east London forensic service meant that he could not see Mr Foskett more frequently than once every four weeks. Furthermore, he had no community psychiatric nurses and only one social worker. He thus underlined the limitations in the service he could offer, if he was to take over the supervision of Mr Foskett. These remained right through the time that he had responsibility for him.

12. Just over one month later, and almost eight years to the day from the date on which the original order committing Mr Foskett to hospital was made, he was conditionally discharged by warrant issued by the Secretary of State under section 42(2) MHA. There were four conditions imposed: i. Residence at Lyndhurst Hostel, London N12, ii. Supervision by Graham Bull, social worker, iii. Keep in touch with supervising officer as directed and iv. Attend a psychiatric outpatient clinic as directed by a consultant psychiatrist.

13. It is interesting to note that the need for supervision to be by a forensic psychiatrist was not actually stipulated by the Home Office.

14. A further multi-disciplinary case conference took place on 3 December and this appeared to set up more supervision than directed by the conditional discharge. At this meeting Mr Scott, the Lyndhurst project manager, notified of a delay in the availability of a place for Mr Foskett until early in the New Year, but also that he had been getting on well during his visits there so that he offered Mr Foskett the chance to increase on them and spend Christmas there if he so wished.

15. Mr Scott also said that Barnet District Psychiatric Services provided overall supervision for their clients and their local mental health managers would have to be notified when Mr Foskett moved there. He advised as to other services available in Barnet and that Dr Brett, general practitioner, would provide general medical cover. Care plan meetings were to be held monthly at Lyndhurst and were to be meetings 'on the lines of 117 Meetings'. After a brief period with Dr Abrahamson, Dr Feldman was to arrange follow up in the outpatients once he was discharged and Professor Coid would see him three to four times a year in addition. Any recall was to be as discussed in the previous meeting, to Goodmayes. PC's hospital admission was noted.

16. By February 1993, Mr Foskett was showing signs of losing patience with the delay in his discharge. He remained well, but turned Lyndhurst down due its distance from his mother and local roots. The Home Office wrote to him stating that his conditional discharge was only authorised to Lyndhurst. By 22 March Mr Foskett had reviewed his decision, and his discharge took effect on 26 March 1993.

COMMENT

17. This was a well planned discharge that included two large multi disciplinary meetings. The plans laid before the Home Office were detailed and included consideration of the relationship, as well as contingency arrangements for relapse and re-admission. The one possible shortcoming was that there was no contact with mental health services in Barnet at this time. We have already commented in Chapter Four on the issue of a joint assessment of Mr Foskett and

PC and the need to reach a specific understanding of PC's mental health problems together with the likely impact on Mr Foskett.

18. Professor Coid made the limitations in his own role and what he could offer abundantly clear to the Home Office. He was unable to offer a complete service with the back up of a community psychiatric nurse and social worker. He worked in an over stretched, under resourced service and was taking Mr Foskett on at the request of the Home Office. Social supervision was to be conducted by Mr Bull from Newham social services. The initial arrangement included outpatient appointments with Dr Feldman and the intention to involve Mr Foskett with local Barnet psychiatric services.

19. This was in fact a complex melange of service provision covering three different areas of London: Newham, Barnet and Hackney. Through the process of referral to the Advisory Board and Professor Coid, and efforts made thereafter to meet their concerns, there is little doubt that managing Mr Foskett's future risk was given a great deal of service input.

20. However, this also left a lack of clarity as to how the medical supervision would work in practice, and when Barnet psychiatric services would become involved because they had not been involved in the planning process. Mr Scott, while describing the available service, was not able to commit Barnet Health Authority to any particular course of action. Looking back we find that the failure to involve Barnet psychiatric services at this early stage was regrettable and may well have had adverse consequences for the future hand over of Mr Foskett's care to local psychiatric supervision. However, any meaningful role for Barnet was probably dependent on his taking up residence there, and at that time it was thought that Mr Foskett would return to Newham.

21. There was a lack of clarity over the roles to be played by Dr Feldman and Prof Coid. By July 1993 Dr Feldman handed over care to Prof Coid completely, but prior to that their roles were not clearly delineated and the impression given is that it was Prof Coid who was expected to be involved in the short term only.

22. In this way, however, the after care obligations placed on the relevant authorities by section 117 MHA were fulfilled. This states that *'It shall be the duty of the*

[Primary Care Trust or] [Health Authority][27] and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after care services for any person to whom this section applies until such time as the [Primary Care Trust or] [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services' (s.117(2)), and further the section stipulates that the responsible authorities are those in the area in which the patient concerned is a resident, or to which he is sent on discharge by the hospital in which he was detained (s.117(3)).

23. This provision has given rise to much litigation in relation to the extent of the duty to provide services and the responsibility of authorities for patients residing out of their original areas. There was no issue in Mr Foskett's case concerning the extent or level of the services being provided for him. Newham authorities had assumed responsibility for part of the funding of his hostel placement, medical and social supervision. This was the correct course for them to take. Later, and with some persuasion, Barnet took over this role.

24. The High Court has clarified this issue stating that the relevant after care bodies for a patient discharged into a different area from his original residence will remain those of his area of origin, until such time as the patient is no longer in need of such services.[28] This is the case even if there is no prospect that the patient will ever return to that area. This would only change if the patient were to be detained in the new area under one of the MHA provisions attracting section 117 after care services. In this case Barnet services assumed responsibility when it was known that Mr Foskett would remain in Barnet and would be absolutely discharged into the area. There was no obligation to engage local services sooner, but this would in our view constitute good practice.

25. By virtue of the conditional discharge and the continuing restriction order (section 41 MHA), Mr Foskett remained liable to recall to hospital and the Home Office maintained a supervisory role over Mr Foskett. The responsible medical officer's

[27] At the time in question this duty would have fallen upon the East London and City Health Authority precursor to North East London Strategic Health Authority. See Chapter One.
[28] *R v Mental Health Tribunal ex p Hall* [1999] 3 AER, 132. Scott-Baker J at first instance. See also Department of Health Circular LAC (2000) 3.

obligation to provide annual reports continued (section 41(6)) until the absolute discharge in April 1995.

26. A conditional discharge allows compulsory supervision of a patient in the community. Supervision should be provided by the person who can bring most by way knowledge, expertise and resources to the particular case. The purpose of formal supervision is to protect the public from further serious harm by assisting re-integration and close monitoring of the patient's mental health or a perceived increase in risk. A further purpose of a conditional discharge is that it allows a patient to be re-established in the community testing his ability to cope and remain risk free before a decision is taken to absolutely discharge him.[29]

27. The role of the Home Office has been described as being to receive reports (quarterly or half yearly) from the supervising doctor and social worker and, usually after a period of five years, to consider an absolute discharge on the recommendation of supervisors. Sometimes this may be done after two years if the patient's offending history is less serious. Difficult cases may take longer.[30]

After care post conditional discharge

28. Mr Foskett was seen seven times by Professor Coid in 1993, nine times in 1994 and three times in 1995 prior to his absolute discharge in April 1995. He hosted two section 117 review meetings, one in October 1993 and the other in June 1994, during that time having taken over as responsible medical officer from Dr Feldman in August 1993.

29. Mr Foskett was seen by Dr Feldman in the outpatients clinic at Goodmayes Hospital after his discharge from hospital. She took over his care from Dr Abrahamson in May 1993.

30. The first section 117 review meeting took place on 13 May 1993. Mr Foskett was being seen by Mr Bull fortnightly. At that stage, his future plans included returning to live in Newham. He had seen Professor Coid the week before and that note indicates that there was discussion regarding PC and her treatment at

[29] *After-Care of Conditionally Discharged Restricted Patients – Notes for the Guidance of Social Supervisors,* (1997).
[30] *The Mentally Disordered Offender,* ed K Herbst and J Gunn, (1991).

the Maudsley Hospital. Mr Foskett had said that her symptoms were much improved. He was open about how it affected their sex life. Mr Foskett had coped with the change and the move well. He did not experience any symptoms of depression.

31. He was continuing with art therapy at Goodmayes Hospital and relaxation and yoga at the East Ham Centre. Until the hand over to Professor Coid, Mr Foskett was seen at the outpatient department roughly at monthly intervals. He was noted to be doing well. His lithium levels were at that time being monitored at the East Ham Centre.

32. Hand over to Professor Coid of responsible medical officer duties was canvassed with the Home Office in July 1993 by Dr Feldman, due to what she described as 'catchment area' difficulties. She communicated some of PC's difficulties to Prof Coid in a letter of 8 July 1993. PC had been invited to a section 117 meeting on 29 July which Prof Coid could not attend. In that letter, she outlined PC's progress at the Isaac Mark's Unit of the Maudsley Hospital and that she had achieved 40% of her goals. She reported that PC still had 'thoughts of pushing people under trains and wanting to eat dog shit'. PC had recounted some difficulties with Mr Foskett, details of which are not provided, as a result of having to become more assertive with her therapy. Dr Feldman suggested that Professor Coid may want to see them together as a result. On 1 September Dr Feldman signed a section 117 termination form.

33. Prof Coid discussed PC with Mr Foskett at their next meeting on 2 August 1993 when Mr Foskett is reported as saying that he was able to express annoyance with her. The relevance of this being that he was unable to do so with his wife, although this is not expressly noted. Professor Coid did not see them together at this time.

34. In December 1993, a letter from a chartered psychologist at the Maudsley Hospital to Dr Chang, PC's general practitioner, said that PC had attended three out of six sessions with her and was dependent upon her boyfriend accompanying her. She said that feelings about her relationship with Mr Foskett were explored and PC found it difficult to assert herself within it. She advised

that specialist help may be required to deal with PC's altered feelings about the relationship to prevent frustrations building up and the consequences to either partner of that happening. At that point, she said that she was not able to help anymore and that longer term treatment was more appropriate more locally. There is no evidence that this was followed up. However, PC appeared to remain well for the next year.

35. Mr Foskett was by this time expressing his wish to withdraw from the group at Goodmayes and then later that same month also mentioned leaving the East Ham Centre group. He was not enthusiastic about transferring groups to a location closer to Lyndhurst. In September, it was also noted that PC was now 'doing unusually well with some setbacks.'

36. At the next section 117 meeting in October 1993, the medium term plans were discussed in the light of Mr Foskett settling well into Lyndhurst, with good relationships with staff and other residents. His capacity for work was the next focus. Later that month in a progress report for the Home Office, Graham Bull noted that PC was staying overnight at Lyndhurst once a fortnight.

37. Mr Foskett withdrew from art therapy by Christmas that year. The therapist wrote to Dr Coid expressing the department's view that this was appropriate and that given his 'personality and his limitations' he had made considerable progress and should concentrate on building a life outside the hospital. In spite of their suggestion that he should discontinue after February, Mr Foskett never returned. He was encouraged to do so in order to work through the feelings relating to leaving the group and the leaving process. He declined to do so and was discharged on 10 March 1994 from their list.

38. At the end of December 1993, Mr Foskett gained a new key worker at the East Ham Centre and these sessions continued. On 7 March 1994 Mr Bull wrote to Prof Coid informing of his departure from the service on 15 March. Prof Coid wrote back on 21 March with a strident objection to his leaving the service before another social worker was appointed to supervise Mr Foskett. He referred to the statutory responsibility of Newham social services to provide seamless

supervision. He informed the Home Office of this failure and the current lack of supervision of a restricted patient.

39. By a letter of the same date, Mr Scott of Lyndhurst notified Prof Coid that the new social worker was Khadija Patel who was on leave until 1 April. It is clear that they had discussed the lack of a social worker the previous week and Mr Scott had taken steps to find out what was going to happen. The section manager was to act as responsible social worker until Ms Patel returned from leave, and in her absence the duty social worker would provide necessary cover. Mr Scott was proposing to arrange a meeting with Ms Patel prior to taking his own leave on 8 April. Prof Coid responded with a review date on 9 June, a date which coincided with his seeing another patient at Lyndhurst.

40. Ms Patel contacted Prof Coid by letter of 30 March notifying him of the date for her meeting with Mr Foskett on 6 April. She sought information for a Home Office progress report which was outstanding. Prof Coid responded with a copy of his last report to the Home Office of February 1994. He referred her to previous information that should be in her files, including a description of the index offence and his own lengthy report of March 1991. He asked her to let him know if she did not have this information.

41. The East Ham Centre reported that Mr Foskett was committed to his programme with them. He related Mr Foskett's views regarding cessation of art therapy and that he had sufficient individual contact and support with his social worker, Prof Coid and the East Ham Centre. He was also seen by Dr Brett for his medication and monitoring of his lithium levels by now. Issues for careful thought in the coming year included accommodation, and in particular, where he will live, whether Newham or Barnet, whether he will work and his relationship with PC.

42. By July 1994, Mr Foskett is recorded as expressing a wish for accommodation of his own and had signed a consent form authorising Prof Coid to release information to a housing agency in Finchley, Barnet. By January 1995, he was on the medical priority housing list, however, Barnet vacillated over his eligibility for housing due to what is recorded as a 'local policy difficulty'. Lyndhurst enlisted the help of Newham social services to overcome this problem. It

appears that Barnet Housing Department agreed to house Mr Foskett once he was absolutely discharged and with the support of the Barnet Community Support Team (CST). This is discussed further in Chapter Eight. He was finally allocated independent accommodation in October 1996.

43. In relation to PC, the January 1995 review conducted by Prof Coid and Mr Scott, noted that the relationship is a good, solid long term one. It is mature and both have a 'great deal of insight into present and future difficulties they say they may encounter living together. They have discussed amongst themselves and with professional (sic) their past histories, which has brought them to be quite supportive towards each other during time (sic) of need. Pstays overnight at Lyndhurst once a week. This is a facility they both negotiated some months after Dennis (sic) admission.'

44. In December 1994, a letter from the Maudsley Hospital indicated that PC had been seen there once again having been re-referred by her general practitioner, Dr Chang. Although up to this point she appears to have had a relatively good year, in that there are no records relating to her attendance for help to her general practitioner, she was by now a very unwell woman again. The letter spoke of her experiencing intrusive thoughts relating to harming others including children, grandchildren and her mother. She was ruminating about Mr Foskett's relationship with his mother. There was mention of her rituals.

COMMENT

45. The Panel saw evidence of care planning and multi-disciplinary team work in the planning of Mr Foskett's discharge from Goodmayes Hospital, and also while he was at Lyndhurst in the form of section 117 MHA review meetings. There were regular reports to the Home Office from Prof Coid and the Newham social workers. The original plan changed once he was at Lyndhurst, Prof Coid took over psychiatric supervision, contact with Barnet psychiatric services did not materialise until Mr Foskett was absolutely discharged and the importance of monitoring the relationship receded. No provision was made as to what should happen in the event of a need for an admission to hospital in a crisis after Dr

Feldman left, and Hackney Hospital became the formal detaining authority. These changes were not incorporated into a new plan.

46. There was no formal CPA operational in Newham at this time. The background to the CPA has been extensively covered in other homicide inquiry reports. It is worth briefly recapping some elements of it.

47. The Care Programme Approach (CPA) was introduced in 1990 as the framework for the care of people with mental health needs.[31] It was intended to be implemented by April 1991 and to run in tandem with the local authority Care Management system,[32] but this did not happen until later. Originally intended to apply to inpatients at the point of discharge, and to new patients in specialist services, it was extended to cover everyone in touch with specialist mental health services; that is everyone dealt with other than in primary care settings exclusively. However, the Audit Commission reported in 1994 that many districts had failed to implement CPA. Further guidance on implementation was given in 'Building Bridges' (DoH 1995).

48. Key elements of the CPA included:[33]

- Systematic assessment of health and social care
- Formulation of a care plan to address needs
- Appointment of a key worker to deliver care
- Regular review
- Amendment as necessary from time to time
- Service user involvement

49. The Panel saw a report prepared for the North East London SHA[34] as a result of five independent inquiries carried out into homicides in the area served by East

[31] *Caring for People* (1989*); The Care Programme Approach for people with a mental illness referred to specialist mental health services.* HC(90)23/LASSL(90)11)
[32] NHS and Community Care Act 1990
[33] In 1999 the CPA was revised and integrated with local authority Care Management and its importance was emphasised in the 'National Service Framework for Mental Health' (DoH 1999). Additional requirements included:

- Two tiers of CPA, one standard and one enhanced
- Key workers were replaced by care co-ordinators

Standard is defined as being low key and essentially involving only one agency or professional, whilst enhanced is for those with multiple and complex needs who may be at risk of harming themselves or others and who are likely to disengage from services.
[34] Independent Inquiries: review of action and lessons (2004)

London and The City Mental Health Trust (ELCMHT) which is now responsible for services previously covered by the Newham District Health Authority. Criticisms had been made in each Inquiry of the ELCMHT approach to the use of CPA. A comprehensive CPA policy was introduced in 2001.

50. The Panel understood that formal CPA responsibilities for Mr Foskett had passed to Barnet in 1995 with his absolute discharge. However, we noted that PC remained a Newham resident and should have been covered by the ELCMHT CPA from at least 2001 onwards because she was a psychiatric outpatient at this time (see Chapter Five).

51. The Inquiry finds that the quality of supervision provided by Dr Feldman over this period was good. She provided information about PC in her handover to him. Prof Coid was proper in his approach to providing supervision to a restricted patient and reporting to the Home Office. He was rightly angered by the lackadaisical attitude of the social services to ensuring proper social supervision cover when Mr Bull left. However, this was quickly resolved.

52. What is not known are details of the relationship with PC at this time. We know that she was staying overnight, and Mr Scott of Lyndhurst hostel suggested in evidence that this was allowed following a joint assessment by the couple's respective Newham teams. There is no evidence of this and it seems unlikely in that PC had no team involvement.

53. The Scotts knew little of PC's mental health problems and no concerns about this were brought to their attention. They found the relationship reassuringly normal and there were no concerns about it reflected in the care plans. Thus, this key element of Mr Foskett's risk assessment and the need to monitor the relationship was unknown to them.

54. There was a marked lack of curiosity as to details of PC's own condition. Dr Feldman had provided some details when she handed over to Prof Coid, but there was never any subsequent review of PC's disorder. At Lyndhurst the relationship was viewed very positively and there is no reason to doubt the accuracy of this assessment, because as noted before there were very positive aspects to it. However, she was by December 1993 quite unwell (see Chapter

Five), and this appears to have been unknown to anyone responsible for Mr Foskett. Her therapist had concerns regarding the effect of her illness on the couple in the context of the build-up of frustration within the relationship and suggested couple counselling. The Maudsley Hospital knew that Mr Foskett was a restricted patient who had killed two people, but took no steps to contact his carers either. The need for a closer relationship and an exchange of information between the three sets of professionals, i.e. Newham, Lyndhurst and the Maudsley, is highly apparent at this time. The circumstances were such that there could not have been a justifiable objection based on confidentiality.

55. A thorough review of this relationship should have been undertaken periodically by the whole team. It should have formed part of the ongoing supervision concerns of the social worker and the staff at Lyndhurst Hostel. It was not, and the issues around the relationship were diluted. The stresses caused by the relationship, identified in Prof Coid's earlier assessments, were not pursued and the case moved quickly to an absolute discharge.

56. PC had been ill over this period as noted in her therapist's letter to her general practitioner in December 1993, referred to above. Mr Foskett did not bring any difficulties in the relationship to the attention of anyone caring for him. His over compliance and good behaviour brought about a general reliance in him reporting difficulties that was probably not in fact warranted, although circumstances were such that no crisis resulted for a very long time. The issue of his compliance is addressed in more detail in Chapter Four and the comments made regarding risk assessments in long term care apply equally at this stage in Mr Foskett's care.

Chapter Seven

ABSOLUTE DISCHARGE

An alternative approach?

1995

Introduction

In January 1995, Mr Foskett applied to the Mental Health Review Tribunal for an absolute discharge from his liability to detention under sections 37 and 41 of the MHA. On 11 April 1995, two years after he was conditionally discharged to Lyndhurst Hostel and ten years after his index offences were committed, Mr Foskett was granted an absolute discharge by the tribunal. The evidence from professional carers presented to the tribunal was unanimous in its support of Mr Foskett's application.

This was a key moment in his care because the consequence was that he was no longer subject to obligatory statutory supervision. An absolute discharge marks a significant step into freedom for those who have been subject to a restriction order. Mr Foskett was entitled to after care services pursuant to section 117 MHA, which does not carry any mechanism for ensuring or enforcing compliance with after care. Although he did continue to see Prof Coid twice a year, and reluctantly saw a social worker from Barnet, Frances Gauthier until 1998, he refused to have his psychiatric supervision transferred to the local Barnet Community Support, later Mentally Disordered Offenders, Team. This meant that by the time his mental health deteriorated in 2003, Mr Foskett was only seeing Prof Coid and had no contact with local services at all (Chapter Eight).

In addition, at this time in 1995, Mr Foskett was still living in the supported environment of Lyndhurst Hostel, there having been difficulty obtaining a flat for him from Barnet. It seems surprising that he could have been granted an absolute discharge prior to having his ability to live independently tested and assessed. This is particularly so in light of the potential strains placed on his mental health by PC's own illness in the event, as was by then expected, that they should co-habit. This was a specific high risk scenario that was identified by Prof Coid in his report of 1991 (see Chapter Four).

The issue for the tribunal, and the key difference between a conditional and an absolute discharge, was whether or not Mr Foskett needed to remain liable to recall to hospital for further treatment (section 73(1)(b) MHA). There was no question over whether or not the statutory criteria for a discharge, which had been satisfied at the time of the conditional discharge, were still satisfied (section 72(1)(b) MHA). The question before the tribunal was whether Mr Foskett would now be entitled to an absolute discharge or remain on a conditional discharge.

The Inquiry Panel was concerned to determine to what extent the tribunal's decision, and the evidence before it, involved an assessment of the relationship with PC and any risk to her, and how the risk of any future relapse in his mental health was assessed. This chapter sets out and considers the evidence before the tribunal and whether the tribunal's decision was flawed in any way. It also then considers the question of the correct approach when a mentally disordered person has committed the most serious of offences, but is assessed as presenting a low risk of future offending ie. a very low risk of serious harm, and additionally has remained symptom and problem free for a period of ten years after the index offences. Should such a patient be subject to life long liability to recall as would be the case had he received a discretionary life sentence and released on life licence?

The Inquiry was unable to locate and take evidence from Khadija Patel, the Newham social worker allocated to Mr Foskett at this time. We did have available her report to the tribunal and other records.

Tribunal's decision

1. The decision of the tribunal, signed on 11 April 1995 by His Honour Judge William Barnett QC, was brief and recorded that it was 'satisfied that it is now no longer appropriate for the patient to remain liable to recall to hospital for treatment.' The full reasons provided were as follows:

   "The patient suffers from a relapsing depressive illness which with the aid of medication has been in remission for nearly 10 years. When he presented to the Tribunal he was symptom-free and the Tribunal accepted that he would continue to take his medication particularly in view of his remorse and concern about his index offences. The tribunal accepted the evidence of Dr Coid and the contents of the report of Dr Ghosh that with appropriate medication relapse was unlikely and that if it came it would be gradual and readily detectable. The professionals

caring for him were clear that if absolutely discharged he would continue to adhere to any treatment programme that was recommended and if medical help were needed it would be obtained. As long as his mood remains normal he presents no danger to anyone and in spite of the stresses that occur in the hostel where he lives he has remained equable."

Evidence before the tribunal

2. The social circumstances report was provided on 24 February 1995 by Khadija Patel, the Newham social worker from the adult providers team based in Stratford, London, who had been his allocated worker since March 1994. Her report was brief and indicated that he was doing well at Lyndhurst Hostel, was taking his medication and felt that he was likely to do so for a very long time. He was able to manage himself well in relation to his domestic affairs, such as finances and cooking. She explained that it was felt to be wise, in view of the Newham location of his index offences for accommodation to be sought in Barnet. Ms Patel made no mention of the relationship with PC, but did state that Mr Foskett 'has always been very forthcoming in getting in contact with our Social Services Department, and it is envisaged that he will continue to do this. Dennis feels that he is able to ask others to support him when he feels that he needs help.' She made no specific recommendation regarding discharge, but did not provide any evidence against it.

3. The Inquiry heard evidence from Bernard Scott and his wife Danielle Scott, who managed and ran Lyndhurst Hostel and who now live in Corsica, France. Mr Scott was also Mr Foskett's home support worker. We are grateful to them for the trouble they took to attend the Inquiry. Mr Scott provided a report dated 22 March 1995 for the tribunal which supported Mr Foskett's application and fully endorsed his ability to live independently and his commitment to taking medication, stating that he had 'gained the insight in to his past mental health problems which will serve to prevent a reoccurrence of his index offence'. He also referred to Mr Foskett's short, medium and long term goals. These included, respectively: attending monthly meetings with Dr Coid and Ms Patel, preparing for independent living in Barnet and finally, living with PC. Mr Scott referred to the 'long and what appears to be healthy adult relationship with his

girlfriend Pauline, who collectively negotiated with the home a facility for her to spend overnight stays at the home.'

4. In evidence to the Inquiry, Mr and Mrs Scott confirmed their belief that Mr Foskett was ready to be absolutely discharged. Mr Scott said 'There was nothing that led me to believe…that Dennis would have committed another index offence at that time.' Mrs Scott underlined their appreciation of the role of lithium carbonate in maintaining Mr Foskett's stability, and told us that PC was advised to be careful 'because she was also a depressed person and the two of them could play on each other's mental health.' They last saw Mr Foskett some two or three years after he had left Lyndhurst when he was still very well.

5. PC was not seen by the Scotts as having severe mental health problems. They knew she had been an inpatient at Goodmayes Hospital and had depression. Mrs Scott said PC spoke when spoken to and was very quiet. This was not the 'bolshy' person Jonathan Ash - PC's therapist at the Maudsley Hospital from 1998 – described (see Chapter Five). They had taken reassurance from the relationship, and there were no concerns over it that were reflected in care plans. Mr Scott told us that had he felt it necessary he would have arranged a dual multi-care plan review with those responsible for PC, and that he had done this before in relation to another patient.

6. PC's records show that she had been formally diagnosed with obsessive compulsive disorder while an inpatient at the Maudsley in 1992 (see Chapter Five). It is clear that her mental health was never completely well and suffered a multitude of physical problems in addition. This was not known to the Tribunal.

7. Professor Coid, as Mr Foskett's responsible medical officer, provided a comprehensive report dated 28 February to the tribunal which was supportive of an absolute discharge. As he correctly pointed out in evidence, he did not positively recommend an absolute discharge but stated that he was 'no longer in a position to recommend that he was suffering from mental illness of a nature or degree which makes it appropriate for him to be liable to be detained in hospital for medical treatment, or that it is appropriate for the patient to remain liable to be recalled to hospital for further treatment.'

8. The report referred to Mr Foskett's progress generally and while in Lyndhurst Hostel. It stated that he had suffered from occasional 'flu and colds without any evidence of the return of his depressive symptoms and that there were no signs of dangerousness towards PC with whom he had been allowed to go on holiday. The relationship was described as 'established', and it was known that there was sexual contact between them. Her continuing obsessive compulsive disorder with rituals was recorded, together with the fact that Mr Foskett 'claimed to have been to talk (*sic*) to her about his offence and his previous relationship with his wife Margaret.' He was 'courteous and cooperative when seen in outpatient clinics which he attends punctually at all times.'

9. He concluded that since being maintained on anti-depressant medication, Mr Foskett had remained asymptomatic and that the medication 'appears to prevent a further relapse'. Importantly, he noted that Mr Foskett's symptoms progressed rapidly to a very severe state in the episode prior to the index offences. His formulation of the index offence and risk factors now focused more on medication preventing relapse of his mental illness. In the context of the dynamics of his relationship with his wife, Prof Coid said that he *'formed the impression that disinhibition resulting from his severe, agitated and psychotic depression was the primary factor in the index offence. This might have been combined with factors of long term repressed feelings of irritation and hostility towards his wife that had never been vented a normal manner. It is also possible that these emerged explosively following the final precipitant of being told to persevere with medication by his GP, a preparation in which he had no faith, and which he at the time believed was making him worse. Although such a form of stress would seem trivial, in Mr Foskett's highly disturbed and agitated mental state, and with his progressively distorted view of reality, it may well have combined with these other factors to produce the final homicidal burst.*'

10. On this basis, he posited that the risk of future dangerousness hinged on the risk of relapse of this condition. Even though Mr Foskett had not had any experiences of severe stress while being supervised, it was his opinion that 'there was nothing to indicate that he is particularly vulnerable to a further episode of depression unless he were to cease taking his medication'. There

was no evidence that the relationship with PC and her neurotic illness was a source of stress for Mr Foskett.

11. Professor Coid said in evidence that, on this occasion, his opinion was informed by the fact that Mr Foskett presented such a low risk over 'what seemed to be a long period'. Asked about the tribunal's erroneous finding that relapse would be gradual, Prof Coid said that he often did not agree with the precise terms of a tribunal's decision, but that in any event he was clear on the issue of Mr Foskett's risk of rapid relapse and was always mindful of that fact. [78] He confirmed that this finding would not have been based on his oral evidence to tribunal.

12. We asked Prof Coid how he addressed the issue of liability to recall. He said he placed particular reliance on past history, especially of compliance. There was no evidence that Mr Foskett was somebody who did not comply, and he referred to the fact that this had in fact been the case right up to the last time that he saw him in July 2003. He also referred to the need for 'increasing testing out', and acknowledged that Mr Foskett was in fact not tested out in the sense that he remained at Lyndhurst Hostel at the time of absolute discharge and had not been tested in independent living. Looking back, he felt that this may have been due to a sense of frustration that housing had been difficult to arrange for Mr Foskett and there was a need to move him on, but he also referred to a difference in practice at that time whereby the impetus was to move patients on.

13. Prof Coid was satisfied, in spite of the error by the tribunal relating to the likely speed of relapse, that the supervision put in place for Mr Foskett after his discharge was sufficient bearing in mind his history. This view did not deny the fact that a risk always existed with restricted patients, but accepted that the alternative view was that a patient would otherwise never achieve an absolute discharge. Prof Coid said that his practice had changed over the years and he is more cautious now when making recommendations to tribunals. Even so, Mr Foskett presented very few of the problems he was used to dealing with in restricted patients. He said 'this was really small time stuff for a forensic psychiatrist….risks were fairly low compared to the others [patients]. Also I was in a situation where taking the risks….did not seem such a big deal as it might to me now'.

14. The tribunal also had the independent report of Dr Chandra Ghosh, consultant forensic psychiatrist, then at Broadmoor Special Hospital, Crowthorne, Berkshire, commissioned by Mr Foskett's solicitor. Her assessment was based on interview with Mr Foskett and a review of his history. She too, supported an absolute discharge and stated that he was not a risk to himself or others while he remained on medication. She agreed with Prof Coid on the issue of the need for recall. She relayed Mr Foskett's view of the difference between PC and his wife Margaret. He had said that he did not see PC suffering in the way that his wife did when she had an epileptic fit. He found PC's illness less distressing than the epilepsy his wife had. He had also demonstrated an awareness that any stress within the relationship could result in a deterioration in his mental state, as a result of which it was his intention to progress through the relationship with caution. He had said that he would refer any stress he felt to both his psychiatric and social supervisors.

15. The Home Secretary provided the only contrary view to the tribunal. In his statement provided under rule 6 of the Mental Health Review Tribunal Rules 1983, he said that it was too soon to conclude that Mr Foskett would not again become 'susceptible to a seriously adverse reaction to stress, or cease medication if not subject to the formal compulsion of a restriction order.' He stated that the 'continuation of statutory supervision with the sanction of recall is the most effective way of assisting his continuing rehabilitation whilst safe-guarding public safety.' It is reasonable to state that it is not unusual for the Home Secretary to oppose a restricted patient's discharge before a tribunal in these terms. Where there is a serious concern that a dangerous person may be discharged, the normal practice is for the Home Secretary to be represented by experienced counsel at the tribunal. There was no such representation at this tribunal.

16. The Inquiry received written evidence from the Mental Health Unit at the Home Office. It stated that a restriction order is unique in providing a person subject to compulsory treatment under the MHA, the opportunity to live in the community, subject to the safeguards provided by professional supervision and the Home Secretary's power to recall them to hospital i.e. pursuant to a conditional discharge. We were provided with statistical evidence of the success of this

system, which allows approximately one third of restricted patients to live in the community where they commit fewer serious offences than life licence prisoners, with less than 2% re-offending seriously within two years of discharge. The MHU has no figures available on the re-offending rates of those given an absolute discharge, because they only come to its attention if made the subject of a further restriction order. The Home Secretary's view to the tribunal was emphasised, and the view expressed that Mr Foskett may have been deprived of the support available under a conditional discharge prematurely.

17. If the tribunal was considered to have taken an irrational or otherwise unlawful decision, it would have been open to the Home Secretary, or detaining authority, to challenge it by way of judicial review proceedings in the High Court. This did not happen.

COMMENT

Restricted patients and the tribunal's discharge powers

18. The legal criteria for an absolute discharge are contained in sections 72(1)(b) and 73(1) of the MHA. By virtue of section 72(1)(b), a patient becomes entitled to a discharge from hospital if any one of the stipulated criteria are no longer satisfied. Thus, in the case of a restricted patient, the Home Secretary or the Mental Health Review Tribunal must discharge the patient if they are no longer satisfied that i) he is then suffering from a mental illness, psychopathic disorder, severe mental impairment or mental impairment, or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in hospital for medication treatment or ii) it is necessary for the health or safety of the patient, or for the protection of other persons that he should receive such treatment.

19. In Mr Foskett's case, he was considered to satisfy these criteria by the Home Secretary in November 1992, and consequently a warrant discharging him from hospital at that stage conditionally was issued. The key difference between a conditional and an absolute discharge lies in section 73(1)(b), which states that an absolute discharge is only appropriate if 'the tribunal are satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further

treatment'. This was essentially the only live issue for the tribunal hearing Mr Foskett's case on 11 April 1995.

20. A patient who like Mr Foskett is totally asymptomatic and compliant with medication, or even considered to have completely recovered from an episode of mental disorder, and entitled to a discharge by virtue of the section 72 criteria, remains a 'patient' within the MHA and may still lawfully be subject to a conditional discharge and liable recall to hospital for further treatment. This approach, in use by tribunals at the relevant time, allows the authorities to monitor progress and manage risk factors in the community before an absolute discharge is made, and has been specifically endorsed by the European Court of Human Rights in Strasbourg.[35] In such circumstances, an absolute discharge is thus not obligatory, and a conditional discharge could lawfully continue though not indefinitely. An absolute discharge would become appropriate once a reasonable period of testing out had taken place. Reasonableness in this context is likely to depend on identified risk factors and so dependent on the facts of any particular case.

21. A patient who is conditionally discharged is obliged to comply with the conditions imposed upon him or run the risk of recall. (s. 73(4)). This allows a significant degree of control over a patient such that if he should default on medication or supervision, or if his behaviour should otherwise cause sufficient concern, then if necessary he can be recalled to hospital by a warrant issued by the Home Secretary. The aim is to provide adequate support for the patient in the community and the protection of the public.[36] This is the system that the Home Office MHU referred to as 'highly successful' in the management of restricted patients.

22. A tribunal has a wide discretion when imposing conditions which must be necessary and reasonable. Conditions may be designed to take account of treatment needs in the community and risk to the patient and the public. In some cases, it is only the imposition of appropriate conditions that makes a discharge

[35] *Johnson v UK* (1997)
[36] *R v Merseyside MHRT ex p. K* [1990]

viable and a patient treatable in the community. The inability to implement such conditions would make the patient detainable in hospital.[37]

23. In theory, no conditions need be imposed at all and a patient may simply be subject to recall for further treatment. In practice, the process of recall is only made effective through conditions providing for supervision and monitoring. The provision allowing for recall makes no mention of the commission of serious harm, and the discharge criteria make no reference to likelihood of serious harm, a precondition to the imposition of a restriction order, either. Recall is linked to the deterioration of a patient's mental health and the need for further treatment.

24. If there is no dangerous or serious criminal behaviour associated with the patient's mental illness, then a patient may be detained in hospital under civil MHA powers instead of being recalled by warrant, and thereby losing the benefit of his conditional discharge. Recall by warrant is therefore likely, as a matter of practice, to be associated with dangerous behaviour. In Mr Foskett's case, there was of course a clear link between a deterioration in his mental health and the risk of dangerous behaviour. Even so, a deterioration need not have automatically have triggered recall if it was detected in time, and could be treated on a voluntary (or involuntary) basis in a local hospital.

25. For Mr Foskett the power of recall arguably presented little additional safeguard because he was expected to seek medical help if necessary and considered likely to co-operate with any suggested course of action, including a voluntary admission to hospital. However, the tribunal did expressly consider the issue of recall as it is required to do because "The possible consequences for the safety of members of the public and the patient, when an order of absolute discharge is made are such that the question of liability to be recalled must be dealt with expressly."[38]

26. There was no legal or other challenge to this decision, and it must be safe to assume that this was because by that stage the Home Secretary was satisfied that the decision of the tribunal was not irrational or otherwise unlawful, even if he did not agree with it.

[37] *R(H) v Secretary of State for the Home Department* [2003]; *W v Doncaster MBC* [2004].
[38] *R(SSHD) v MHRT* [2001]; *R(SSHD) v MHRT* [2004].

27. The tribunal's alternative, had it been concerned to maintain statutory supervision for longer to allow Mr Foskett's ability to cope with the stresses of independent living and his relationship with PC to be monitored, and while he engaged with local services, would have been to re-impose the conditional discharge. There is no reason to suppose that Mr Foskett would have resisted local services at this point, if still subject to the coercion of a restriction order. On the other hand, had the conditional discharge been extended in Barnet (as opposed to following a move back to Newham), the possibility of testing out would have depended on Barnet housing and psychiatric services accepting responsibility prior to his absolute discharge. It is not possible to say now whether this is in fact likely to have happened.

Tribunal's decision

28. The Inquiry Panel aired and considered concerns as to whether, in retrospect, the decision to absolutely discharge Mr Foskett in April 1995 was right. This was particularly in view of the fact that it left Mr Foskett without any obligation to comply with supervision only two years after his conditional discharge. We have concluded that while it was not a perfect decision, on the evidence available as demonstrated by the written reports, it was well within a range of reasonable decisions that the tribunal could properly make at that time. Furthermore, in terms of preventing the killing of PC, or the relapse of Mr Foskett, it is highly unlikely that any continued statutory supervision pursuant to a conditional discharge would have persisted until 2003. It is likely that he would have achieved an absolute discharge at least by 1998.

29. The tribunal clearly misconstrued the evidence relating to the speed with which any relapse would occur, but we do not think that this error was sufficient to vitiate the entire decision of which it was a relevant though not essential part. The way in which Mr Foskett was supervised, or offered supervision, thereafter was more influenced by his compliance and perceived reliability. A great deal of reassurance was taken from the expectation that he would seek help should his mental state deteriorate. Prof Coid assured the Panel that the tribunal had not expressed his view in that regard.

30. What was essential to the decision, was that Mr Foskett was symptom free and that the tribunal accepted that he would continue to take his medication. It also accepted the medical evidence that if he did so, relapse was unlikely, that he would seek medical help if it were needed, and that in this way he presented only a very low risk of harm. The professional opinions were based on Mr Foskett's high degree of compliance and a real confidence that he understood the need to take his medication and to seek help if he became unwell. A 'gradual' and 'readily detectable' illness would undoubtedly offer reassurance, but it is conceivable that even in its absence, Mr Foskett's compliance and overall wellness could have been the decisive factors. We do not consider that the overall reasoning of the tribunal was obscured by this error, nor do we disagree that medication was preventing relapse and the key to managing risk.

31. The Tribunal expressly considered the issue of liability to recall, as it is statutorily required to do, and was persuaded by the medical evidence that relapse was unlikely with medication and the Mr Foskett would continue to co-operate with any treatment plan and obtain medical help if it were needed. Further, Mr Foskett had been compliant with medication for so long that, were this to be the only relevant risk factor, it was probably reasonable to conclude that further testing of his responses to stress e.g. of living independently, would not be necessary, especially if he was to remain under a treatment plan voluntarily as he said he would. From the tribunal's point of view, because the weight of evidence was so overwhelmingly in favour of an absolute discharge, this was not an unreasonable decision. The fact that the Tribunal had a clear alternative available to it which the Inquiry Panel would have preferred (see below), does not render its decision wrong or unlawful.

32. Of more concern, is the lack of any reference to the relationship with PC, which again reflects the fact that this had become a peripheral issue by now. We are critical of the failure of the professional carers to perform any proper assessment of PC's illness, its course and likely prognosis, with a view to reaching an informed view to place before the Tribunal as to how much stress it could cause to Mr Foskett and its likely impact on him. This would not have been an easy prediction to make, but needed a formal joint assessment at that stage, because he was about to move out of formal supervision.

Risk analysis and joint assessment of the couple

33. The lack of a joint assessment between Mr Foskett's and PC's carers at this time, demonstrates a stark omission in relation to the analysis of risk. Here was a man who had killed his wife and female general practitioner, saying that his intention was to live with his vulnerable girlfriend. Compliance with medication was an important factor, which by itself indicated a low risk, but the expectation that the couple would co-habit introduced a different risk dimension that had previously rightly been assessed as high. Views had previously been expressed that this was a situation that should never be allowed to pass. It changed the assessment thus far of a long term low risk, and demanded a full re-assessment of risk.

34. In the context of a change in the risk dynamics, the unquestioning reliance on his compliance is also unsophisticated, especially where again Prof Coid had previously identified the complexity of Mr Foskett's presentation and the existence of unaddressed (or untreatable) personality problems and amnesia. An analysis of the factors affecting compliance is presented in Chapter Four. It is relevant to both risk and insight. A formal re-focusing on this issue at this key moment is also likely to have emphasised its importance to the couple, especially in terms of the likely consequences of a relapse in Mr Foskett's mental illness. The reassurance provided as a result of his long term wellness to the professionals involved in his care, was equally relevant to the couple. No-one believed that he would re-offend, and that included Mr Foskett. However, his belief had to be seen in the context of his over-compliant, passive personality, his ability to repress frustrations and his belief that he was 'special' and different to other mentally ill people.

35. Both Prof Coid and Dr Ghosh addressed the issues around the relationship, and again relied on Mr Foskett's degree of compliance and understanding in expressing confidence that he would seek help if necessary. Prof Coid was also persuaded by the apparent lack of any problems within that relationship up to that point. Mr Scott considered it an established relationship, and neither he nor

his wife thought that PC gave any indication of significant mental health problems. Ms Patel's report said nothing about the relationship at all.

36. There was a clear tension here between the impetus to move Mr Foskett on because he was so well and considered to be so compliant, and the lack of any testing of the relationship once he was in independent accommodation. By this stage, it was acknowledged that his intention was to live with PC eventually. From past events and analysis, this was the situation in which any risk presented by Mr Foskett would be at its highest should his mental state relapse.

37. It is the Panel's view that as circumstances were now changing dramatically, in particular the step from conditional to absolute discharge and the removal of the restriction order and statutory supervision was a big one, it was important to conduct a full review of the relationship, which should have involved consideration of PC's mental disorder and its effect on Mr Foskett should they co-habit. This should have been carried out jointly with PC's carers. As far as we have been able to identify, these would have been practitioners at the Maudsley Hospital and her general practitioner at this stage. A re-assessment of risk factors, including a review of those previously identified by Prof Coid in 1991, was also necessary.

38. Instead, great reliance was placed on Mr Foskett's compliance with medication to prevent a relapse, and the expectation that he would present himself for treatment should any problems arise. Prof Coid recorded that Mr Foskett was 'courteous and punctual', but did not relate it to a later reference to his over-compliant, passive personality, always eager to please and capable of repressing problems and frustrations. He may appear to have coped well with the stress of PC's illness, and in fact did so because it did not cause him to relapse, but nothing was known of the detail of her illness, her rituals and obsessive behaviour, and its course and prognosis, or that there had been concerns for the couple expressed by PC's therapist. These opinions were not expressed on the basis of any concrete assessment. Lyndhurst staff were very positive about the relationship, stating that the couple had a good level of insight into present and future difficulties, but this still does not address the fundamental point of the lack of a formal joint assessment in the face of an altered risk situation.

39. It may be that PC's carers too had a responsibility to follow up their concerns regarding the couple, but that is not the focus of this Inquiry. Here was an opportunity for Mr Foskett's team to evaluate the position and make formal contact with PC's carer's, such that they too would have been made fully aware of what was happening in the couple's lives and who to contact should the need arise. We see this as a matter of common sense, particularly in the light of the probable absolute discharge of Mr Foskett.

40. It is this Inquiry's view, that the evidence to the tribunal in support of absolute discharge was premature. Given his history, what was required was that Mr Foskett's relationship with PC should have been monitored while he was in independent living and still under conditional discharge. He should also have been encouraged to engage with local services at this point. Even had a further period under conditional discharge been conducted with Mr Foskett remaining at Lyndhurst, the relationship issue would have been flagged up for future management by local services and underlined the significance of any relapse to Mr Foskett and PC. It is likely that he would still have achieved an absolute discharge by 1998 or so,[39] by which time there would have been an opportunity to test out his relationship, the realities of daily living with PC and his professed compliance, including with local services, further. Although it is not possible to say what difference this might have made to the eventual outcome, we are of the view that this was clearly indicated at this time.

41. Following Mr Foskett's absolute discharge, PC underwent several sessions of behavioural therapy in 1995, and then became much less well in around 1998 when she started being seen on a regularly basis in outpatients in Newham. Ultimately, of course we know that it was not until Mr Foskett ceased taking his lithium carbonate that he relapsed, in conjunction with a deterioration in PC's condition, and that they had coped seemingly well for eight years after his absolute discharge in spite of her being quite unwell at times. This suggests that it is more likely that it was the discontinuation of medication that tipped the balance, but the context of an unsupported high stress relationship was also

[39] He was statutorily entitled to apply to a mental health review tribunal every twelve months if made promptly (section 70 MHA). The analysis presented has assumed that by 1998 an absolute discharge was highly likely based on Mr Foskett maintaining his wellness, but an earlier tribunal may have allowed such an application sooner and possibly by 1996.

important. This does not alter the Panel's view that a full and joint appraisal of the relationship was called for at this time. It was not known in advance that things would proceed so smoothly for so long, and so was as much a matter of good fortune as anything else. It certainly was not due to a well assessed and controlled process. We now know how severely ill PC had been throughout most of her life and those caring for Mr Foskett at that time needed to know this too (see Chapter Five).

42. It is always possible that the Tribunal, faced with evidence of an increased risk should the couple live together, would still have absolutely discharged Mr Foskett, but we think this was unlikely. Impressionistic evidence from many forensic psychiatrists is that some patients remain well for many years while on a restriction order, but deteriorate once absolute discharge is achieved. Of course, Mr Foskett continued to comply with medication for many years and his non-compliance at the point of absolute discharge was related to the level of his supervision. The Home Office has endorsed the value of the restriction order in preventing re-offending. The conclusion must be that they remain well because they respond to the constraints and boundaries that the restriction order provides. One response is that if patients have demonstrated their reliability and compliance with treatment, then civil sections of the MHA are sufficient to manage them subsequently. We would question the validity of such a response in the context of our analysis of the changed risk dynamics in Mr Foskett's case in 1995. In our view, a longer period under conditional discharge was required in the circumstances of this case, but as suggested above this is unlikely to have lasted beyond 1998 at the latest.

43. We have been unable to find any published research that deals with this point, and the Home Office does not collect statistics on re-offending and relapse rates once a person is absolutely discharged. We have been concerned with only one case in which re-offending occurred eight years after the absolute discharge. However, we believe that the extent of any problem post absolute discharge should be established through research, and would be valuable in informing practice around the long-term safety and care of patients at risk of committing violent crimes. This issue is discussed further below.

RECOMMENDATION 3

The Home Office and Department of Health should jointly commission research into the effects on rates of re-offending and relapse of an absolute discharge in patients who have committed serious violence or homicide.

Effect of absolute discharge and section 117 MHA obligations

44. Once a patient is granted an absolute discharge, he stops being liable to be detained in hospital and the restriction order ceases to have effect.73(3). At this point, the patient is under no obligation to comply with services or supervision and cannot be subject to any sanctions for failing to do so. He is entitled to, and health and social services have a duty to provide, after care by virtue of section 117 MHA. There is no difference at this point with a discharge under a civil section such as section 3 MHA. The duty is to *"provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies and until such time as the [Primary Care Trust or] [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services"* (section 117(2)). Such services cannot be imposed on a reluctant patient, and a question that is often posed is how proactive a service must be in trying to engage such a patient before discharging them from their case load? There is no universal answer, but instead services are expected to respond to the needs and problems of the individual.

45. Mr Foskett was always going to remain at Lyndhurst Hostel, even if he was absolutely discharged by the tribunal in 1995, which given the weight of evidence must always have been the likely outcome. There had been difficulties securing independent accommodation for him, and none was in fact found that was suitable until October 1996. There was no question, therefore, that he was simply going to drop out of sight on discharge and lose contact with services. There had been no discharge planning meeting prior to the tribunal, as should otherwise have occurred if Mr Foskett was to be discharged from Lyndhurst

immediately, but there is no duty to have after care in place prior to a tribunal hearing.[40]

46. The tribunal had evidence of the difficulties in finding accommodation for him before it. The evidence of after care consisted of Dr Coid's offer to continue seeing Mr Foskett and an expression of confidence that he would co-operate with psychiatric and social supervision as he had assured Dr Ghosh he would. There was an after care planning meeting on 6 July 1995. In the event, he did continue seeing Dr Coid at the Hackney Hospital and a social worker, Frances Gauthier, from the Barnet Community Support Team (later the Mentally Disordered Offenders Team). He saw the social worker until early 1998 when she left her post. He remained well throughout, making the transition to independent living without incident.

47. It is the Inquiry Panel's view, that in the circumstances the after care provision made for Mr Foskett on absolute discharge was acceptable. This is considered in more detail in Chapter Eight, along with the issues surrounding trying to engage Mr Foskett with local Barnet services.

A different approach: life licence

48. In an earlier chapter, the public outcry when Mr Foskett was sent to a local hospital was referred to (Chapter Three), and we considered the propriety of a low secure hospital disposal in his case, concluding that given the medical evidence and the low risk of serious harm he posed to the public, this was a reasonable court disposal. We also raised the possibility that had there been an appeal against the imposition of the restriction order in 1985, there was a chance that it would have been successful, with the result that Mr Foskett is likely only to have been subject to a hospital order under section 37 MHA without restrictions.

49. The public reaction was based on the perception that placing someone who had committed a double homicide in a local hospital did not afford sufficient protection to the public. There did not appear to be any question mark over his placement in a hospital without punishment, but over the level of security in which he was placed, and hence the safety of the public.

[40] *R(W) v Doncaster* [2004]. Jones, R, *Mental Health Act Manual,* 9th ed para. 1-1086.

50. A discretionary life sentence is intended to offer protection to the public. It carries a punitive and a preventative element, whereby release is dependent on the level of dangerousness the prisoner is assessed to pose to the public.[41]

51. Murder is the only offence that attracts a mandatory life sentence (Homicide Act 1957). There are many other offences for which a discretionary life sentence may be imposed, including manslaughter by reason of diminished responsibility. The discretionary life sentence was developed as a form of preventative detention for unstable, dangerous offenders. Its rationale is to protect the public from an unstable offender, while in theory at least, at the same time allowing earlier release if the offender progresses rapidly so as to cease being a danger.[42] In the same way as a hospital order with unlimited restrictions, it allows for a harsher penalty than might otherwise be warranted or proportionate to the gravity of the offence, although this is not its intention.

52. Again echoing the provisions of section 41 MHA, a discretionary life sentence may be imposed if it is 'necessary to protect the public from serious harm from the offender' (s. 80(2)(b) Powers of the Crown Court (Sentencing) Act 2000). It can only be imposed for violent or sexual offences (s. 161). The criteria are that: 1) the offence(s) in themselves are grave enough to require a very long sentence (e.g. a fixed sentence of 15 or more years would have been appropriate), 2) the nature of the offences, or the defendant's history indicate that he is of an unstable character likely to commit such offences in the future, 3) if further offences are committed, the consequences to others may be specially injurious: (*R v Hodgson* (1968)). Broadly speaking, a discretionary life sentence is reserved for those who cannot, for whatever reason, be dealt with under the MHA, (e.g. untreatable or not yet properly diagnosed), yet who are in a mental state which makes them dangerous to the public. It allows their progress to be monitored, and for them to be kept in custody for as long as public safety requires it.[43]

53. Today the sentencing court fixes a tariff period which must be served before a person becomes eligible for parole on life licence. The tariff is based on an

[41] *Thynne, Wilson and Gunnell v UK* (1991)
[42] *Prison Law,* Livingstone, Owen, McDonald
[43] *R v Wilkinson* (1983).

assessment of the appropriate fixed term, including any remission to which the prisoner would be entitled (s. 34(1) Criminal Justice Act 1991 now s. 82A 2000 Act above). In 1985, the appropriate period was fixed by an administrative act of the Home Secretary in consultation with the trial judge and the Lord Chief Justice, a practice which usually led to considerable delays before a tariff was fixed and an automatic minimum sentence of six or seven years.[44]

54. Release is dependent on a finding by a Discretionary Lifer Panel (DLP), constituted very similarly to an MHRT for restricted patients, that a person no longer poses a 'substantial' risk . They then become entitled to release on life licence. Conditions of licence may be set, and must include supervision of the offender by the probation service, and are also likely to include some residence conditions. Under section 31(2) of the Crime (Sentences) Act 1997, 'A life prisoner subject to a licence shall comply with such conditions….as may for the time being be specified in the licence'. A person who fails to comply with the conditions of their licence may be recalled to prison. (Section 32).

55. The purpose of supervision by the probation service is 'Protecting the public is a statutory aim of the National Probation Service. Rehabilitation of offenders is the best guarantee of long-term public protection…. Our greatest concerns will always be around potentially high risk sexual and violent offenders and our resources will always be applied where the risk appears to be the greatest…Probation, the Prison Service and police all work closely to manage offenders on their release from prison and when they are in the community. Arrangements in each probation and police area ensure that specialist panels carefully and regularly assess individual offenders and exchange and use information to combine supervision and surveillance. National standards set include producing written supervision plans, ensuring regular meetings and (as appropriate) participation in behavioural and other programmes, keeping records of failure to comply and instigating breach/recall action where conditions have not been complied with.[45]

[44] This practice was declared *Wednesbury* unreasonable in *R v SSHD ex parte Handscomb* (1988).
[45] See www.probation.homeoffice.gov.uk/files/pdf/national_standards.pdf.

56. Thus far, therefore, there appear to be significant similarities between the procedures under a hospital order with restrictions, and a discretionary life sentence, and especially with release on conditional discharge under the former and life licence. Three key differences are that a) a hospital order (with or without restrictions) is not punitive, b) release and recall are dependent upon medical considerations hinging on the need to be in hospital for further treatment, and c) a life licence means that a person's liberty is at the 'discretion of the executive for the rest of his life' (*Weeks v UK* (1988)), whereas a person subject to the MHA may be absolutely discharged. A person could be recalled to prison lawfully so long as the recall was consistent with the objectives of the sentencing court.

57. In making a hospital order the court is placing an offender in the hands of doctors, thus there is no question of 'punishment and relinquishing from then onwards its own controls over them.' (see Butler Committee Report, HMSO (1975)). There is no issue of a minimum tariff sentence to be served, nor any pretence at any exercise to ensure the proportionality of the duration of the hospital order to the gravity of the offence. While intended to be non-punitive, in fact, and especially once an unlimited restriction order is also made, a person effectively loses their liberty, and is subject to compulsory treatment, for an indefinite period of time. They do not lose their 'criminal' status, in that the hospital order is recorded on their criminal record, and they acquire a forensic history that will remain with them forever. This is true whatever level of hospital security ensues. Mr Foskett, even at Goodmayes Hospital, was subject to a significant interference with his liberty for many years. Thus a hospital order, particularly with restrictions should by no means be regarded as a soft option. The possibility that a person may in fact be detained for longer than any appropriate term of imprisonment under this regime was recognised by the Court of Appeal in *R v Birch*. At the other end, there have been those given a hospital order and discharged after a short time.

58. A restriction order is imposed to reflect an offender's antecedents and risk of serious harm. Here again, is an overlap with a discretionary life sentence and the introduction of the question of dangerousness. Yet the need for further

treatment in hospital remains the core rationale to be applied at the time of discharge (conditional or absolute).

59. It is difficult to deny or disagree with the appropriate sense of humanity that lies behind the principle that a mentally disordered offender should be detained in a hospital and not be punished for their crimes, and indeed, the Home Office Mental Health Unit accepts that this is the proper approach. The Inquiry was told of 'the Government's determination that mentally disordered offenders be treated, not punished, where that can be safely achieved', and that this justified the difference between the release arrangements for discretionary life prisoners and those subject to the MHA. The rationale behind this is that mentally disordered offenders detained under the MHA are 'persons of unsound mind' for the purposes of the ECHR, and may only be lawfully detained where there is objective evidence of a persisting mental disorder of a nature or degree requiring medical treatment (*Winterwerp v Netherlands*).

60. This Inquiry Panel would certainly not seek to disagree with that principle. In principle, placing a mentally ill offender in need of active treatment in prison could also potentially violate the prohibition against cruel, inhuman and degrading treatment under article 3 of the ECHR (*Aerts v Belgium; Keenan v UK*). But the House of Lords has held that more recent legislative provisions, allowing a mentally disordered offender to be sentenced to a term of imprisonment, are not wrong in principle, unless he is not fit to be tried or is not responsible for his actions (*R v Drew*). This acknowledges the fact that a person with a known mental disorder, may not be mentally disordered at the time of offending or sentence and only manifest symptoms later, or that a sentence of imprisonment is necessary for the protection of others. In these circumstances, provisions exist to transfer a prisoner to hospital for appropriate treatment (section 47/49 MHA), thus complying with the requirements of the ECHR.

61. There is a blurring of principle between a discretionary life sentence and a hospital order with restrictions, such that a clear boundary between the two is hard to define. The dangerousness or potential dangerousness of a person may be the proper defining criterion, whereby they would be subject to life long executive control and recall to prison. The House of Lords in *R v Drew* has

suggested that a court may take into account the appropriate method of release when considering a hospital order with restrictions or discretionary life sentence. There is clearly a need for some flexibility in the system so that in situations lacking in clarity in terms of dangerousness, diagnosis and susceptibility to treatment, the option remains to sentence a person to a term of imprisonment, but yet have them treated in a hospital for so long as necessary. This was advocated by the eminent Brenda Hoggett (then a Law Commissioner and now Lady Hale, a member of the House of Lords judicial committee), and has to a limited extent been implemented in relation to those with psychopathic disorder (section 45A MHA).

62. The current system, including under the MHA, would allow for a system of life long control for anyone who has committed a homicide, regardless of whether they have a mental disorder and are regarded as entitled to treatment, and not punishment. It is dependent upon rigorous risk assessment.

63. Currently, the distinction drawn suggests that if someone is ill and entitled to treatment, then they may eventually be well enough to take complete responsibility for themselves once again, and to re-enter society on the same terms as everyone else. On the other hand, even if they are mentally disordered, but deemed to be particularly dangerous, they may never be restored to society in the same way. As a moral principle, this position is defensible and proper, but as a matter of legal practicality, there is the distinct possibility that it may lead to unfairness.

64. Unfairness arises by virtue of the fact the system is dependent upon the accurate prediction of dangerousness, of mental disorder and generally the behaviour of an autonomous individual. Such prediction is notoriously difficult to perform with any reliable degree of accuracy, and yet clinicians are expected to, and indeed relied upon, to do so in the interests of the public. Dangerousness is not a medical or psychiatric quantity to be given a value by a doctor, but a social concept dependent on the situation in which a person finds him or herself (Bean, 1986). An over cautious approach might safeguard the public, but how can false positives resulting in longer detention or life long supervision be properly justified? Of course if a person is truly dangerous, then society has a right to be

protected whether they are mentally disordered or not, and whether they are treatable or not.

65. This is a long running debate and we cannot resolve the conundrums raised, nor rehearse it in full in this report. However, apparently clear principles are obscured in practice. In terms of those like Mr Foskett who remain well and incident free for eighteen years, it seems likely that the pragmatic response is that whichever system they are subjected to the actual prevention of a further serious offence is reduced the longer they have remained trouble free. Even under a life licence, the likelihood is that after time elapses all that remains is the liability to recall, with much looser supervision, as with Mr Foskett. Thus, the opportunity for actual intervention before anything happens is diminished. What is more likely is that such a person becomes detainable more quickly after they have re-offended.

66. Mr Foskett's case presents a special problem because his risk was adjudged by all to be very low and to a defined category of individual, but that small risk when realised results in a serious offence. That risk is little changed by the fact that he has committed a third homicide. The fact that he is now in a medium secure unit, and unlikely to be discharged for many years, must carry a significant punitive element. In his case, of course, the mental disorder is of such overwhelming proportions when it strikes that his responsibility for his actions at that moment is severely diminished. But how diminished is his subsequent responsibility for maintaining his restored mental health, and should he be allowed to take complete responsibility for it given the likely outcome should it deteriorate again?

67. It is easier to predict risk when more offences have been committed. So now he will not be allowed to have that responsibility probably for a very long time, but at the time in question, it is difficult to conclude that it was unreasonable for him to have had that responsibility.

68. Had he been subject to a discretionary life sentence, the outcome in terms of powers of supervision would have been different, and he would have been subject to statutory supervision for life, but how different would the practice have been for someone so well, compliant and presenting a low risk? How closely

monitored would such a person have been following eight successful years after release? It is difficult to conclude that the safety net provided would have been drawn that much closer than it was in fact. Chapters Eight and Nine consider the after care and follow-up provided to Mr Foskett.

Chapter Eight

POST ABSOLUTE DISCHARGE
LIFE IN BARNET

1995-1998

Introduction

In the previous chapter, the Inquiry Panel criticised the failure to perform a full risk assessment, including a joint assessment with PC's carers in the light of the proposed absolute discharge and Mr Foskett's expressed intention that they should live together as a couple. The Panel's view was that the absolute discharge was premature because it afforded no opportunity to test out the relationship, or Mr Foskett's apparent compliance once Mr Foskett moved into independent accommodation.

This chapter focuses on events after the absolute discharge in April 1995 and examines the care provided to Mr Foskett. The main issues arising are:

- The transfer of care to Barnet and contact with local services
- The reluctance of Mr Foskett to accept local services
- His move into independent accommodation
- The role and value of social supervision

This is the period leading up to 1998, the time when social supervision by Barnet services ceased. As noted in the last chapter, he was by now no longer subject to formal statutory supervision. There was a duty placed on health and social services to provide him with after care services under section 117 MHA and he was, therefore, entitled to such services, but not bound to accept them. Although living in the London Borough of Barnet at Lyndhurst Hostel as before, as an original resident of the London Borough of Newham, the obligations under section 117 remained with Newham until a formal transfer took place and his care was accepted by Barnet.

At this time in 1995, the relevant Barnet authority would have been the Barnet Health Authority, later the Barnet, Enfield and Haringey Health Authority and then the North

Central London Strategic Health Authority. The provider of community and mental health services in Barnet was the Barnet Healthcare NHS Trust which operated a joint service with the London Borough of Barnet community services (the relevant social services authority). They provided the community services team (CST) based at Moxon Street, Barnet. From around June 1997, the mentally disordered offenders team (MDO) came into being and was based in Burnt Oak. In April 2001, Barnet Healthcare merged with other north London trusts to form the current provider, Barnet, Enfield and Haringey Mental Health NHS Trust.

Up to October 1996, Mr Foskett was still at Lyndhurst Hostel, there having been problems with arranging independent accommodation in Barnet because of the reluctance of Barnet Housing Department to accept responsibility for Mr Foskett. By July 1995 this was resolved. The absolute discharge triggered a transfer of care from Newham to Barnet services, such that Mr Foskett then came under the supervision of a social worker from the Barnet CST, Frances Gauthier and Dr (Prof) Coid at Hackney Hospital, in spite of efforts to engage him with a local psychiatrist. Prof Coid, as he made clear at the very outset, and prior to the conditional discharge, was in no position to offer a full package of services to include social supervision. The role of the Barnet services came into focus in 1997 when the MDO team was formed, and again in early 1998, when Ms Gauthier left the service. At this point, and until the homicide in July 2003, Mr Foskett was left under the informal supervision of Prof Coid alone, thus raising questions as to his precise role.

However, until the absolute discharge in April 1995, Mr Foskett was still being supervised by Khadija Patel, social worker from Newham social services and Prof. Coid. There were two main issues at this time, the first concerning the transfer of Mr Foskett's care to the CST in Barnet (and later the MDO team) and, the second, securing independent accommodation in the London Borough of Barnet.

The Inquiry Panel was particularly concerned to understand the first because of the earlier expressed need to monitor the relationship with PC, and the fact that in 2003 when his mental illness deteriorated and he killed PC, he had no local service contact he could turn to in a crisis. Although Mr Foskett was in fact supervised by Ms Gauthier of the CST, and then the MDO, until early 1998, a question arose during the course of the Inquiry as to whether Mr Foskett was in fact formally their client because clinical

responsibility remained with Prof Coid. However, a key factor in the failure to engage Mr Foskett locally, and affecting care planning on his behalf, had been his very great reluctance to accept the services of the full team and any new professionals which came to light at the very first care planning meeting in July 1995.

Mr Foskett remained very well throughout this period and was spending much time out and about from Lyndhurst hostel prior to the absolute discharge, staying either at his mother's house, or with PC. PC was a regular visitor at the hostel and stayed overnight. After the absolute discharge, it is apparent that he spent less and less time at the hostel, coming back to pick up mail and discuss his housing difficulties. From the time he was in independent accommodation in 1996, he and PC were effectively co-habiting, travelling between their respective flats in Barnet and Newham, although this may not have been apparent to those supervising Mr Foskett.

As for accommodation, Mr Foskett was offered a flat in Barnet in February 1996, but rejected it because it reminded him too much of his former home with his wife. His decision was supported by Prof Coid and Mr Scott. He accepted another flat in September 1996, and finally moved into a brand new purpose-built one bedroom flat on 13 October 1996. However, by December he was complaining about the noise at the flat, and was concerned about its effect on his mental health. The noisy flat remained an unresolved issue at the time that Ms Gauthier left Barnet in 1998.

The Inquiry Panel was pleased eventually to locate Ms Gauthier in Cornwall and we are grateful to her for travelling to London to give her evidence. The social work notes obtained from Barnet had initially been very sparse, Ms Gauthier's contact sheets were not provided until a specific request was made for them after she confirmed their existence. The Panel was given the impression that the lack of integrated notes at the time may have been responsible for this oversight, as these notes belonged to the London Borough of Barnet, and not the Barnet, Enfield and Haringey NHS Trust. As noted in the preface to this report, it is clear from the moment an Inquiry is announced that all relevant documents must be secured and provided to it. The work of this Inquiry would have progressed more smoothly and expeditiously had these notes been provided at the earliest opportunity. There is no doubt as to their relevance to this Inquiry's investigation.

Transfer of care to Barnet in 1995

1. The role of Barnet services in the care of Mr Foskett came up for review on three occasions: i) in 1995 after the absolute discharge by the CST, ii) in January 1997 in anticipation of the formation of the MDO team and, finally, iii) in January 1998 when Ms Gauthier was leaving the service. The initial referral to the Barnet Community Support Team was made on 5 May 1995 by Khadija Patel of Newham social services. The purpose of this was for continuous liaison with Lyndhurst Hostel and with the Barnet Housing Department. There was also to be a section 117 MHA meeting on 6 July, at which it was envisaged that the formal hand over to Barnet CST would take place.

2. Frances Gauthier, social worker with the CST, took responsibility for supervising Mr Foskett. She had very recently joined Barnet in anticipation of the formation of the MDO team. Her experience included the resettlement of long term psychiatric patients into the community, and she had qualified as a social worker in 1993. Between 1993 and 1995, she worked in a rehabilitation hostel for clients recovering from acute mental illness. This included supervising patients under sections 37 and 41 MHA and helping them to gain independence. When she left Barnet in 1998, she moved to the regional secure unit in Ealing, West London, where she worked as an approved social worker. She moved to Cornwall in 2000.

3. By the meeting of 6 July 1995 there was a clear plan to transfer Mr Foskett's care to the CST, with clinical care to be provided by Dr Neil Margerison, consultant psychiatrist. Prior to that meeting, however, Frances Gauthier, and an occupational therapist from the CST, carried out an assessment of needs/care programme approach assessment[46] on Mr Foskett in June which

[46] There were three assessment regimes overlapping at this point to provide care for Mr Foskett and all similar in substance and intended outcome. Two were statutory: section 117 MHA 1983 and section 47 of the NHS and Community Care Act 1990 which incorporates the section 117 and other statutory duties. The third was the Care Programme Approach (CPA) promulgated for those with severe mental illness and in contact with specialist mental health services. What is important is that there was a duty to provide Mr Foskett with health and social care services under section 117. CPA is relevant because it prescribes a mechanism for making the effective provision of community service to a person with mental illness who has been subject to care by specialist services whether or not under MHA compulsion.

reflected this plan. The plan included the hand over of care from Prof Coid to Dr Margerison over a three month period, and for a move into independent accommodation after six months.

4. The assessment of needs recorded the relationship with PC briefly. It stated that Mr Foskett acknowledged difficulties with his insight when unwell, but otherwise made no mention of risk factors, or the need to monitor the couple's relationship. The review meeting in July was concerned with the practicalities of the transfer, and not with the substance of supervision in the sense of an actual care plan. Ms Gauthier's role was to assist Mr Foskett finding suitable accommodation.

5. As a result of this meeting, it was clear that Mr Foskett had been accepted as a client of the Barnet CST, which was to offer a comprehensive mental health and social care service to him, which included being seen by Dr Margerison. But Mr Foskett announced his concerns at being 'overwhelmed' by too much professional involvement. He was advised that he would in fact probably only have to see the psychiatrist and social worker. He was also advised that he had to be in touch with the team as a pre-condition of his acceptance for re-housing through the Barnet Housing Department.

6. However, problems arose between Mr Foskett and the CST because of the condition that he should be linked in with a social worker for six months prior to leaving Lyndhurst Hostel and moving into independent accommodation. Ms Gauthier recorded that he was very angry with the CST's decision to effectively monitor his mental health for six months prior to any move. By this time, he was a high priority with the housing department and was expecting to receive an offer of accommodation imminently. By way of compromise, Ms Gauthier suggested taking the assessment back to the CST, with a view to suggesting working with Lyndhurst with social work support from Barnet to settle Mr Foskett into independent accommodation. This was confirmed to him in writing in early August, the six month trial period was cancelled, and he would only need to see Ms Gauthier and Dr Margerison.

7. By this time, Mr Foskett had already by letter indicated his decision against transferring his care to Barnet, preferring instead to remain seeing Prof Coid over in Hackney, and accepting social work help via his general practitioner only. Newham social services expressed its concern over the break down in the relationship between Mr Foskett and Barnet. There was a clear worry over his housing situation, as Barnet housing department would need to be informed if Mr Foskett was not to be seen by Barnet CST.

8. In this letter, Mr Foskett had also expressed his dissatisfaction at the wording of the care assessment undertaken by Ms Gauthier. He said that he was unhappy that information regarding his index offences had been disclosed to the housing department without his prior consent. Later Mr Scott from Lyndhurst wrote to her, requesting a change in some of the wording of that assessment. A letter was sent to the housing department with an amended assessment, although it is not clear from the records held by the Inquiry in what way it had changed. The letter referred simply to errors pointed out by Mr Foskett. It also referred to his anxiety about the references to the index offences, which he wanted to be reassured would be sensitively handled by those directly involved in his case only.

9. Prof Coid was aware of the difficulties Mr Foskett was having with Barnet CST, and although he had written to Dr Margerison on 18 July 1995 regarding a hand over to him, on 9 August Prof Coid wrote to Mr Foskett saying that he was happy to continue seeing him as an outpatient and offering him an appointment. He was asked to bring PC along if he wished.

10. Ultimately, Mr Foskett was seen on one occasion only by Dr Margerison's successor at the CST, in about May 1996. There are no direct notes of this in the records, but that a meeting took place was confirmed by Ms Gauthier in her evidence to the Inquiry and was recorded by her. There is a suggestion that Mr Foskett did not like the new psychiatrist and refused to see him again. However, a later note by Ms Gauthier at the end of 1996, indicated that they had been waiting for Mr Foskett to change his mind about seeing the psychiatrist. The result of the process was that Mr Foskett remained seeing Professor Coid, and Ms Gauthier until she left her job in early 1998.

11. Ms Gauthier described herself in many documents as being Mr Foskett's care co-ordinator. The monitoring and supervision of Mr Foskett by her over this period is described separately below.

MDO team 1997

12. On 2 January 1997 Ms Gauthier notified Prof Coid that a new team had been established in Barnet: the Barnet Community Mental Health Team based in Edgware would specialise in work with mentally disordered offenders. Later the offices transferred to Burnt Oak. Dr Meena Naguib, consultant psychiatrist to that team told the Inquiry that it became operational in June of that year. Ms Gauthier was to be one of the forensic social workers and would take Mr Foskett and other of her clients from the CST on as part of her responsibilities.

13. This was before the arrival of assertive outreach which was introduced to Barnet in 2001. The MDO team was set up with one consultant psychiatrist offering six sessions (equivalent to three full days) a week, two social workers, three community psychiatric nurses, and one part-time clinical psychologist as the clinical staff. Dr Naguib described a case load of 60-70 patients usually in hostel or independent accommodation and subject to the care programme approach (CPA).

14. Ms Gauthier anticipated that Mr Foskett would be transferred to the care of a forensic psychiatrist and CPN, and that she would remain his social worker. Mr Foskett, however, did not think that he needed the services of a specialist team, and his preference was for his case to be closed, but he was happy to remain with Prof Coid with a contact number in Barnet for emergencies. She sought Prof Coid's opinion on the option of him continuing to see Mr Foskett, with the Barnett team offering social work support and crisis support if necessary. Alternatively, she canvassed the possibility of closing the case over a three to six month period, because Mr Foskett had been stable for so long and was not considered a risk to others.

15. Prof Coid's response stated that he would continue to see Mr Foskett as an outpatient, as that was his expressed wish. He said that technically it would be preferable for the local team to see him, but Mr Foskett had invested a lot of

faith in him. Any decision regarding the closure of the case was for Ms Gauthier to take, but that it was not necessary for her to do so with a view to the protection of the public. Prof Coid told the Panel that it became apparent to him by the end of 1995, that Barnet was not providing a full service to Mr Foskett after all and that he had not been seeing a psychiatrist locally. He told the Inquiry that he had tried to telephone the relevant consultant, but without success. He said that it was this lack of contact with psychiatric services in Barnet, together with the fact of Mr Foskett's faith in him, that prompted his offer of continued support on an informal basis. Any destabilisation would be dealt with by the local services.

16. Prof Coid told the Inquiry that he held a somewhat cynical view of what Barnet was in fact offering Mr Foskett, and assumed that their preference would be to close the file on him. In fact, Ms Gauthier did not close his file, and supervision continued as before. She was concerned that there were still outstanding issues, particular over his housing that he would require help with. Thus, Ms Gauthier maintained her role with him, supervising and assisting on housing issues.

MDO team 1998 and transfer summary

17. The crunch time for Mr Foskett's contact with services in Barnet came in early 1998 when Ms Gauthier left the service. In December 1997, she wrote a document headed 'transfer summary' attempting to pass his care onto a colleague. It provided a summary of her contact with Mr Foskett, including details of his ongoing problems with his noisy flat and that, therefore, he lived almost permanently with PC in Newham. She offered some analysis as to why he was unable to get used to the noise in the flat, suggesting that it may indicate that he was reluctant to take responsibility for independent living. This Mr Foskett rejected, as he did the prospect of a new social worker, until new housing became available. He was on the waiting list for another flat. She said that he was managing well, and would contact services if his mental health deteriorated. She identified as a specific problem, the continuity of services should a crisis arise and an admission to hospital become necessary, because

Mr Foskett was being seen by Prof Coid in Hackney and was not linked in to a local community mental health team.

18. Ms Gauthier explained that she was concerned that if Mr Foskett should terminate contact with the team, and he did not have any contact with them for sometime, then they may not respond quickly enough in the event that he contacted them for help. She felt that it was important that he knew that the team was still responsible for him, and that there was a specific person he could make contact with. It was important in her view for someone to understand that when Mr Foskett presented with anxiety about something seemingly trivial, like a telephone bill, that they should respond quickly. In spite of his resistance, she had been able to maintain contact with him, and monitor his mental health under the guise of practical support, and that was acceptable to him.

19. Under the heading 'ongoing issues', she had raised the relationship with PC. While outlining the positive, she also said that PC's chronic disorder had to be taken into account. She wrote that this was a disorder that 'fluctuates which may impact on his mental health'. Her supervision notes are relevant to this opinion and are considered in more detail below. She had witnessed first hand, PC's reaction to a visitor in Mr Foskett's home, and the impact of her OCD in that situation. The action to be taken was for Dr Naguib to contact Prof Coid and for Mr Foskett to discuss the situation with him also.

20. By the time that Ms Gauthier left, Mr Foskett's care had not been handed over to anyone, but his file was not closed. In retrospect, the Trust now feels that the case should have been closed and a formal CPA transfer to Prof Coid arranged. Richard Groves, community psychiatric nurse, the team leader who would have been responsible for allocation of the file was not available for interview due to ill-health, and his manager confirmed that he never in fact saw Mr Foskett. No further contact is acknowledged or recorded. However, Prof Coid records the name 'Lucy' in the context of a Barnet social worker in his note of October 1998, and Dr Naguib mentioned that there was a social worker with that first name attached to the MDO team. There is no detail available of any further contact and we assume, therefore, that it was of minimal kind.

21. Thereafter, there was some brief written contact between Dr Naguib and Prof Coid. There were no telephone calls or meetings. Dr Naguib wrote in April 1998 wanting to know where they stood. He said that Mr Foskett only tolerated Ms Gauthier for housing assistance, and would now only accept follow up from Prof Coid. He had never agreed to input from the MDO team, although entitled to their services. He sought advice about how they could contribute, and wanted clarity around where Mr Foskett would be admitted should his condition deteriorate, and how admission to Barnet might interfere with continuity of care.

22. Prof Coid's reply was delayed until October because Dr Naguib's letter had been misfiled. Again, Prof Coid acknowledged that Mr Foskett should be under the care of Barnet, but that as he was resistant to changing doctors, and he said that Mr Foskett was 'adamant' on this point, and that he Prof Coid would continue to see him. Prof Coid expressed Mr Foskett's attachment to him, based on his perception that he had been 'rescued' from Goodmayes Hospital by Prof Coid. If inpatient care became necessary, however, this was to be in Barnet.

23. Dr Naguib responded on 10 November 1998, saying that he understood Mr Foskett continued to remain mentally stable and compliant with medication. He summarised that contact would remain with Prof Coid and Dr Brett, and that his blood lithium levels were being checked six monthly. He said that he respected Mr Foskett's reasons for not losing his attachment to Prof Coid and not accepting a new team, which would take some time to get to know him. He said that he appreciated Prof Coid's kindness in keeping Mr Foskett under his care. He asked that the MDO team be kept regularly informed about his progress. Inpatient treatment should be arranged via Barnet psychiatric services, unless he needed medium security.

24. Again, Prof Coid's view was that Barnet was resistant to taking responsibility for Mr Foskett. He said in evidence that he was, in fact, keen to hand over care to Barnet, and could alternatively have discharged him altogether, whereupon Mr Foskett would not have been seen by anyone. But Mr Foskett was keen to carry on seeing Prof Coid, he was an undemanding patient, and he therefore agreed to see him on an informal basis. He felt that Barnet was discharging its

statutory obligation to Mr Foskett in making this approach, but was not actually offering a service.

25. Dr Naguib did not accept this view. It was also his firm view that Mr Foskett was not a client of the MDO team at the time. Ms Gauthier's view that he was, based on the fact that he had been transferred from her existing case load at the CST. However, she did accept that clients of the MDO team would normally be required to see Dr Naguib on a regular basis, something that Mr Foskett never did. Thus, as a matter of formality, Mr Foskett may not have been a client, but they were aware of him. He had been supervised for three years by a team member, but the supervision he received from her was outside the formal structures of that team. Dr Naguib's view as to what they could do for Mr Foskett was highly influenced by the fact that they could not force themselves upon a reluctant person. He was adamant that they were not resistant to taking over Mr Foskett, and cited other restricted patients that they had taken over from out of the area, and from Prof Coid.

26. Ms Gauthier expressed deep unhappiness with the way in which the MDO team was set up, and the attitude of other team members to her caseload from the CST. She said she had experienced difficulties in interesting her colleagues in her cases. She had, by the time it was finally set up, built up a specialist case load of clients based at special hospitals and regional secure units, and transferred all their files over to the MDO. This Inquiry has not sought to delve into those issues, which are now historic. From her perspective, however, she felt isolated and undervalued by her colleagues. The reality for Mr Foskett was that until 1998, with Ms Gauthier's input, he was receiving supervision which came from the MDO team, and had available the facilities of that team had the need arisen.

Supervision and monitoring up to 1998

27. Throughout this period, and until the middle of 2003, Mr Foskett remained very stable and mentally well, coping admirably with the stress of the noise in his new flat and the unlikelihood of rapid re-allocation. Ms Gauthier's notes for late 1996 and into 1997, indicate this was a pre-occupation for him, especially as

the noise meant that his sleep was disrupted and he worried about a deterioration in his mental health as a result. In January, it is noted that he was adamant that he could not live in it. He had discussed this problem with Prof Coid and had disagreed that he might find living with PC stressful.

28. Ms Gauthier was clearly able to address issues around the index offence with Mr Foskett, and her notes are long and detailed. For example, on 11 April 1996 they had discussed PC and his wife's epilepsy, as well as some details around the index offences and his amnesia of that event. On 26 April she was concerned about how he would cope with PC going into hospital for a hysterectomy, and offered him support over that period. In May 1996, Mr Foskett had told her that he found it stressful filling in Disability Living Allowance forms because they reminded him of the possibility of a serious relapse. She saw both Mr Foskett and PC in August at the Moxon Street office: they were planning a short holiday together. There was discussion about the relationship. She saw them again together in October. At this time, it was noted that appointments with Prof Coid were offered indefinitely, and until Mr Foskett was ready to start seeing Dr Albazaaz exclusively.

29. Ms Gauthier arranged to see him at his flat every other month. After moving, Mr Foskett did not want to change his general practitioner, again because he did not want to tell yet another person about his index offence. He, therefore, remained with Dr Brett, who he had been seeing while at Lyndhurst, and who took over the process of monitoring his blood lithium levels. In the early days in the flat, Mr Foskett was spending two days a week at PC's, and said that he had no immediate plans to move in with PC permanently.

30. In May 1997, Mr Foskett had expressed some concerns over PC's health. Ms Gauthier responded by asking him to let her know if this affected his own mental health. In June, Ms Gauthier received a telephone call from Mr Foskett who was in an aroused state because PC had been asked to sign on for work. This had left her in a highly distressed state, and he was worried for himself that this may trigger feelings in him of inappropriate treatment, as at the time of his index offence, regarding the issue of medication in his case. He had dealt with it with humour and spoke directly to the Department of Social Security. He

wanted to be able to reassure PC. He had said that it helped to talk to Ms Gauthier, and was encouraged to call again if he needed to talk.

31. In July, there was a long and interesting note about Mr Foskett's relationship with his mother. In particular, that she used to greet him by kissing him on the mouth and only stopped doing so when he entered Goodmayes Hospital. He had not liked this and felt it to be inappropriate. PC had fears regarding the nature of the relationship between Mr Foskett and his mother, which Mr Foskett denied and were most probably unfounded.

32. By the end of 1997, Ms Gauthier noted that Mr Foskett's needs were confined around the issue of housing. He had, however, raised concerns over PC's health and said that she was unstable. PC's own notes reflect that she was feeling very low and worrying about everything. Suicidal ideation without intent was noted and her medication was altered. PC had stopped her behavioural therapy and her GP was asked to review and refer her to local services if her depression worsened. Unfortunately, this letter coincided with Mr Foskett and PC finding her mother dead at her home, an event which appeared to exacerbate her depression over the next year or so. Mr Foskett discussed this with Ms Gauthier later. He was concerned that the sight of the dead body may trigger his own memories of the bodies of his victims. There followed an insightful conversation about how good his relationship with PC was, spoke of his love for his wife and that PC was not a substitute for her. Mr Foskett had said that he enjoyed his chats with Ms Gauthier, but did not feel the need to continue the sessions. At this point, the question of whether the file was to be closed was raised.

33. This was approaching the time when Ms Gauthier was due to leave the Barnet service. Mr Foskett had been offered alternative accommodation, but turned it down due to it being in a poor decorative state. As a result, he was to be taken off the housing list for a year, but had plans to apply for a mutual exchange, and to approach and to seek a transfer through the housing corporation.

34. Ms Gauthier discussed these events at a multi-disciplinary team meeting of the MDO team, and then on 15 December presented Mr Foskett's case to the

team. This resulted in the transfer summary discussed above. Her note is that Prof Coid was to be contacted by Dr Naguib for clarification of his role and his opinion of what input the MDO should give.

35. By January 1998, Mr Foskett was still only spending two days a week at his flat. He also indicated his preference to remain with Prof Coid with the MDO as a contact for the future, and then, as noted above, the issue of closing the file altogether arose. The notes are incomplete, but the last entry available on the contact sheets was on 2 March 1998, when no outstanding concerns were recorded.

36. Prof Coid's notes over this period were briefer, but reflected similar matters to those in Ms Gauthier's. She was, of course, seeing Mr Foskett more frequently and recorded more detailed conversations of his day-to-day anxieties and concerns. In fact, it appears that he was able to discuss his stresses and concerns more readily with her. For example, he does not appear to have mentioned his concerns over the DLA application form, or his concerns over PC's illness or her having to sign on for work, to Prof Coid. On the other hand, in March 1998, which was his first consultation after finding PC's mother dead, he did raise this with Prof Coid, who noted that he was 'clearly very shaken by the experience, but appears to have handled it well.'

37. As noted above, there were no formal reviews of care between Ms Gauthier and Prof Coid after Mr Foskett left Lyndhurst Hostel in October 1996. Instead, he had the benefit of their supervision on a separate and informal basis. Prof Coid did not receive a copy of the transfer summary, as this was seen to be an internal document for the purposes of the new supervisor. From 1998, this reduced further still to Prof Coid only, who saw him no more than twice a year until 2003.

38. After the absolute discharge took place, Ms Gauthier told us that Mr Foskett was hardly ever at Lyndhurst Hostel, and he was staying either with his mother or PC, both in Newham. After he got his own flat, he and PC were together all the time, spending weekends at his flat. During the week they stayed at PC's flat. By this time, they were fully co-habiting, a fact which Prof Coid did not

become aware of. He noted, and told the Inquiry, that he thought it was a weekend relationship only, and he did not know that Mr Foskett had effectively become her carer, or she his carer. In June 1997, he noted that Mr Foskett was still awaiting re-housing and stayed most of the time at PC's or his mother's home. In October, Mr Foskett was disappointed that he could not move in with PC.

39. Ms Gauthier visited Mr Foskett at his flat and saw the couple together. She said that PC's OCD meant that during her visit, PC would spend the time in the bath due to her fears of germs and contamination caused by visitors. She knew that Mr Foskett went to stay at Newham, but said that he was never away for long. At that time, she did not see them as isolated in spite of PC's OCD. They went out regularly together, especially to a local market.

40. PC had been discharged by the Maudsley Hospital after several sessions of behavioural therapy in the first half of 1995. Other than that, the absence of notes indicates that she was probably relatively well, save for a hysterectomy in April 1996. Mr Foskett told the Inquiry that from Lyndhurst days, PC relied on him to do the housework. Even when the local council provided her with domestic help, she insisted that he re-clean her house. However, he emphasised to us that she was also a very loving person.

COMMENT

Transfer of care to Barnet

41. Responsibility for Mr Foskett's after care under section 117 of the MHA was accepted by Barnet health and social care services after he was absolutely discharged. The transfer did not occur smoothly, and Mr Foskett's co-operation was not well handled. He was resistant to involvement with the new service at the outset, but this was not helped by what appears to be a rather poorly handled decision to defer his move into independent accommodation for six months. The intention to settle Mr Foskett within the CST before any move may have been appropriate, but here immediately the effect of the absence of the restriction order made itself felt. There was nothing that could be done to insist that Mr Foskett follow this course of action. At the same time, however,

little effort seems to have gone into persuading him of the wisdom of this course of action. In the event, however, he did not in fact move into independent accommodation until October 1996.

42. At no point, does there appear to have been any real effort to persuade Mr Foskett to switch psychiatric supervision to local services. He had refused to see the CST psychiatrist and Dr Naguib who took the view that services could not be forced upon him. That of course was true, but did not prevent efforts to persuade Mr Foskett to transfer. This should have involved multi-disciplinary/agency meetings to discuss and negotiate the matter between Barnet services and Prof Coid, who had previously highlighted to the Home Office that a significant shortcoming in his ability to supervise Mr Foskett was the lack of a full multi-disciplinary team behind him, thus demonstrating his understanding of the value of the same. Mr Foskett's memory, now tinged with regret in hindsight that he did not accept Barnet services, is that no-one, including Prof Coid, pushed him or tried to persuade him to accept local services.

43. There were numerous opportunities for such meetings to occur, most identifiably in 1997 and early 1998. The Inquiry Panel is satisfied that Ms Gauthier's motives in approaching Prof Coid in 1997 were uncomplicated, and she was genuinely seeking his views on how to proceed. There should have been some attempt at personal liaison between the new consultant to the MDO team Dr Naguib and Prof Coid, at least by telephone at this point and then again in 1998. The key point here was that Mr Foskett had recently moved into independent living, and Prof Coid was receiving no independent account of how he was managing. In spite of his assessed low risk, independent living moving towards co-habitation was the high risk scenario that required long term support and monitoring. Supervision had become disjointed and no efforts were made to join it up again.

44. The Inquiry has already commented on the need for periodic risk reviews (Chapter Four), particularly when circumstances have changed. The possibility of co-habitation changed the risk dynamic, even in the face of Mr Foskett's apparent compliance, and this required formal assessment.

45. It is the Inquiry's view that had a joint assessment been undertaken with PC's carers prior to the absolute discharge, then the severity of her condition, its fluctuating nature and likely adverse impact on Mr Foskett's own mental health, would have become apparent and kept the need for supervision and support of the couple to the fore. Had this been properly understood, the appropriate outcome would have been for a) greater efforts to be made to persuade Mr Foskett to engage fully with the MDO and/or b) once Ms Gauthier left, for a social worker, or other supervisor, to be allocated with a view to maintaining periodic contact, and providing support for Mr Foskett in his relationship with PC, in addition to some ongoing housing issues. It is apparent from Ms Gauthier's work (see below), that her persistence paid off and was, for all his resistance, appreciated by Mr Foskett. Leaving the file open, with no allocated worker, served no purpose at all.

46. In practical terms, while Mr Foskett was being seen by Ms Gauthier, there was no problem with the arrangement as it was. Her notes are full and she has recorded in depth conversations with him. It is clear that she took the opportunity to monitor his mental state while ostensibly dealing with his housing problems. He, in turn, told the Inquiry that she spent a good deal of time with him.

47. The unconventional set up post 1998, when Ms Gauthier had left, did on one view have the merit of keeping Mr Foskett in contact with services, albeit not local services, and provided continuity of care from a clinician renowned for his work with forensic patients who had known Mr Foskett since 1991. We comment further on this arrangement in Chapter Nine. Prof Coid was unable to offer social supervision. Cynicism is often a by-product of working in an over-stretched and pressured environment, nevertheless, the Inquiry Panel believes that it was probably unfounded in this instance. Prof Coid's opinion of Barnet did not seem based on specific knowledge of Barnet or its individuals, but rather he told the Inquiry that he 'assumed' that Barnet was resistant to forensic patients based on his general experience of local services.

48. It is the Panel's view that due to the nature of Mr Foskett's index offences, the fact that he was effectively co-habiting with a vulnerable woman, for whom he

was caring, and who was to some extent at least caring for him, and the identified risks posed by that situation, any arguments relating to Mr Foskett's right to autonomy and private life now that he was absolutely discharged were compromised. Some contact should have been maintained, and was justifiable between Barnet MDO and him, into the indefinite future. Ms Gauthier's notes indicate the number of issues that arose that he required assistance with, some of which concerned PC. In our view, while Mr Foskett remained in a close relationship with a vulnerable woman, he would always require support from services.

49. Equally, regardless of his or PC's level of co-operation, periodic assessments involving PC's carers should have taken place. It is not possible to determine now in retrospect what the level of that contact might have been in 2003, but it would have kept all concerned properly informed in case of future need or crisis. At this point, we do not envisage that if all was going well that services would have to have been intrusive, but that a discrete presence could properly have been maintained, with occasional visits to Mr Foskett and PC at their respective homes.

Mr Foskett's resistance to new services and professionals

50. At the point of absolute discharge, the supposedly compliant Mr Foskett took full advantage of his freedom to put the brakes on the level of supervision he would accept. This accords with the anecdotal experiences of some forensic psychiatrists, that the removal of a restriction order can lead to destabilisation of some otherwise compliant patients, which we commented upon in Chapter Seven. If the attendant risks are high, but hospital admission nor recall possible, this may result in a thorny dilemma in terms of risk management.

51. Mr Foskett's resistance was unexpected, yet supervision could not at this time be forced on him, but could have been better negotiated (see above). In Chapter Four, the Inquiry raised a question as to how much was actually understood of Mr Foskett's apparent compliance and true insight into himself, his illness and the risks posed by it. The Inquiry sees his refusal to co-operate at this time as an important change in his presentation and compliance with

services that required review. Taken in conjunction with the imminent move into independent living, and potential co-habitation with PC, this underlines the need for continued contact with Mr Foskett into the future, as outlined above.

52. Mr Foskett's resistance was not questioned, and his apparent compliance and otherwise undemanding presentation, dominated the way in which he was viewed. He was not a difficult client for Prof Coid to continue seeing – he complied with appointments and was polite, and no crisis was expected. Equally, from Barnet's point of view, we surmise that even without being resistant to accepting Mr Foskett as a client of the MDO team, the arrangement whereby he was supervised by someone recognised as an eminent forensic psychiatrist, was hard to challenge. Prof Coid was willing to entertain the possibility, even if he did not agree with it, that perhaps others were intimidated by the prospect of challenging him, or being seen to take away his patient.

53. It is also the Inquiry's view, that had the absolute discharge been delayed, Mr Foskett's compliance with local services could have been tested out while he was still subject to the coercion of a restriction order, and any resistance better managed (see Chapter Seven).

The value of social supervision

54. In spite of the shortcomings of the processes used, particularly, the failure to conduct formal reviews of Mr Foskett's progress and care after his move into independent care, and the difficulties engaging Mr Foskett in after care, the Inquiry Panel is of the view that Ms Gauthier did a good job of monitoring and supervising him over a period of almost three years. She showed the true value of a social supervisor and was able to get him to open up to her about the issues relevant to the management of his case. These were everyday issues which caused him stress, and included some reference to PC and her illness. No one else, including those at Lyndhurst and probably even Prof Coid, had been able to achieve such a good rapport with Mr Foskett.

55. Ms Gauthier used an intelligent approach to get around Mr Foskett's undoubted resistance to involvement with new services, so that although ostensibly supporting him in terms of housing and practical matters, she was able to

engage him on issues closely linked with his mental health and well being. Her notes demonstrate that she offered him support at times when she foresaw stress for him, and that he sought her support at times when he foresaw stress and anxiety for himself. Her notes also demonstrate a good deal of insight on his part into potential stressors for him, and an acceptance of an outlet for discussing these problems which he took without resistance.

56. Her input at this time, in terms of supervision, was more frequent than might have been expected of a psychiatrist, who would necessarily have seen Mr Foskett less frequently, and probably never in his home setting. Thus, the fact that Mr Foskett refused to see a psychiatrist from the locality did not create a problem, and Ms Gauthier was able to achieve a good understanding of the issues in Mr Foskett's case. Her notes and approach showed that she provided the essential monitoring and supervision over this period, and an effective point of local contact. Her work demonstrates the crucial input of a social supervisor who is able to make home visits, and draw on information other than self-report in forming judgments.

57. Ms Gauthier was thoughtful and willing to work with flexibility to ensure that Mr Foskett's needs were met. Her notes show that she discussed Mr Foskett with other members of the team at MDT meetings, and that it was her intention that Mr Foskett should continue to be monitored by the team, so that he maintained a link with local services in case of a crisis. Unfortunately, this did not come to pass, and Mr Foskett was left without a local link.

58. However, Ms Gauthier and Prof Coid were working in isolation of each other. There was no formal application of CPA standards. There were no systematic assessments, care plans or regular reviews at the most crucial time i.e. after Mr Foskett moved into independent living. There was a formal transfer from the CST to the MDO, but as Mr Foskett was never seen by Dr Naguib he was not considered to be a client of that team, especially after Ms Gauthier left. Ms Gauthier considered herself to be Mr Foskett's care co-ordinator, but she and Prof Coid met only once at the very outset in 1995.

59. While it is clear that Ms Gauthier addressed her mind to the possibility that Mr Foskett would lose contact with local services and the consequences of that happening and worked hard to engage him, formal reviews should not have been allowed to cease. The result was that all her hard work was not communicated to Prof Coid, who her own team relied on thereafter to provide contact and supervision. Nor, indeed, did Prof Coid seek input from her as he should have done. An important point that Prof Coid was not aware of was the extent to which Mr Foskett and PC were in fact co-habiting, albeit at two addresses. This may have raised questions in relation to PC as Mr Foskett's carer and vice versa. This is considered further in Chapter Nine.

60. The Inquiry endeavoured to take evidence from Mr Richard Groves on the issue of case allocation following Ms Gauthier's departure. He was unable to attend the Inquiry due to long-term ill health.

61. Eventually, following correspondence between Dr Naguib and Prof Coid in 1998 as described above, Mr Foskett remained under the informal supervision of Prof Coid alone. Inpatient care, if needed, was to be provided by Barnet, who asked for regular information from Prof Coid about Mr Foskett's progress.

RECOMMENDATION 4

Barnet, Enfield and Haringey Mental Health NHS Trust should a) review the application of CPA principles, and b) ensure that the Barnet MDO team reviews its allocation of cases and application of CPA to all cases that are open, but not active.

RECOMMENDATION 5 (see Chapter Nine)

Barnet, Enfield and Haringey Mental Health NHS Trust and East London and The City Mental Health NHS Trust should review all forensic patients with an element of care in another locality to ensure the full application of CPA principles and follow-up.

Chapter Nine

DEATH OF PC

1998 - 2003

INTRODUCTION

Professor Coid saw Mr Foskett twice in each of 1998, 1999 and 2000. He saw him once in 2002 and then twice in 2003, their final meeting taking place about one week before PC's death. By this time, eight years had elapsed since Mr Foskett had been absolutely discharged, and eighteen years since the original index offences. His brief notes are the only record of this period in Mr Foskett's life that the Inquiry Panel had available. He attended his GP for blood tests and very rarely for anything else, however, in October 2000 he was referred to a dermatologist. In order to fill in the gaps, where possible, to elucidate how he and PC were functioning at this time, the Panel turned to her notes, and also to the testimony of Mr Foskett's brother and the statements taken by the police after the homicide. The Panel has been able to form a general impression as to how they were living, but with little detail.

The issues arising for consideration are:

- The role of Professor Coid
- Mr Foskett's relationship with PC
- PC's illness and Mr Foskett's role as PC's carer
- The lack of social supervision and the need for contact with local services

1998-2003

1. In 1999 Prof Coid noted that Mr Foskett remained without depression. His notes mention PC, her OCD and that she was seeing a psychotherapist. This was Jonathan Ash at the Maudsley Hospital. He also noted that Mr Foskett was still waiting to move to another flat. Later in the year, there are notes of

PC's high blood pressure and separately that Mr Foskett said that he was enjoying his life.

2. Since January 1998, PC had been receiving far more intensive therapy and input from services than previously. This is summarised in Chapter Five.

3. In around May 2000, Mr Foskett saw another flat, but was not interested in taking it. He reported feeling low when he had a bad cold and some associated anxiety. This left him after about two days. His general practitioner increased his lithium level which was found to be low. PC was still being seen at the Maudsley Hospital. In December Prof Coid saw them both. They recounted an episode of irritability in Mr Foskett, though not depression, that lasted for one week and which coincided with a prescription of steroid cream for his skin complaint. Otherwise all was well.

4. Prof Coid did not see Mr Foskett at all in 2001. Prof Coid had suffered a serious accident while on holiday, resulting in emergency treatment abroad and inpatient treatment back in the UK. He told us that during this period, Mr Foskett was offered the opportunity see a colleague, but declined. Prof Coid returned to work at the end of 2001, and saw Mr Foskett again in March 2002, when he reported the discovery of allergies to many substances for which he had been tested at Finchley Memorial Hospital and Hammersmith Hospital. The entry recorded unremarkable details about his mood, PC's physical health and his visits to his mother, who was by then aged 93. Prof Coid underwent major surgery and was unable to see Mr Foskett again until the end of this year.

5. In 2003, Mr Foskett was seen twice by Prof Coid, the first in January when in a longer note than usual he recorded that Mr Foskett reported that he had been anxious in 2002 for two days without any identifiable reason, save for some problem with the department of social security regarding his benefits being stopped. This had gradually worn off and there had been no more severe symptoms. They had discussed PC and her ongoing OCD, and Prof Coid had been told that Mr Foskett spent his weekends with her.

6. Prof Coid's final meeting with Mr Foskett was on 21 July 2003, about one week before he killed PC. At this interview, Prof Coid recalls that he was looking less well than usual and reported experiencing some anxiety since his benefits problem earlier in the year. He had remained anxious, especially in the previous two weeks. He was experiencing anxiety for periods of three to four hours at a time, but there was no change in the level of anxiety. He specifically denied palpitations, tremors, panics and the like. He was sleeping only four hours a night and waking more anxious. He reported being a little irritable, but not more than usual. He denied any changes in concentration, subjective depression and reported feeling better having increased his amitryptiline medication by 25 mg. Prof Coid expressly noted that he had no suicidal or homicidal ideation.

7. Although PC is not mentioned in the note of this meeting, Prof Coid told us that he did not report any problems concerning her, and their relationship appeared to remain good. Prof Coid said that this was a routine feature of his assessments of Mr Foskett. Again, although not noted, Prof Coid said that he did specifically ask about upper respiratory tract infections, but nothing was revealed. He says he also discussed with him what he was to do if there was any deterioration. Mr Foskett reassured him that he would telephone if he deteriorated to make an earlier appointment, and felt that he could attend his GP if he could not contact Prof Coid. In a letter to the general practitioner Dr Brett noting Mr Foskett's anxiety and lack of sleep over the previous two weeks, he recorded that he made a further appointment to see Mr Foskett three weeks later on 11 August, and that he also advised a further increase in the level of amitryptiline to 150 mgs at night. These changes he wrote onto his appointment card. Prof Coid told the Inquiry that he remained of the view that Mr Foskett was a low risk to himself and others.

8. Prof Coid wrote to Dr Brett after both meetings in 2003, which was unusual. In January, he reported that Mr Foskett had been unwell in July 2002, that this was not precipitated by a viral illness and that he was not in contact with any other services by choice. He advised that a more assertive approach was not necessary due to Mr Foskett's level of co-operation. He reported that the risk posed was low, and that the relationship with PC was good. Dr

Brett received these letters, but in spite of his longstanding involvement with Mr Foskett, knew little detail of his mental disorder and index offences. However, he was monitoring his lithium levels, and he would have referred Mr Foskett to local services immediately if he knew that he had not been taking his lithium.

9. Mr Foskett and his brother paint a completely different picture of the events around the 21 July, as do PC's notes in relation to her own illness. Mr Foskett told the Inquiry, and those investigating the death of PC, that he had stopped taking his lithium for about two months due to a notion picked up in an off-the-cuff remark that his itching and skin problems may have been caused by it. He re-started it about one month before he killed PC, although he could not be precise as to the timing, and he says, as a consequence, never mentioned this important detail to Prof Coid, who heard it for the first time when he attended the Inquiry to give evidence.

10. Mr Foskett re-started it due to the re-emergence of his depression. He was aware that he was ill again, and he went to see Prof Coid on 21 July 2003, having made arrangements for PC to get food and provisions brought to her by his brother, because he expected to be admitted to hospital. This was confirmed to the Inquiry by his brother, who also said that on the way back home from his appointment with Prof Coid, Mr Foskett had said that he felt like jumping under a train. Mr Ken Foskett told the Inquiry that his brother came home, lay down and did not want to talk. His voice was 'sinking'. He said that PC was very concerned about him.

11. Prof Coid was very surprised to hear that Mr Foskett had temporarily ceased his lithium and failed to tell him about it. He had also failed to mention that his thoughts were racing. He speculated that it could indicate that Mr Foskett was too afraid to admit this lapse to him, or that his mental state was in fact more deteriorated than he presented. Prof Coid was genuinely sad to hear that Mr Foskett was prepared for admission to hospital.

12. Additionally, Prof Coid had no idea of the social isolation of the couple, or that Mr Foskett was essentially PC's carer. By this time, they had no friends

according to Mr Foskett and were together all the time. As he became ill, Mr Foskett was unable to do the housekeeping and was not sleeping. PC relied on him a lot, but he gave evidence that he could not remember much about her mental state at that time because he was preoccupied with his own, which he said was part of the depression. Prof Coid thought, as he had recorded, that they only saw each other at weekends.

13. Prof Coid assured the Inquiry that if he thought Mr Foskett was becoming more depressed in a stressful situation, he would have called in the local Barnet services. A complicating feature was that he was, in fact, in Newham with PC as he deteriorated. He felt that the lithium was still the key, but that the circumstances clearly mirrored those in 1985 i.e. illness and stress. He said that he could have arranged an admission within 24-48 hours. It was clear that Mr Foskett's condition deteriorated rapidly in the days after his consultation with Prof Coid, and to an extent that he was unable to call for help himself. We will never know why PC did not call for help.

14. What we do know, is that she herself was very ill and this was documented by her therapist at the Maudsley, Jonathan Ash on 9 and 15 July. She had presented in a state of crisis to Dr Waterdrinker on 22 July feeling suicidal, and having taken an overdose of paracetamol on the previous Sunday. PC told her that she went to her fiancé every now and again, but stayed indoors at all times. She was reassured and referred to the East Newham CMHT. This episode is described in more detail in Chapter Five.

15. On Monday 28 July, the emergency services received a telephone call from Mr Foskett at around 1 o'clock in the morning, in which he said that he had killed his 'wife' and taken an overdose. The police found PC with multiple lacerations to her head and neck, and she had bled to death. Mr Foskett could not remember what had happened.

16. In his statement to the police, PC's father said that he had received a telephone call from his daughter on the Thursday before she died i.e. 24 July. She was concerned for Mr Foskett. On Friday she was very depressed and crying her eyes out, but she did not know why. The couple had visited him on

the Saturday, and Mr Foskett was nervous and on edge. PC said nothing about him. On Sunday 27 July no one answered the telephone when he called.

17. Two notes were found in the flat, one beside PC which read 'I love you, cannot take any more. So depressed'. The other said 'note on memo: help me'. There is no indication as to which of them might have written these notes. Mr Foskett did not recall them in interview with the police. However, at least the second is likely to have been by Mr Foskett because it seems to refer to a message recorded by him on the telephone answering machine. The following is the police transcript of that message: 'I'm ill, I can't believe what I've just done. I did tell Dr Coid…..that I wasn't feeling too good, didn't he see it and Jonathan at the….., what's the matter with them. Don't they know what's happening. Can't no one in the community see how ill I am. No one wants to know no one at all and now look what's happened. Oh last night was hell. Hell, hell. I woke up this morning I didn't know where I was, what I was doing there. Look…..now, I can't believe that P's laying there, I just cannot believe it. Anyway I'm going to end my life now…..care in the community.'

18. Subsequent assessment concluded that Mr Foskett's killing of PC was triggered by him stopping lithium, receiving letters regarding rent owing and his benefits being stopped. Severe depression was probably the primary factor with PC's own mental health problems probably an ongoing cause of frustration for Mr Foskett. What was not clear was the final precipitant causing the homicidal outburst.

19. One of the complicating features of this case, is that Mr Foskett's mental health deteriorated while he was in Newham staying with PC. Barnet services would have had to know where she lived and been willing to reach Mr Foskett there or mobilised Newham services. Dr Brett said that he had no knowledge of PC at all, and would not have known what to do if Mr Foskett had called him from Newham. He had no contact with Newham services.

20. Mr Foskett was sentenced at the Central Criminal Court in London on 21 May 2004, following a guilty plea to manslaughter on the grounds of diminished responsibility. He was sent to a medium secure unit under sections 37 and 41 MHA once more, which is where he remains.

COMMENT

Role of Prof Coid

21. This Inquiry Panel is very much in favour of flexible working. Patients' individual needs must be taken account of in the provision of services, and practitioners must not feel hemmed in by protocol and policy so that the required service cannot be provided. However, such practice must occur within the spirit, if not the letter, of prescribed frameworks such as CPA. Thus, Prof Coid placed himself in a vulnerable position by seeing Mr Foskett on an occasional basis without any team back up in the form of social supervision; no reviews or assessments or provision of information to local services.

22. As stated above, he needed at least the back up of an allocated worker in Barnet with whom to communicate his reviews of Mr Foskett. It is clear to us that consultant psychiatrists supervising patients from outside their areas must have some team back up on the ground, able to step in when a crisis or other need arises. This falls within the CPA ethos of multi-disciplinary working, even if it is across agencies.

23. Prof Coid was clearly aware of this shortcoming in his handling of this case when he gave evidence to the Inquiry. He pointed out that CPA, as implemented in East London since 2001, would not allow him to supervise Mr Foskett in that way today. It was totally inadvisable for him to see Mr Foskett who was living in another borough without any social supervision. He also candidly acknowledged in evidence that perhaps he had been too arrogant in thinking that he would be able to spot a deterioration in Mr Foskett's mental state.

24. He placed himself in a position where he was totally reliant on information provided by Mr Foskett regarding himself and his relationship with PC. The result was that on 21 July 2003, his assessment of the risks posed by Mr Foskett was flawed. Mr Foskett had been unable to tell him of PC's severe condition, and most importantly that he himself was very unwell.

Remarkably, Prof Coid was unaware that they were effectively co-habiting, even if they maintained separate homes.

25. Prof Coid's alternative would have been to discharge Mr Foskett in the absence of social supervision back up, in which case he would probably have turned to his general practitioner, or no-one, for help. This course would have run against the high risk situation in which Mr Foskett was living with PC. Any discharge should have involved local Barnet services and a further assessment of risk. We would feel less able to criticise Prof Coid's approach had joint assessments including PC taken place, and a considered decision taken that they were managing well and would seek help appropriately should they need it. Unfortunately, decisions were taken in the absence of available information. Further, any joint decision around this time would have highlighted PC's illness and the fact that Mr Foskett was her carer and in need of support.

Joint assessment and social supervision

26. Drawing back to look at the larger picture, what emerges is that Mr Foskett and PC were two severely mentally ill people at this point in time. If, as we have suggested, joint inter-agency assessments had been conducted periodically, we think it is likely that this clearly risk-laden situation would have come to the attention of those professionally responsible for one or other of them. The National Service Framework in 1999 had identified the need for the assessment of carers needs, and Mr Foskett would have fallen within that requirement in relation to PC. It requires that individuals who provide regular and substantial care for a person on CPA should have their needs assessed. The care co-ordinator should be aware of the carer, communicate with the carer and decide whether the carer needs a full assessment (by the Local Authority), provide information and record the carer's role in the care plan.

27. Had PC received a proper assessment in August 2002 or June 2003 under CPA, her carer, who was Mr Foskett, is likely to have been identified and known to Newham services. This should have had the further result of

alerting Prof Coid that the couple was effectively co-habiting and to the extent of PC's ongoing problems. This should have resulted in far more support for the couple. This point is relevant also to the Barnet services in or around 1998, and as Ms Gauthier left the service. A full review of Mr Foskett's needs at that time is highly likely to have revealed the extent to which they were in fact co-habiting, and that PC was also subject to psychiatric supervision (see Chapter Eight).

28. It is our view that some contact should have been maintained with Mr Foskett by the Barnet MDO throughout, even if sporadic this would have given Mr Foskett a local contact. A skilful practitioner such as Ms Gauthier would have been able to negotiate closer contact.

29. Thus, we are bound to say that by 2003, on the basis of Mr Foskett's apparent success, and even with an understanding of the potential risks posed by his relationship with such a vulnerable woman, any continuing supervision of him was likely to have been conducted at some distance. It is still our view that the circumstances demanded that the Barnet file should remain open with an allocated worker. Of course, the file did remain open, and Prof Coid was asked to provide updates which he did not. It is our view that a proper channel of communication between Prof Coid and Barnet should have been maintained, and that this would have required periodic reviews.

30. Ultimately, the most realistic route to providing social support was probably that described in relation to PC, and the need to support the couple via her carers from the time she commenced regular contact with Newham in 1998.

31. We have raised questions over the way in which PC's referral to the Newham CMHT in 2002 and June 2003 remained unimplemented. We think that Newham must look closely into why this was so, because it is possible that had the CMHT become involved with PC, especially in June 2003, that any assessment of the couple at that time would have highlighted that they were in difficulty and that Mr Foskett's mental health was also deteriorating.

Mr Foskett's compliance

32. The Inquiry has commented throughout on the assumptions made about Mr Foskett's compliance, which did not bear analysis when referred to the early assessments made of his personality in Goodmayes Hospital. In particular, that his level of insight into himself, his illness and the risks posed by it were not one and the same. These differing levels of insight, driven by his over-compliant and passive personality traits, came to the fore in July 2003, when he was simply unable to inform Prof Coid of the most important developments in himself, presumably for fear of letting Prof Coid down, or letting himself down as the 'model' patient.

33. What is highly regrettable is that these features were known about, but failed to inform later assessments of Mr Foskett, which appeared to take his compliant nature at face value. We think that this point hinges on the failure to test him out more, prior to absolute discharge, whereupon the issues surrounding the relationship and his resistance to services should have been re-assessed. Mr Foskett did present a low risk while he was at Lyndhurst Hostel, but the moment he moved into independent accommodation and expressed the intention to co-habit with PC, the risk dynamic changed completely. The main failing in this case was the failure to appreciate this point, to take stock of PC's mental illness and to impress upon Mr Foskett the need to offer support and supervision in the long term as a result of it.

34. For this purpose, Mr Foskett needed to remain under the restriction order for longer. How much longer is a very knotty issue. We have discussed issues of autonomy and the alternatives to MHA disposal in Chapter Seven.

35. It is clear that Mr Foskett's illness deteriorated quickly and suddenly such that he was able to present himself to Prof Coid at St Bartholomew's Hospital on 21 July, but by 27/28 July had obviously deteriorated significantly. PC's father's evidence also indicates that this must have been a dramatic change, in that Mr Foskett had been able to drive over to see him on the Saturday. His brother, on the other hand, suggests a period of deterioration over a few days.

36. Enforced periodic contact with a social supervisor in the context of a double homicide may be justifiable in terms of the intrusion in to a person's private life, but if that supervision took place quarterly or less frequently, it may not have picked up Mr Foskett's rapid deterioration over a space of a number of days. Furthermore, what sanction could be applied in the event of a refusal to comply with social supervision following an absolute discharge?

37. It is easy to view the striking similarity of this repeat offence to the original index offences entirely as a matter of service failure, because with hindsight all the signs were there. But in our opinion this would be a mistake. It is possible to see where services could have been different, but any resultant difference to the outcome is difficult to pinpoint. A very important factor is that these were two strong willed people, highly resistant to outside interference in their lives.

RECOMMENDATION 1 (see Chapter Five also)

East London and The City Mental Health NHS Trust (now incorporating Newham community mental health services) should 1) review the implementation of its CPA policy with a view to establishing the reasons why the referrals of PC to the East Newham CMHT in 2002 and 2003 did not occur and/or were delayed, 2) review the definitions and inclusion criteria of standard and enhanced CPA.

RECOMMENDATION 2 (See Chapter Five)

Barnet, Enfield and Haringey, and East London and The City NHS Mental Health Trusts, should review the implementation of CPA policy to ensure compliance with current guidance relating to the needs of carers.

RECOMMENDATION 5 (see Chapter Eight)

Barnet, Enfield and Haringey Mental Health NHS Trust and East London and The City Mental Health NHS Trusts should review all forensic patients with an element of care in another locality to ensure the application of CPA principles and follow-up.

CHAPTER TEN

SUMMARY
CONCLUSIONS
RECOMMENDATIONS

Summary

1. Dennis Foskett killed PC in July 2003 while suffering severe depression. He has a relapsing depressive illness that is well controlled on medication, such that he is considered to present a low risk of serious harm. His early history and the offences in 1985 show that his depressive episodes were increasing in severity and the rapidity with which they progressed. It is now apparent that medication is the primary factor in keeping him well, but it is also clear that other factors that have contributed to his relapses have included stress within relationships and his over compliant personality.

2. The relevance of a stressful relationship was quickly identified during his inpatient stay at Goodmayes Hospital (1985 to 1993) in the context of his role as carer for his wife, who had epilepsy. The nature of his relationship with his wife and the course of his early illness is summarised in **Chapter Two**.

3. Somewhat controversially, having committed a double homicide in 1985, Mr Foskett was placed at Goodmayes Hospital, Essex, a local psychiatric hospital, for treatment under sections 37 and 41 of the Mental Health Act 1983. He was a restricted patient whose discharge from hospital could only be sanctioned by the Secretary of State for the Home Department or a Mental Health Review Tribunal. In **Chapter Three** we considered the propriety of this placement, and concluded that it was appropriate. We also discounted the role of any adverse reaction to medication in the 1985 homicides.

4. It is a great tragedy that following the events of 1985, eight years at Goodmayes Hospital, two years under conditional discharge and eight years following his absolute discharge in 1995, Mr Foskett re-offended in 2003 by killing his girlfriend, PC. He did not relapse in the intervening years. He is not a man with a history of violence prior to 1985, or of random killing. He

has been violent on two occasions in his entire life, but these have resulted in the awful deaths of three people. The key issue that this case raises is what is the proper course of supervision, over a long period of time, of a person who presents a low risk of serious harm? How is such a person, and those around him, to be kept safe?

5. In **Chapter Four** the Inquiry looked at the treatment and assessment process at Goodmayes Hospital between 1985 and 1993. Mr Foskett was not a problem to manage in a local psychiatric hospital, and the public's concerns at his placement (see Chapter Three), in fact, proved groundless. The role of the Home Office, by virtue of the restriction order and the use of the Advisory Board on Restricted Patients, also provided a counter-balance to these concerns, so that issues of public protection were kept to the fore.

6. Mr Foskett remained under assessment and treatment at Goodmayes for eight years, in which time he received as much assessment and input as was available. Drs Paul Bowden and Jeremy Coid, both experienced forensic psychiatrists, provided reassurance and guidance to Dr Feldman in the face of her acknowledged trepidation and inexperience with restricted patients. The input of the Home Office and the reference to the Advisory Board, equally, meant that perceived shortcomings in the assessment process were raised prior to conditional discharge. These referred explicitly to personality and relationship issues.

7. These shortcomings were largely addressed by Prof Coid in his report of March 1991, in which he provided an analysis of issues that had not been addressed, including an over-controlled and passive personality, which required monitoring, particularly in the context of Mr Foskett's relationship with a vulnerable woman. He provided a risk assessment based primarily on the need to keep Mr Foskett's depressive illness under control to prevent a relapse, but which also outlined his tendency to repress ongoing and potentially frustrating factors e.g. within a relationship, that he might conceal from others, or himself, the presence of any such factors, especially should they occur in the context of a further episode of depression.

8. As a result, a good working understanding was reached of Mr Foskett's personality, the index offences and the likely effect of a stressful relationship. What was lacking, however, was a more specific understanding of PC herself, and the likely stresses that this relationship would bring to bear upon Mr Foskett, whether or not they lived together, with a view to planning a strategy of support and management for the future. The couple therapy on offer was not suited to a full analysis of the relationship and its likely problems, but laid the foundations for further work by the whole team which could have been pursued while he was subject to conditional discharge.

9. A joint assessment between Mr Foskett's and PC's care teams should today be automatic. In 1991/2 this could easily have been achieved because of Dr Feldman's dual role as consultant to both parties, and it was clinically indicated for the future management of the case. Dr Feldman referred PC to the Maudsley Hospital for specialist help with her behavioural problems in around late 1991. The issue highlights the need for good communication and cross team work, especially in a case such as this where both parties were heavily reliant on mental health services. The threshold for sharing information should have been low, because it was needed in order to keep the couple safe due to Mr Foskett's history of homicide. Furthermore, as time passed, periodic re-assessments of the risks posed within the couple should have been jointly assessed. This is what the facts of the case demanded, because Mr Foskett had killed his previous partner and his GP. Opportunities for joint assessment existed right up to the point of absolute discharge in 1995 and beyond (Chapter Seven).

10. A separate, but related issue, is that of the use of guidance regarding carers in respect of both Mr Foskett and PC as mutual carers, especially latterly, i.e. around 1998 and thereafter. This was considered in Chapters Five and Nine.

11. Much reliance came to be placed on Mr Foskett's actual compliance with medication and attendance at outpatients appointments, when issues around absolute discharge and subsequent supervision arose. That he was compliant became an axiomatic feature of his presentation, treated as being synonymous with complete insight into his illness and the risks he posed. In

our opinion, this notion needed to be challenged and questioned as part of a periodic review of risk. There is little evidence to suggest that he was sufficiently challenged, especially around the time of his absolute discharge. The evidence does suggest that the care team were falsely reassured by the fact that Mr Foskett was easy to manage and was eager to please.

12. Looking at features of his personality, as identified during his time at Goodmayes, there is a question to be raised as to how much was understood in relation to his apparent compliance and his true insight into himself, his illness and the risks it posed. It is now apparent that they were not coterminous. We find that this discrepancy was recognised at the time he was in Goodmayes, but was somehow lost over time. There were features of his personality that were unlikely to change, but needed to remain in the forefront of risk assessment into the future. These features were:

    a. That he found it difficult to acknowledge that he had committed two homicides to others in his therapeutic group and was eager to limit those who were told, to the extent that later he resisted this information being passed onto appropriate housing authorities who were be responsible for finding him independent accommodation (Chapter Eight).

    b. He was noted to consider himself 'special' and Dr Feldman clearly did not trust his over compliant behaviour, added to which he had demonstrated that he was capable of being deceitful.

    c. He was a 'model' patient, and the Advisory Board were concerned that this should be challenged. He had found it difficult to tell Dr Glickman of his paranoid symptoms, and later in 2003 similarly, he had been unable to tell Prof Coid that he was very ill and wanted admission to hospital. It is now apparent that this is likely to have been a manifestation of his over-compliant personality – his need to be seen to be the 'model' patient.

    d. Aspects of his personality were also important with regard to his relationship with PC and his ability to bring to light any real difficulties he was facing within it.

e. In addition, Mr Foskett was noted to have limited insight into his relationship with his wife and then PC.

13. In the event, what happened on conditional discharge was that issues around Mr Foskett's personality and that of couple assessment, receded into the background, never to be formally re-addressed. Mr Foskett's well being and ability to cope with PC over a long period of time, offered unassessed reassurance that all would remain well.

14. **Chapter Five** considered PC's severe mental health problems. Based on a selection only of her records, it was readily apparent that she had a severe mental disorder in the form of obsessive compulsive disorder, together with a multitude of co-morbid physical problems that meant that she was at times very unwell. Her mental health needs increased from around 1998, at which time she was being seen regularly by a behavioural therapist at the Maudsley Hospital in South London, and as an outpatient by consultant psychiatrists in Newham. She was referred to, but never seen by, the East Newham CMHT, and was acutely ill in around June/July 2003. We have identified concerns regarding the implementation of CPA policy in Newham, including definitions and inclusion criteria, and also of the application of guidance regarding carers, as Mr Foskett was of PC (recommendations 1 and 2). These were considered further in Chapter Nine.

15. The Inquiry found good evidence of care planning and multi-disciplinary team work at the point of Mr Foskett's discharge from Goodmayes Hospital in April 1993, and this was considered in **Chapter Six**. Whilst he was at Lyndhurst Hostel, there were regular section 117 MHA meetings, initially with Dr Feldman and then with Prof Coid as he took over responsibility for Mr Foskett. Mr Foskett remained under the supervision of Newham Health and Social Services and there was no formal CPA in Newham at this time. A comprehensive policy was introduced in 2001, and the Inquiry has had cause to question its application and use in relation to PC.

16. Mr Foskett remained very well and compliant with medication at Lyndhurst Hostel. He took part in art therapy and occupational therapy. There were no

concerns about his relationship with PC, and they had negotiated that she have overnight visits once a week. We have found what we consider to be a remarkable lack of interest and curiosity into her mental health needs. Clearly, at this time, when they were not co-habiting, this was a less pressing point, but we consider that the progress of the relationship should have formed an active part of Mr Foskett's supervision at this time, and it did not.

17. In **Chapter Seven** we considered one of the key issues related to the long term management of patients under a restriction order of the MHA, namely, the value of a conditional discharge, enabling a patient to live in the community and the effects of removing the restriction order, whereby the patient is no longer under any compulsion to comply with supervision. We have found that there has been no research around the effects of removing a restriction order in terms of compliance with team supervision, the rates of re-offending and relapse. We think that this would be a valuable piece of research in informing practice around the long term safety and care of patients at risk of committing violent crimes (recommendation 3).

18. It is our view that Mr Foskett's absolute discharge in February 1995 was premature. The absolute discharge was a big step, even while remaining under the relative strictures of Lyndhurst Hostel, and without further testing out in independent living. On the evidence presented to it, the decision of the tribunal to discharge Mr Foskett was probably reasonable. It was based on Mr Foskett's wellness on medication, that he would adhere to any treatment programme that was recommended and that, if medical help were needed, he would obtain it himself. The view taken was that the need for the power to recall him was removed by Mr Foskett's compliant behaviour.

19. Our main criticism concerns the lack of a joint assessment at this time (and identified first in Chapter Four) between Mr Foskett's and PC's carers, which we consider to be a significant omission in relation to the analysis of risk. It compounded the earlier identified limitations in the couple therapy offered at Goodmayes Hospital. The expectation that the couple would co-habit introduced a different risk dimension that had previously rightly been assessed as high. Views had been expressed while Mr Foskett was in

Goodmayes Hospital that this was a situation that should never be allowed to pass. In our view, it changed the assessment thus far of a long term low risk and demanded a full re-assessment of risk.

20. We are also critical in the context of the changing risk dynamics of the unquestioning reliance on Mr Foskett's compliance. Again, the complexity of Mr Foskett's presentation and the existence of unaddressed personality problems and amnesia had previously been identified (see Chapter Four). A re-focusing on this issue now was important in terms of both risk and insight. There was evidence that his compliant behaviour did not, for example, signify insight into the relationship issues around the index offences. Re-focusing at this time would have been important for the clinical team, any new team, for example, in Barnet taking over Mr Foskett's care, and for the couple.

21. It is our view that what was required was that the relationship should have been monitored while Mr Foskett was in independent living and still under a conditional discharge. An understanding of the daily dynamics within the relationship would have been obtained, and most importantly, that although they never actually lived together in one place, they were effectively co-habiting and caring for each other. It is not possible to say that this course of action is likely to have influenced the ultimate outcome, but in our view, it was indicated at this time. It is likely that Mr Foskett would have achieved an absolute discharge by about 1998 in any event.

22. An extended conditional discharge would have been important in encouraging Mr Foskett to engage with local Barnet services, a factor in keeping the couple safe into the future, and which proved a difficulty after the absolute discharge.

23. We have considered whether there was an alternative system that would have enabled closer contact to be maintained with Mr Foskett for longer. In particular, we looked at the system of life licence within the criminal justice system, and concluded that there is unlikely to have been any practical difference in the intensity of monitoring eighteen years after the index offences between that system and the mental health system. The intensity of

supervision would depend on the assessed risks and potential dangerousness of the person. We would have liked to have seen efforts continuing to engage and support Mr Foskett and PC, but their resistance, his assessed low risk and the fact that they had coped so well for so long were influential factors.

24. We cannot say that even had Mr Foskett's absolute discharge been delayed until about 1998, that he would have been subjected to more intense supervision that is likely to have detected the significance of his relapse in 2003.

25. **Chapters Eight** and **Nine** considered the follow-up provided to Mr Foskett after the absolute discharge. Mr Foskett was statutorily entitled to after care under section 117 MHA. This role passed to Barnet health and social services. Mr Foskett refused to engage fully with the local services and was never seen by a psychiatrist at either the community support team, or later the mentally disordered offenders team. We have found this refusal to engage with Barnet to be an important change in his level of compliance that required review, especially in conjunction with an imminent move into independent accommodation and co-habitation with PC. He continued to be seen by Prof Coid over in East London, and Frances Gauthier, a Barnet social worker.

26. The events around 1998 are important. At that time, Ms Gauthier left Barnet, and Mr Foskett's supervision diminished to informal bi-annual meetings with Prof Coid. Once Ms Gauthier had left the service, Mr Foskett's case remained open, but no-one new was allocated to him. We have been critical of the efforts to engage Mr Foskett and the communication between Prof Coid and the Barnet teams. The particular problem was that Prof Coid was not able to provide social supervision for Mr Foskett.

27. At this stage, Mr Foskett and PC were effectively co-habiting and caring for each other. In our view, this was a situation that required sensible supervision and support more assertively because there were risks attached to it. Again, at this stage in around 1998, any arguments relating to Mr

Foskett's right to autonomy based on the fact that he had remained well and compliant with medication for so long, was compromised. However, he could not be forced to accept any supervision. We have also found that regardless of the level of co-operation offered by Mr Foskett and PC, there should have been some contact with PC's carers and periodic assessments of the couple undertaken in that way.

28. We are critical of the lack of any application of CPA standards to the supervision that ensued for Mr Foskett, and in particular the failure to hold any joint reviews between the Barnet MDO and Prof Coid. Professor Coid placed himself in a position that meant that he was working on his own and reliant on self-report by Mr Foskett for information regarding how he and PC were getting on. He could have withdrawn altogether, but continued to offer informal supervision at Mr Foskett's request. The Panel is in favour of flexible working that takes an individual's needs into account. Practitioners must not feel hemmed in by protocol and policy so that the required service cannot be provided. However, such practice must occur within the spirit, if not the letter, of prescribed frameworks such as CPA (recommendations 4 and 5).

29. **Chapter Nine** looked at joint assessment and social supervision again. PC's mental health needs had intensified by 2002, and the role of Newham services in relation to PC came into focus. PC was being seen in outpatients in Newham and by a therapist at the Maudsley Hospital. There were two attempts to refer her to the East Newham CMHT before July 2003: the first in August 2002 and the second in June 2003. It has not been this Inquiry's role to investigate the care provided to PC. However, it is clear that had those referrals been completed, the couple's difficulties may have been identified, and that Mr Foskett's role as carer would have resulted in separate and a joint assessment of their needs. This was the responsibility of Newham services, who in our view should undertake a review as to why these referrals did not take place.

30. By July 2003, both Mr Foskett and PC had deteriorated considerably. Mr Foskett had taken himself off his lithium medication for a short period, fearing

that it was contributing to his dermatitis, and re-started it as he felt himself becoming unwell again. PC had presented again on 22 July 2003, when another referral to the East Newham CMHT was made, but not followed through before she died.

31. Mr Foskett saw Prof Coid on 21 July 2003, and he was expecting to be admitted to hospital. However, he did not tell Prof Coid that he had ceased his lithium for a short period, nor the full reality of the symptoms he was experiencing. Prof Coid appreciated a change in Mr Foskett, and increased his amitryptiline medication and made another appointment to see him three weeks later. Mr Foskett killed PC on 27 July.

Conclusions

Joint assessments and risk assessments

32. Mr Foskett killed his wife and general practitioner in 1985, and issues around the nature of his relationship with his wife were identified in the process of understanding the reasons why he killed them while he was at Goodmayes Hospital. Our most strident criticism has been focused on the lack of joint assessment of Mr Foskett and PC and the dynamics in that relationship.

33. We have identified several points in the history at which the need to assess the couples dynamics jointly should have been carried out in the process of re-addressing risk. The most obvious was at the point of absolute discharge, when it was Mr Foskett's expressed intention that they should co-habit.

34. We have allied this criticism to the process of ongoing risk assessment, especially in the light of Mr Foskett's over-compliant personality and 'model' patient presentation, which was known to be superficial. Mr Foskett did present a low risk of harm until he moved into independent living and began effectively to co-habit with and care for PC.

35. We have not sought to make any recommendations around the need for joint assessments and ongoing risk assessments. We see these as being practice issues determined by the case in hand, such that further recommendations regarding protocols and procedures would, in our opinion, be superfluous.

Current practice in which CPA principles are now expected to be entrenched, demands periodic separate and periodic joint reviews, the content and substance of which must be dictated by the individual circumstances of each case.

36. Long term safety will depend on an analysis of an individual's risk at any moment in time and the realisation of previously identified risk factors. In this case, the intention to co-habit went unchallenged and unassessed. By this time, Mr Foskett had remained well and compliant with medication for ten years, and it is not difficult to see why this was influential in subsequent decision-making. No one expected him to re-offend.

37. However, risk issues must remain to the fore in the care of long-term patients to enable them to live safely in the community, as much as to safeguard those at risk. This is a difficult practice issue, but it clearly depends on a rigorous analysis of risk at the outset. Today actuarial tools would be used to assist clinical judgment and are certainly likely to highlight the relationship issue as a major ongoing supervision need. Clear risk assessment and management plans are now expected to be routinely carried out for patients such as Mr Foskett. We identify the following as important features of risk plans:

    i. They must be periodically reviewed and re-formulated if they are not to lose value and currency in the long term.

    ii. They provide the best basis for long-term supervision for all involved in an individual's aftercare.

    iii. They must highlight high risk scenarios. Where low frequency, but high impact events, are at issue, maintaining vigilance over high risk scenarios is important, if necessary over long periods of time. This necessitates ensuring that the appropriate configuration of aftercare exists, and is maintained.

CPA and social supervision

38. Mr Foskett was fortunate, in some senses, that he was able to rely on the periodic, if informal, supervision of Prof Coid. This should have been highly effective had Mr Foskett been able to tell him about stopping his lithium and the extent of his symptoms. But as before, when he had been unable to tell Dr Glickman how bad he had been feeling in 1985, he was unable to do so, with disastrous consequences.

39. This highlights the importance of a more structured multi-disciplinary supervision, whereby a practitioner is not reliant only on the information provided by the patient. Also, had the crisis been understood, Prof Coid might well have struggled to achieve an admission to hospital via Barnet, who by that time had no up-to-date information about Mr Foskett (see recommendation below). A further complication was that Mr Foskett and PC were in fact spending most of their time in Newham where she lived.

40. In our view, some support structure should have been in place around Mr Foskett with Barnet at its core. This might have been more likely had the risk posed by his co-habitation with PC been better appreciated.

41. It seems to us to be a significant shortcoming in services that the moment a county or borough boundary is crossed, services become confused or cease altogether. We do not see that this should be the case if sound CPA principles follow the patient (see recommendation below).

Mr Foskett's compliance and the death of PC

42. The Inquiry has commented throughout on the assumptions made about Mr Foskett's compliance, which did not bear analysis when referred to the early assessments made of his personality in Goodmayes Hospital. In particular, that his level of insight into himself, his illness and the risks posed by it were not one and the same. These differing levels of insight, driven by his over-compliant and passive personality traits came to the fore in July 2003, when he was simply unable to inform Prof Coid of the most important developments

in himself, either for fear of letting Prof Coid down, or of letting himself down as the 'model' patient.

43. It is also clear that Mr Foskett did relapse quickly and suddenly, such that there appears to have been a dramatic deterioration in his condition after he saw Prof Coid on 21 July. We have criticised the lack of joint assessments and risk assessment, particularly around 1995 and 1998. But it is clear to us that Mr Foskett is highly likely to have been absolutely discharged by 1998, five years before he killed PC.

44. In the final five years, Mr Foskett remained well, coping with PC and her problems. We think it unlikely that even had he had an allocated supervisor at Barnet that he would have been seen regularly enough to intervene effectively in his relapse when it happened.

45. It is easy to see the striking similarity of this repeat offence to the original index offences as entirely a matter of service failure, but in our opinion that would be a mistake. It is possible to see where services could have been different, but any difference to the outcome is difficult to pinpoint. A very important factor is that these were two strong willed people, highly resistant to outside interference in their lives. It is also important to note that Mr Foskett had remained very well, without any relapse for a period of eighteen years and in contact with Prof Coid, whom he had known since 1991 and who knew him better than any other professional. In terms of continuity, one could not have asked for more.

46. In the end, it is our impression that the most likely route by which any difference might have been made to the outcome was through the involvement of Newham services with PC. Any assessment of the couple in the final year is likely to have highlighted the need for support for them both, and may have alerted Prof Coid at least to the potential stressors within the relationship.

Other relevant matters

47. Finally, we think that it is important to emphasise that homicides by people with mental illness are uncommon. The National Confidential Inquiry[47] reports that within the general population:

- Around a third of all perpetrators of homicide had a diagnosis of mental disorder based on life history; the most common diagnoses were alcohol dependence, drug dependence and personality disorder.

- Seven per cent of people convicted of homicide in England and Wales, and 6% in Scotland, were committed to psychiatric hospital.

- Five per cent of all perpetrators of homicide in England and Wales (7% of those with a psychiatric report), and 2% in Scotland, had a diagnosis of schizophrenia.

- Nine per cent of people convicted of homicide had a diagnosis of personality disorder. (England and Wales only)

48. Of those with mental illness at the time of the homicide, fifteen per cent of people convicted of homicide in England and Wales (for whom psychiatric reports were available), and 5% in Scotland, had symptoms of mental illness at the time of the offence. Mentally ill perpetrators were less likely to kill a stranger than those without mental illness. Three people per year were found 'unfit to plead', and two per year were 'not guilty by reason of insanity'.

49. Nine per cent of all perpetrators in England and Wales had been in contact with mental health services in the year before the offence. At least 18% had been in contact with services at some time. The most common diagnoses were personality disorder and schizophrenia and almost half of these with any service contact had a history of alcohol and drug misuse.

50. The assessment and prediction of risk is not an exact science, and Mr Foskett's presentation on any actuarial measurement was low prior to the killing of PC. This is not an error or failing within the system, but serves to

[47] See "Key Findings: Homicide Research" available at http://www.national-confidential-inquiry.ac.uk

underline the complexity of the judgments that need to be made. Cases of homicide by depressed patients are highly complex and difficult to manage.

51. We would like to re-iterate that although mental health professionals must be accountable for good practice, they cannot ultimately be expected to carry complete responsibility for the actions of their patients. There is a limit to the control and influence which it is possible for them to achieve over any individual. It would also be wrong to overlook the right of a patient to refuse interventions by the services.

Recommendations

52. The recommendations we have made appear in the text at relevant points and are summarised below. It will be important for the Primary Care Trusts in Barnet and Newham, responsible for commissioning services, to oversee recommendations 1, 2, 4 and 5 and to ensure that they are implemented.

RECOMMENDATION 1 (Chapters Five and Nine)

East London and The City Mental Health NHS Trust (now incorporating Newham community mental health services) should 1) review the implementation of its CPA policy with a view to establishing the reasons why the referrals of PC to the East Newham CMHT in 2002 and 2003 did not occur and/or were delayed, 2) review the definitions and inclusion criteria of standard and enhanced CPA.

RECOMMENDATION 2 (Chapters Five and Nine)

Barnet, Enfield and Haringey, and East London and The City NHS Mental Health Trusts, should review the implementation of CPA policy to ensure compliance with current guidance relating to the needs of carers.

RECOMMENDATION 3 (Chapter Seven)

The Home Office and Department of Health should jointly commission research into the effects of an absolute discharge on compliance with supervising teams, rates of recidivism and relapse.

RECOMMENDATION 4 (Chapter Eight)

Barnet, Enfield and Haringey and East London and The City Mental Health NHS Trusts should a) review the application of CPA principles, and b) ensure that the Barnet MDO team reviews its allocation of cases and application of CPA to all cases that are open but not active.

RECOMMENDATION 5 (Chapters Eight and Nine)

Barnet, Enfield and Haringey Mental Health NHS Trust and East London and The City Mental Health NHS Trusts should review all forensic patients with an element of care in another locality to ensure the application of CPA principles and follow-up.

JOINT ACTION PLAN

Recommendation	Action Taken To Date	Further Action	Responsible	Date
East London and The City Mental Health Trust should • Review the implementation of its CPA policy with a view to establishing the reasons why the referrals of PC to the East Newham CMHT in 2002 and 2003 did not occur and/or were delayed • Review the definitions and inclusion criteria of standard and enhanced CPA	Revised CPA Policy approved by the ELCMHT Board in February 2006. This clarifies all relevant standards, roles and responsibilities. CPA documentation has also been reviewed. The referral of PC was delayed because a number of appointments were cancelled, mainly by ELCMHT. The ELCMHT Board now monitors the number of unallocated cases and cases being assessed on a monthly basis The ELCMHT Community Services Review identified that a number structural and qualitative improvements were required across the Trust. The review endorsed the findings of a pilot study in Newham that creating closer links between outpatient services and CMHTs and suggested the restructuring of CMHTs to provide consistent and robust specialist assessments. ELCMHT's Integrated Healthcare Governance Committee routinely monitors and audits the application of standards across the Trust. The Trust audited supervision practices in Newham in 2005 and in 2006 established a performance management mechanism for middle managers to resolve performance issues. Re-audit of supervision standards and action plan will be completed before the end of 2006.	BEH and ELCMHT will undertake a shared learning exercise with particular emphasis on the quality of individual's experience of services and psychotherapeutic interventions provided Complete Trust-wide implementation of Community Services Review Action Plan and roll out Newham pilot. Monitoring by Trust Board and local Partnership Boards, next report September 2006. Implementation of Action Plan following re-audit of supervision standards to be monitored by Executive Directors on a quarterly basis through Directorate Performance Management Team.	Directors of Operations BEH/ELCMHT ELCMHT Borough and Clinical Directors Directorate Management Team	Nov 2006 Sept 2006 Aug 2006 onwards

Recommendation	Action Taken To Date	Further Action	Responsible	Date
Barnet, Enfield and Haringey Mental Health NHS Trust and East London and The City Mental Health NHS Trust should review the implementation of CPA policy to ensure compliance with current guidance relating to the needs of carers.	<u>BEH</u> CPA Policy and supporting documentation reviewed in November 2005. Trust policy prioritises working with carers according to recognised good practice. <u>ELCMHT</u> See above. In addition Section 11 of the ELCMHT CPA Policy identifies specific standards to ensure appropriate involvement of carers and families. Standards include assessments, plans, information and consent. Newham has an active Carers Forum and is represented at the Newham Partnership Board by the Carers Worker funded by the London Borough of Newham. The Partnership Board has commissioned a study of the impact of CPA on carers. The Newham Partnership Board will consider revised guidelines for the use of the Mental Health Grant to enhance choice. Commissioners monitor the achievement of performance standards through the routine monitoring of the Section 31 Agreement between the Trust and London Borough of Newham. In 2005/06 the number of carers assessments, support packages and funded carers plan had risen significantly from levels reported in 2004/05.	<u>BEH</u> Annual audit of CPA policy implementation Local Authority and BEH Board to receive regular reports on carers assessments and action taken Report on study of impact of CPA on carers to be considered by the Newham Partnership Board and action plan agreed. Implement revised guidelines for use of Mental Health Grant in Newham ELCMHT Board reports to include key performance data relating to carers. Include audits of services and practice relating to carers in local annual audit programme. Resulting action plans to be agreed by Directorate Management Team	 Clinical Audit Manager Director of Nursing Carers Support Worker/Newham Partnership Board Deputy Borough Director Director of Information/Borough Director Clinical Director, Newham	 Aug 2006 Dec 2006 Oct 2006 Oct 2006 Sept 2006 Ongoing

Recommendation	Action Taken To Date	Further Action	Responsible	Date
The Home Office and Department of Health should jointly commission research in to the effects of an absolute discharge on compliance with supervising teams, rates of recidivism and relapse.		NHS London to write to Department of Health and Home Office	Assistant Director Mental Health NE	July 2006
Barbet Enfield and Haringey Mental Health NHS Trust and East London and The City Mental Health NHS Trust should • Review the application of CPA principles • The Barnet Mentally Disordered Offenders team should review its allocation of cases and applications of CPA, to all cases that are open but not active	<u>BEH</u> Barnet MDO Team has reviewed allocations of CPA and application of CPA. All service users in the care of the MDO team are under CPA and there are no inactive open cases. <u>ELCMHT</u> All boroughs with ELCMHT forensic service have identified Consultant Forensic Psychiatrist and forensic CPN and hold regular 'surgeries' to provide advice on referrals and risk management issues. Forensic CPNs attend key CMHT review meetings. There is a clear link through to the local joint agency safety arrangements including MAPPA. All applications for residential placements made through the Mental Health Panel in Newham must be supported by appropriate risk assessment, contingency and care planning documentation. Placements are monitored to ensure appropriate care is provided. ELCMHT has completed a review of Forensic Services looking specifically at the links between general and forensic services.	Ongoing reviews Newham Partnership Board and Directorate Management Team to review the effectiveness of the Newham Mental Health Panel Trust Board to agree action plan from Forensic Service Review	Barnet Borough Director Deputy Borough Director Director of Operations	Ongoing April 2007 Dec 2006

Recommendation	Action Taken To Date	Further Action	Responsible	Date
Barnet Enfield and Haringey Mental Health NHS Trust and East London and The City Mental Health NHS Trust should review all forensic patients with an element of care in another locality to ensure the application of CPA principles and follow up	BEH The responsibility for service users living in other boroughs is transferred to designated teams according to the CPA and transfers policies. ELCMHT See above	BEH Monitor practice Clinical Governance and Service Improvement Group to review DF Inquiry report and recommendations BEH/ELCMHT to review case transfer policies and handover protocol and share learning	 Director North London Forensic Service Director of Nursing BEH Director of Nursing/ ELCMHT Director of Operations	 Ongoing Oct 2006 Nov 2006

APPENDIX A

Chronology of Key Events in DF's Life

Early history

1958	Aged 15 first diagnosed with depression following 'flu.
1964	Married; wife Margaret (eventual victim) epileptic.
1970	Aged 27. Lost job as charge hand due to 'flu bout.
	DF suffers second episode of depression following 'flu. He is admitted to hospital for 10 days. DF reports feeling suicidal and aggressive towards others.; attended for admission to Goodmayes.
1974	Third episode of depression
1975	PC diagnosed with depression.
1979	Referred to Goodmayes by GP, Dr E Glickman (eventual victim).
1980	Appointment at East Ham Memorial Hospital
1981 - 1982	DF referred again to East Ham Memorial Hospital for depression and treated as outpatient until April 1982.

1985: Homicides of wife and GP; admission to Goodmayes

May 1985	DF ill with 'flu and depression, attended GP (Dr Glickman) who prescribed tetracyclic anti-depressant. DF reported feeling reckless and agitated.
17 May 1985	Mrs F called Dr Glickman who left surgery at 6.45pm. At 7.10pm DF seen by neighbour outside house, very distressed. Bodies of two women discovered in back room of DF's home.
21 May 1985	DF taken to HMP Brixton, possibly experiencing auditory hallucinations on admission.
17 Sept 1985	DF offered place at Goodmayes Hospital.

22 Nov 1985	DF convicted on 2 counts of manslaughter at Central Criminal Court and sentenced under sections 37 and 41 of Mental Health Act 1983 i.e. hospital and restriction order unlimited in time.
17 Dec 1985	DF admitted to Goodmayes Hospital. Admission summary describes him as 'model' patient with fair degree of insight. No psychotic features.

1986 – 1987: Treatment at Goodmayes Hospital

March 1986	Dr Minas is the Responsible Medical Officer.
May 1986	Visit to wife's grave discussed.
October 1986	Home Office grants permission for visit to wife's grave on 21/10, but DF unable to face visit.
November 1986	Preparations for visit to wife's grave.
	Dr Minas makes first statutory report to the Home Office: DF continues to improve and poses no danger unless he discontinues medication.
March 1987	Nursing reports that individual therapy has progressed; recommendation for group therapy in OT.
April 1987	DF undergoes psychology assessment.

1987 – March 1993: Goodmayes Hospital and relationship with PC

August to October	PC being seen for depression
November 1987	Home Office grants DF escorted leave.
	PC (eventual victim) admitted to Goodmayes, has been seeing Dr Minas as an outpatient.
December 1987	DF and PC become engaged.
February 1988	DF on escorted leave to visit mother.
May 1988	DF transferred to community care ward (Magnolia) with long stay patients. DF is unsettled following move and reported as not eating, sleeping or mixing with other patients.
July 1988	Home Office permission to DF to join ward outing.
Aug-Nov 1988	DF taking regular escorted leave. Steps are taken to reduce DF's dependence on staff for medication and he is reported as doing well on self-medication.

Dec 1988	Dr J Feldman takes over as RMO from Dr Minas.
Feb 1989	Report by Dr P Bowden recommends a further two years at Goodmayes and close monitoring of DF's relationship with PC.
	Plans to see DF and PC together as a couple; queries made about the possibility of couple therapy.
March 1989	Home Office authorises unescorted day leave at RMO's discretion.
April – May 1989	Meeting with PC, DF and Dr Feldman. PC feels uncomfortable talking in front of nursing staff. PC to attend Margaret Scott centre and for couple therapy. Dr Feldman sought couple assessment from family therapy centre. PC described as being a very difficult person with personality disorder and obsessional neurosis.
	Dr Feldman sought advice from doctor at Maudsley Hospital re use of lithium with Amitryptiline prophylatically.
	Mental Health Review Tribunal decision on 24th May, DF not to be discharged.
	East Ham Family Centre offered couple assessment for DF and PC.
June 1989	DF took unescorted leave.
	Dr Feldman advised Elizabeth Bennett on how to get PC to attend couple therapy appointment. DF later attended appointment, but PC did not. Service is suspended for restructuring.
July 1989	DF late back on three outings.
	Medication review: DF to begin Lithium and gradually reduce Amitryptiline.
31 July 1989	DF's medication reviewed. DF starts Lithium; Amitryptiline to be decreased gradually until at maintenance dose. DF to re-referred to family centre.
August 1989	Psychiatric assessment: DF is aware of illness and reason for being in hospital.
October 1989	Lithium blood levels are high; dose is briefly discontinued and then restarted. Lithium monitoring continues.
	DF makes a number of unescorted visits home. Dr Feldman requested Home Office for overnight leave.

November 1989	Lithium levels high; dose stopped for 48 hours.
	Home Office allowed 4 overnight leaves.
December 1989	Annual statutory report.
	DF given 2 days leave a week for a 4 week trial.
January 1990	DF and PC not attending couple therapy.
24 January 1990	Case conference at Goodmayes to discuss possible conditional discharge for DF.
25 January 1990	Dr Feldman contacted hospital manager regarding possibility of preparing for DF's discharge by linking in with community, to avoid negative press coverage.
30 January 1990	Dr Feldman contacted East Ham Centre: DF and PC still in need of couple counselling.
February 1990	Elizabeth Bennett contact regarding first referral in May 1989 for couple counselling.
March 1990	DF became employed.
	Dr Feldman requested permission for overnight leave to a group home organised by Dr Abrahamson. Permission refused.
	Janice Hiller, clinical psychologist invited DF and PC to assessment in April.
April 1990	PC will not engage in counselling.
June 1990	Home Office expressed concerns re PC.
July 1990	DF spending 4 nights a week at mother's home and more time in community.
	PC still not attending couple counselling sessions.
September 1990	Home circumstances report for Advisory Board by social worker. Interim report from East Ham Centre sent to Home Office.
November 1990	Annual report by Dr Feldman sent to Home Office. Advisory Board set for January 1991.
December 1990	Home Office report: family history.
February 1991	Formal decision by Advisory Board.
	Home Office letter: Dr J Coid to be engaged with view to obtaining indication of direction for rehabilitation. DF seen by Dr Coid.

March 1991	PC asked Dr Feldman for counselling with DF.
April 1991	Report of toxic effects of lithium.
	Dr Coid confirmed opinion on nature of illness to Dr Feldman
	Home Office agreed to continued efforts to mobilise DF regarding relationship with PC, counselling in the context of preventing DF and PC cohabiting, and supervised hostel accommodation for DF.
May 1991	Lyndhurst identified as possible hostel by Dr Feldman. Plan for DF and PC to see psychologist for couple counselling.
July 1991	PC now living with her mother.
September 1991	Leave plan prepared for DF.
October 1991	DF accepted at Lyndhurst Hostel, Finchley, Barnet.
November 1991	PC referred for psychological therapy to the Maudsley and to Newham services by Dr Feldman.
May 1992	Meeting with advisory board.
June 1992	PC assessed at Bethlem Hospital.
July 1992	Multidisciplinary meeting to agree Section 117 after care arrangements as funding for DF to move to Lyndhurst in place, room available at Christmas. Programme for year drawn up: care at Lyndhurst under Mr B Scott, GP Dr Brett. Plan agreed for DF to have rehabilitation in the medium term plan, with long-term plan for independent living.
August 1992	Hospital managers support DF plan. Minister agreed in principle to transfer to Lyndhurst and sought quarterly reports.
September 1992	DF assessed by Dr Coid, reportedly DF is happy with move to Lyndhurst. Advisory Board's view is that DF should be supervised by forensic psychiatrist, but note lack of resources and staff. Dr Coid cannot see DF more than once a month as outpatient. No community team back up.
November 1992	Secretary of State agreed transfer to Lyndhurst. Dr Coid will continue to review DF's progress and quality of supervision at Lyndhurst.
27 November	Secretary of State issues warrant of conditional discharge under section 42(2) MHA.
December 1992	Case conference: agree that Barnet mental health services will provide overall supervision. Care plan: monthly meetings

	coordinated by social worker. Dr Feldman to arrange follow-up in outpatients once discharged; Dr Coid to see DF 3-4 times a year. Vacancy at Lyndhurst delayed.
January 1993	Plans for discharge to Lyndhurst going ahead.
February 1993	DF rejects Lyndhurst as too far away from his mother.
	Maudsley respond that PC is making positive progress
March 1993	DF agrees to accept move to Lyndhurst
26 March 1993	DF conditionally discharged to Lyndhurst initially under the care of Dr Abrahamson. Dr Coid and Dr Feldman responsible for future care. Appointment made with Dr Coid for May 1993.

April 1993 – September 1996: Lyndhurst

April 1993	Regular report on DF sent to Home Office.
May 1993	DF seen by Dr Coid; PC still being treated at Bethlem Hospital for Obsessive Compulsive Disorder. Care plan meeting held; DF is positive, still employed at print shop. Social Worker sees DF once a fortnight. Dr Abrahamson transfers care of DF to Dr Feldman.
July 1993	Appointment with Dr Feldman, DF appears well. Lithium levels being monitored at East Ham Memorial Hospital on a monthly basis with updates sent to Dr Coid, Lyndhurst and social worker.
	Dr Feldman reports on PC's progress to Dr Coid and mentions difficulties with DF.
August 1993	Dr Coid report on DF. Dr Coid agrees to take over case.
	PC being seen at Maudsley for OCD
September 1993	Dr Feldman and social worker sign S117 termination of aftercare form. Dr Feldman to stop seeing DF; Dr Coid to take over as RMO.
October 1993	Meeting with DF, Mr Bull, Mr Scott. DF has settled well into hostel, reported as having good relationship with staff and other residents. S117 meeting held at Hackney Hospital, future meetings every 3 months. Regular progress report to Home Office: seeing DF fortnightly, initially weekly for first month. PC reportedly staying overnight at Lyndhurst once a fortnight.
December 1993	Stewart Whitehead takes over as contact at Newham Healthcare, East Ham Centre.

Jan – Mar 1994	DF reported good Christmas with PC and mother. No depressive symptoms. PC has been discharged from Bethlem. Social Worker left Newham 15/3; no successor appointed to DF's case. Dr Coid wrote to Mr B, C3, and director of social services re statutory duty of department and need for continuity for DF. Khadija Patel new Social Worker appointed but is on leave until April.
April 1994	Dr Coid met new Social Worker, who has visited DF at Lyndhurst. DF staying at mother's for a week, and seeing PC regularly.
May 1994	Dr Coid report for Home Office.
June 1994	DF seeing social worker every two weeks and has monthly sessions with key worker. DF seen by Dr Coid
August 1994	DF discharged from East Ham Centre. DF has started to use local MIND drop-in centre in Barnet.
September 1994	Dr Coid sees DF and reports no problems.
October- Nov 1994	DF has no symptoms of depression and is waiting for decision regarding long term housing
January 1995	DF still awaiting offer of accommodation and applies for discharge to Mental Health Review Tribunal.
February 1995	Dr Coid report for Tribunal supports absolute discharge; highlights compliance with medication as a key issue. No indications that DF's relationship with PC is a source of stress.
April 1995	Dr Coid reports DF has no problems or symptoms, and remains well on medication. Independent forensic psychiatrist writes in support of absolute discharge.
11 April 1995	Mental Health Review Tribunal decision agreeing to absolute discharge for DF.
May 1995	Referral to community support team in Barnet; Social Worker remains Khadija Patel. Care coordinator Frances Gauthier appointed.
June 1995	Community Care/CPA assessment: Plan to hand over to community support team (CST).
July 1995	DF accepted by Barnet Multi-disciplinary Team; DF anxious he will be overwhelmed by professional involvement. Dr Coid contacts Barnet psychiatrist following review meeting with DF.

August 1995	Ms Gauthier to sort out housing: DF to have 6 month trial with Community Support Team input. Lyndhurst will support DF when he moves. Will have monthly meetings with social worker
	PC moderate progress with behaviour therapy.
September 1995	Dr Coid: DF still at hostel, looking for flat in Barnet and waiting for appointment with psychiatrist at Community Support Team. Barnet Community Care team say he does not have to go through prolonged assessment.
November 1995	Dr Coid: DF still at hostel
January 1996	Flat offered to DF but unsuitable, care coordinator successfully appeals against offer to Barnet Housing Department.
April 1996	Appointment with Community Support Team Psychiatrist does not materialise DF. PC to have hysterectomy. No depressive symptoms identified in DF.
May 1996	Care Coordinator arranges outpatient appointment with Psychiatrist in Barnet
July - Sept 1996	Offer of Bed and Breakfast accommodation rejected as unsuitable. DF keeps regular appointment with Dr Coid

October 1996 – June 2003: Barnet

13 October 1996	DF left hostel, moved into newly-built flat, continues to see PC regularly.
December 1996	Care Coordinator report to housing officer that noise in flat is affecting DF's health.
January 1997	Frances G report to Dr Coid regarding new forensic CMHT/MDO team. DF reports continuing problems with noise in his flat.
	Dr Coid reports he is happy to see DF as outpatient. FG to consider closure of DF's case.
	PC referred to Dr Feldman by GP
February –Nov 1997	DF still experiencing problems with noise, not sleeping, denies symptoms of depression. DF stays with PC and his mother regularly and waits to be re-housed.
June 1997	PC referred to Maudsley by her GP.

20 November 1997	DF offered new accommodation. Care Coordinator prepares transfer summary from Mentally Disordered Offenders Community team, covering DF's housing problems, mental health, problems with continuity of service and outlining the need for future contact. PC feeling low; assessed as having suicidal ideation with no intent and advised to make a referral to the local service if the depression worsens.
January 1998	PC starts to attend regular outpatient appointments at East Ham Memorial Hospital.
March 1998	Care Coordinator leaves service DF is to contact CMHT (MDO) until replacement worker is found. DF and PC find PC's mother dead on the floor on pre-Christmas visit. No depression symptoms reported by DF.
April 1998	Richard Groves to take over from FG as Care Coordinator until further appointment made. DF will now only accept follow-up by Dr Coid.
May 1998	PC refused home visit by social worker from Newham CMHT.
June 1998	PC being seen by psychiatrist as outpatient, no need to be seen by CMHT and case closed.
September 1998	PC states at outpatient appointment that her OCD puts a strain on her relationship with DF.
November 1998	DF seeing Dr Coid twice a year.
March 1999	Dr Coid: does not detect any signs of depression in DF who is hoping to be re-housed. PC's OCD remains the same.
April 1999	PC attends psychology sessions at East Ham Day Hospital.
September 1999	DF misses appointment with Dr Coid and is rescheduled for November.
November 1999	DF reports no depressive symptoms although is still waiting to be re-housed.
May 2000	DF had seen another flat but was not interested in taking it. DF reported feeling low to Dr Coid after cold 3 months previously, some anxiety. GP increased Lithium level.
July 2000	PC being seen regularly at Maudsley Hospital.
December 2000	DF and PC attend appointment with Dr Coid
July 2002	PC reviewed at Newham at request of Maudsley and referred to CMHT as a result. DF reports feeling anxious to Dr Coid.

December 2002	DF missed appointment with Dr Coid, rescheduled for January 2003.
January 2003	DF reported anxiety in July 2002 but is not expressing any depressive symptoms. DF's relationship with PC remains good although she is reportedly depressed and anxious with suicidal thoughts. Report from Dr Coid to Dr Brett DF's GP, stating that DF's flu in July 2002 was not precipitated by viral infection.
June 2003	PC experiencing high blood pressure (since 2001) and breast pain. PC seen by Dr Waterdrinker in outpatients; at same time therapy sessions at Maudsley were ending, severe OCD issues noted. Referral made to CMHT in Newham

July – May 2004: Homicide of PC

21 July 2003	DF attends regular appointment with Dr Coid. Dr Coid suggests Dr Brett increases level of Amitryptiline. To be reviewed in 3 weeks. PC seen by Dr Waterdrinker in a distressed state and feeling suicidal.
28 July 2003	DF calls emergency services (1.02am) having killed PC and taken an overdose.
8 August 2003	DF indicted for the murder of PC between 25 and 29 July.
22 December 2003	DF admitted to Camlet Lodge Medium Secure Unit at Chase Farm Hospital.
21 May 2004	DF pleads guilty to manslaughter and is sentenced by the Central Criminal Court to be detained under Section 37/41 MHA 18983 and admitted to Camlet Lodge Medium Secure Unit at Chase Farm Hospital.

APPENDIX B

North East London NHS
Strategic Health Authority

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF DENNIS FOSKETT (DF)

Terms of Reference

1. The Inquiry has been set up in accordance with the Department of Health Guidance HSG (94) 27: Guidance on Discharge of Mentally Disordered People and their continuing care in the community, in order to inquire into the care and treatment of Dennis Foskett following his conviction for the murder of PC in July 2003.

2. The Inquiry will be chaired by Aswini Weereratne, barrister, with Dr James Anderson, Consultant Forensic Psychiatrist, and Angela Greatley, Director of Policy, Sainsbury Centre for Mental Health as panel members.

3. The Inquiry will:

   3.1. Identify the health and social care services used by DF
   3.2. Examine all the circumstances surrounding DF's care and treatment and present a first draft of its report to the North East London Strategic Health Authority by 31 July 2005, designed to reduce the likelihood of such an event recurring.
   3.3. The commissioners must be given fair notice and explanation by the Inquiry team of any expected delay in their concluding their work.

4. The Inquiry will particularly look at:

   4.1. The quality and scope of his health and social care
   4.2. The appropriateness and quality of any risk assessment, care plan, treatment or supervision provided, having particular regard to:

      4.2.1. His past history
      4.2.2. His psychiatric diagnosis
      4.2.3. His forensic history
      4.2.4. His history any alcohol misuse
      4.2.5. His assessed health and social care needs
      4.2.6. Any inter-agency issues arising, including communication between primary care, Mental health and social services
      4.2.7. Carers assessment and carers' needs
      4.2.8. Cross boundary issues raised by DF residing in the London Borough of Barnet, whilst a Responsible Medical Officer (RMO) from

East London and The City Mental Health Trust was responsible for his care.

5. 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.

6. The extent to which his care and treatment plans

   6.1. Reflected an assessment of risk
   6.2. Were effectively drawn up, communicated within and beyond mental health services, and monitored
   6.3. Were complied with by DF.

7. The Inquiry will examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care of DF 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.

8. The Inquiry will examine the adequacy of the communication and collaboration between the statutory agencies and any family or informal carers of DF.

9. Consideration of the management of risk should consider with equivalent attention the risk to himself and the risk to others represented by DF, and whether his treatment and care were proportionate.

10. To consider such other matters relating to the issues arising in the course of the inquiry as the public interest may require

APPENDIX C

INQUIRY PROCEDURE

Introduction

1. The Inquiry is independent of its sponsors.
2. The Inquiry will be known as "the independent inquiry into the care and treatment of Dennis Foskett".
3. All hearings of the Inquiry will be held in private: this means that the press and other media will not be allowed to attend hearings. There will be no cross examination of witnesses except by members of the Inquiry panel and counsel for the Inquiry panel.
4. Witnesses will be given an opportunity to comment on the evidence of others where relevant and necessary and as provided for below by way of written representations (see paragraphs 10, 17 and 18).
5. The Inquiry hearings will be conducted as informally as possible. Evidence will be led by the panel members and will ensure that the views of all those participating in the inquiry process, and in particular the victim's family, are properly and fully canvassed in evidence (see paragraph 22 below).
6. Factual evidence will be sought from a) those working for the agencies/services involved with Dennis Foskett at the relevant time, b) "lay" witnesses, being family, friends or others with direct knowledge of Dennis Foskett and not within the identified agencies/services.
7. Advice may be sought from relevant experts on policy and practice issues.

Written evidence

8. Each factual witness will receive letters informing them:
   a) of the terms of reference and the procedure adopted by the Inquiry
   b) of specific areas and matters on which the Inquiry wishes them to provide evidence in addition to anything the witness him or herself wishes to raise
   c) of the method of accessing records relevant to their own role in the care of Dennis Foskett for the limited purpose of responding to the Inquiry.
9. Witness evidence is to be provided in writing in the first instance: written statements will provide the basis for any oral evidence which the Inquiry may deem necessary.
10. Not every witness written to will automatically be invited to give oral evidence unless this is specifically requested by the witness with reasons.
11. All witnesses asked to provide written evidence will be provided with a list of factual witnesses written to so that they may i) indicate whether

in their opinion any material witness has been omitted and ii) suggest areas of inquiry with any of the proposed witnesses.

Hearings and oral evidence

12. Details of venue and recoverable expenses incurred in attending to give oral evidence will be provided at the time a factual witness is notified by the Inquiry panel of the need for such evidence. Witnesses will be offered an opportunity to familiarise themselves with the venue in advance of giving evidence.
13. Witnesses attending in person to provide evidence may raise any matter they feel might be relevant to the Inquiry.
14. Witnesses may bring with them, at their own personal cost, a lawyer or a member of a defence organisation, friend, relative, colleague or member of a trade union, provided that no such person is also a witness to the Inquiry: it is the invited witness who will be expected to answer questions. It is expected that if required agencies/services will provide legal assistance to staff/officers from whom evidence is requested by the Inquiry.
15. Factual witnesses will be asked to affirm that their evidence is true.
16. Questions asked will take into account representations made by the family and other factual witnesses or agencies or professional bodies and any advice received from experts.
17. Oral evidence will be recorded and a transcript sent to the relevant witness to check for factual accuracy.
18. Any points of potential criticism concerning a witness of fact which may be material to the Inquiry's findings will be raised with that witness either directly at the time they first attend to give evidence to the Inquiry in person or in writing at a later time. They will be given a full opportunity to respond (usually in writing). A summary of any relevant evidence or, if appropriate an extract of the same, will be provided by the Inquiry for that purpose.
19. 18 above will also apply to any matter which falls short of a criticism but where the evidence of one witness may be material to that of another.

Other evidence

20. A press statement inviting anyone with relevant information to contact the Inquiry may be issued and the Inquiry may invite such persons to make written or oral representations.
21. Representations may be invited from relevant professional bodies, agencies and individuals as to their views and any recommendations on the issues arising, including on the present arrangements for persons in similar circumstances to Dennis Foskett.

Victim's family

22. The family of PC will be given a full opportunity to contribute to the Inquiry process and to consult with the Inquiry. In particular, family members will:
    a) Be provided with copies of the terms of reference and procedure
    b) Meet informally with the panel members or the inquiry manager
    c) Be asked to provide a list of potential witnesses together with issues/questions they consider to be relevant
    d) Be provided with a list of proposed witnesses prior to hearings for their comments and questions
    e) Give formal evidence to the inquiry
    f) Be provided with a copy of the final Inquiry report.

Publication of report

23. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments that appear within the narrative of the report, and any recommendations, will be based on those findings.
24. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as disclosed within the body of the Inquiry's final report.
25. The findings and any recommendations of the Inquiry will be presented in a report and made public by the Health Authority.

January 2005

APPENDIX D

LIST OF WITNESSES

ORAL EVIDENCE: Expert, Professional and Lay Witnesses

1. Professor Jeremy Coid, consultant forensic psychiatrist, St Bartholomew's Hospital, London.
2. Bernard Scott, Director Lyndhurst Care Home, Finchley, Barnet.
3. Danielle Scott, Lyndhurst Care Home as above.
4. Dr Charles Brett, GP.
5. Dr Meena Naguib, Consultant Psychiatrist, Barnet MDO team.
6. Dr Joan Feldman, former Consultant Psychiatrist, Goodmayes Hospital (now deceased).
7. Dr Mathew Chang, GP
8. Jonathan Ash, former Nurse consultant, Maudsley Hospital.
9. Janice Hiller, Head of sexual health, Goodmayes Hospital, Essex
10. Terry Molloy, Art Psychotherapy, University of London.
11. Frances Gauthier, former social worker, Barnet MDO team.
12. Dr Astrid Waterdrinker, former Consultant Psychiatrist, East Ham Memorial Hospital.
13. Dr J Craissati, Head of Forensic Clinical Psychology Services, The Bracton Centre, London
14. Dennis Foskett
15. Kenneth Foskett (Dennis' brother)

WRITTEN EVIDENCE: Expert and Professional Witnesses

1. Dr D Abrahamson, Retired Consultant Psychiatrist, Goodmayes Hospital
2. Jane Scott, Assistant Director, Barnet, Enfield and Haringey NHS Mental Health Trust
3. Nigel Shackleford, Mental Health Unit, Home Office.
4. Ann Richardson, Head of Mental Health Programme, DoH.
5. Prof David Healy, North Wales Dept of Psychological Medicine.
6. Dr Andrew Payne, consultant forensic psychiatrist, Broadmoor Special Hospital.

NO RESPONSE/UNTRACEABLE

1. Richard Groves, Barnet MDO team
2. Graham Bull, Newham social worker.
3. Khadija Patel, Newham social worker.
4. G. Bunyan, nurse/psychologist, Goodmayes Hospital.
5. Stewart Whitehead, East Ham Memorial Hospital.
6. Elizabeth Bennett, East Ham Family Centre.

APPENDIX E

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MM

STANDARD WITNESS LETTER

(professional)

CONFIDENTIAL

Dear

Independent inquiry into the Care and Treatment of Dennis Foskett

This Inquiry has been set up by the North East London Strategic Health Authority by virtue of its obligation to do so under NHS Executive Guidance (HSG (94)27) following the killing of PC by Dennis Foskett in July 2003.

I have been appointed as manager to the Inquiry and am writing to you on behalf of the Inquiry panel. The members of the Inquiry are: Ms Aswini Weereratne (chair), a barrister; Dr James Anderson, consultant forensic psychiatrist and Angela Greatley, Acting Chief Executive at the Sainsbury Centre for Mental Health.

Copies of the Terms of Reference set for the Inquiry, and of the procedure to be adopted are attached for your information. Please read these documents which have been drafted with the aim of enabling the Inquiry panel to fulfil its duty to investigate the relevant matters fully and fairly.

Dennis Foskett has given his consent to the disclosure of all the records relating to the medical treatment he received and the care provided by all the agencies with which he has been in contact up to and including 23 July 2003. An initial examination of these records indicates to us that you may have relevant evidence to contribute to the Inquiry.

We are currently writing to all those people from statutory services who can be identified from the records we have received as potentially having relevant evidence for the Inquiry. We are also writing to people who knew Dennis Foskett or PC on a personal basis. We are sending you a list of all those being written to in accordance with paragraph 11 of the enclosed procedure.

The Inquiry panel invites you to attend an interview with the panel on *. The panel requests you to prepare a written statement of your evidence in advance of your attendance at the hearing. Please could you ensure that your statement is sent to me to arrive by *.

The original records are being held at [location of relevant agency/records], after being copied by the Inquiry. It would probably help you in completing your statement to refer to those records to which you were a direct contributor. If you encounter any difficulty in gaining access to the records you need then I will do my best to help you from the copies held by the Inquiry. Any records (or copies) given to you must of course be kept securely and confidentially and returned.

Matters to be covered by your evidence

Please feel free to raise any issue that you may feel is relevant to the Inquiry whether professional or personal. The Inquiry panel will deal with all information received as sensitively as possible. More specifically, we should be grateful if your statement could outline your

background, training and experience. It should define the entire period of your contact with Dennis Foskett, state the reasons for that contact and describe your role and involvement and with specific reference to:
*

Could you also please review the enclosed list of factual witnesses and include in your statement the following:-

1) The name and, if possible, the contact details of any material witness you consider to have been omitted from the list

2) Suggested areas of questioning for any of the witnesses on the list or for any new witnesses you identify

Procedure

The interview will be taking place on *, at *. It will be held at 10 Doughty Street, London WC1N 2PL. A map is attached. Please confirm that you will be able to attend at this time and date.

We would hope to keep interviews as short as possible, and hopefully no more than one or two hours, but are unable to provide a more precise time estimate, though some interviews may be shorter and others longer given the length of time that Dennis Foskett was cared for by mental health services.

You will note from the procedure and schedule that the Inquiry hearings will be held in private. Interviews will be transcribed verbatim by a professional transcriber who will also be present. You can attend with a legal, trade union, or other advisor, friend or colleague, but this should not be someone who is connected with the commissioning of the Inquiry and its Report, in order to avoid any possible conflict of interest. Once again I refer you to the written procedures that are enclosed.

If you would like more information, please contact me on 020 7655 6710, or by emailing dulara.khatun@nelondon.nhs.uk.

We look forward to hearing from you and enclose a SAE for your reply.

Yours sincerely

Dulara Khatun
Inquiry Manager

APPENDIX F

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF DF

STANDARD LAY WITNESS LETTER

CONFIDENTIAL

Dear

Independent Inquiry into the Care and Treatment of Dennis Foskett

This Inquiry has been set up by the North East London Strategic Health Authority by virtue of its obligation to do so under NHS Executive Guidance (HSG (94)27) following the killing of PC by Dennis Foskett in July 2003.

I have been appointed as manager to the Inquiry and am writing to you on behalf of the Inquiry panel. The members of the Inquiry are: Ms Aswini Weereratne (chair), a barrister; Dr James Anderson, consultant forensic psychiatrist and Angela Greatley, Acting Chief Executive at the Sainsbury Centre for Mental Health.

Copies of the Terms of Reference set for the Inquiry, and of the procedure to be adopted are attached for your information. Please read these documents which have been drafted with the aim of enabling the Inquiry panel to fulfil its duty to investigate the relevant matters fully and fairly.

The Inquiry panel understands that you had contact with Dennis Foskett and/or with PC prior to her death and you may have relevant evidence to contribute to the Inquiry

As well as writing to people, who knew Dennis Foskett or PC on a personal basis, we are also currently writing to all those people from statutory services who can be identified from the records we have received as potentially having relevant evidence for the Inquiry. We are sending you a list of all those being written to in accordance with paragraph X of the enclosed procedure.

The Inquiry panel has decided that certain individuals will be asked to attend to give oral evidence. They are marked on the list with a *. As far as the rest of the witnesses are concerned, the panel has not yet decided whether to ask them to attend to give oral evidence. That decision will be made when the panel has had an opportunity to read their written statements.

In accordance with the above, the Inquiry panel invites you to attend an interview with the panel on *.

You may, if you wish, prepare a written statement of your evidence to assist you. If you do, it would be helpful if you could send it to me to arrive by X.

Matters to be covered by your evidence

It is for you to decide what information you think would be of help to the Inquiry but the panel would be grateful if your statement could outline your relationship with Dennis Foskett or PC - how and when you got to know her/him/them and how long the relationship lasted; relevant information shared with you etc. Please also tell us if there are any matters that you wish to raise with the Inquiry that you consider to be relevant to the terms of reference.

Could you also please review the enclosed list of factual witnesses and include in your statement the following:-

3) The name and, if possible, the contact details of any material witness you consider to have been omitted from the list

4) Suggested areas of questioning for any of the witnesses on the list or for any new witnesses you identify

I know that the preparation of a statement or giving evidence to the Inquiry may raise painful memories for you but I am sure you will agree with the need for a full Inquiry to allow recommendations to be made for any improvements to services to prevent future homicides and I thank you for your willingness to assist the Inquiry.

Procedure

The interview will be taking place on *, at *. It will be held at 10 Doughty Street, London WC1N 2PL. A map is attached. Please confirm that you will be able to attend at this time and date.

We expect interviews to last between one and two hours, though some may be less and some may last longer given the nature of the care provided over a relatively long period of time.

You will note from the procedure and schedule that the Inquiry hearings will be held in private. Interviews will be transcribed verbatim by a professional transcriber who will also be present. You can attend with a legal, trade union, or other advisor, friend or colleague, but this should not be someone who is connected with the commissioning of the Inquiry and its Report, in order to avoid any possible conflict of interest. You will be sent a copy of your interview transcript to make any correction or alteration you choose. Any interviewee who may be the subject of potential criticism in the final report will be sent a copy of any part(s) of the draft report containing such criticism and will be able to respond to it, either by further interview or in writing, if s/he so chooses. The team will take any further evidence into account before producing the final report.

If you would like more information, please contact me on 020 7655 6710, or by emailing dulara.khatun@nelondon.nhs.uk.

We look forward to hearing from you and enclose a SAE for your reply.

Yours sincerely

Dulara Khatun
Inquiry Manager

APPENDIX G

12 April 2006

Dear [ ],

Re: Dennis Foskett Inquiry Report

Firstly, may I, on behalf of the Panel thank you for your valuable input and co-operation with this Inquiry. As you are aware from our recent telephone discussion and the Inquiry procedure that you received at the outset of this process, it is the practice in these inquiries to give anyone who may receive some criticism a 'preview' of any such comments so that they may have an opportunity to respond before the report is finalised. This process is necessary in the interests of fairness and is helpful in ensuring factual accuracy of the report

I am, therefore, enclosing xxx draft chapters and xxx extract of a draft chapter in which we have commented on your particular involvement in the care and treatment of Mr Foskett. You will note that the drafts that I am sending you also include comments on the practice of others where they overlap with yours. I have taken the decision that it is necessary for you to see as much of what has been written as possible to aid your full understanding of the way in which the Panel has reached its conclusions. However, that does mean that you have not been sent the entire draft and to that extent the sections that you have been sent provide only part of the picture. I am enclosing the 'Contents' page in the hope that this will at least give you an idea of the report structure and what you are missing. I am afraid this is unavoidable and necessary in the interests of preserving confidentiality of all those concerned in the Inquiry and I am certain that you will understand this requirement. Extracts from Chapter [ ] are being sent to other practitioners in a similar manner.

For that reason and also because the report is still only in draft form, the Panel would like your express confirmation that you will keep all material sent to you strictly confidential. This means that you must not use, divulge nor discuss any part or parts of it, whether in writing or verbally, with any other person either in a personal or a professional capacity. Additionally you must not copy it.

The Panel appreciate that you may wish to seek advice on the sections sent to you from an advisor (legal, professional or a friend). In those circumstances, the Panel ask that you restrict the number of advisors to only one, that you notify us of the name of the person you have chosen and that you undertake to bring this requirement of confidentiality to their attention and seek their agreement to it.

Please remember that these sections are in *draft* form and are, therefore, subject to change in terms of style and substance.

The Panel are sure that you will understand the need for confidentiality in this sensitive area of work. I shall be grateful if you could indicate in writing that you accept the conditions under which these report sections are being sent to you when you return your comments on them. I would be happy to receive these by email to [ ] no later than [ ] or in writing to [ ]. If I have not received any response by that date the Panel will

assume that you have no comments to make and proceed to finalise a draft for the commissioning authority which is due by [ ]. If you would like to contact me please telephone on the number you already have or send me an email.

Thank you for your further co-operation and I look forward to hearing from you.

Yours sincerely,

Aswini Weereratne
Inquiry Chair

APPENDIX H

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