EXECUTIVE SUMMARY

INTRODUCTION

1 At the Central Criminal Court on 3 August 2000 Mr NJ was found unfit to plead, by reason of mental disorder, to charges that he murdered Miss MH at her home in Hanwell between 31 January 2000 and 3 February 2000. The Court made him the subject of a Hospital Order and he was subsequently transferred to Ashworth Hospital, a high security psychiatric hospital near Liverpool.

2 Mr NJ has remained so seriously ill that he has been incapable of contributing to the Inquiry or of instructing representatives to give evidence on his behalf. The medical evidence indicates that this severe degree of incapacity has existed continuously since his arrest on 2 February 2000.

3 Mr NJ has a long history of mental illness. His first contact with psychiatric services was in 1990, after he was suspended from University following complaints by fellow students of his aggressive actions and sexual behaviour. Details were communicated to NHS psychiatric services in Ealing after he returned to his mother's home there in December 1990. In March 1991 he registered with a general practitioner who also referred him to the local psychiatric service, where he was first seen as an outpatient in April 1991.

4 From 1991 until his arrest in February 2000, Mr NJ was under the continuous care of psychiatric services in Ealing. In September 1994 he was allocated a council flat of his own. His first hospital admission was in February 1992, the first of nine admissions from then to the end of 1998. Three of those admissions involved compulsory detention under the Mental Health Act, the last of which was under Section 3 of the Act for 5 months in 1998.

5 The final period of Mr NJ's treatment as an in-patient continued for almost two years from December 1996 until late November 1998. In February 1998 responsibility for his treatment and care was transferred from the Acute Service to the Rehabilitation Service.

6 After three weeks trial leave at his flat, Mr NJ was discharged there in January 1999. The Care Programme Approach (CPA) discharge assessment was initially set at the highest level, to include a programme of weekly care, visits from community psychiatric nurses (CPNs), support from community support workers and the availability of a social worker as care manager. His care and treatment programme also included attendance at a local day centre and he had ready access to his general practitioner, who had known him since February 1996. Mr NJ lived alone but had regular contact with his mother, who also lived locally and she continued to give him regular support and care in personal, practical and material ways.

7 Miss MH, whom Mr NJ killed, had lived since November 1987 in the flat below Mr NJ's. She also suffered from schizophrenia and was receiving support from local

services. She and other immediate neighbours had reported to health and social services workers and to Ealing housing department in November 1999 and January 2000 details of Mr NJ's disturbed and aggressive behaviour by day and playing loud music at night.

STATUS OF THIS INQUIRY

8 In cases of homicide resulting from the actions of a patient receiving treatment or care because of mental disorder, the Secretary of State expects the health and social services involved to conduct an immediate investigation. Furthermore, after the completion of any legal proceedings, it is always necessary to hold an inquiry which is independent of those authorities. Ealing Primary Care NHS Trust's predecessors accordingly arranged such an immediate investigation, which in April 2000 reported an opinion that the killing of Miss MH *'could not reasonably have been prevented'*. This fuller independent Inquiry, which was set up in September 2002, having now reviewed all the available evidence, has come to a different conclusion.

HOW MR NJ'S CARE AND TREATMENT EVOLVED

9 The record of Mr NJ's initial assessment and care at Ealing in 1990 was sensitive to his confusion and distress and incorporated his mother's views. In the period from 1990 to 1994, as the diagnosis of schizophrenia became established, clinical reports did not describe a pattern of severely disturbed behaviour. However, at the same time the relationship with his mother on whom he depended for his accommodation, care and social support was deteriorating, owing to his increasingly difficult personal behaviour, and reached breakdown point in 1994. He then became homeless, after which his disturbed behaviour was more often reported in medical and nursing records.

10 Mr NJ's poor capacity to cope independently became evident as soon as he moved to his flat in September l994, but care plans and treatment continued to be dictated by his strong preference to live on his own. In fact he spent 10 of the next 26 months in hospital, and often stayed with his mother at other times. He developed systematised paranoid delusions about people close to him, to such a degree that Miss MH as his nearest neighbour reported her concerns, his mother described his paranoid beliefs, and medical notes recorded that his persistent delusions about Nazis now related to his near neighbours. His compliance with medication lapsed, he was drinking heavily and a sequence of admissions and discharges to hospital became an essential feature of his clinical treatment, care and management.

11 His consistently poor capacity for self-care was later confirmed by two hostel placements, where his poor tolerance of other people was also demonstrated by his very challenging attitudes and his disturbed behaviour towards staff and residents. These factors and the concerns of his mother and neighbours were not reflected in changes to his care programming.

12 In the early stages of his illness Mr NJ tended to present at clinical interview as pleasant although psychotic, but his acutely disturbed behaviour towards other people was insufficiently identified. His treatment became reactive to events and a longitudinal

view was not developed. In consequence the importance of making clinical judgments with regard to his behaviour and actions was not specifically recognized and shared within the clinical team and with his carers in the community.

13 On admission, Mr NJ would usually settle quickly on the ward, where he was generally co-operative and showed few signs of thought disorder. His delusional beliefs gradually intensified in relation to religion and race, but aggressive behaviour increasingly became the clearest indicator of his most severely psychotic episodes.

14 Although Mr NJ's tendencies for violence figured prominently in Mental Health Act medical recommendations, they were not fully reflected in subsequent medical summaries and care plans. His increasing recourse to weapons was identified by ward staff, his CPN and his mother but not systematically recorded in care plans as a significant risk factor. An assault on a blind wheelchair patient in June l995, his purchase of a baseball bat expressly for defensive purposes as reported by his mother and recorded in his notes in May 1996, and an attempted stabbing of another patient in April 1997 were not logged in ways to aid a fuller awareness of any further threatening and intimidating behaviour. The relationship of his psychotically dangerous beliefs to his actions was not separately recorded and analysed, or shared between those responsible for his ongoing care and treatment.

15 The planning and organization of Mr NJ's transfer from the Acute Service to the Rehabilitation Service lacked thoroughness. By 1997 it had become appropriate to arrange his transfer to this specialist service for continuing long-term treatment, but the hand-over process was protracted by Mr NJ's unwillingness to move, and it became poorly focused. The team taking on responsibility for his care received some incorrect details regarding his most recent aggressive behaviour and they also recorded several misleading assumptions of their own in relation to risks of violence and his behaviour towards women both recently and in the past.

16 Although Mr NJ was appropriately a detained patient, the plans for his discharge continued to be dictated by his preference to live alone at his flat. The imposition of close medical supervision, comprehensive nursing support and programmed practical help could have been attempted within a framework of sanctions through leave under Section 17 of the Mental Health Act. This option and also the opportunity to make a Supervision Application were lost by the decision to discharge him from compulsory detention before he left hospital. The alternative option of a Supervision Register was not seen as viable, although it had been used to some effect on a previous occasion.

17 At the time of his discharge in 1999 there was a failure to examine his increasing delusional misidentification of a number of women in proximity to him as his sexual partners. This started with a fellow patient, then a close neighbour, next a nurse and finally his social worker. The nature of these delusional assertions was recorded, but not examined in relation to his history over the preceding 9 years. He had also begun in 1995 to misinterpret other women's intentions towards him and to frighten them with his persistent attentions. The combination of misidentification and misinterpretation from 1998 onwards represented a very serious additional danger.

18 The plans for his discharge did not include observation and supervision of his known violent tendencies or of the emergent risk of sexual aggression. In these respects, the risk assessment completed by his CPN as keyworker was inevitably incomplete, inaccurate and misleading. The clinical team then depended largely on the CPNs' reports of their contacts with Mr NJ on home visits, which were also incorrectly assumed to have been at least weekly, and there was no system for continuing regular medical review in the community which would have provided a perspective other than the CPNs'.

THE FINAL MONTHS

19 Mr NJ was not seen by a consultant psychiatrist between June 1999 and the homicide seven months later. From June 1999 onwards the consultant psychiatrist as his responsible medical officer (RMO) could form a view of Mr NJ's changing clinical state only by interpreting the reported information of junior medical staff, CPNs, social workers and carers.

20 Despite an accelerating deterioration in Mr NJ's condition, the consultant psychiatrist and members of the clinical team did not firmly intervene in December 1999 and January 2000. He was recorded to have refused his depot medication, to have become aggressive, evasive and increased his drinking, so that the clinical team began to include him in a small group described as priority patients in the minutes of community meetings. They also incorrectly investigated the use of a Supervision Application under the Mental Health Act.

21 Despite those acknowledgements of his increasing needs, the CPA plan remained unchanged. The CPN visited Mr NJ more frequently, but was unable to administer his medication and found him unwilling to respond to any form of questioning at a time when it had become increasingly essential for Mr NJ's closest clinical observers to gauge at first hand what was in his mind. It was therefore inappropriate for them to have judged Mr NJ as *'unsectionable'* on such superficial evidence of his mental state.

22 The reports they received in January 2000 of assaults by spitting at Miss MH and then by kicking another woman in the buttocks gave the clearest signal, in public, that Mr NJ was again psychotic and becoming dangerous. As in the past, his actions spoke more clearly than did the few symptoms of his mental state which could be gleaned from the superficial contacts which he allowed to his CPN and his social worker.

23 The state of his mental health and the evident need to protect other persons would have fully justified Mr NJ's admission under the Mental Health Act in mid-January 2000, as it had on other occasions in the preceding five years. An attempted assessment at his home on 24 January 2000 was frustrated by his arrest relating to the reported assaults.

24 In the absence of a structured court diversion scheme, it was inappropriate for his consultant psychiatrist, CPN and social worker to have then depended on police powers under the Mental Health Act or on the court proceedings for assault to deal with Mr NJ's

urgent mental health needs. If the consultant had a doubt at this stage it would have been possible for him to seek advice from forensic medical colleagues who worked in the same Trust as himself.

25 The absence of a court diversion scheme may have contributed to the hiatus in decision-making in the two week period from Mr NJ being charged with the assault to his appearing in Court. However, the police had involved relevant health and social services professionals in the processes of charging, answering bail and appearance at Court. The police knew Mr NJ was mentally disordered and that an assessment under the Mental Health Act was in hand. Their response to a request from the Rehabilitation Service regarding use of Section 136 of the Mental Health Act was appropriate and reflected a proper understanding of those legal powers and responsibilities in the circumstances prevailing at the time the request was made.

26 The apparent gaps in the awareness of clinical team members regarding the legal limitations which then applied and in December 1999 of the inapplicability of a Supervision Application are in themselves very serious matters. The extent to which their misconceptions contributed to the delay in responding to the dangerous behaviour of a well-known patient who was acknowledged to be relapsing is a poor reflection on their comprehension of those statutory powers and related Code of Practice guidance.

27 The records in January 2000 continue to describe events from day to day but did not reflect a longitudinal understanding of Mr NJ's mental illness and most crucially of its recent most aggressive manifestations. In the last two weeks of his treatment the review process had acknowledged that he needed priority attention and that his behaviour was causing concern, but because of his refusal to co-operate with the treatment plan, the CPN and social worker could maintain only superficial contact with him.

28 Those two weeks gave sufficient time for the consultant psychiatrist to have imposed the medical assessment which was essential in view of Mr NJ's assaultative actions, together with his continuing refusal to accept medication, excessive drinking and general failure to care for himself.

29 The people in continual contact who experienced his disturbed activities, notably his neighbours, were seriously alarmed by Mr NJ's behaviour and did their best to report their observations. The housing services unacceptably delayed the communication of those reports, but the information contained was already known to members of the clinical team by the time of the attempted mental health assessment on 24 January 2000.

30 If he had been detained under the Mental Health Act before 31 January 2000, it would have been necessary to report that to the Court. Clinical assessment after admission would then have provided the opportunity to examine fully the relationship of Mr NJ's severe mental illness to his increasingly threatening behaviour, which were known to have involved the two reported assaults in the preceding three weeks. The delay in arranging such a hospital admission in order to complete an essential psychiatric assessment was clearly avoidable and in consequence so was the second and fatal assault on Miss MH.

CHANGES TO PRACTICES, PROCEDURES AND POLICIES

31 Whilst the Inquiry's findings are critical of the individual and collective decisions and actions of members of the Rehabilitation Service, we have also indicated a number of significant issues relating to local policies, management systems and staff training which need to be carefully reconsidered and kept under continuing review.

32 The clinical records relating to Mr NJ begin with descriptions of events and allegations in 1990 involving other women who had been in close proximity to him and had reported themselves as victims of his disturbed and aggressive sexual behaviour. Relevant professionals maintained detailed notes of Mr NJ's day-to-day treatment and care. Those notes thereafter reflect the stages of his evolving illness and the effects of his increasing disability on his capacity to look after himself or to accept care from other people. The records generally reflect a consistent commitment to treat him as an individual and to understand his distress, confusion and anger.

33 However, the records were largely narrative, and lacked focus on outcomes, or longitudinal perspectives on Mr NJ's clinical condition and assessments of the known risks in his behaviour. They suggest that clinical team members were well used to working together in each phase of outpatient, inpatient and after-care, but that teamwork was based largely on traditional methods, in particular on multi-disciplinary ward rounds.

34 A task-based record system to focus individual treatment and care as recommended since 1990 by the NHS policy entitled the Care Programme Approach was not adopted in Ealing until 1995 and, even then, its initial adoption by the Rehabilitation Service, which was responsible for Mr NJ's care and treatment after Mr NJ's final discharge into the community, was limited. The Inquiry was told that the system has since been extensively revised to record and focus on issues as they arise and on the concerns highlighted by CPA reviews.

35 Since 1994, NHS policies and procedures on risk assessment and risk management have been nationally advised as essential to effective Care Programming and were further endorsed in November 1995 in the form of advice from the Minister of Health (*Building Bridges November 1995*). Those practice standards were not fully accepted and adopted in Ealing until 2000 onwards.

36 Other systems to record and review dangerous behaviour were not generally employed. For example, the recommendations of several major Inquiries and resulting practice guidance have emphasized the importance of maintaining accurate personal histories and of ensuring that subsequent related events are sequentially noted and kept under review. Mr NJ's personal history was mainly described in sub-sections of the medical summaries on admission or discharge written by junior doctors, who often repeated their predecessors' wording, but sometimes omitted significant information.

37 The significance of the self-harm and threatening actions involving sexually aggressive behaviour first reported by his University in 1990 became gradually eroded. The fact that the University had found it necessary to suspend and exclude him became recorded by the time of his transfer to the Rehabilitation Service as *'left prematurely after an allegation of sexual assault'*; and that he was *'accused of rape but not charged'.*

38 The only risk assessment process used in the Rehabilitation Service was originally adopted on an ad hoc basis by its CPNs and was not shared by medical staff. The associated training and multi-disciplinary awareness was similarly unsystematic. The assessments of Mr NJ's risks were inadequately completed, with insufficient regard to his recorded history and incomplete information regarding his behaviour before discharge, when in the community and as his aggressive actions increased.

39 Despite the recommendations of the investigation in 2000 and the subsequent action plan, the Inquiry has not been reassured that risk assessment procedures and training are yet adequate in the Rehabilitation Service. Witnesses did not appear confident in this regard although there have been some additional opportunities for training in the last two years. The latest (2001) operational policy for the team still does not stress the centrality of safety and risk management in the service's aims.

40 The implementation of training policies appeared patchy and to have depended on the interests and abilities of individuals within the organisation. There was little evidence before 2000 of systematic training and education to introduce the national practice standards of the Care Programme Approach, to instil the importance of risk assessment and risk management or to promote procedures reflecting the developments of the CPA and subsequent NHS guidance.

41 There appeared to have been a lack of commitment and driving force at management level to ensure that staff received training and development which would enable them to understand the changing nature of their roles, in particular to develop the keyworker role in multi-agency operations and the involvement of patients and carers, or in the use of procedures for assessment, planning and delivery of patient care. At present, with the introduction of a new workforce strategy, the integrated service expresses confidence that all staff teams and services should be enabled to identify training needs on an annual basis, with associated reviews of personal goals and service objectives.