Independent Inquiry into the Care and Treatment of Peter Bryan

Part Two

A report for NHS London

September 2009

NHS
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Contents

Part one

Introduction 6

Background 14

Early Years and the Homicide of NS 17
Rampton Hospital 31
John Howard Centre 92
Riverside House 162
Topaz Ward 349
The Homicide of Brian Cherry 364

Part two

Commentary and Analysis 375

Map of Key Locations 376
The Homicide of NS 384
Rampton Hospital 388
John Howard Centre 409
Riverside House 457
Topaz Ward 618
The Homicide of Brian Cherry 646

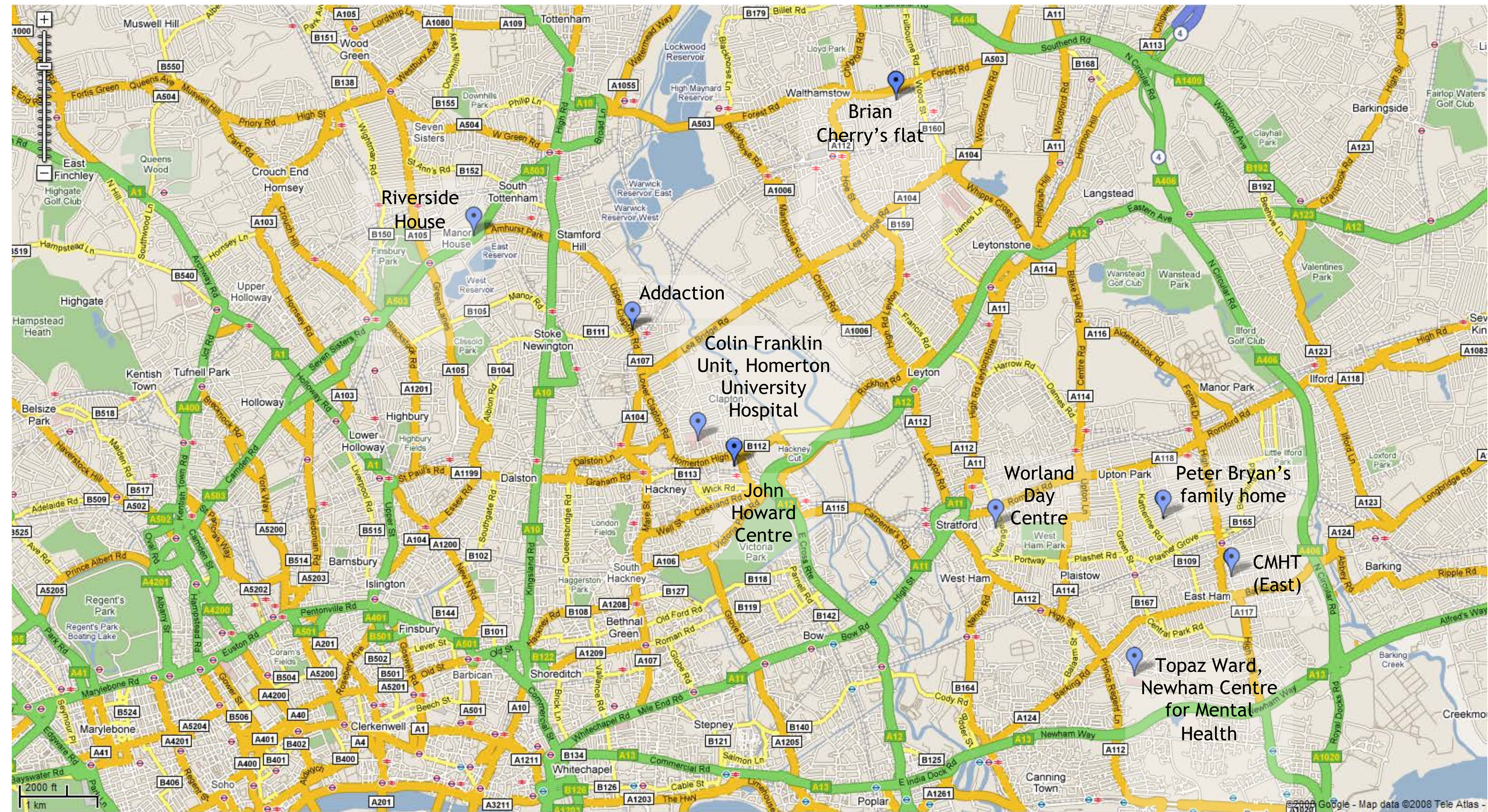
Recommendations 667

Appendices

Appendix A – Terms of Reference 682
Appendix B – List of Interviewees 685
Appendix C – List of witness mentioned in the report 687

COMMENTARY AND ANALYSIS

Map of Key Locations



We have deliberately made this Commentary and Analysis section both lengthy and detailed.

We have considered this matter over a long period of time and we realise that the detail does matter so that a clear picture is given of what the professionals who were responsible for the care and treatment of Peter Bryan were dealing with.

It is important to get a sense of Peter Bryan's 'ordinary' behaviour on an everyday basis, so that one can try to understand the difficulties which the professionals faced.

We have therefore lifted relevant sections from the Background section so that our criticisms are put into some context with the day-to-day reality of dealing with this particular individual.

However it is essential to read the whole Background section to really understand where our findings have come from.

The Background section is mainly a narrative of the daily handwritten notes and relevant reports from Rampton Hospital, the John Howard Centre, Riverside House and Topaz Ward which have been copied virtually verbatim from the records.

In this Commentary section the narrative lifted from the Background section is in normal typeface and the Panel's comments are in bold. All quotations are in italics.

The homicide of Brian Cherry by Peter Bryan was particularly horrific and bizarre and understandably generated considerable public outrage and concern, fuelled by extensive media coverage and somewhat lurid headlines in the tabloid press.

Given the horrific and bizarre features of the killing which occurred only some 3 hours after Peter Bryan had been given permission for leave from a psychiatric unit (as well as the fact that Peter Bryan had already killed someone 11 years earlier (NS, his employer's 20-year-old daughter) and killed again shortly after the death of Brian Cherry, the Inquiry Panel are well aware that the public and the media will expect the Panel to find that it was only too obvious that Peter Bryan was mentally ill at the time of the homicide and to make

serious and damning criticisms of the professionals involved in his care and treatment for failing to recognise the obvious.

It is therefore important to emphasise from the outset the atypical nature of Peter Bryan's mental disorder, which meant that he did not display the usual and expected signs of schizophrenia and appeared to behave normally even when seriously mentally unwell.

Another important factor is that, other than a couple of minor incidents during his early years at Rampton Hospital, Peter Bryan had not displayed any signs of aggressive or violent behaviour since he killed NS.

One of several psychiatrists who interviewed Peter Bryan and prepared a report for the Court at his trial for the homicides of Brian Cherry and Richard Loudwell (the fellow patient he killed in Broadmoor Hospital shortly after being sent there following the homicide of Brian Cherry) concluded:

"When he is relapsing he can appear relatively free of symptoms much of the time…

In my view, this is a measure of how, when psychotic, he can appear relatively normal while remaining capable of extreme and unpredictable violence."

RMO6, one of Peter Bryan's RMOs at Broadmoor, told us:

"There have been occasions when new members of the nursing staff join the team and they tend to get a false sense of security – if I can put it that way – because there is this perfect patient, model patient, no problems whatsoever. But we then have to remind them 'go read the notes, get news from other staff' - and in terms of risk he is probably the most dangerous patient on the ward, although he is the easiest to manage at this point in time…

That is a paradox, and Peter Bryan does try to project that everything is fine, no problems, and he can be good at that."

Part of Peter Bryan's innate dangerousness is his ability to appear 'normal' even when severely mentally disordered.

However, it is only with the benefit of hindsight that this has been recognised. Indeed, his diagnosis now includes personality disorder as well as paranoid schizophrenia.

It should also be remembered that prior to the killing of NS, Peter Bryan was not known to the psychiatric services.

After this homicide, he remained in hospital for some six weeks being treated for severe fractures to his lower legs and ankles and was then transferred to Brixton Prison.

It was not until 5 October 1993 – more than six months later – that he was referred to a consultant forensic psychiatrist for assessment. This was the first time that he had been seen by a psychiatrist.

The only descriptions of his mental state and behaviour prior to the first homicide came from statements made to the police the family of NS and some accounts given by his parents (although they had been in the Caribbean in the weeks leading up to NS's death.)

By the time he was seen by a psychiatrist, the acute phase of his illness had long passed, although he was showing behaviour in prison which was suggestive of some form of paranoia.

Therefore, prior to the homicide of Brian Cherry, no mental health professional had ever seen Peter Bryan when he was acutely unwell and therefore no one had any accurate picture of what he would be like when he was relapsing.

What was also not made clear in the media reporting of the homicide was that for the week prior to the killing of Brian Cherry, Peter Bryan was a voluntary patient on Topaz Ward, Newham Centre for Mental Health, not because it was thought that his mental state warranted such an admission to a psychiatric ward, but for his own safety. This was because relatives and friends of a young girl who had accused Peter Bryan of indecently assaulting her were 'out to get him' and Riverside House (the supervised hostel where he was living) could no longer take the risk of accommodating him and there was nowhere else for him to go at short notice.

However he was kept under observation while on the ward, was given (and appeared to take) his antipsychotic medication every night, and was not permitted to leave the ward despite being an informal patient.

From the time of his admission on 10 February 2004 until the time that he left the ward on 17 February (having been given permission to do so for the first time) only some three hours before killing Brian Cherry, he appeared to be settled, friendly and compliant and showed no signs of any psychotic symptoms.

There are many criticisms which we have had to make about the overall care and treatment of Peter Bryan but it is important to stress that it is unlikely that anything other than a recall to hospital as a compulsorily detained patient pursuant to Section 42(3) MHA[1] (which applies to patients who are subject to Section 37/41) could have prevented the homicide of Brian Cherry. However, as we explain later in this section of the Report - it is by no means clear that such a recall could have been easily implemented in the circumstances which prevailed immediately before the killing.

From what we now know about the unusual presentation of Peter Bryan's mental illness, it is also likely that any recall would only have been temporary and may only have postponed any homicide rather than have prevented one ever having taken place again.

It is also important to emphasise that many of the criticisms which we make are inevitably influenced by the benefit of hindsight and the ability to view the larger picture, having studied all the documents and having interviewed all the relevant witnesses.

The professionals who were responsible for the care and treatment of Peter Bryan while he was in the community did not have the same benefit of hindsight, nor did they necessarily have access to all of the detailed information which the Panel have been able to examine, and they had to make their decisions on an ongoing basis while we have made our findings after interviewing more than 60 witnesses and after lengthy deliberation.

[1] S. 42(3) MHA: The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under subsection (2) above by warrant recall the patient to such hospital as may be specified in the warrant.

Although there were areas of some of the professionals' practice which have caused us concern, it must always be remembered that only Peter Bryan was responsible for the death of Brian Cherry.

There was no particular failure by any individual professional which directly precipitated the tragic outcome.

There was, however, a systemic failure to ensure that the key professionals allocated to care for Peter Bryan in the community had the necessary experience to deal with someone with his forensic history and complex presentation.

The two professionals (RMO5 and Social Worker 5) who provided statutory supervision for this unusual and complicated Section 37/41 patient were a general adult psychiatrist who never before had had responsibility for a patient who had killed someone, and a very inexperienced social worker who had no training in mental health.

It may be that in the grand scheme of things, Peter Bryan was let down to some degree by these professionals, but the Panel are of the view that they should never have been asked to take responsibility for someone like Peter Bryan in the first place.

The members of the community team also failed to work together as a proper team, and instead tended to work as individuals who each happened to have been allocated to Peter Bryan's care.

This made it much easier for Peter Bryan to manipulate situations by convincing the individual professionals that he had plausible explanations for any concerns they might have had about his mental state. This allowed him to deflect and diminish such concerns.

Even when they met as a team for a CPA or an emergency meeting, Peter Bryan managed to hijack the meetings to deal with his written Agendas, and the professionals became repeatedly embroiled with him in negotiation over his many and repetitive demands and complaints, and were thereby distracted from focusing their efforts on assessing his mental health.

They tended to deal with each concern on an ad hoc basis and therefore there was no recognition of the cumulative nature of their concerns.

Had they stopped and thought about this accumulation, and reminded themselves why Peter Bryan was on Section 37/41 in the first place, it should have increased the level of their general concern about him.

We do however acknowledge that Peter Bryan's mental state was extremely difficult to assess.

Even only a few hours after the homicide of Brian Cherry, it was not possible for a consultant forensic psychiatrist to elicit much evidence of active psychosis.

In his sentencing remarks at Peter Bryan's trial for the homicides of Brian Cherry and Richard Loudwell, the Judge said:

"Of particular concern is your ability to mask the psychotic symptoms under a veneer of near normality. You did that… when you killed Brian Cherry".

Therefore, even though we have had to make serious criticisms of some of the professionals' care and treatment of Peter Bryan, it must be remembered that he at no time displayed the classic signs of schizophrenia - even when he must have been mentally unwell - and that his presentation has confounded even highly experienced forensic practitioners.

It is therefore not surprising that those who did not have the benefit of experience in dealing with the more subtle signs and symptoms of mental and (with the benefit of hindsight) personality disorder, were not aware of the difficulties of assessing the risks and dangers he posed.

Everyone should recognise that Peter Bryan was not completely open and honest with his care team. He had decided to withhold information from them and instead of being co-operative he preferred to be manipulative and confrontational. He attempted to dominate fellow patients and conducted a lengthy campaign of official complaints directed at all

those responsible for his care and treatment. Any possibility of effective therapeutic intervention by the professionals was subverted by Peter Bryan.

There were three pivotal points in Peter Bryan's pathway from Rampton Hospital to the homicide of Brian Cherry. They were key decision making events when things could have gone in quite a different direction had different decisions been made.

The first was the Mental Health Review Tribunal (MHRT) decision on 28 March 2001 which was followed by his transfer from Rampton to the John Howard Centre.

The second was his transfer from the John Howard Centre into the community - and in particular his transfer from the forensic psychiatric service to the general psychiatric service.

The third was the alleged indecent assault on a 17-year-old girl less than two weeks before the homicide.

The Homicide of NS

1. Peter Bryan was not known to the psychiatric services before he killed NS in March 1993, although after the homicide both the mother of NS and Peter Bryan's parents described how he had exhibited bizarre behaviour over the preceding months.

2. Whilst on remand in Brixton Prison, Peter Bryan made two unprovoked attacks on fellow inmates and it was thought that these were suggestive of a paranoid response and he was visited and assessed by nurses from the department of forensic psychiatry at Hackney Hospital. They considered him to be paranoid and mistrustful of others and were concerned that he had the potential for violence towards others.

3. He was therefore referred to Psychiatrist 1, Consultant Forensic Psychiatrist at the Interim Secure Unit at Hackney Hospital who assessed him for two hours in Brixton Prison on 5 October 1993.

   This was the first time that he had been assessed by a Consultant Psychiatrist.

4. An hour and a half into the interview he spontaneously volunteered that his family and friends called him 'OBI-One'. He said that he had a doll that he used to stick pins into whilst practising Voodoo at home, putting the doll on a cushion, sticking pins into it and burning candles.

   His father and brother denied all of this when we interviewed them.

5. He said that he would write people's names on paper – including that of the mother of NS and others he believed were against him – and would then burn the paper. He said that this process gave him a *"quickening"* and a *"rush"*. He said that he had to carry out the Voodoo to keep nature in its proper pattern.

6. He described watching a TV programme about a man cooking a particular dish and said that *"men had died to try and eat that food…The way he cooked it – it has substance, it has punch in it, it has something in it!"*

   This was the only time in the next 10 years leading to Brian Cherry's killing that there is any reference in the recorded notes that Peter Bryan had mentioned voodoo to any professional involved in his care.

When asked shortly after his interview with Psychiatrist 1 about this reference to voodoo, he said that "*(Psychiatrist 1) asked if it was voodoo. I told him he could call it voodoo if he wanted*", but that there was no more to it than that.

With the benefit of hindsight, the reference to voodoo and cooking something which provided something powerful perhaps takes on some significance.

Since being at Broadmoor following the homicide of Brian Cherry, Peter Bryan described the act of cannibalism as being part of a long-standing interest that he had in black magic and voodoo which went back to his teenage years.

His former RMO at Broadmoor, RMO6, told us that Peter Bryan seemed to have a very well entrenched delusional system in which he believed that some people are vulnerable and weak and are what he described as being "*at the lower end of the food chain*" and that they should be '*done away with*'. His belief seemed to be that, if he ate his victims, he would derive strength and power from them.

It is perhaps strange that such an apparently deep-seated belief was only ever mentioned on that one occasion in the 11 years between the first two homicides.

7. Psychiatrist 1's initial impression of Peter Bryan was that he was suffering from some form of paranoid psychosis which may well have been a schizophrenic illness. He recommended a referral for admission to Rampton High Secure Hospital for assessment prior to his Court appearance which was due in the second week of December 1993.

8. On 18 November 1993, Peter Bryan was assessed by RMO1, Consultant Forensic Psychiatrist at Rampton Hospital.

9. RMO1's conclusion was that Peter Bryan continued to suffer from a paranoid psychosis which had developed at the time of the homicide, and that he required further psychiatric assessment in hospital. Given his potential dangerousness, RMO1 advised that the assessment should be carried out in conditions of high security and he therefore recommended that Peter

Bryan should be admitted to Rampton Hospital under Section 35 of the Mental Health Act ('MHA') 1983[2] in order to allow the assessment to take place.

10. Peter Bryan's solicitors also asked Psychiatrist 3, Consultant Forensic Psychiatrist, to see him and prepare a medical report for the Admissions Panel who would consider whether to offer a bed at Rampton.

11. On 24 November 1993, Psychiatrist 3 wrote:

"I found his mental state hard to assess. Although I am confident that he suffers from a psychotic illness the symptoms are not well defined and I found it impossible to come to a diagnosis. I have spoken both to (Psychiatrist 1) and to (RMO1) (Rampton) and they also have the same view."

12. Peter Bryan was admitted to Rampton Hospital on 17 December 1993.

13. By the time RMO1 came to make a further report to the court at the end of January 1994, Peter Bryan had continued to display paranoid thinking since his admission to Rampton and he had accused nursing staff of victimising him and racially abusing him, and had made complaints to the catering department because of his belief that attempts had been made to poison him.

14. However repeated mental state examinations did not demonstrate any other symptoms of schizophrenia.

15. RMO1's conclusion was that the in-patient assessment had confirmed that Peter Bryan was suffering from mental illness in the form of a paranoid psychosis, the symptoms of which were exacerbated by stress.

Three highly experienced consultant forensic psychiatrists had therefore been unable to make a definitive diagnosis in respect of Peter Bryan's mental illness.
The Rampton notes refer mainly to a diagnosis of paranoid psychosis, but they also acknowledge that Peter Bryan probably suffered from paranoid schizophrenia.

[2] S.35 (1) MHA: Subject to the provisions of this section, the Crown Court or a magistrates' court may remand an accused person to a hospital specified by the court for a report on his mental condition.

What was significant was that he did not display the classic 'first rank' signs of schizophrenia.

In the 11 years between the homicides of NS and Brian Cherry, no mental health professional ever saw Peter Bryan showing any florid signs of psychosis. The atypical nature of his presentation made not only his diagnosis but also his treatment and management extremely difficult, in particular in relation to assessing risk. This was to be a key factor in the killing of Brian Cherry.

However RMO1 was able to identify that stress was a clear trigger factor for Peter Bryan's mental illness. This was an important identification.

16. On 4 March 1994 the final hearing of the criminal proceedings took place at the Old Bailey. Peter Bryan was convicted of manslaughter on the grounds of diminished responsibility and wounding (in respect of NS's 12-year-old brother). He was sent back to Rampton Hospital under Sections 37 and 41 of the Mental Health Act 1983[3].

[3] Section 37 MHA: 'Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law… the court may by order authorise his admission to and detention in such hospital as may be specified in the order…'

Section 41 MHA: '(1) Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, 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, that it is necessary for the protection of the public from serious harm so to do, the court may… further order that the offender shall be subject to the special restrictions set out in this section, either without limit of time or during such period as may be specified in the order; and an order under this section shall be known as "a restriction order".'

Rampton Hospital

1. In the early months at Rampton there were several entries in the notes which described Peter Bryan's threatening and abusive behaviour to both staff and other patients, but such behaviour was usually short-lived.

2. At a ward round in early May 1994 it was noted that it was currently difficult to establish Peter Bryan's degree of dangerousness. He did not appear to be developing any signs or symptoms of schizophrenia.

3. He was started on depot[4] antipsychotic medication on 17 May 1994. Before that he had not been given any antipsychotic medication.

4. In mid-August 1994 RMO1 decided that Peter Bryan was showing no symptoms of mental illness and he directed that the antipsychotic medication should be gradually withdrawn and the situation would then be re-assessed.

   At this stage, Peter Bryan had only been on antipsychotic medication for three months. It was the only time that he was given depot medication prior to the homicide of Brian Cherry. Subsequent anti-psychotic medication was always prescribed in tablet form.

5. In an interview in early October 1994, Peter Bryan said that he felt very satisfied with his life at Rampton. He saw the hospital as a sort of retreat from the '*pressures of society*'.

6. He talked about the homicide as being "*destined to happen*" and said that it had made a man of him. He said that he had learnt not to reveal his innermost thoughts to others as they might use them against him.

7. He also talked a lot about his criminal friends whom he admired and said that he liked to think that he required high security as this conferred status.

8. Several days later he said that Rampton life was quite pleasant and better than life "*on the outside*". The following month he again described himself as being very happy to stay in Rampton and thought that he needed to stay another 25-30 years and even then would probably prefer to stay on there.

[4] Depot antipsychotic medications are given by intramuscular injection, usually every 2-4 weeks. They are usually used when adherence to a regime of oral medication is likely to be problematic.

Comments like this made the Inquiry Panel speculate whether the killing of Brian Cherry may have occurred because Peter Bryan found life in a high secure hospital easier to cope with than life in the community and it gave him a feeling of identity and asylum. We acknowledge that this is pure speculation.

9. By March 1995 there had been no return of any obvious signs of mental illness since the antipsychotic medication had been stopped and at the end of April 1995, Peter Bryan was transferred to Hawthorns Villa Ward. It was at that time a Pre-Discharge ward.

   In 1999 it became the Personality Disorder ward, but he remained on the ward, being one of only very few patients who remained there without a diagnosis of personality disorder. Some years later Peter Bryan described himself as a "*trainee psychopath*" and also described how he felt that he had "*learnt things from being on a ward for psychopaths for five years*".

   After the homicides of Brian Cherry and Richard Loudwell he has been given the dual diagnosis of paranoid schizophrenia and personality disorder.

10. By July 1995 RMO1 was noting a gradual but definite deterioration in Peter Bryan's behaviour since his transfer to Hawthorns Villa. He was being provocative towards others, was making minor threats to staff and he had exposed himself to a female domestic which was probably not accidental.

11. He was also expressing feelings of tension and said that he should have been placed on a long stay ward as he was going to end up as mentally ill as the worst of them. He was unable to articulate his feelings beyond this but appeared preoccupied and troubled.

12. Although RMO1 could not elicit any depressive symptoms he thought that Peter Bryan might benefit from the reintroduction of a major tranquiliser and therefore he restarted him on antipsychotic medication. This time it was in oral form – trifluoperazine (Stelazine) 5mg twice a day.

13. By the end of September 1995 Peter Bryan was already requesting a reduction in his medication as he said that he was "*feeling better and well behaved*" but the nursing staff reported that he had been demonstrating confrontational behaviour over the previous 2-3 weeks.

14. The notes for this period record that Peter Bryan had been involved in a fight with another patient, had been making unprovoked physical and verbal attacks on others and had displayed inappropriate behaviour on several occasions.

15. The nursing notes over the next six months illustrate that Peter Bryan was pushing the boundaries with the staff a lot of the time. He showed great reluctance to participate in any meaningful treatment programme and by June 1996 was asking to come off medication altogether.

16. In mid-June RMO1 noted that Peter Bryan's overall behaviour was less disinhibited and more reasonable when on antipsychotic medication but that he disliked taking it.

17. In August 1996 Peter Bryan was noticed on two occasions standing completely naked outside the shower cubicle while female members of staff were using the facilities.

18. Four days later Peter Bryan told a fellow patient that he was going to murder someone. When asked about this comment by the nursing staff he said that it was a joke and that he meant only to shock his fellow patient.

Peter Bryan frequently made very inappropriate comments – often with a racial or some kind of 'shock' content - which he would then try to minimise as 'only a joke'. It is difficult to know whether these comments were just jokes or were part of his underlying personality/paranoia.

19. There are numerous references in the notes over the years that he was at Rampton that Peter Bryan would take on the role of the 'class fool' and would indulge in what was described as 'horseplay'. At other times he spent long periods in his room, not joining in any activities.

20. However towards the end of 1996, Peter Bryan seemed to settle down and there were no real management problems with him. He began to participate in ward activities and treatment classes.

21. In the first 3 months of 1997, Peter Bryan attended 12 sessions with a clinical psychologist and a psychiatrist who concluded that their findings fitted neatly with the stressor-vulnerability (or diathesis-stress) model of illness which they described as:

"'Stress' occurs when demands, either external or internal, exceed or tax an individual's ability to cope, and judging by Mr Bryan's perception, translation, and interpretation of the above stressors, the pre-offence period is marked by increasing stress.

The above stressors are precipitant factors in the development of Mr Bryan's mental illness, and are deemed to be, in this particular case, both necessary, and sufficient, for the committing of the index offence."

Yet again stress was identified as a trigger factor for Peter Bryan's mental illness.

22. He was asked in one of these psychology sessions how a friend who knew him intimately might describe him as a person and his reply was noted as:

- *Outgoing*
- *Bubbly*
- *Caring*
- *Understanding*
- *Happy-go-Lucky ("best quality")*
- *Greedy (ie food)*
- *Can be selfish sometimes*
- *Gets angry easily – although he claimed to be able to cope better, and has been able to relax more and stop dwelling on events during his time at Rampton.*

'Happy-go-lucky' or a 'Cheeky Chappie' is how many of those who were involved in Peter Bryan's care while he was in Rampton described him. They gave the panel the impression that he was a bit of a 'Jack the Lad' - 'a likeable rogue' - but on the whole they found him amiable and compliant and almost none of them felt threatened by him in any way. They did however tell us that he did always try to assume a controlling role, for instance chairing patients' meetings, something he continued at Riverside House (the forensic hostel where he lived when discharged back to the community).

Nurse 3, Peter Bryan's named nurse on Hawthorns Villa from December 1999 told us:

"My first and lasting impression of him is that he was quite a cheeky chappie, a bit of a rogue. He would like to try and get one over on people in a manner whereby he would

barter with other patients, try and do the same with staff, try to ply you with Mars bars to sweeten you up and soften you up and that kind of thing.

He was always jovial, always chatty, always friendly. I didn't see any problems with his mental health when I first arrived and that continued throughout the two years. I can't remember seeing any of the problems he had when he was first admitted."

Psychologist 4 started on Hawthorns Ward as the ward psychologist as a newly qualified clinical psychologist in October 1999. She saw Peter Bryan for several sessions and described her first impression of him as:

"Cheeky chappie - which is not meaning to sound patronising, but he was jovial, he always had a fairly big smile on his face. He very much liked a laugh and a joke and used to interact with people most of the time. He wasn't particularly known for being high in the hierarchy of patients on the ward. Working with him was more interesting in that my impressions in the first couple of sessions was that he saw me as pretty young, pretty naive. There was a distinct pattern of - not in a particularly hostile way - but seeing just how far he could push - basically how on the ball I was. That settled down very quickly when I asked him if that was what he was doing."

23. Over the next two years Peter Bryan seemed to have decided that he would do everything possible to persuade those caring for him that he no longer required detention under high security. He attended most of the classes and activities that he was supposed to attend.

Nurse 1 who ran the Anger Management Group knew Peter Bryan from the time that he went to Hawthorns Villa in 1995. He told the Panel:

"There were clearly two characters in Peter Bryan during that time. There was one who I perceived as wanting to challenge boundaries, push group norms, run with the more disruptive element of the ward, disengage from treatment, believed he was beyond any sort of reproach - and then to the latter end of my time, so 1997 onwards, he spontaneously engaged in treatment, couldn't do enough in terms of himself and others, stopped being 'the village idiot' (as he used to call himself) and actively engaged in all that was asked of him.

After 1997 and up to late 1998 when I assessed him, I wouldn't know what went on because I wasn't actually on the ward, but then when he joined my treatment group he was exemplary. He was the only person in the group who attended every single treatment session, so he attended 36 out of 36, actively engaged, was a good group member, offloaded his true thoughts and feelings, helped others…

… the one thing that stuck out in my mind is when he decided to engage it was almost as if a switch had been flipped - he had just gone like <u>that</u> and said 'That's it, I'm sorting myself out'. If memory serves me correctly it was proposed to him that he needed to engage to progress, and after a short period of time he was then asking 'When can I start psychology? When can I get engaged in treatment?' So it was as if there was this understanding: 'Hang on, I've got to do something to move on here'."

24. Despite this change in behaviour, Nurse 1 had considerable concerns which he documented at the time about the fact that Peter Bryan tended to suppress and control his anger as well as the fact that he became excitedly aroused and amused by violence and that his thoughts on violence had not been evaluated.

25. This concern was also highlighted by the clinical psychologist Psychologist 4 in her report dated 29 September 2000:

    "It appears that Peter Bryan attempts to over-control his anger and he stated that he doesn't express anger as he's not sure when he would stop. He reported that it had been several years since he had become aggressive and therefore was not clear what circumstances would prompt him to be aggressive."

    Peter Bryan's thoughts and reaction to violence were never in fact evaluated. They should have been, particularly given what was known then about the violent killing of NS and what is now known about the level of violence he was capable of when aroused.

26. By the Spring of 1999, RMO3, who by then was Peter Bryan's RMO at Rampton, was of the opinion that he no longer needed to be held in high security and referred him to the forensic services at the John Howard Centre, a medium secure unit in Hackney.

27. He was assessed on Hawthorns Villa by JHC Psychiatrist 1, Honorary Specialist Registrar in Forensic Psychiatry at the John Howard Centre and Forensic Social Worker 1, employed by Hackney Social Services. They agreed that he was ready to be transferred to a medium secure unit, and JHC Psychiatrist 1 subsequently asked his nursing and psychology colleagues at the John Howard Centre to assess Peter Bryan at Rampton with a view to such a transfer.

28. On 3 August 1999, Peter Bryan was assessed by Psychologist 3, Chartered Clinical Psychologist, and Nurse 2, Senior Nurse at the John Howard Centre, who recommended that it would be appropriate to transfer him to an environment of lower security.

Despite the decision in 1999 that Peter Bryan no longer needed the high security environment of Rampton Hospital and the fact that the John Howard Centre agreed in principle to his transfer, it would be another two years before Peter Bryan was actually transferred from Rampton Hospital to the John Howard Centre.

Such a delay is not unusual. It very often takes this long a period of time before an appropriate bed becomes available and the necessary Home Office authority is in place.

29. On 1 November 2000 Peter Bryan requested a Mental Health Review Tribunal (MHRT) hearing which subsequently was fixed for 28 March 2001. He was to be represented at the MHRT by Solicitor 1, a solicitor recommended to him by another patient on Hawthorns Villa Ward.

Solicitor 1 has a Masters degree in Mental Health Law and has considerable experience sitting as a legal member of Mental Health Review Tribunals. He has also written articles about MHRTs.

His involvement as the legal representative of Peter Bryan was to have a significant impact on the subsequent course of Peter Bryan's continuing care and treatment.

30. On 28 February RMO3 wrote to RMO4, Consultant Forensic Psychiatrist at the John Howard Centre, informing him of the forthcoming MHRT on 28 March and asking him if he would be able to give an indication before that date of when a bed was likely to become available.

31. On 17 March Peter Bryan was interviewed by Psychiatrist 6, Consultant Psychiatrist, at the request of Peter Bryan's solicitor Solicitor 1, in order to prepare an independent psychiatric report for the MHRT.

32. Psychiatrist 6 recommended that Peter Bryan should be granted a Deferred Conditional Discharge – the deferment to allow for all the facets of the multidisciplinary aftercare package for him to be firmly established, but which would also allow for his transfer from Rampton to the John Howard Centre, prior to his eventual discharge from hospital altogether.

33. Solicitor 1 prepared a detailed Skeleton Argument for the MHRT. He did not seek an absolute discharge on behalf of Peter Bryan.

34. He argued that, as no after care plan had as yet been formulated for Peter Bryan, the Tribunal must either defer the direction for a conditional discharge or adjourn the MHRT to a later date. Solicitor 1 submitted that the Tribunal should adjourn the hearing rather than defer it, but that this should not prevent Peter Bryan being moved to the John Howard Centre in the meantime. He also set out in his Skeleton Argument the conditions he sought as being appropriate to impose on any discharge order.

35. On 27 March a statement was submitted by the Home Office for consideration by the MHRT which concluded:

"*The Home Secretary is prepared to consider any detailed proposal for a move to another hospital. So far none has been made. In the meantime the Home Secretary remains satisfied that Peter Bryan is appropriately detained in Rampton Hospital.*"

36. The Tribunal sat at Rampton Hospital on 28 March 2001 and, having heard all the evidence, concluded that

(a) Peter Bryan continued to suffer from mental illness but the illness had been fully controlled by medication over the past five years

(b) As a consequence of the medication the illness was no longer of a nature or degree warranting liability to detention

(c) Peter Bryan was entitled to be conditionally discharged from detention (and therefore liable to recall)

(d) Appropriate conditions would include co-operation with medical and social supervision and submitting to random drug testing. There may also be a need to exclude him from certain areas

(e) There would need to be a condition that he resides at a suitable hostel which will need to include 24 hours per day staffing by staff experienced in the care of restricted patients.

These were the conditions which had been suggested by Solicitor 1.

He told us that the fact that the Tribunal had adopted more or less verbatim the wording which he had put in his skeleton argument and had put in the 'buzzwords' he wanted to have mentioned, had been very helpful when it came to the later Tribunal hearings.

37. As no such arrangements were yet in hand and to avoid the potential delay which can take place on a deferment of a conditional discharge, the Tribunal decided that it was appropriate, in the light of recent case law cited to them by Solicitor 1, to adjourn the granting of the discharge until appropriate steps had been taken and arrangements made. It was further directed that the adjourned hearing was to take place on 29 August 2001.

The Tribunal had not in fact granted a conditional discharge - the final decision on that had been adjourned - but the fact that they had stated that Peter Bryan's illness was no longer of a nature or degree warranting liability to detention, and the subsequent interpretation by others of the Tribunal's decision that Peter Bryan was "entitled to be conditionally discharged" had significant ramifications at the later adjourned MHRT hearing and for his subsequent care and treatment at the John Howard Centre.

38. On 17 April 2001 RMO3 wrote a letter to the Home Office for their urgent consideration as RMO4 had verbally offered a bed at the John Howard Centre in Hackney for Peter Bryan within approximately 4 to 6 weeks. He asked them formally to consider Peter Bryan's transfer on trial leave from Rampton Hospital to the John Howard Centre in Hackney.

39. The letter contained the following:

"Please note that in Mr Bryan's case there appear to be two separate patterns of risk. The first relates to his mental illness, delusions and his behaviours thereof. This area of risk appears to be well contained in that he is stable in his mental health on medication and there has been no recurrence of behaviours suggesting acting out of delusional thinking. The second and perhaps the more pertinent in terms of risk to re-offend in the future is his history, unrelated to his illness, of his lifestyle that included the use of instrumental violence to obtain money, street muggings, functioning at the fringes of gangs, use of and selling drugs, an acknowledgement of conning and manipulating people and a relative comfort with a criminalized lifestyle. It would be this area that would concern me more in terms of future risk and to manage this I would suggest supervision through Probation Services, including random drug screening and monitoring his associates and activities (when he is eventually released into the community). I would recommend this in addition to standard mental health follow-up."

Supervision through the Probation Service was not in fact possible since Peter Bryan had not been subject to a prison sentence, but the Panel consider that RMO3's suggestion that Peter Bryan's associates and activities should be monitored when he was eventually released into the community was a sound one.

Once he was in the community, Peter Bryan's associates appeared to be mainly drug users and dealers, prostitutes and teenage girls. It was through this association that he met Brian Cherry.

The Panel are of the view that the key professionals involved in Peter Bryan's care and treatment did not do enough to try to warn him of the risks involved in mixing in such circles, despite knowing that he was doing so.

40. At the beginning of June 2001 Social Worker 4 contacted several hostels to see if they would be available as a suitable placement for Peter Bryan. In the course of those enquiries he requested that Peter Bryan be placed on the waiting list for Riverside House, a 24 hour supervised hostel in the Seven Sisters Road.

41. On 15 June 2001 a Pre-Admission Assessment was carried out by two nurses from the John Howard Centre, the Acting Ward Manager and Nurse 4, a staff nurse, to assess Peter Bryan's suitability to be transferred to Colin Franklin Ward.

Colin Franklin Ward was the Pre-Discharge unit and was geographically separated at a considerable (but walking) distance from the main unit of the John Howard Centre and was in fact a locked ward in Homerton Hospital which is a general hospital, and included a maternity ward in the same building.

Because it did not have a secure perimeter – nor its own grounds – 'ground leave' for any patient of Colin Franklin Ward included access to some of the local shops adjacent to the Homerton Hospital.

42. The following was the opinion of the nursing assessors in their report:

"Mr Bryan has shown himself to be very motivated in attendance to all aspects of his current rehabilitation programme and appears to have exhausted the opportunities available to him within such a secure environment.

It is well documented that Mr Bryan's mental health is susceptible to stress. Mr Bryan himself has directly and indirectly expressed high levels of anxiety re transfer to a less secure unit. Admission onto a ward within the main unit of the JHC would provide a greater degree of security and sense of safety for Peter and facilitate a smooth, less stressful transition into the medium secure setting.

There have been frequent episodes of manipulative behaviours towards others and periods of aroused behaviour. These have been contained within a well structured maximum security Personality Disorders Unit at Rampton Hospital. A question mark exists on how Mr Bryan will respond in a less structured environment. A period of adjustment within the security of the main JHC would be beneficial for Mr Bryan prior to transfer to a less secure and highly independent environment such as Colin Franklin Ward."

The Panel are of the opinion that these two nurses correctly identified a potential risk in admitting Peter Bryan to a ward which, although it was a locked ward, was not part of the main unit nor within the secure perimeter of the John Howard Centre, and which was a more independent environment than the main unit.

Unfortunately their view did not prevail and when Peter Bryan was transferred on trial leave to the John Howard Centre, he went straight to Colin Franklin Ward.

They also identified that his mental health was susceptible to stress and that he was extremely anxious about being in a less structured unit.

At the time of the homicide of Brian Cherry, Peter Bryan was once again being faced with a transfer to a less structured environment and was under a considerable amount of stress.

Unfortunately it does not appear as though his key professionals at that time remembered or took on board the fact that his mental health was susceptible to stress.

43. On 15 June 2001 the Home Secretary consented to Peter Bryan being granted a period of 6 months trial leave in the care of RMO4 at the John Howard Centre.

44. The Home Secretary's consent was given on condition:

"That (RMO3), as the patient's responsible medical officer, direct under section 17 (1) that, during the leave, the patient shall submit to such treatment medication as (RMO4) considers necessary and which has been directed or agreed by you as the responsible medical officer to be in the patient's interests or for the protection of others…"

This letter makes it clear that RMO3 remained Peter Bryan's RMO until such time as the Home Secretary formally approved the transfer of Peter Bryan to the John Howard Centre.

45. On 6 July an Approved Social Worker (ASW) Social Worker 4, together with the Forensic CPN, who respectively were to be Peter Bryan's Social Supervisor and Care Co-Ordinator on his eventual discharge into the community) visited Peter Bryan at Rampton to carry out an assessment of his needs and what community follow-up package and placement he should be offered should the Tribunal grant the conditional discharge he was seeking at the adjourned MHRT on 29 August 2001.

46. They discussed Peter Bryan's progress with one of the female staff nurses on Hawthorns Villa. She said that she had known him for over two years and over that period he had not been involved in any aggressive incidents (verbal or physical) and described him as a friendly and outgoing person. She said that there had been times when other patients had tried to provoke him but he had never responded.

47. She said that he was fully compliant with his medication and did not need reminding to collect his tablets. However there were no self-medication programmes on the ward therefore his compliance had not been fully tested.

48. She reported that there had been no incidents of him taking illicit drugs on the ward, and when staff had been suspicious that he might have done, drug screening had always tested negative. He attended the drug and alcohol group and had stated to staff that he intended to abstain totally from drugs in the future.

49. The ward staff felt that overall he was ready to take the next step to a Medium Secure Rehabilitation Unit but that it would be too much for him to cope with a move straight into a hostel in the community.

50. Social Worker 4 and the Forensic CPN then interviewed Peter Bryan.

51. They informed him of the plans to transfer him to the John Howard Centre which he seemed very pleased about. He said that he had no worries or anxieties about moving out of Rampton, and said that if he were to be conditionally discharged at the adjourned MHRT he felt that he would be able to cope living in the hostel which was found for him.

52. He said that his solicitor had explained to him that the two available options were either two small steps, JHC and then a hostel or one large one straight from Rampton to a hostel.

53. As far as medication was concerned he said that he believed that he needed to take medication and if people did not believe him, he would be happy to take depot medication.

54. He stated that he had given up drugs and would not take them again. He stressed that he was attending a drugs and alcohol programme at Rampton and was keen to follow a similar type of session if he were to leave Rampton.

55. When asked about his feelings towards Asian women, he said that he had no problem with them but accepted that it was probably not a good idea to have a relationship with them again.

56. When asked about a recent incident when he had become increasingly restless and unable to sleep at night when some of those issues had been discussed with him, he responded in a

slightly suspicious manner by saying that RMO3 had said recently that he was showing traits of a psychopath and needed more medication. He felt that RMO3 was trying to '*mess his discharge up'* and that was what was upsetting him.

57. Social Worker 4 and the Forensic CPN's Report contained the following under the section headed 'Opinion/Recommendations:

"Although he has been stable in his mental state and compliant with his medication for the past few years, he has never been tested out in a lesser secure environment as part of his rehabilitation, so how he would react is still unknown. It is clear from his history that prior to the Index Offence he was under considerable stress which appeared to precipitate the onset of his psychotic illness.

We understand, at the time of writing this report, that the Home Office has given permission to Mr Bryan to be given 6 months trial leave at the John Howard Centre. Therefore, we feel it is important that Mr Bryan is transferred as soon as possible to the Colin Franklin Unit (John Howard Centre) under Section 17 leave. This is so that he can participate in an active rehabilitation programme and be closely assessed by the Team and how he copes with stress and if there are any risk factors evident…

When he is assessed and accepted for an appropriate (hostel) placement we would recommend for gradual periods of Section 17 leave to the placement so that he can be assessed on how he is coping in his new environment.

Mr Bryan appears to have gained a lot of insight into his mental illness and how it contributed to his Index Offence. He also appears to have good compliance with his medication and understands the need to take it. Factors that would increase his risk of re-offending in a similar way to his Index Offence are a relapse of his mental illness and drug and alcohol abuse. To try and minimise these risk factors we recommend that he continues to have a psycho education, which should also include his family. Following on from this it may be prudent to do some work around early warning signs and to draw up a relapse contingency plan with him and the hostel staff.

As highlighted in (Psychologist 4)'s (Clinical Psychologist) risk assessment dated 29th September 2000, it was felt that when he leaves hospital he would be a high risk of resuming a criminal

lifestyle which he had prior to his Index Offence….To minimise the risk of this from happening it is important that he is closely supervised and monitored in the community. This would include close monitoring by hostel staff for any evidence of this type of criminal activity and regular visits from his Social Supervisor and Forensic CPN at his placement…"

58. Peter Bryan was transferred to the John Howard Centre on 12 July 2001 under the care of RMO4, Consultant Forensic Psychiatrist.

The Panel have no doubt that it was appropriate to transfer Peter Bryan at this time from the high security of Rampton Hospital to the John Howard Centre which is a medium secure unit. He had spent 7½ years there, which was an average length of time in a high secure hospital.

He had not shown any signs of active psychosis throughout the time that he had been at Rampton, he had responded well to a fairly low dose of oral antipsychotic medication and for some considerable time he had not displayed any aggressive or threatening behaviour. He had been described as "a model patient" by many of those caring for him at Rampton and they found him likeable although at times immature and manipulative.

RMO2, one of Peter Bryan's RMOs at Rampton Hospital, told us:

"I remember Peter Bryan as being a very pleasant and affable patient, who had a good sense of humour, who in some respects blended into the wall paper on the villa. He did not have any significant specific treatment needs, he was somebody who was managed on medication and whose mental health appeared to be stable, and in some respects, doing his time before moving on."

Although not all of the work which needed to have been done had been completed at Rampton, it was anticipated that such work which remained would be completed during Peter Bryan's stay at the John Howard Centre. It was no longer necessary to complete the work in a high secure environment.

The Panel is concerned that Peter Bryan was transferred straight to Colin Franklin Ward rather than to the Admissions ward at the John Howard Centre - which would have been the normal procedure.

Almost everyone we spoke to from the John Howard Centre was surprised that he had been transferred straight to Colin Franklin Ward.

Colin Franklin Ward was intended as a pre-discharge ward and JHC Consultant Forensic Psychiatrist 1 (who had developed the ward as part of the John Howard Centre in the late 1990s, while he was Clinical Director) told us that this was very important in terms of what it was and its philosophy. He told us:

"We called it a medium secure ward because all our facilities are medium secure, but it wouldn't pass muster as a medium secure ward in the sense that there was no fence and it was essentially a locked ward. The idea of its operation was to expand the service by putting the 12 or so best patients in the service there - those who were closest to the door - to discharge.

It is not, clearly, a medium secure ward and so to bring someone there is setting you on a certain course of action. It is sort of saying 'the person is close to discharge', whereas bringing them into the John Howard Centre and assessing the person gives you the chance to decide whether the person is suitable for a pre-discharge ward, and then to discharge."

The Panel are strongly of the view that admitting Peter Bryan straight to Colin Franklin Ward from Rampton Hospital did *'set* (those responsible for his care and treatment) *on a certain course of action'* and indeed that course of action to some extent coloured all of his future management.

When asked by the Panel whether it surprised him that Peter Bryan went straight from Rampton to Colin Franklin Ward, RMO1 (Peter Bryan's RMO for his first few years at Rampton) said:

"It does - because one thing that did happen was that when he went from the very structured setting of a central ward - the main admission ward - to the less structured setting of a villa, he definitely caused more problems. He had already demonstrated that if you removed a tight structure from him there was the scope for problems to develop, so that is something that slightly surprises me."

Sheila Foley, former Chief Executive of the Trust, described Colin Franklin Ward as follows: *"You walked through the door and it didn't feel like somewhere that was particularly therapeutic. It felt like somewhere that people were just sitting around and nothing therapeutic was happening. It felt like a holding place."*

Peter Bryan himself seemed to need the security of a structured environment and, as his life became more and more unstructured over the couple of years following his discharge from Rampton Hospital, he appears to have become more stressed and anxious about his future, even though this may only be recognisable with the benefit of hindsight.

However, it is our understanding that a bed had become available on 6 July 2001 on Colin Franklin Ward and that, had Peter Bryan not gone to the John Howard Centre, he may well have been discharged straight to a community hostel by the Mental Health Review Tribunal. The Panel considers that the transfer to the John Howard Centre was appropriate, but that, if the only bed that was available was on Colin Franklin Ward, there should have been an internal transfer or exchange so that a patient who had already been in medium security for some time and was now suitable to be on the pre-discharge ward, should have been transferred to the bed on Colin Franklin Ward and Peter Bryan should have been admitted to one of the wards within the secure perimeter of the John Howard Centre.

There was also considerable surprise expressed by almost every witness we spoke to about the brevity of his stay in the John Howard Centre.

We were told by several witnesses that the average stay in a medium secure unit for a patient transferred from a high secure hospital is 18 months to 2 years. This is necessary because it is effectively a period of rehabilitation between often many years in a high secure institution and onward progression to living in the community.

Peter Bryan spent 7½ years at Rampton Hospital. He spent only six months at the John Howard Centre.

The Home Office gave consent to his transfer to the John Howard Centre on six months 'trial leave'. This meant that, if anything untoward happened within those six months, he could be returned immediately to Rampton Hospital.

'Six months trial leave' did not mean that it was intended that he should only remain at the John Howard Centre for six months prior to discharge into the community.

However, as we will explain later in the Report, it was an exceptional set of circumstances - whereby everything required for his discharge into the community unexpectedly fell into place - which ultimately resulted in Peter Bryan spending such an unusually short time in medium security.

Strictly speaking, since he had only been transferred on trial leave, RMO3 remained Peter Bryan's RMO until such time as the Home Office granted leave to formally transfer him to the John Howard Centre (which they did only the day before he was actually conditionally discharged into the community).

On the whole the Panel was impressed by the handover arrangements between Rampton Hospital and the John Howard Centre.

Members of various disciplines from the John Howard Centre went to interview Peter Bryan at Rampton and carried out their own assessments and they also attended the pre-discharge CPA (Care Programme Approach[5]) meeting at Rampton. RMO3, Peter Bryan's RMO at Rampton, attended the first CPA meeting at the John Howard Centre.
This gave the John Howard Centre personnel various opportunities to identify the key elements which had been learned about Peter Bryan during his 7½ year stay at Rampton Hospital.

However the Panel consider that the following were the key elements in relation to Peter Bryan's care and treatment which should have been learned from his time at Rampton and should have been 'handed over' to those who would be responsible for him at the John Howard Centre:

- **it was difficult to make a definite diagnosis of his illness because he did not demonstrate the classic signs of schizophrenia**

[5] The Care Programme Approach was a 1991 Department of Health initiative to improve the coordination of the care and treatment of people with mental illness.

- his mental health was susceptible to stress and stress was a trigger factor to him becoming mentally unwell
- he tended to over-control and suppress his anger
- violence gave him a "buzz" and he became excitably aroused by violence
- he was good at hiding his feelings
- he would say what he thought someone wanted to hear and could be manipulative [(RMO1) an experienced forensic psychiatrist told the Panel that his abiding memory of Peter Bryan was that he was very difficult to get through to and to get an open account of anything from him and that he never really felt that he got underneath the surface]
- there was no clear view of the events which had led to the killing of NS. The detail changed with every version that Peter Bryan gave various professionals who discussed the homicide with him
- he enjoyed 'getting one up' on people
- his behaviour -in particular when relating to women - was often immature and naïve
- he still had needs in terms of treatment which had not been met or needed to be revisited.

The main criticism we have to make about the hand-over from Rampton to the John Howard Centre is that neither those handing over Peter Bryan's care nor those taking it over extracted these key elements from the various Rampton reports and assessments and amalgamated them into a simple core document which would then be readily accessible to anyone in the future who needed to know the essential details about Peter Bryan.

The Notes for the Guidance of Supervising Psychiatrists published by the Home Office (now the Ministry of Justice) states as follows[6]:

[6] The most up-to-date Ministry of Justice Notes for the Guidance of Social Supervisors and for Supervising Psychiatrists are annexed to this Report.

"14. …it is essential that the supervising psychiatrist should receive, as early as possible before discharge, detailed written information about the patient which can be retained for reference in the records of the responsible hospital management. All supervisors should possess comprehensive background information about the patient and his offending history. It is crucial that these records are available to successive supervising psychiatrists and to officers of the responsible primary care trust.

15. Discharging hospitals are advised that the full package of information provided to the supervising psychiatrist for retention should cover the following aspects of the case:

(a) A pen-picture of the patient including his diagnosis and current mental state;

(b) Admission, social, offending and medical history;

(c) Summary of progress in hospital including insight into disorder, state of compliance and extent to which tendency to offend has been addressed by the care programme;

(d) Present medication and reported effects and any side effects;

(e) Any warning signs which might indicate a relapse of his mental state or repetition of offending behaviour together with the time lapse in which this could occur, and details of any individuals or groups who may be at particular risk;

(f) A report on present home circumstances; and

(g) Supervision and after-care arrangements which the hospital considers appropriate or inappropriate in the particular case."

Although this Guidance is intended only for a patient's discharge from hospital into the community, we consider that a similar process should have been followed on Peter Bryan's discharge from Rampton Hospital to the John Howard Centre and that the principles set out in the guidance are good practice which should always be followed on the transfer of a patient from one team to another.

In addition they should have reported which issues had already been addressed and in what way and the outcome of the work already carried out.

Peter Bryan had been at Rampton Hospital for some 7½ years and his clinical notes were therefore voluminous. The clinical notes contained all the necessary information, but a single comprehensive discharge document containing an overview of his time at Rampton would have been of great assistance to those who would have responsibility for him in the future.

Had this been done, the professionals from the general psychiatric service who were ultimately responsible for Peter Bryan's care in the community would have had the benefit of the experience of the forensic psychiatric service's views on key elements of the presentation of this complex patient.

It may well have helped them to recognise the more subtle features of his illness and not be lulled into a sense of false security when he did not show florid signs of mental disorder.

John Howard Centre

1. The need for an inpatient unit offering a level of security below that of the high secure hospitals (Broadmoor, Rampton and Ashworth) was first identified in the mid-1970s, But it was a further decade before many of the units became operational.

2. They were known as regional secure units (RSUs) reflecting their link with the then regional health authorities.

3. In some areas of the country, Hackney in East London being one such area, the secure unit was initially located in an existing hospital estate and was called an 'interim secure unit' until a purpose-built unit could be commissioned.

4. Medium secure units (MSUs) as they are now called, occupy a step down in security from high secure hospitals, but offer a more containing and restrictive regime than the low secure hospital units. Their patients may be admitted from high secure hospitals as part of the rehabilitation process leading to eventual discharge into the community, or from prisons, or the courts, for further assessment and treatment of their mental disorder. Less frequently patients may be admitted directly from the community or from hospitals lower in the security hierarchy.

5. All the patients are detained under the provisions of the Mental Health Act 1983 (or related mental health legislation) and many will have been convicted (or are yet to stand trial) for serious criminal offences that necessitated their detention in units with heightened security.

6. The initial expectation was of admissions lasting no longer than 18 to 24 months but experience has proved that this is frequently exceeded.

7. The first interim secure unit in the North East London locality opened as a 12 bed unit in about 1987. At that time and into the mid-1990s, many patients had to be placed in the independent sector and there were still a large number of patients in high secure hospitals.

8. In 1995 a 43 bed regional (now called medium) secure unit called the John Howard Centre was opened in Hackney. Despite the increase in the number of available beds, there were still many patients in high security and in the private sector. There were three consultants responsible for the patients.

JHC Consultant Forensic Psychiatrist 1 became Clinical Director in the late 1990s. He told us that he saw it as his chief goal to develop local forensic services because:

"Without local services I felt that you were never going to get sufficient staff on the ground to do work, and you weren't going to develop close working relations with general adult psychiatry. So, with the beds come personnel, and with personnel comes the opportunity to change your model"

He told us that in the late 1990s the forensic service received some money for a rehabilitation service and by 1999 they had 30 additional beds. The responsible Authority then indicated that they would fund a further 30 bed secure service, but according to JHC Consultant Forensic Psychiatrist 1, the Trust was too disorganised and the opportunity was lost.

JHC Consultant Forensic Psychiatrist 1 was so frustrated and disillusioned that he left the Trust at the end of 2000 and only returned at the beginning of 2004 (a matter of a week or two after the homicide) after there had been extensive managerial and staff changes and he felt that the Trust was heading in a new and more positive direction, in particular with a greater understanding about forensic psychiatry.

We interviewed various witnesses at executive level who all described the dysfunctional nature of the John Howard Centre in the early 2000s. It was a time of change, with a change of senior management as well as a change in nursing management.

Sheila Foley was Chief Executive of the Trust from November 2002 (just after Peter Bryan left the John Howard Centre) to August 2006. Her background was as a nurse working in mental health and for five years she had been Chief Executive at Rampton Hospital.

She told us that:

"I went to the Trust Board and said that the John Howard Centre kept me awake at night and that the John Howard Centre had the ability to bring the Trust down."

The Service Manager, who had previously worked with Sheila Foley at Rampton, was appointed to the John Howard Centre in November 2003. She described her impression when she arrived:

"It was a little chaotic. It had gone through quite a lot of different managers who hadn't stayed very long, so there was no sense of consistency with any staff groups. There were issues around practice within all the professions. It had also gone through a process of quite a lot of expansion in terms of beds and things, which I thought was very good but perhaps they hadn't been thought through very well."

Other witnesses told the panel that the John Howard Centre had been nicknamed the 'Frankie Howerd Centre'.

In 2003 there was a 'purge' of staff at all levels at the John Howard Centre. The Panel has been told that there has been an improvement in standards since then, but this Inquiry has to make its findings against the background which prevailed in 2001 to 2002 when Peter Bryan was there.

We have been told that the anticipated time in medium security before discharge into the community for those patients transferred from high security is 18 months to 2 years. This time is necessary to complete rehabilitation for someone who has been detained in a high secure institution - often for many years - and is necessary as much for the individual's safety and well-being as it is for the safety of the public.

Peter Bryan's time at the John Howard Centre was therefore intended to be a period of rehabilitation after 7½ years in the structured environment of high security at Rampton Hospital. There was work which still had to be done and in particular he had not had any unescorted leave into the community.

9. Nurse 5 was appointed as Peter Bryan's Primary Nurse on his admission to Colin Franklin Ward in July 2001 and remained his Primary Nurse throughout his six month stay in the John Howard Centre.

The Panel were impressed with the careful and detailed notes which Nurse 5 made and with his various assessments of Peter Bryan. We were also impressed with him when we interviewed him for this Inquiry.

He described Peter Bryan as follows:

"It is not that I didn't like him. He was like any other patient whom I was treating and I have to develop a relationship…However with Bryan I developed a relationship but there was a kind of coldness as a character. It is difficult to describe it. I did not have difficulty in relating to him but there was a kind of coldness that I could not go beyond in relating to him as with some patients whom you get to like a little more."

10. About two weeks after his transfer, Nurse 5 noted after a one-to-one session with Peter Bryan: *"Clearly what is emerging is that Peter is a character who indulges in a lot of lying for which nursing staff need to be aware"*

Peter Bryan therefore needed to be treated with a high level of suspicion when it came to what he told clinical staff about himself. Because he appeared clinically well with an absence of observable symptoms, there was an over-reliance by those caring for him on his self reporting when it came to assessing risk, and the Panel believe that too often Peter Bryan's explanations for things he did and had done were accepted without further exploration because they appeared plausible and he appeared to be well.

11. On 14 August 2001, only a month after his transfer, JHC Psychiatrist 3 wrote to the Home Office requesting some escorted community leave for Peter Bryan. In her letter, JHC Psychiatrist 3 emphasised that the adjourned MHRT was scheduled for 29 August and that it appeared that the Tribunal would recommend conditional discharge without deferment. She therefore emphasised that the John Howard Centre were very keen to facilitate Peter Bryan's rehabilitation as soon as possible.

In fact on 19 July the MHRT had already been postponed from 29 August at Rampton to 24 October at the John Howard Centre. This is standard practice when a patient is moved from one hospital to another. JHC Psychiatrist 3 appeared to be unaware of the change of date. The clinical team should have been kept informed of such events.

Her letter also shows that the clinical team believed that, at the adjourned Tribunal hearing, Peter Bryan would be discharged from the John Howard Centre into the community.

12. On 14 August Peter Bryan was also assessed by the Manager and Deputy Manager of Riverside House, a 24 hour supervised hostel in the Seven Sisters Road, London N4 to see if he would be a suitable resident for their hostel once he was discharged from the John Howard Centre.

13. The Manager's Assessment Report following that meeting described what they had been told by the nursing staff on Colin Franklin Ward:

"Ward staff informed us that Peter has shown some institutionalised behaviour on the ward: he persuades fellow patients to purchase tea, coffee and cigarettes from him. The nurse also expressed that staff observed racist tendencies in Peter such as rebuking, condescending and sarcastic behaviour. Staff said that Mr Bryan is a pleasant and friendly man, he mixes well with staff and patients. There have been no incidents since his admission and he is very co-operative with all of his care. There has been no illicit drug use and he is always compliant with all of his therapies and medication. Peter receives escorted ground and community leaves. He is always co-operative with his leave and there are no recorded problems. Staff said that all members of the team agree recommendations to the MHRT that he be conditionally discharged to a community placement."

14. The Riverside report set out a detailed Care Plan for Peter Bryan in the knowledge that there was a high potential for relapse because he had not yet been tested in a community setting.

15. The Report's 'Conclusions and Recommendations' were:

"He has a psychiatric history dating back to 1993 and Peter himself admits to having paranoid thoughts since 1991. His clinical teams record that he has been free from delusions and hallucinations since 1995. He demonstrates good insight and has aspirations to remain free of illicit drugs. He has posed no management problems in Rampton Hospital or during his time at the John Howard Centre.

Having read his history and met with him, we are of the opinion that for Peter to remain safely in the community for any period of time will take much staff input and support as detailed in the proposed care plan above.

We feel he will fit in well with the current residents in the home and that he will be compliant in the short term with house rules in regards to illicit drug use and antisocial behaviour. We feel however that as Peter gains confidence and time elapses, he will begin to drift back to using and dealing with drugs and that it will be difficult to keep him mentally stable and safe in the community. To prevent such a relapse will require robust input from all those responsible for his care in the community.

We are however concerned that Peter currently persuades fellow patients to purchase items from him on the ward. This suggests similarities of his money lending to drug dealers prior to the index offence."

The penultimate paragraph of this report is prophetically accurate and the Panel agree with the view that 'robust input from all those responsible for Peter Bryan's care in the community' was necessary to prevent a relapse in his mental health.

Unfortunately, the input from the key professionals was not as robust as perhaps it could have been.

16. On 3 September there was a CPA (Care Programme Approach) meeting attended by RMO4, (the consultant psychiatrist responsible for Peter Bryan at the John Howard Centre), RMO3, (Peter Bryan's RMO at Rampton Hospital), the Manager and Deputy Manager 1 of Riverside House amongst others.

17. The general consensus, minuted by JHC Psychiatrist 3, Specialist Registrar to RMO4, was:

"It was generally felt by most disciplines, including nursing, his medical team from Rampton and therapy and education, that a further period of time is needed in medium security in order to get to know Mr Bryan and allow adequate time for disciplines to assess him thoroughly. A request has also been made for escorted community trips, but we are still waiting to hear from the Home Office."

18. The nursing note of the CPA meeting stated:

"The team is not sure what went on in the last tribunal and they felt that they were pressurised to have Peter discharged."

"His lawyer (Solicitor 1) has his agenda – Agree that things have to be put in place
Human rights that he should not be retained (sic)

Take six to nine months to fulfil conditions"

It was therefore clearly the view of everybody as at the beginning of September 2001 that more time was needed to get to know Peter Bryan and to be able to assess him thoroughly. This is in stark contrast to the note made by the Manager of Riverside House just three weeks earlier on 14 August that she had been told by the ward staff that all members of the team agreed that all members would recommend Peter Bryan's conditional discharge to a community placement.

It also seems to be the case that the MHRT hearing had unsettled the team and that they had felt under pressure to discharge Peter Bryan. It is the Panel's view that this had a material influence on his 'transit' through the John Howard Centre.

19. During September 2001 two occupational therapists (OTs), Occupational Therapist 1 and Occupational Therapist 2, conducted three separate assessment sessions with Peter Bryan, two of them jointly. Occupational Therapist 2 then prepared a detailed report which contained the following extracts:

"The first session was facilitated by a female therapist. During this session Peter was relatively appropriate and able to answer most questions in detail. In the second and third sessions the interviews were also co-facilitated by a male therapist. In both of these sessions Peter presented with veiled hostility and "splitting" behaviours. Peter attempted to make it clear he did not like the female therapist and exaggerated the friendliness of his interactions with the male therapist. The female therapist asked the majority of the questions in the interview.

These behaviours were particularly apparent in the second session. When Peter was asked questions regarding his mental health and skills he began pacing the room complaining of pins and needles in his ankles, he made racial remarks and described his potential for controlled physical aggression. Despite his evident difficulty in coping with these questions Peter remained in the room and agreed to meet the following week to complete the interview. In the third session he was more relaxed although continued to display splitting behaviour.

It is unclear why Peter began to display these behaviours. He did not appear to be psychotic at any time throughout any of the interviews. It may have been due to a combination of the questions becoming more challenging, anxiety and/or Peter feeling the need to "show-off" to the male therapist…

Peter views his main difficulty as being in the MSU and this leaves him feeling out of control. He feels that he is 40% in control of his life and the Home Office controls the rest. Peter stated that he does not understand the Mental Health Act…

Peter perceives he has learnt to control his temper. He identified that if he feels that he has a lack of choices or is "backed into a corner" he is likely to become angry. Peter states that when he becomes angry his ankles become tense. However in Peter's descriptions of how he manages his anger he describes the amount of violence that would be necessary to use, rather than solving the situation rationally…"

The Panel believes that, in the period immediately before he killed Brian Cherry, Peter Bryan felt that he had run out of choices and was "backed into a corner". After the homicide he described experiencing a clicking of his ankles when he was stressed, and that this was an indication that he was *"ready for extreme physical action"*.

With the benefit of hindsight, it is clear that Peter Bryan had quite a good insight into his own relapse indicators.

"…Peter was asked about his coping strategies regarding his mental health. At this point of the interview he began to complain of pins and needles in his ankles and began pacing the room. He stated that he finds it difficult to remain feeling confident about himself, this fluctuates from day to day. He also describes anxiety as being a problem. When he feels panicky he states he ponders things over, paces up and down and will smoke a cigarette. Peter

reports that when he feels depressed he tries to think logically and weighs up the pros and cons. Peter stated that unwanted thoughts or voices are controlled by medication. He stated that he still has his "fantasies"…When asked how he manages anger Peter stated he "weighs up each individual situation - with you (indicating the female therapist) you would need a slap whereas he (indicating the male therapist) would need a punch"…

Summary and Conclusion

Areas of potential risk:

- *In the interview Peter found it difficult to cope with questions that he found challenging and displayed verbal hostility. Peter was particularly hostile to the female therapist who was asking the majority of the questions*

- *Peter appears to have maladaptive coping strategies regarding anger management. He had a poor perception of what anger management involved. Describing it in terms of controlled aggression rather than employing strategies other than violence*

- *In the past Peter had a lack of structure and lack of clear roles in his life. His habitual behaviours revolved around crime and drug taking. Without clear structures in place for Peter on his release, there is a likelihood that he will relapse and/or re-offend".*

The Panel considers that this was a very good report which showed considerable understanding of Peter Bryan's psychology and it illustrated the benefit of multi-disciplinary working.

These joint assessment sessions were the only time during Peter Bryan's stay at the John Howard Centre when he was exposed to two co-workers (rather than one-to-one sessions), especially one male and one female. They reveal evidence of his different attitudes to men and women and his tendency to display "splitting" behaviour in that situation.

The report also highlighted how Peter Bryan had a poor perception of anger management, describing it in terms of the control of violence rather than the avoidance of it.

We consider that the concluding sentence set out above: "*Without clear structures in place for Peter Bryan on his release, there is a likelihood that he will relapse and/or re-offend*" was extremely perceptive.

Unfortunately, we do not believe that clear enough structures were put in place for Peter Bryan once he was discharged into the community.

Forensic Social Worker 1, the forensic social worker attached to the John Howard Centre who had assessed Peter Bryan at Rampton in 1999 and who had been his social worker initially when he was discharged from Rampton, told us:

"He had the capacity to learn and take things on and an action would follow with that, which went in his favour because you felt there was hope.

If you gave him positive actions to do, he would do them and everything would be okay. Peter responded to that, but that was it. So when he did not know what else to do when he was in the community and he had more free rein, he had to live up to his own expectations which he perhaps did not have."

20. On 4 October 2001, JHC Psychiatrist 3 wrote a report for the Mental Health Review Tribunal which contained the following extracts:

"Progress at the John Howard Centre, Medium Secure Unit

Mr Bryan was transferred from Rampton Hospital to Colin Franklin Ward, on July 12 2001. Since his transfer, Mr Bryan's mental state remains stable with no evidence of psychosis. He has been compliant with his medication, Trifluoperazine 5 mg bd…

According to the nursing staff, Mr Bryan's behaviour has generally been settled since he has been at the John Howard Centre, apart from a few sarcastic comments and one report from a female nurse that she perceived him as intimidating on one occasion.

Concerns were raised by the nursing staff about Mr Bryan reporting a dream in which he had intercourse with an Indian girl, and it was felt that a psychologist should explore this in the

context of the dream's real meaning and its implication in terms of his risk when he is discharged into the community.

In terms of therapy and education, Mr Bryan has engaged in a six-week introduction programme and an occupational therapy initial interview, which was carried out over three sessions. Areas of potential risks were outlined. In the interview, Mr Bryan found it difficult to cope with questions he found challenging and displayed verbal hostility, particularly to the female therapist. Mr Bryan also demonstrated maladaptive coping strategies regarding anger management with poor perception of what anger management involves. He described it in terms of controlled aggression, rather than employing strategies other than violence. It was also highlighted that Mr Bryan has had a lack of structure and lack of clear roles in his life. His habitual behaviours revolved around crime and drug taking, and without clear structures in place for Peter, there is a likelihood that his mental state will deteriorate and that he will start taking drugs again with a risk of re-offending. The occupational therapy team feel that a further assessment is necessary of his activity of daily living skills and further assessment of social and interaction skills. They feel that they need to continue to build a rapport with Mr Bryan in order to work with him to develop adoptive coping strategies to manage stress, anger and anxiety. They also believe that he needs further work to develop budgeting and money management skills…

OPINION and RECOMMENDATIONS

… It is the opinion of the clinical team caring for Mr Bryan, including his medical team from Rampton Hospital, that a further period of time is needed in medium security to allow time for disciplines to complete thorough assessments and construct clear and structured treatment programmes. These will include:

(i) Psychological interventions which have started to address sexual development, premorbid personality and substance abuse in the context of his index offence and future risk.

(ii) A referral to the Tower Hamlets drug and alcohol outreach team for an assessment and advice about management and with the aim of their involvement in Mr Bryan's future care in the community.

Our ability to assess the risk he poses in the community is limited and we still have not heard from the Home Office regarding escorted community leave to enable us to make attempts towards gradual re-integration into the community.

We would like to recommend that Peter Bryan remain on his Section 37/41 in the John Howard Centre for a further period so that we can undertake the above tasks."

The last two paragraphs of this report seem to envisage that the team needed to set up a programme to further assess the risks that Peter Bryan might pose once he was living in the community, and that any reintegration into the community would be gradual and only after escorted community leave had been attempted.

We consider that this report should have been more robust in emphasising the need to keep Peter Bryan in medium security for a further period of time. Had the report been more detailed and specific, we believe that the MHRT may well have been more reluctant to conditionally discharge him when they did, even if the clinical team had supported a conditional discharge.

On 18 October the Home Office granted 12 escorted periods of day leave at his RMO's discretion. He had his first escorted leave on 4 November when he went to Hackney Wick Market for a two-hour trip.

21. Nurse 5, Peter Bryan's Primary Nurse, also prepared a report in preparation for the MHRT which concluded:

"In conclusion, Mr Bryan should be expected to spend enough time in this unit to enable the clinical team to analyse and interpret the type of psychopathology which contributed to the Index Offence, and how it relates to the fantasies that he has expressed in the past. This will enable the team to produce a package of care which will eventually enable Mr Bryan to be released into the community with the minimum risk."

These two reports both conclude that it would be beneficial for Peter Bryan to remain at the John Howard Centre for some time as there was considerable work still to be done.

The recommendation of the clinical team (including the team from Rampton) to the MHRT therefore appeared to be that they required more time in order that they could properly assess the risk that Peter Bryan might pose following discharge from the medium secure unit and then construct clear and structured treatment programmes.

Further assessments were carried out in the following few months but we did not find any evidence of 'clear and structured treatment programmes' having been devised, let alone provided.

No formal risk assessment was carried out other than the proforma assessment completed by Nurse 5 on Peter Bryan's admission to the John Howard Centre.

22. Forensic Social Worker 2, who had taken over from Forensic Social Worker 1, wrote a Social Circumstances Report for the MHRT which contained the following extracts:

"I asked the patient to outline to me his relapse indicators and he responded with some guidance. In summary, the following was disclosed: relapse might occur after two weeks off treatment and be associated with low mood, hostility, paranoia, poor self-care. Abnormal experience in terms of auditory hallucinations was denied."

Once again this showed that Peter Bryan had a good sense of his own relapse indicators.

"In the event of concern the patient spoke of seeking help from his clinical team and if that did not work. 'I would break a window and get arrested'."

Statements like this caused the Panel to speculate whether Peter Bryan's challenging behaviour culminating in the indecent assault on P4 some two weeks before the homicide - if not the homicide itself - was such an attempt to elicit a response to his own concerns about his mental health. There were of course many other factors which we consider later in this Report.

23. The report concluded:

"Mr Bryan is a patient who suffers from a profound and enduring mental illness, which in the past had been linked to criminal activity and substance misuse. The patient has made

significant gains whilst at Rampton Hospital, and in my opinion there is now a need to evaluate these skills in a more challenging environment at a lower level of security.

The patient is now in the process of assessment and in my view it would be premature to consider discharge prior to the completion of that work. I would therefore ask the Mental Health Review Tribunal to uphold detention subject to Section 37/41. If the Mental Health Review Tribunal were minded to discharge detention I would ask that a deferred conditional discharge is considered."

This was yet another recommendation from another speciality in the multi-disciplinary team for further time in medium security to properly assess and evaluate any potential risks.

It is difficult to understand why the team later retreated from this position so quickly.

24. Almost immediately after Forensic Social Worker 2 prepared this report, Forensic Social Worker 3, took over from him as Peter Bryan's forensic social worker.

    This was the third change of social worker on the forensic team in the three months that Peter Bryan had been at the John Howard Centre. This is perhaps illustrative of the instability of the forensic service at this time. Such frequent changes could not allow any consistency of involvement in Peter Bryan's care.

25. On 22 October there was a 'Mini CPA Meeting' led by JHC Psychiatrist 3. The Team discussed Peter Bryan's MHRT on 24 October. The nursing notes record that JHC Psychiatrist 3 and the rest of the Team were agreed that a deferred conditional discharge was necessary as he had only been on the ward such a short time and needed more assessment and sessions. Also he had not yet had any unescorted leave and could not be assessed properly.

    This decision appears to misunderstand the purpose of a deferred conditional discharge. It is not to allow more time for an assessment, because if assessments are still required, the clinical team should not be recommending discharge from hospital.

    A deferred conditional discharge operates when the criteria of the discharge from hospital (as opposed to from Section) are met, but it cannot be implemented because the conditions

of the conditional discharge cannot be met – for example appropriate accommodation is not available.

RMO4 was not present at this 'mini-CPA' and the decision to recommend a deferred conditional discharge perhaps reflects the inexperience and lack of specialist knowledge of JHC Psychiatrist 3 at that stage of her training.

It could have been picked up by RMO4 in a supervision session with JHC Psychiatrist 3, but her evidence to us was that supervision was not a regular or systematic feature of her placement at the John Howard Centre. She told us:

"It wasn't a regular 'Let's meet on a Friday at such a time and we'll sit down for an hour and we'll talk'. It was very much more that if I had anything I wanted to discuss with him, I would go and find him – go into his office, sit down and go through it with him."

She confirmed that it was more up to her to identify potential problems than regular supervision.

The Royal College of Psychiatrists recommends a protected hour of face-to-face supervision with the consultant each week.

The Panel considers that there should have been at least one hour of individual supervision per week for someone of JHC Psychiatrist 3's relative inexperience.

26. It was further noted that a community general psychiatrist, RMO5, had been identified to take over Peter Bryan's care, and that the Manager at the supervised hostel, Riverside House, had agreed in principle to take him.

27. The MHRT to decide Peter Bryan's appeal against detention sat on 24 October 2001. However the Tribunal consisted of three different members from those who had sat on the MHRT panel on 28 March.

28. Peter Bryan's solicitor, Solicitor 1, challenged the Tribunal's right to hear the matter, arguing that as the original MHRT had been adjourned, it was 'part heard' and could only be heard by the original three members.

29. The hearing was therefore adjourned again to allow the Tribunal to investigate the legal position, for Solicitor 1 to prepare a written Skeleton Argument setting out the basis of his legal challenge and to give the Home Office four weeks to respond to the legal submissions.

30. Following the hearing Forensic Social Worker 1 wrote this to Social Worker 4:

"The tribunal yesterday was an interesting one from legal points of view!

Basically, Peter's solicitor began by requesting an adjournment. He stated clear reasons why he wanted an adjournment rather than a deferment on grounds that Peter is likely to be discharged sooner by having this tribunal adjourned rather than insisting that this Tribunal grant a conditional discharge that would have to be deferred.

The reasons for requesting the adjournment are as follows:

1. *This Tribunal board are not to enquire further into Peter's mental state with regard to detainability. (This evidence has already been heard by the Tribunal at Rampton that as good as said he should have a conditional discharge)*

2. *To give the Health Authority and Local Authority an opportunity to get the conditions met.*

The Tribunal considered these requests and on deliberation agreed to the adjournment as the solicitor was challenging a major point of law that this Tribunal did not feel able to address without advice from their own counsel…"

31. It was noted after a ward round on 29 October 2001 that the main discussion at the ward round had been about the adjournment of the MHRT. It was apparently decided that the social worker would write to the Home Office about the legalities, as they believed that Peter Bryan had already been granted a conditional discharge by the MHRT which had been held while he had still been at Rampton Hospital.

32. According to the recorded note, the thinking of the clinical team appeared to be that Peter Bryan had been transferred to the John Howard Centre because the conditional discharge could not be facilitated at Rampton because it was a high secure hospital.

If it correctly reflects the discussion at the ward round, this note demonstrates that the clinical team had perhaps misunderstood what had happened at the first MHRT.

The Tribunal which had sat at Rampton had decided that *"Peter Bryan was entitled to be conditionally discharged from detention"* subject to suitable arrangements for any conditions being in place. As no such arrangements were yet in hand and to avoid the potential delay which can take place on a deferment of conditional discharge, the Tribunal were persuaded by Solicitor 1's submissions that it was appropriate, in the light of recent case law, to adjourn the granting of the discharge until appropriate steps had been taken and arrangements made.

The Panel interpret this as meaning that the conditional discharge was not actually granted at the original MHRT hearing, although the Tribunal had been satisfied that Peter Bryan's mental illness was no longer of a nature or degree which required detention in hospital. The Tribunal did not grant the conditional discharge and then defer its implementation until suitable arrangements were in place. It adjourned the hearing in order for suitable arrangements to be put in place so that, once arrangements were in place, the conditional discharge would be granted with immediate effect.

When we asked Solicitor 1 to clarify the situation, he told us:

"When he went to the John Howard Centre he did not have a conditional discharge. The Tribunal had met and had adjourned."

The Panel's view is that this ambiguity of the legal position affected the management and treatment of Peter Bryan whilst he was at the John Howard Centre. It was meant to be a period of rehabilitation, but as a consequence of the clinical team's perception that Peter Bryan was going to be discharged within a very short period of time, there were no plans to engage in any real treatment (rather than assessment) work.

33. There was a ward round on 12 November. Most of the feedback was good although Occupational Therapist 2 reported that Peter Bryan appeared evasive and he queried whether he needed to work on anger management and stress management.

Anger and stress were probably two of the main trigger factors which led to Brian Cherry's homicide. Unfortunately there was no further work carried out on anger management and stress management, despite Peter Bryan himself frequently saying that he would like to continue with psychology sessions even after discharge from the John Howard Centre.

34. By the time of a ward round on 10 December 2001 the clinical team were stating that they felt that there was no compelling reason why Peter Bryan could not be conditionally discharged at the next MHRT which was now scheduled for 11 January 2002, although the date of the actual discharge might need to be deferred to allow arrangements for follow up care.

It was less than seven weeks since the MHRT at which the clinical team had recommended that further time was needed to carry out appropriate assessments and to initiate unescorted leave. No unescorted leave had as yet been initiated.

The Panel do not understand what had really been achieved in the intervening period which could have led the team to change their mind. It is as if they were influenced by the fact that they believed that a conditional discharge was a 'fait accompli'.

35. Between September and December 2001, Peter Bryan had had 12 one-to-one assessment sessions with a consultant clinical psychologist, Psychologist 5. He prepared a comprehensive report dated 14 December for the CPA meeting which was due to be held on 7 January 2002, four days before the MHRT.

Psychologist 5 had trained and qualified in South Africa and had then come to the UK in 1999. In 2001 he had obtained the British qualification which allowed him to be registered as a Chartered Psychologist in the UK.

In September 2001 he had come to work at the John Howard Centre as a consultant clinical psychologist specialising in the rehabilitation service. This was only a three-month placement as he had agreed to cover for that period of time because there was no psychologist on the medium secure team. However, when we interviewed him in January 2006, Psychologist 5 was back working at the John Howard Centre as a consultant psychologist in personality disorders.

Peter Bryan was Psychologist 5's first patient in a medium secure setting.

His report was an excellent report and we make no apologies for having set out relevant extracts at some length in the Background section to this report and for repeating much of it again in this section.

It is important that anyone reading this Inquiry Report has a clear picture of how Peter Bryan was when he was discharged into the community. In our opinion Psychologist 5's report gives valuable insight into the psychological makeup of Peter Bryan and provides helpful indications of areas of potential risk. In our opinion it would have made an excellent Risk Assessment.

36. The following are relevant extracts from this document:

"RELEVANT FEATURES OF MENTAL STATE AND BEHAVIOUR

Mr Bryan was always appropriately dressed, punctual for each appointment and appropriately apologetic when he arrived late for reasons beyond his control. He made intense eye contact, related warmly and established an easy rapport. His level of engagement did not falter when the issues to be addressed were uncomfortable for him, if anything he increased his engagement because he expressed how eager he was to press ahead into new and unexplored territory in terms of his understanding of the events which led to his incarceration. While Mr Bryan was appropriately serious at times his initial contact was sometimes jokey and over-familiar. These interactions may possibly have had a fatuous quality to them. Mr Bryan showed the capacity to express himself well at times, using subtle distinctions and showing adroit reasoning capabilities. He also demonstrated sophisticated inter-personal skills and a capacity for immediacy and integrity in his emotional relating…

There were no other overt signs of a psychotic disorder or a mood disorder. Mr Bryan's cognitive functioning was not formally tested. He showed the capacity for sustained concentration although it did require an effort from him and he remarked upon being tired after sessions. On occasion Mr Bryan did not recall detailed discussions that we had had previously. He showed considerable insight into aspects of his mental health difficulties, the symptoms that manifested when he was most ill and the role of medication in establishing and maintaining his mental health…

Mental State:

The presentation described above suggested to me that Mr Bryan is well treated on a low dose of anti-psychotic medication. However there is evidence of an on-going underlying vulnerability to psychotic thought processes. The stress of psychology sessions and the shifts in the delusional components of his account of the index offence indicate the slowly resolving nature of his delusional thinking processes. It is difficult to know the extent to which this has completely resolved in relation to incidents in the past and this may account for some (but not all) of the outstanding discrepancies between his current account and those in the depositions. This suggests that Mr Bryan's ego resources remain to some extent impaired by his illness and that his capacity to cope with various forms of stress will be an on-going vulnerability in need of support.

Once again stress was identified as a significant factor in Peter Bryan's mental illness as well as underlying psychotic thought processes.

Cognitive functioning assessment

…Mr Bryan appeared to manifest non-specific memory encoding problems and there is a strong possibility that some of his errors in social judgement are manifestations of dys-executive syndrome that presents in persons with a diagnosis of schizophrenia. What is described as 'immature' behaviour has at times seemed fatuous to me and there have been occasions of incongruity of affect. Aspects of Mr Bryan's social interaction style could thus be seen as residual features of his schizophrenic illness…

Personality Style

Mr Bryan has in the past remarked to previous assessors that he was a "psychopath in training" when resident on a ward for personality disorders for 5 years in Rampton Hospital. He also remarked that previous reference to psychopathic traits in a MHRT report was "thrown out by the judge". In the context of a severe and enduring mental illness it is important to distinguish between "trait versus state" issues. As described above, aspects of Mr Bryan's current presentation can not fail to be influenced by his primary diagnosis and this should temper inferences regarding his personality, not least of which because they stigmatise without offering understanding…

There have been reports of Mr Bryan engaging in "power games" with staff and fellow patients at Rampton Hospital and there have been instances of this here at the John Howard Centre. At Rampton Hospital Mr Bryan showed a concerning interest in weaponry and an excitability when speaking of violence by others. However it is also noted that this has decreased over the years. He was observed to say things to shock his audience and at times this gave offence. Aspects of Mr Bryan's behaviour could be attributed to a "thrill-seeker" trait.

In Mr Bryan's favour regarding his personality style are reports that he maintained warm and productive relationships with a wide range of staff members over a period of many years. He engaged in activities whole-heartedly and did not give the impression that he did so simply for instrumental gain but that he had concern and respect for members of staff. He is described as having a "lovely sense of humour" at Rampton Hospital. He has demonstrated to me that he does not tolerate without comment anyone who he sees as disrespectful towards him. This can bring him into conflict with authority…

Criminogenic needs:

The history of offending described in previous reports places Mr Bryan at significant risk of further criminal activities. This included assaults and muggings of specifically targeted vulnerable people, the carrying of knives from a young age, attempting to procure a gun prior to his index offence, drug dealing and various types of fraudulent activities. In the course of this assessment it became clear that Mr Bryan has not completely worked through the range of cognitive distortions and justifications available to him to justify illegal activities, petty or otherwise. However 7 years in hospital has provided him with a very different perspective on his relationship to society and the wider community…During this assessment we explored the grey area where entrepreneurial behaviour, which he shows in abundance, can shade into activities that are not entirely legal. We also addressed to some extent the problem of how these activities can escalate and create more and more risks of harm to others of various kinds. As a result of these discussions Mr Bryan has shown that he is capable and interested in such reflection but not that this is a completed piece of work…

Psychologist 5 has identified that there was still work that needed to be done in respect of Peter Bryan's involvement with illegal and antisocial activities which in the past had led him to carry weapons and to present the risk of harm to others.

Heterosexual relationships:

Mr Bryan showed the full range of features described in previous reports regarding his psychosexual development… described a wide range of sexual experiences and a blasé attitude towards talking about sex. He had contact with pornographic films from a young age and these appear to have been formative of his outlook towards women and intimidating at the same time. He described a number of genital sexual experiences but that he has always stopped short of full sexual intercourse…

It is not clear to me that it is significant in terms of specific risk factors that his victim was Asian. It may be significant in this regard that while on remand in Brixton Prison Mr Bryan made 2 apparently unprovoked attacks on fellow in-mates. It has become clear in the course of this assessment that Mr Bryan has a sexual preference for Asian women and that he is likely to be attracted to Asian women in the future. However, he is also attracted to women from other ethnic groups. Where ethnicity is an issue would be if he were spurned by a woman he was interested in and she was Asian or white, he may attribute this to racism on her part. This would add insult to injury, so to speak, and may provoke a response from him. During the course of the assessment I did provoke Mr Bryan with questions regarding an underlying hostility towards women. He was initially shocked by this but eventually responded positively in the sense of acknowledging that his sense of vulnerability and fear of humiliation may make him more verbally aggressive than if he did not anticipate rejection. He was interested in this avenue and wanted to explore it further.

Psychologist 5 recognised that it may not be significant that Peter Bryan's first victim was Asian and a female. He has also highlighted that Peter Bryan had made two apparently unprovoked attacks on fellow inmates at Brixton Prison. However he appears to stand alone in this way of thinking, as almost everyone else saw any potential future victim of Peter Bryan as being likely to be a young Asian woman. Psychologist 5 identified a more generic risk of violence as opposed to a particular sector of society.

The need for on-going psychology work

On the need for further psychology work, I have been struck that all three of the main psychology contacts have been assessments rather than interventions. All his therapeutic interventions as such have been group-based. Nevertheless, there have been significant

indicators of behaviour change and growth in spite of this. In the course of this assessment it was not possible to gain real access to his experience of the early familial context and the affective quality of his relationships with his mother or father. It is clear that Mr Bryan would like to have a better understanding of himself in some areas. However, the apparent vulnerabilities in Mr Bryan's mental state and the degree of stress he feels when sessions are more emotionally challenging would suggest that a "sealing over" approach is more appropriate at present. If Mr Bryan were to enter into a relationship, given the nature and circumstances of his index offence, it would be appropriate to consider a referral to a psychology service to assist him in managing the relationship and the stress it would bring.

<u>Relapse Signature</u>

Arising out of the above, features of a "relapse signature" that can be identified are as follows:

- *Low mood*
- *Irritability*
- *Subtle signs of an increase in paranoid ideation*
- *Illogical statements or disorganised reasoning*
- *Escalating social inappropriateness and sexually disinhibited behaviour*
- *Ideas regarding racism towards him or the expression of racist ideas himself towards others*

It has been noted in Rampton Hospital reports that Mr Bryan's family were not able in the past to respond appropriately to overt signs of distress and paranoia in the past. However, even on a ward at Rampton Hospital his symptoms were difficult to detect. It is possible that the subtle signs of a breakdown in his mental health could mistakenly be attributed to personality features."

As identified by Psychologist 5, all of the psychology work carried out with Peter Bryan took the form of assessments rather than interventions. The Panel believe that more interventional work should have been carried out.

This had been identified as well by Psychologist 4 at Rampton Hospital. She told us:

"He definitely needed to do more work in understanding what his risk factors were and how he would manage those - not about risk assessment but about risk management."

With the benefit of hindsight, we believe that Psychologist 5's description of Peter Bryan's relapse signature matches very well with how Peter Bryan was presenting in the weeks leading up to the homicide.

Of particular significance is the final sentence "*It is possible that the subtle signs of a breakdown in his mental health could mistakenly be attributed to personality features*".

In the Panel's opinion this is exactly what happened in those crucial weeks before Peter Bryan killed Brian Cherry.

Unfortunately those responsible for his care and treatment at that time appeared to fall into the very trap identified by Psychologist 5, and attributed subtle signs of a breakdown in his mental health to personality features.

The Panel however acknowledges that it would have been more difficult for those without the benefit of a forensic psychiatric training to recognise these more subtle signs of mental disorder.

"RECOMMENDATIONS

1. *It may be important in discharge planning to obtain the reports that are not available referred to above.*

2. *A Treatment Planning Meeting of 13 June 2001 at Rampton Hospital indicated a need for mental health needs to be addressed in community follow-up and this will require "full multi-agency working". Financial hardship will put Mr Bryan at risk of engaging in illegal activities to boost his income. He would therefore be at risk of returning to drug dealing as he did before, even if he is not using drugs himself. It may be necessary to consider the involvement of the probation services at an early stage.*

Although Peter Bryan appears not to have returned to using drugs on a regular basis himself, he clearly was associating with habitual drug users, and Peter Bryan told us when we interviewed him that he was involved in drug dealing to some extent.

Although in fact it would not have been possible to involve the probation service in Peter Bryan's management, Psychologist 5 was right to highlight the risk of Peter Bryan returning to illegal activities. As we will elaborate later in this report, we consider that those responsible for his care in the community did not recognise that the activities of those with whom he was associating might destabilise his rehabilitation.

3. *The meeting of his educational needs may have been interrupted in his transfer to the John Howard Centre and this may need to be addressed.*

4. *Mr Bryan engaged well at Rampton Hospital with the education department. How our service will address Mr Bryan's employment and vocational needs remains unclear at this point.*

5. *Mr Bryan will require active support in the community if he is to avoid a return to substance mis-use. He has expressed a willingness to attend any services we are able to arrange for him.*

6. *Further psycho-education regarding relapse indicators and how to respond when in the community should be clarified.*

7. *Mr Bryan indicated to me that he does not wish to live with his family. However, the treating team at Rampton Hospital made considerable efforts to maintain contact with his family and at one point there was the suggestion that Mr Bryan could explore the possibility of work with his brother who runs a painting and decorating company. It may be necessary to consider re-initiating this contact.*

8. *Mr Bryan has requested a mentor, a service user, for support were he to be discharged into the community. This is a very appropriate request and could be initiated while he is still an in-patient through a befriender scheme.*

As far as we are aware, Peter Bryan never had such a mentor in the community. It is possible that such a mentor might have been some help to him and this suggestion should have been explored further.

9. *Consider a re-test on WAIS-III if concerns regarding cognitive functioning become clinically relevant.*

10. *Consider referral to psychology or counselling services should Mr Bryan enter into a relationship or if there are other sources of stress that threaten the equilibrium he has attained at present."*

Peter Bryan on several occasions requested ongoing psychology sessions in the community. Despite there clearly being 'sources of stress' in the months leading up to the homicide, no further counselling was offered to him. However the Panel acknowledges that lack of resources would have made such sessions difficult to facilitate.

37. On 21 December JHC Psychiatrist 3, Specialist Registrar to RMO4, wrote an Addendum Report for the MHRT. It was signed by RMO4. This is the report in full:

"This is an addendum report for the Mental Health Review Tribunal, which should be read in conjunction with the original report, dated 4th October 2001

Progress at the John Howard Centre since 4th October 2001.

Mr Bryan's mental state has remained stable, free of psychotic symptoms and he has been compliant with his antipsychotic medication.

He has been polite and appropriate and has not been a management problem on the ward.

Mr Bryan has been seen individually by a consultant clinical psychologist on 12 occasions between 10th October and 12th December 2001. Important recommendations for future management were made which will be outlined below.

Unfortunately the report did not make further reference to Psychologist 5's 'important recommendations for future management'.

When we asked JHC Psychiatrist 3 why those recommendations were not set out in her report, she was surprised when she realised that they had not been, and could only explain that she must have thought that Psychologist 5's report was going to be put before the Tribunal. The Tribunal's written decision contains a list of those documents which it had seen, and Psychologist 5's report was not amongst those listed.

RMO4 also expressed surprise that Psychologist 5's recommendations were not incorporated into the report. He told us that he thought that there must be a page missing and that it was an incomplete report which we were considering, however there is no evidence that it was anything other than the report which went before the Tribunal. The report appears several times in exactly the same form in various sections of the documentation that we have received.

The report was signed by RMO4.

Mr Bryan has been consistently attending individual sessions with the occupational therapists and has been clear of what needs he would like to address. These include community activities, stress management, budgeting and drug and alcohol management. Mr Bryan interacts well and has been willing to look more in depth at his needs.

Current Medication

Trifluoperazine 5 mg bd….

Current Leave

Mr Bryan has now been granted escorted community leave by the Home Office and has had ten escorted trips so far. Mr Bryan has coped very well during these and he has been appropriate throughout without incidence. We are now seeking Home Office permission for unescorted leave.

OPINION

1. *Mr Bryan's mental state has remained stable and he has continued to engage well in structured therapeutic activities which have been available to him.*

2. *Disciplines have now completed their assessments and he has been having successful community trips enabling re-integration into the community.*

3. *We would now support a conditional discharge from his Section 37/41 of the Mental Health Act 1983. However, we would request time to arrange for his aftercare, and aim to begin planning in a CPA meeting on 7th January 2002. The prospective community RMO, RMO5 (Newham locality) is aware of the plans. Funding and availability of the hostel are being addressed."*

As we have already stated, RMO3 remained Peter Bryan's RMO until the Home Secretary formally transferred Peter Bryan to the John Howard Centre. This did not take place until 10 January 2002.

Given the fact that RMO3 remained Peter Bryan's RMO, he should have been consulted for his opinion as to whether or not it was appropriate for the John Howard Centre clinical team to recommend conditional discharge to the MHRT.

RMO3 had attended the first CPA meeting at the John Howard Centre on 13 September 2001, when it was concluded that more time was needed to assess Peter Bryan and to facilitate unescorted leave before a conditional discharge could be recommended by the clinical team.

There is no evidence that he was consulted again before the John Howard Centre clinical team wrote the report of 21 December 2001.

He should have been a central part of the decision as to whether or not to recommend a conditional discharge, and no decision should have been made without RMO3's approval. The Panel also consider that the report of 21 December 2001 was inadequate for what was likely to be a final decision about a conditional discharge into the community.

There is no discussion in the report about risk and there is no emphasis on the fact that Peter Bryan had not yet had any unescorted leave into the community (although it does mention that permission for such leave had been requested from the Home Office).

The Panel considers that a Risk Assessment should have been prepared for the MHRT, and this was even more important if the clinical team felt that a conditional discharge was a fait accompli.

This Addendum Report for the MHRT makes it clear that in the eight weeks since the 'Mini CPA Meeting' on 22 October, the clinical team had changed its mind about Peter Bryan's suitability for 'immediate' discharge into the community. On 22 October the team had agreed that a deferment of any discharge was necessary as Peter Bryan had only been at the John Howard Centre for a short time and needed more assessment and sessions. In particular he had not yet had any unescorted leave and therefore could not be assessed properly.

Since 22 October Peter Bryan had had six further psychology sessions with Psychologist 5, as well as some one-to-one sessions with his Primary Nurse and perhaps some OT sessions.

He had also had 6 escorted trips into the community but had not yet had any unescorted leave.

The main purpose of unescorted leave into the community is to hand responsibility and control back to the patient and to test his response to that and to assess any reactive behaviour.

It is the panel's opinion that, without testing Peter Bryan's compliance with unescorted leave, a full and proper risk assessment could not be carried out.

As we have already said, almost everyone from the John Howard Centre whom we interviewed was surprised that Peter Bryan only remained in the medium secure unit for a period of six months. This was unanimously accepted to be an exceptionally short period of rehabilitation after a lengthy stay in a high secure hospital.

We consider that, if the clinical team had changed its mind within an eight week period in relation to needing a considerable period of time in which to get to know Peter Bryan and to fully and properly assess him, the Addendum Report should have set out full and detailed reasons for this change of mind.

In her 4 October report, JHC Psychiatrist 3 had said that a further period of time at the John Howard Centre was needed in order for thorough assessments to be completed and for clear and structured treatment programmes to be constructed.

Included in what was still needed to be done was a referral to the Tower Hamlets drug and alcohol outreach team for an assessment and advice about management with the aim of their involvement in Peter Bryan's future care in the community. This had not yet been done. In fact once he was discharged into the community, Peter Bryan had to investigate and arrange drug counselling for himself with a voluntary sector service, Addaction.

The latest report identified that stress management still needed to be addressed. This was an important area, but it was in fact never dealt with.

Also - as we have already mentioned - by the time of the adjourned MHRT, he had still not had any unescorted leave.

JHC Psychiatrist 3 was RMO4's Specialist Registrar. She told us that she was very junior at that point in time in terms of forensic psychiatry and it was her first proper training placement with a forensic consultant.

JHC Psychiatrist 3 told us that RMO4 encouraged her to take responsibility for things whilst at the same time increasing her confidence by ensuring that she had regular supervision from him.

RMO4's encouragement of JHC Psychiatrist 3 to take responsibility is commendable but, as we have identified above, supervision by RMO4 was not a regular and systematic feature as recommended by the Royal College of Psychiatrists, but was more the ability to initiate a conversation with RMO4 when JHC Psychiatrist 3 identified a problem which she wished to discuss with him.

We asked JHC Psychiatrist 3 whether, at the time of the final adjourned MHRT hearing in January 2004, there was ever any consideration given to recommending that Peter Bryan should stay in the John Howard Centre, as they had recommended in the first report.

She told us:

"The reasons we would have recommended he stayed in hospital were firstly that he had only been there six months. Secondly, we still didn't know him in great detail. He had had an in-depth psychological assessment but other than that I think we felt that the length of time he'd been there was relatively short, and he hadn't had any unescorted leave up to that point. I think we felt he should have stayed a period longer than he did."

She told us that there was still some feeling amongst the team that Peter Bryan's discharge was premature and accepted that it was fair to say that really the team did not support the discharge, but felt under pressure to support it because it seemed inevitable. She said:

"Certainly if you look at it in hindsight and you read it now, you think – gosh - for him to be discharged without having unescorted leave!"

She confirmed something which we had suspected, which was that part of the reason for the team feeling under pressure was that Peter Bryan *"had a very clever, smart solicitor who was representing him… who certainly had a way of coming in and telling you how it was - this is what the outcome would be"*.

When we asked RMO4 whether or not it would have been open to the Trust to have sought legal advice about the tribunal, he told us:

"We didn't think about that. If I had to put it in the simplest possible way, this was a patient who committed manslaughter in 1993, spent 7½ years in Rampton, 5 of which he was largely asymptomatic and complying with everything he was doing."

This viewpoint appears to ignore any responsibility to continue to assess risk. Achieving discharge for a forensic patient who has killed once is not just a question of remaining well and doing what he is told. The clinical team needs to have an understanding of why the killing occurred in order to address any risk concerns for the future.

"Then he comes to us on a predetermined trajectory about getting straight out, with this prejudged outcome from the tribunal that he is conditionally discharged because he no longer meets the criteria."

This viewpoint is contradicted by the decision taken at the CPA on 3 September, when RMO3 (Peter Bryan's RMO at Rampton) was present, when the consensus of both the Rampton and the John Howard Centre team was that a further period of time was needed in medium security in order to get to know Peter Bryan and to allow adequate time to assess him thoroughly.

If it had really been the case that Peter Bryan did not meet the criteria for detention, he would have to have been discharged, and arguments of needing more time for assessments would have been futile.

"Quite honestly, we did not see this as a legal conundrum. It was more a case of 'what are we going to do about managing this as effectively in clinical terms as we can?', rather than 'we are terribly confused about the legal aspects of this'."

Although the clinical team do not have to argue legal points in the tribunal, they do need to take the legal situation into account when deciding on a course of action.

RMO4 might not have been uncertain about the legal aspects of the case, but the MHRT, presided over by a QC, had adjourned to clarify the legal position for itself. The ward round on 24 October had resolved to contact the Home Office about the legal situation because it was not clear at that stage.

To manage Peter Bryan effectively in clinical terms meant having a treatment plan and addressing risk concerns.

Any assessments which had been carried out whilst he was in medium security had not been translated into a clear operational treatment plan that was delivered in the community.

RMO4 also told us that he had discussed the MHRT with Peter Bryan's solicitor, Solicitor 1:

"By the time we got to the second Tribunal we had already been in conversation. He knew what we were prepared to support and we knew what he wanted for his client.

From the point of the 24 October 2001 tribunal we knew that what he wanted for his client was a conditional discharge and that's it – full stop. That became clear. He brought that out into the open.

I can't tell you how many conversations I've had with (Solicitor 1) because I can't remember, but I know we did communicate and we did communicate before the next tribunal.

Both sides knew what we were going for. I suppose you have these conversations because you want to test the ground about what issues are going to be…

I don't think we were bothered so much by how cunning or not (Solicitor 1) was going to be. By the time we got to the tribunal of January there was broad agreement about the outcome for Peter Bryan, so we knew he was, one way or another, going to be conditionally discharged.

I think it was more a case of 'there are things we want to put in place and we should just make that known to the tribunal', but we were very aware - and this was us being quite sensible about it.

By the time of the ward round on 10 December we knew the hostel was in place, (RMO5) was in place, I was in place – everyone".

As far as we can tell from the clinical notes, the only time that RMO4 had seen Peter Bryan on his own while he was in the John Howard Centre was on 10 December 2002 when the only issue noted as being discussed was the question of consent to medication.

RMO4 saw Peter Bryan on other occasions when he was an inpatient in the John Howard Centre (at ward rounds or in CPA meetings) but this was in the company of other members of the clinical team.

Following his discharge from the John Howard Centre, Peter Bryan attended several outpatient appointments with RMO4. However, we have not seen any of RMO4's clinical notes relating to those appointments.

The Panel consider that it would have been good practice for RMO4 to have taken the opportunity to hold individual one-to-one interviews with Peter Bryan during the six months he was at the John Howard Centre, both in order to get to know him before he was living in the community, and more importantly to satisfy himself that Peter Bryan was ready to be discharged into the community.

38. On 7 January there was the final CPA meeting before the MHRT. It was headed by RMO4. Psychologist 5's report, which had been prepared for the CPA meeting, was presented to those in attendance.

Psychologist 5 was not there in person to present his report. He was on annual leave, but would not be returning to the John Howard Centre as he had completed his three month period on the Unit. It may be that, because Psychologist 5 did not personally deliver his report, the importance of some of his observations was not appreciated.

39. JHC Psychiatrist 3 made a detailed note of the meeting, the relevant extracts of which are set out in the Background section of this report.

40. In that note she set out what Peter Bryan's relapse indicators were:

"<u>Relapse Indicators</u>

1. *Developing paranoid ideas. For example thinking that people are following him and spying on him.*
2. *Becoming infatuated with females leading to inappropriate sexual behaviour*
3. *Abusing drugs, leading to a risk of deterioration in his mental state."*

These 'Relapse Indicators' are quite different from those identified by Psychologist 5 in the report which he prepared for the CPA meeting. We do not know why this should have been the case, but it is clear to us that Psychologist 5's description of Peter Bryan's 'Relapse Signature' - in particular his identification of 'subtle signs' of deterioration in his mental health - was never part of the thinking behind his management once he was discharged into the community.

It is noteworthy that Peter Bryan's own concept of his relapse signature was remarkably accurate and highlighted stress, anger and a feeling that he 'could not win' as relevant trigger factors.

Unfortunately it is also evident that the professionals responsible for Peter Bryan's care in the community were unaware of Psychologist 5's views and seemed to be working on a relapse signature which involved a return to drug use, preoccupation with Asian women and paranoid and persecutory thoughts.

They also did not appear to attach any weight to Peter Bryan's own description of his trigger factors, despite having recorded them in his community notes.

41. Forensic Social Worker 3's note of the CPA meeting records that, although both JHC Psychiatrist 3's report and Forensic Social Worker 2's report recommended a discharge, circumstances suggested that Peter Bryan's discharge was a "*fait accompli*".
Social Worker 4, the Approved Social Worker (ASW) who was to be Peter Bryan's Social Supervisor in the community, told us:

"My understanding was that it was always going to be six months, and that we were responding to a timetable that was already set in motion… I felt all along as if six months was non-negotiable and that we had to do something within six months."

This reinforces our belief that the clinical team at the John Howard Centre had always treated Peter Bryan as only being in the unit until such time as the MHRT resumed its adjourned hearing. They never considered that they would be able to successfully challenge his discharge.

When we asked Solicitor 1 whether the discharge could have been challenged by the clinical team, he told us:

"They didn't even have to put up an argument. The frustration of doing the work that I do is that by merely just not contacting people you can delay implementation virtually indefinitely…the implementation is so complex and difficult in any event, because of the number of agencies involved and the funding requirements and everything else - so you require the greatest goodwill and energy to get it done. All you've got to do is not push

very hard and it won't happen. So if they had felt 'We would like him for a longer period of time' they could have got that one way or the other…

When I represented him on 28 March 2001, my view then was 'If I can get him out within three years I will have done very well', because it is coming out of high security and getting through all those obstacles. So I was very pleased with the outcome of the first hearing. If it had all gone pear-shaped after that and he had just stayed in the John Howard, I would still have thought that that was a very good result, because that is then the building stone for going on the next time."

As it happened it was an exceptional set of circumstances whereby everything fell into place at the same time which accelerated Peter Bryan's discharge into the community. This is explained later in this section.

42. On 9 January 2002 the Home Office sent a Supplementary Statement by the Home Secretary for consideration by the Mental Health Review Tribunal. It stated:

"The Home Secretary has noted (JHC Psychiatrist 3)'s report dated 21 December 2001. In particular, he notes that Mr Bryan is considered to be suitable for conditional discharge from hospital.

The Home Secretary notes the progress made by Mr Bryan but feels that discharge from hospital would be premature at this time. Mr Bryan has only been tested on a limited amount of community leave so far, and the Home Secretary would wish to see his suitability for discharge thoroughly tested with a further series of escorted and unescorted community leaves, including overnight leave to any proposed discharge address.

He also considers it important that work is carried out to address Mr Bryan's substance misuse before discharge from hospital is considered."

This Home Office response stating that the Home Secretary did not support a conditional discharge was not recorded as a document which was seen and considered by the Tribunal at the hearing.

It should have been read, documented and commented on and therefore, if the Tribunal did not in fact have this document before them at the hearing, they must have overlooked the fact that they did not have a response from the Home Office.

If they did read the Supplementary Statement, there should have been some reference to the view of the Home Office in the reasons given by the Tribunal for their decision, especially since the Home Secretary did not support a conditional discharge from hospital at this time.

43. On 11 January 2002 the MHRT Panel sat at Homerton Hospital. This was the same Panel which had adjourned the hearing in October 2001 to consider Solicitor 1's legal submissions and objections further.

44. Coincidentally the MHRT was held exactly one day before the 6 months trial period at the John Howard Centre ended.

JHC Psychiatrist 3 was the sole medical representative of the clinical team at the Tribunal hearing. She told us that as far as she could remember, other than the previous adjourned hearing, it was the first tribunal hearing where she had been in that position.

She told us that RMO4 did not attend tribunal hearings while she was his Specialist Registrar. RMO4 told us that he attended five MHRTs during the time that JHC Psychiatrist 3 was his Specialist Registrar. It may be that what JHC Psychiatrist 3 meant was that RMO4 never attended MHRTs with her.

As we have stated above, RMO4's initial reaction when he re-read JHC Psychiatrist 3's Addendum Report, was that it was not the complete document. When the Panel put it to him that he had put his signature to it, he said:

"Probably not. My signature is on it. I say probably not because we would always have a discussion about how we are presenting at a tribunal.

A report is one thing. The oral evidence that is given is supplementary to that.

I write very short reports for tribunals, but that is on the basis that I write them as bullet points. Almost in my entire career, except when I was a trainee, in my consultant career all my reports are no longer than three pages, but it is on the basis that I keep the information succinct and I then take the opportunity to explain or elaborate on the points in the tribunal which I will be describing.

I say 'probably not' in that regard, but I am saying that on the basis that I think it is deficient because I know we would have had a discussion about what plans for community care would need to be reflected in the written report.

It might well be that that was the report. If that was the case, then we would have had a discussion about what the oral evidence is going to be, but I can't remember that."

JHC Psychiatrist 3 told us that she vaguely remembered giving evidence but that it lasted only about 10 minutes or so and agreed that that seemed a very short time.

Given that RMO4's view was that it was the oral evidence to a tribunal which was all-important, the panel considers that he should have been there and ensured that the tribunal were fully aware of all the information which they needed to bear in mind when reaching their decision.

This was an important MHRT. A decision was being made whether or not to discharge a Section 37/41 patient who had committed homicide into the community only six months after he had been transferred from a high secure hospital.

The Panel considers that on this occasion, RMO4 should have been present at the Tribunal hearing, especially given the fact that he knew Solicitor 1, and was aware that he was a very clever lawyer who could (in RMO4's own words) 'fox' the Tribunal.

We understand that it is not current practice that a restricted patient's consultant psychiatrist is always present at an MHRT, and we are aware that under the new Mental Health Act 2007, the "responsible clinician" may not be a psychiatrist (and therefore not a consultant psychiatrist). However we still consider that the responsible clinician should be present at any MHRT considering discharge of a patient detained under Section 37/41.

The Panel consider that JHC Psychiatrist 3's lack of experience at that time (this was her first post as a Specialist Registrar) meant that she should not have been put in the position of being the sole medical representative at the MHRT considering the discharge of any Section 37/41 patient.

She told us that this was one of her first MHRTs and she was not really given any instructions as to how to conduct such a tribunal. She said:

"I had a vague idea of what went on, but it really was jumping in at the deep end."

The criteria for imposing section 41 restrictions on a patient are to protect the public from serious harm.

There is a stipulation that the President of an MHRT dealing with the discharge into the community of a Section 37/41 patient must have judicial experience, and the Panel believes that there should be a commensurate level of clinical representation at any such hearing.

No one knew what the Tribunal would do. They had adjourned to consider complex legal arguments and there had been no prior indication as to the way they were thinking in relation to the legal complexities.

The Panel therefore considers that the clinical representation should have been at consultant level for such an important decision.

It is also our view that there was inadequate preparation for such an important MHRT. There appears to have been no discussion between RMO4 and JHC Psychiatrist 3 as to how she should present the clinicians' case at the Tribunal hearing and there should have been.

RMO4 told us that he placed considerable emphasis on the oral evidence at the tribunal hearing and used the written report as a brief summary of the evidence.

It would appear that JHC Psychiatrist 3 was not given any guidance as to how to conduct the evidence or how to deal with possible questions from the tribunal panel or Solicitor 1.

Even if JHC Psychiatrist 3 were to present the clinical team's point of view, given the early stages of her specialist training, it would have been good practice for her consultant to observe the hearing so as to offer comments and guidance in the next supervision session, or to be available to deal with any questions she was unable to field.

The Inquiry Panel looking at the care and treatment of John Barrett made these same points in their report (2006), and it is to be hoped that in future, consultants will give their specialist registrars the guidance and support that is necessary to deal with the complexities of MHRTs.

As we have already stated, the Panel were also concerned that JHC Psychiatrist 3's Addendum Report did not make reference to Psychologist 5's '*important recommendations for future management*', despite the fact that her report states that they would be referred to.

The Panel considers that, if they had read the Addendum report carefully, the Tribunal should have noticed this omission and should have asked JHC Psychiatrist 3 about it.

Also much of the 'preparation' for the hearing appears to have taken place as informal chats between RMO4 and Solicitor 1. Even though we acknowledge that it may be important to know what line a patient's legal representative is going to take, it should always be borne in mind that that legal representative is effectively an opposing party to the clinicians at any MHRT.

45. The MHRT decided that Peter Bryan, should be granted a Conditional Discharge. The following are relevant extracts from their detailed Reasons:

"Today, Peter Bryan seeks a Conditional Discharge, following the adjournment of his earlier tribunal. The view of the Specialist Registrar, (JHC Psychiatrist 3) in a report dated December 21, 2001 and confirmed in evidence is that:

(1) Mr Bryan's mental state has remained stable, and he has continued to engage in structured therapeutic activities which have been available to him.

(2) Disciplines have now completed their assessments and he has been having successful community trips enabling gradual reintegration into the community.

(3) The multidisciplinary team would now support a conditional discharge from Section 37/41. The prospective community RMO was aware of the plans.

(JHC Psychiatrist 3) further supported the concept of the present medical team continuing overall his care and supervision for the next six months, before a transfer to a community medical team is considered.

The view of an independent Consultant Psychiatrist (Psychiatrist 6) by report dated March 21, 2001, which had been before the previous tribunal, supported a conditional discharge.

We heard oral evidence from the Community (Social Worker 4) (ASW), which impressed us considerably. He stressed the need for continued drug monitoring, and he believed, on empirical evidence, that there was a direct link between the taking of illicit drugs and the mental condition of the applicant at the time of the index offence. We entirely agree. (Social Worker 4) also emphasised the potential risk of Mr Bryan returning to the community and the need for long-term close supervision. He himself indicated that he would continue to be directly involved with Mr Bryan closely and he supported Conditional Discharge.

We have considered the statutory criteria in the light of all the evidence including that of Peter Bryan. In particular, we noted that his evidence showed considerable insight into his illness and the need for continuing medication to prevent relapse. He showed an awareness of symptoms if he did relapse. He openly stated his preference to go out with Asian girls, if only to show that he was accepted by the Asian community. At the same time, he would disclose any problems with a future relationship to his key worker or other members of the clinical team. He expressed remorse for the Index offence and accepted himself that illicit drugs had contributed to his illness.

The view of the tribunal is that he no longer suffers from mental illness which makes it necessary for him to be detained in hospital for treatment, but that he should be liable for recall.

Accordingly, there should be a Conditional Discharge under the following conditions…

(The conditions were then set out)

In reaching our conclusion, this tribunal is well aware that he has not had unescorted leave in the community and that his move to an approved hostel has taken place within six months of a move to a medium secure unit. The potential risk that creates can, in our view, be met by the comprehensive conditions imposed, including residence at a specialised hostel."

The Panel considers that it was unfortunate that Peter Bryan spent only six months in a medium secure unit before being discharged into the community and we were concerned that he was discharged without having had any unescorted leave.

It was entirely appropriate to transfer Peter Bryan from Rampton Hospital to the John Howard Centre, but the transfer was only part of the rehabilitation process.

Peter Bryan had been subject to a very controlled and regimented regime at Rampton Hospital where it was not possible to test how he would behave once he was no longer so contained.

Forensic Social Worker 2, who was attached to the John Howard Centre, described the medium secure unit as a *"defrosting"* process. He told us:

"A high secure environment is so different from a medium secure unit, particularly a pre-discharge Ward, and a patient's adjustment is tremendous. There wasn't a defrosting of the patient going through the stages of medium security there might otherwise have been…

Not to put down the special hospitals, but I have always seen them in my mind as like a freezer where we place our patients shortly after an index offence, and initially there is a rush to work on issues. Then there are a number of years where there is dormancy and the nature of the illness, the presentation of the illness is overtaken by routine…

I'm sorry for that description of a freezer, but when a patient is readmitted into a medium secure unit there is a newness of approach…Often the patients complain they have gone back a stage – which they have – and they feel frustrated that they have gone on to an admission ward in medium security. You get a great deal of anger, pushing the

boundaries, and in my view they are actually coming alive again (the defrosting process)…"

We consider that six months was not long enough for Peter Bryan to adapt from the highly controlled atmosphere of Rampton Hospital to the semi-independence of Riverside House.

We agree with Home Office 8 of the Mental Health Unit at the Home Office who told us:

"It is too big a leap, essentially, to move from high security to the community, with only the briefest of stays at medium security. In terms of a structured pathway back to the community, we would normally expect a carefully risk assessed and incremental exposure to the community, in tandem with work addressing both insight into the mental disorder and offending behaviour, and any other issues such as substance misuse.

You would then have a patient progressing with treatment within the detained patient setting, within the hospital, at the same time as we assessed as appropriate the increasing exposure to the community, initially on escorted leave, then on unescorted leave, building up to leave to a potential discharge placement.

Our view was that this process had been accelerated but there were still treatment issues that had not been addressed. There had not been this incremental and risk assessed increasing exposure to the community, which would be prudent."

The Forensic CPN also told us:

"Peter Bryan's bravado would be that he didn't need any support, but deep down he needed some sort of structure.

In comparison to John Howard and Rampton, his care plan was probably the maximum input you would have: 24 hour hostel, forensic CPN, social worker, Addaction, the day hospital and everything. Even though he still had that maximum care package, he was vulnerable in lots of ways. It was all bravado that he could cope without it.

I suppose deep down he found it very stressful and he had really unrealistic plans. When he thought he would come out of the John Howard or Rampton, his view was that he was

going to be living in his own flat within six months, which was totally unrealistic. Even though it was explained to him he would just not comprehend that."

The benefit of hindsight leads us to the view that Peter Bryan found it very difficult to cope with a lifestyle which was unstructured, and the fact that his rehabilitation process in the John Howard Centre was so short lived may well have had a causative effect in the deterioration of his mental health in the months leading up to the homicide.

The Panel acknowledges that, given that (a) the earlier Tribunal had held that Peter Bryan no longer met the statutory criteria for continued detention (b) a place was available for him at Riverside House and (c) his medical team and social worker supported a conditional discharge, it was likely that conditional discharge would be the result of the MHRT.

The media reporting after the homicide made much of the fact that Peter Bryan had been conditionally discharged against the recommendation of the Home Office.

However the Tribunal have a duty to consider whether or not the patient still meets the statutory criteria for being detained in hospital, and discharge against the recommendation of the Home Office is a situation which can and does occur. If the Home Office supports discharge into the community, an MHRT would not be necessary.

The Home Office has no right of veto. Home Office 8 told us:

"With respect to the brevity of Peter Bryan's stay at the John Howard Centre, that was outwith our control, because it reflected the tribunal's decision when it reconvened. That would be a relevant factor in increasing our concern about potential risk - given the relatively short amount of decompression time out of high security."

However, it is the Panel's firm view that Peter Bryan's early discharge from the John Howard Centre instilled in him the belief that his progress towards an absolute discharge and total independence would be equally swift and easy, and that when this was not the case, his disappointment and frustration led to increased stress which may have contributed to the eventual deterioration in his mental health.

46. Shortly after the MHRT, Social Worker 4 wrote to the East London and the City Mental Health Trust and Newham Social Services to inform them of Peter Bryan's imminent conditional discharge from the John Howard Centre and to arrange urgent joint funding for Peter Bryan's placement at Riverside House. He concluded his e-mail:

"Because of the potential risk this man poses to the community his care plan is comprehensive and has stringent conditions attached including random drug screening and drug counselling. His CRMO will continue to be (RMO4), John Howard Centre, and (the Forensic CPN) will be his care co-ordinator. I will be his social supervisor and he will have intensive key worker support at Riverside.

Myself and the team will also be drawing up a comprehensive risk assessment, risk management and contingency plan shortly. The purpose of Riverside is for a clear rehab focus with a view to independent living in the future subject to Home Office approval."

Unfortunately, despite obviously impressing the Tribunal who were reassured that he would continue to be closely involved with Peter Bryan, Social Worker 4 did not continue as Peter Bryan's Social Supervisor and in fact did not see him once he was discharged to Riverside House. He handed over to Social Worker 5 in mid-March 2002.

He and the team did not draw up a comprehensive risk assessment, risk management and contingency plan '*shortly*', and in fact there never were such '*team*' plans at all.

The Forensic CPN and Social Worker 5 each individually prepared their own Risk Assessments within the first six months following discharge, but did not seem to collaborate in any way on those Risk Assessments, nor were they reviewed at any time in the following 18 months leading up to the homicide.

The Panel consider that formal Risk Assessments should have been done as a collaborative exercise and are critical of the fact that there was no clear management or contingency plan devised by the team as had been anticipated by Social Worker 4.

47. On 4 February the section 117 aftercare meeting took place. It was attended by RMO4, RMO5, JHC Psychiatrist 3, SHO2, SHO1, Social Worker 4, the Forensic CPN, Forensic Social Worker 3, the Colin Franklin Ward Manager, Occupational Therapist 1 and Peter Bryan himself.

The Panel are critical of the fact that no one from Riverside House was invited to the section 117 meeting. They should have been – all the more so because residence at the hostel was a condition of Peter Bryan's conditional discharge.

48. The meeting was minuted by SHO1, RMO4's SHO, and the following are relevant extracts of those minutes:

"<u>Plan</u>

Mr Bryan is for discharge to the community and will reside at Riverside Hostel. He has been on several day visits to the hostel and overnight hostel visits will be arranged for him before discharge. His RMO for the first six months upon discharge will be (RMO4) and thereafter (RMO5) will take over as his RMO in the community. His Care Manager will be (the Forensic CPN) and his social supervisor (Social Worker 4). His Care Manager will arrange for him to have a GP while in the community. The hostel will be provided with drug screening kits to test his urine for possible drugs. His anti-psychotic medication will be prescribed by his GP. He will be reviewed regularly by (RMO4) and subsequently by (RMO5) upon discharge. He will have continual outpatient follow up with the dermatologist whom he is currently seeing. The Social Worker will arrange for regular reviews over the next three months. He will be attending the Worland Day Centre for Occupational Therapy activities. He will be referred to VITAL drug rehabilitation services in Newham by his Social Supervisor.

<u>Relapse Indicators</u>

1 Paranoia and suspiciousness
2 Infatuation, especially with Asian girls
3 Drugs and alcohol misuse
4 Irregular compliance with medication…"

"<u>Summary</u>

Mr Peter Bryan has been scheduled for discharge next week to Riverside Hostel after he has undergone two overnight visits there. He will be followed up by (RMO4) who will be his RMO for the first six months and will provide regular statutory reports as required by the Home Office, and thereafter (RMO5) will take over. (The Forensic CPN) will be his Care Manager and

will be co-ordinating his care needs in the community. His Social Supervisor will be (Social Worker 4) who will arrange for his occupational therapy and art therapy activities as well as linking him up with drug rehabilitation services. His Social Supervisor will also be responsible for reviewing him regularly to provide statutory reports as required by the Home Office. He will have a GP whilst in the community and he will continue follow up with his dermatologist. His Social Worker will continue to follow up on his case on a regular basis. His next CPA review date has been decided upon. In crisis RMO will assess and decided on best treatment."

49. After several overnight visits to Riverside House, Peter Bryan was considered to be ready for discharge from the John Howard Centre.

50. His Named Nurse Nurse 5's Discharge Summary stated:

"Peter's mental state on discharge is considered to be settled and stable. He was instructed on relapse indicators and what to do if he feels that his mental state starts to deteriorate. Peter is willing to continue taking his prescribed medication, and will keep in contact with his Social Supervisor and FCPN (forensic community psychiatric nurse). *He will require his mental state to be assessed periodically by the above professionals to ensure that he maintains a good level of mental health, and any adverse changes should be reported and dealt with immediately."*

Despite the fact that the Panel consider that it would have been more beneficial had Peter Bryan remained at the John Howard Centre for a longer period of time, given that a place was available for him at a suitable supervised hostel, his psychiatric care was going to remain with the forensic team for a period of six months, and his clinical team at the John Howard centre had by then supported his discharge, there can be no strong criticism of the decision to conditionally discharge him into the community.

There had been an unexpected turn of events whereby (a) an earlier MHRT had already decided that Peter Bryan was entitled to a conditional discharge (b) a place unexpectedly became available at Riverside House, and (c) the joint funding for that placement (between Health and Social Services) - which normally takes two years or more to be agreed – was forthcoming within the six months.

Solicitor 1 told us that it was these exceptional circumstances in which everything fell into place within six months (rather than taking the more usual two years) which led to Peter Bryan's speedy progress through the John Howard Centre.

The Panel wish to make it clear that they have no criticism of Solicitor 1.

He was doing the best that he could for his client and cannot be criticised for being an effective lawyer. Indeed, he was as surprised as anybody that Peter Bryan was conditionally discharged from the John Howard Centre in as short a time as six months, but it is clear that this only happened because of the very exceptional circumstances mentioned above.

What is important is that this was not one of those cases where Solicitor 1 felt any concern at all that his client was being discharged into the community. He told us that Peter Bryan was not one of those clients where he felt any unease that his effective legal representation had led to the wrong decision being made.

Riverside House

1. Peter Bryan moved into Riverside House on 12 February 2002. His key worker at the hostel was Riverside 1.

Riverside House opened in 2000. It is on the Seven Sisters Road in London N4.

The Panel visited the hostel at the very beginning of its investigations.

It is a residential hostel which is staffed 24 hours a day and which can accommodate nine residents. There were six members of staff. It was nearly always full with a waiting list. At the time that Peter Bryan was a resident it happened that all the residents were male.

It is a family run business. The Manager of Riverside House is the Care Manager, her daughter, Riverside 3, also worked there.

The Manager, her husband Riverside 4, and Deputy Manager 1 of the hostel are all registered mental health nurses who have considerable experience of looking after residents with a forensic history.

It was a condition of Peter Bryan's conditional discharge that he should reside in a hostel staffed by those experienced in the care of restricted patients (ie. subject to Sections 37 and 41 of the Mental Health Act 1983).

The Panel were impressed with both the Manager and Deputy Manager 1 and they were clearly highly regarded by other professionals such as RMO4, Social Worker 4, Forensic Social Worker 1 and Solicitor 1.

The staff at Riverside House appeared to have good communication, observation and reporting skills, their record-keeping was good and they understood the needs of their forensic clientele and their own responsibilities.

The Manager ran Riverside House firmly but fairly and she seemed to have a good instinct about the residents.

Social Worker 4 told us:

"(The Manager of Riverside House) had a better idea about public protection. She was more in tune with risk and what risk people might pose, and I felt she had a much tighter structure for her residents."

When she or a member of her staff had concerns about Peter Bryan's behaviour or mental state, they always promptly contacted either the Forensic CPN or Social Worker 5 to inform them of those concerns and, when appropriate, they asked for an urgent review of his mental state.

The Manager described her first and her overall impression of Peter Bryan to us:

"His mental health at the time appeared to be very stable. He was on very little medication. He was diagnosed with schizophrenia. He didn't exhibit or show any features of schizophrenia when I knew him - throughout my time. His personality: he seemed to work his lifestyle to his own personality that he had developed, and that was consistently pushing the boundaries, always tried to be a step ahead when things would be discussed about him and his care team, like setting up activities to keep him occupied and to enable him to move on…

He never wanted to be, as he called it, "within the system". He exhibited in relation to the other service users within the home that he had this superiority about him. He never saw himself at their level.

He would never give any recognition that he had problems. Then we would have made a plan for care with him, with his care team, and I would discuss that that he should attend this group. Before the care team would have sorted that out, Peter would have gone and he would have the answers. He saw that by doing that they would get him out of the system quicker because he would have achieved all his objectives…

I suppose because the nature of Peter Bryan was through his own personality, you would always be aware of what he was doing and what he was saying. Again it was to avoid splitting and dividing service users within the home. He was very good at manipulation, and he was quite effective with the staff team as well. He didn't like staff who would put him in his place. He didn't like that. As I said earlier on, he more or less saw himself as a member of staff rather than a service user. He just couldn't adhere to any explanation or

reasonable reasoning why he had to stick with the boundaries, and why he could not move out to his own flat…

My relationship with Peter never changed because I had seen the character Peter was. Peter would again manipulate, try to split and divide, and you had to say it as it was to Peter and mean what you said. Personally for me, because of my being the Manager, obviously he thought "If I can break her down I break everyone else down".

That was his operation. That is how he dealt with people. He did the same thing with his social worker, the same thing he tried then, and if Peter did not get immediate gratification then he would be rooting to find something wrong with you and then he could be away complaining again."

2. On the 14th of February Peter Bryan went with his key worker at Riverside House to the Community Mental Health Team (CMHT) East offices in Kempton Road, E6, to meet with the Forensic CPN, the forensic CPN.

The Forensic CPN qualified as a registered mental health nurse in 1985, obtaining a BSc in mental health nursing in 2002. He had some experience as a Ward Manager at a local mental health unit at East Ham Memorial Hospital in Newham and then briefly worked for one year as a community psychiatric nurse (CPN) before taking up the post of a forensic CPN in 1999.

He therefore had no prior inpatient experience or training in relation to forensic mental health care prior to his appointment to a Forensic CPN post in Newham.

The post of Forensic CPN was one of a number of newly developed CPN posts, intended to support local services but highly dependent upon robust links back to the forensic service and both strong and consistent supervision arrangements.

RMO4's view was that the CPNs "*were the eyes and ears of the John Howard Centre to the adult mental health services*".

However the post in Newham was not attached directly to the forensic team at the John Howard Centre and, although the Forensic CPN received some supervision from a Forensic

Nurse Consultant, he was professionally isolated from the forensic service to a considerable degree.

He told us:

"You are isolated from the forensic service. You're not really part of the general adult mental health service. You are interfacing but you are not part of either team. I don't think it was a very satisfactory model of working."

He was part of the Community Forensic Team based in Stratford E15. However, for the purposes of his involvement as the CPN for Peter Bryan, he would see him at the office of the CMHT (East) in Kempton Road, East Ham E6, some three miles away from his Stratford base.

The Kempton Road office is 12.4 miles from Riverside House[7]. It was even longer by public transport. Transport for London gives a travel time of 1 hour 10 minutes from Riverside House to the CMHT in Kempton Road by any combination of public transport.

This made it even more difficult to maintain a close link with Peter Bryan and the Riverside staff, but Peter Bryan used to make the long trip to Kempton Road on a regular basis. The distance might, however, explain why the Forensic CPN and Social Worker 5 did not often make the journey to Riverside House.

It is all the more remarkable that Peter Bryan made the journey so regularly.

3. The Forensic CPN explained to Peter Bryan both his role and that of Social Worker 4 and went over the CPA Care Plan which had been drawn up at the CPA meeting on 4 February.

4. The CPA Care Plan was that Peter Bryan:

   (i) *"would attend the Worland Day Centre would attend VITAL Drug Agency* **(In the end Peter Bryan organised his own attendance at Addaction)**

   (ii) would have regular follow-up with (the Forensic CPN) and (Social Worker 4), with visits alternating between Riverside and the CMHT office in Kempton Road, Newham.

[7] Source: Google Road Maps

(In fact very few of the visits took place at Riverside)

(iii) would have regular urine testing for evidence of drug taking

(iv) would have a review CPA organised at the CMHT office

(vi) would have his bus pass organised by (Forensic Social Worker 3)"

The Care Programme Approach (CPA) is applicable to all adults in contact with the specialist mental health services including care in the community.

The primary purpose of the CPA is to ensure that people in contact with the mental health service have their health and social care needs thoroughly assessed, and that, once identified, those needs are addressed and regularly reviewed in the context of a co-ordinated therapeutic and social care plan.

The development and implementation of a care plan involves members of the interagency multi-disciplinary team (MDT), the patient's GP, the patient and, where appropriate, their carers.

A thorough assessment is undertaken on acceptance of a referral to mental health services. As a minimum, the initial assessment should identify the individual's mental health needs and areas of risk.

The assessment may involve more than one professional and should always be co-ordinated by the Care Co-ordinator.

Any person who is subject to the CPA should have a named Care Co-ordinator who is responsible for co-ordinating care and information sharing, keeping in touch with the service user, and ensuring that their care plan is delivered and regularly reviewed.

The person appointed as Care Co-ordinator should be an employee with a professional qualification in the Mental Health Trust or Social Services and should be chosen by the professional staff involved as being the most appropriate choice based on the service user's needs and the competence of the professional worker. Although the Care Co-ordinator is often a social worker, any care professional, such as a CPN, can be a Care Co-ordinator.

Any person who is subject to Section 37/41 of the Mental Health Act is allocated a Social Supervisor. This is nearly always a social worker with considerable experience in mental health services and therefore in most cases is an Approved Social Worker (ASW) [8].

The Social Supervisor should always have had experience of working with former offenders with mental health problems (known as mentally disordered offenders). This experience is necessary because they work in conjunction with the Home Office[9] and have the power and duty to enforce conditions on the service user as imposed by an MHRT or the Home Office, such as where they must live and whether or not they can work.

The following is the description of a Social Supervisor in the Notes for the Guidance of Social Supervisors provided by the Home Office which was current in 2002:

"These notes are for the guidance of social workers and probation officers. They are about the role of social supervisors to patients who are subject to the special restrictions set out in Section 41 of the Mental Health Act 1983 (a restricted patient) and who have been conditionally discharged from hospital by either the Home Secretary or by a Mental Health Review Tribunal.

The term 'Social Supervisor' is used…to mean social workers and probation officers who have a responsibility to report to the Home Secretary on the progress in the community of such a patient."

When somebody is subject to Section 37/41, their Social Supervisor is often also the Care Co-ordinator.

At the time of Peter Bryan's transfer to Riverside House, Social Worker 4 was his Social Supervisor and the Forensic CPN was his Care Co-ordinator. These were appropriate allocations for someone with Peter Bryan's forensic history.

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[8] To be an approved social worker a social worker has to be 'approved' as having 'appropriate competence in dealing with people suffering from mental disorder'. There are guidelines laid down for the training and experience required for people to become approved social workers. Approved social workers play a key part in the Mental Health Act. In particular they are integral to compulsory admissions, guardianship and supervised discharge.

[9] Wherever there is reference to the Home Office in this Report we mean the Mental Health Unit which is now based in the Ministry of Justice.

Usually the Multi-Disciplinary Team (MDT) working together on individual CPAs, would expect to work regularly as a team.

However in this case, after the departure of Social Worker 4, the individuals who worked together to provide Peter Bryan's care (the Forensic CPN, Social Worker 5 and RMO5) did not routinely work together as a team and this group of key professionals did not work as a group with any other patients. Peter Bryan was unique to these three professionals working together as a team.

This is unusual and may have contributed to the poor communication and idiosyncratic decision-making which has caused us concern.

5. The Forensic CPN visited Peter Bryan at Riverside House on 28 February, two weeks after his discharge.

6. First of all he met with Deputy Manager 1, and Peter Bryan's key worker, Riverside 1, who expressed their concern about the lack of activities and structure for him at Riverside House. They felt that he needed to attend a Day Centre or a work-training centre.

7. The Forensic CPN informed them that applications had already been made to the Worland Centre and to VITAL drug agency and that they should be in contact with Peter Bryan soon. He also gave the Riverside staff urine testing strips so that they could carry out random drug testing on Peter Bryan.

8. The Forensic CPN then spoke with Peter Bryan who said that he felt that he had settled in quite well, but he expressed a wish that he would like to attend some activities during the day as he got bored a lot of the time. He said that most of the other residents were out doing activities for most of the day so that he was very often the only resident left in the hostel during the daytime.

9. The Forensic CPN told him about the referrals that had already been sent to the Worland Centre and VITAL. Peter Bryan also expressed an interest in Core Arts which was a day centre which concentrated on music and art activities. This apparently would require funding and the Forensic CPN told him that this would be considered when the other programmes were established.

In fact it was not until mid-June that Peter Bryan managed to get an assessment interview at the Day Opportunities Service at the Worland Centre in Stratford and it was mid-April before he had an assessment interview with Addaction, a community drug agency, which he had arranged himself.

10. The next visit was planned for 13 March when Peter Bryan was going to see the Forensic CPN at the CMHT office and a joint visit with Social Worker 4 was arranged for 20 March at Riverside House.

11. However, when Peter Bryan went to his appointment at the CMHT office on 13 March, he was told that Social Worker 4 would be handing over his care to a new community social worker, Social Worker 5, who would be his Social Supervisor.

Social Worker 4 was an extremely experienced ASW who was an entirely appropriate choice to be Peter Bryan's community social worker and Social Supervisor.

He had obviously impressed the Mental Health Review Tribunal who appeared to have been reassured by the fact that he would continue for the foreseeable future as Peter Bryan's Social Supervisor.

In fact once Peter Bryan had been discharged from the John Howard Centre to Riverside House, Social Worker 4 never saw him in the community before handing over his role as Social Supervisor to Social Worker 5. This was because he was going to be managing the duty service which was a new function of the CMHT.

In our opinion Social Worker 5 was not an appropriate choice to be Peter Bryan's community social worker and Social Supervisor.

He had qualified as a social worker in 1996, but for the next five years he worked for various voluntary sector organisations as a group advocacy worker, giving support to people at 24 hour drop-in centres.

He had become an agency social worker only on 22 October 2001. Prior to that, he had had no experience actually working as a social worker in a statutory agency (other than a few weeks as a temporary social worker in Essex). He therefore had had no experience of

caseload management. He told us that he had a caseload of about 25 to 30 at the same time as he was social worker for Peter Bryan.

Therefore when he became Peter Bryan's Social Supervisor, Social Worker 5 had had only five months experience as a general social worker.

He had had no training in mental health and no experience as a social worker working with psychiatric patients let alone mentally disordered offenders (other than in a drop-in centre or in an advocacy role).

He told us:

"Before becoming a social worker I started off as a volunteer at a project. I knew nothing about mental health work but I volunteered at this project which was a residential project for people just discharged from the Denis Hill Unit at the Bethlem and Maudsley in Beckenham which is a secure forensic unit. They were discharged into this residential home and I was just there with the manager…That's how I started.

My initial contact in mental health was with people with a forensic history and I then developed my knowledge and my understanding and so forth from there. Even when I was training I used to seek my own placement and one of the placements that I had was the Shaftesbury Clinic which is another forensic unit at Springfield Hospital. I used to go there in visit and they would encourage me to take part in ward rounds, meet with the patients and so forth, and again my understanding of forensics developed from there.

I was working as a builder at the time, but because I enjoyed the work so much I then gave up building work and became a full-time volunteer. I did that for about two years living on Snickers and Ribena because I had no money obviously…so that's where it all started from and that is where I developed my interest in forensic science and so forth."

At the time of the handover from Social Worker 4, Social Worker 5 was still working as a locum agency social worker. His employment as a permanent member of Newham Social Services did not commence until 1 August 2002.

Peter Bryan was the first service user who was subject to Section 37/41 MHA for whom Social Worker 5 had responsibility as a community social worker. He had never been a Care Co-ordinator before - let alone a Social Supervisor.

He was not an ASW (Approved Social Worker). He did not train to become one until 2004, although he told us that most social workers do so within a couple of months of qualifying. (In fact this is not correct. In order to get on an ASW course, a social worker has to have two years post qualification experience.)

The Panel is of the view that an ASW should have been allocated as Social Supervisor for someone with Peter Bryan's forensic history.

Social Worker 4 told us:

"I think it would have been wiser if Peter Bryan had had an ASW because the ASW training is where you pick up quite a lot of stuff about mental health and about forensic mental health and it is a very good training. I think it would have been helpful because he was a tricky individual."

Social Worker 5 told us that at first he did not want to become an ASW as he *"just didn't feel that he wanted to be at the cutting edge of having to section someone"*.

This comment convinced us that Social Worker 5 was not adequately equipped to deal with people with complex mental health problems.

The Panel were concerned that this attitude of being reluctant to have to section someone played a significant part in Social Worker 5's management of Peter Bryan, especially when it came to the question of whether or not he should have been recalled under his Section 37/41 shortly before the homicide of Brian Cherry.

Having said that the Panel does not consider that Social Worker 5 was an appropriate choice to be Peter Bryan's Social Supervisor, we cannot blame him for the fact that he was so appointed. We consider that the fault lies with the senior management of the social service team in allocating such a complex case to somebody without sufficient experience.

It must also be remembered that at the time that he was appointed as Peter Bryan's Social Supervisor, Social Worker 5 had only been working with the CMHT for some four months and only in the capacity of a Locum social worker through an agency. His managers could therefore not have had the chance to fully assess his capabilities at that time, let alone his suitability to supervise for a Section 37/41 patient.

We consider that Social Worker 5 was too inexperienced to fully appraise the potential risks posed by someone with Peter Bryan's complex presentation.

However Social Worker 5 himself believed that he was an appropriate choice to be Peter Bryan's Social Supervisor, and, despite us giving him several opportunities to agree with our view that he had been inappropriately and unfairly placed in that position, he was adamant that he was more than able to fulfil the role.

When we asked him how he felt about taking responsibility for someone who had only been nine months out of Rampton Hospital and had only spent six months at the John Howard Centre, he told us:

"I was quite happy actually – and the reason I was quite happy was because I thought they had obviously identified some of the qualities in me and it made them feel I was able to work with such a difficult client. I say difficult only on the basis that he was 37/41 at the time and we tend to classify 37/41 as being difficult clients, but when I discuss more you will see that I didn't really feel that he was difficult, but certainly at the time that was my feeling."

He told us that other more experienced social workers' (including ASWs) were reluctant to take on a Section 37/41 patient.

We commend Social Worker 5's obvious enthusiasm for his job, but unfortunately enthusiasm is no substitute for experience.

However, we should make it clear that when we asked more senior members of the social services team for their opinion of Social Worker 5's abilities as a social worker, they expressed no concerns about his work, nor did the Forensic CPN, the Manager of Riverside House or RMO5.

Neither the Forensic CPN nor RMO5 were aware of Social Worker 5's inexperience and both believed him to be an ASW.

The Forensic CPN told us:

"What you are saying now about he never had any mental health experience was a shock to me. I never realised that he never had any mental health experience, and if that is the case, I was always under the impression that he did…

He came across as quite on top of things and quite confident…

I didn't question (Social Worker 5)'s experience or qualifications or anything, but I just assumed that he had experience working with Section 37/41s and had worked with those type of people (sic), because if he hadn't and that was his first case, it was a very high learning curve."

The Interim Head of Adult Services for Newham Local Authority, told us:

"You couldn't say (Social Worker 5) was a very weak social worker compared to others in the service. (Social Worker 5) was average compared to others in the service, but in the anecdotal information about people, they thought he was a very able and competent practitioner."

In spite of our reservations about the appropriateness of the appointment, it is apparent that Social Worker 5 established quite a good rapport with Peter Bryan and they had a relatively easy-going relationship. He tried hard to keep Peter Bryan focused on his aim to live independently and constantly told him to keep his head down and stay out of trouble in order to achieve that goal. The role he played was in many ways more like a mentor than a Social Supervisor. Peter Bryan himself told us that *"I had a kind of - how can I put it - Afro-Caribbean bonding with him if you like'.*

Many of the meetings that Social Worker 5 had with Peter Bryan took place in the canteen at the Homerton Hospital. Social Worker 5 told us:

"We would meet at Homerton and have lunch and have a discussion. Those kinds of discussions were less formal and more relaxed, and I would be likely to get more from him rather than in a more formal setting."

This attitude emphasises the fact that Social Worker 5 did not understand his role as Social Supervisor of a restricted patient. He was to all intents and purposes the "eyes and ears" of the Mental Health Unit at the Home Office and was responsible for assessing and reporting on Peter Bryan's mental state and behaviour.

At least initially and for some considerable time, he should have maintained a more formal relationship with Peter Bryan and in our view, it was inappropriate for him to fulfil his role as Social Supervisor over lunch or coffee in the hospital canteen.

The Forensic CPN also told us:

"I thought the relationship I had with (Social Worker 5) was excellent because I got on really well with him. It was very informal in lots of ways. Because I was based 3 miles away, I could ring him at the CMHT and speak to him. If I saw Peter Bryan and (Social Worker 5) wasn't around, I was able to ring him. I'd ring him on his mobile, and he was extremely accessible.

He sometimes brought a balance to the situation because he looked at things from a social point of view. I was looking at things from a risk point of view and whether he was relapsing etc. My opinion at the time was that (Social Worker 5) added a balance to it, even though he was maybe slightly inexperienced."

We are also critical of the lack of any in-depth handover between Social Worker 4 and Social Worker 5. Social Worker 4 seemed to just fade out of the picture and Social Worker 5 just took over. It is significant that initially the Home Office seemed unaware that there had been a change in Social Supervisor and wrote to Social Worker 4 for some time after the change to Social Worker 5, requesting his Social Supervisor's report.

The Home Office 'Notes for the Guidance of Social Supervisors' current in 2002 states:

> *"46. When changes in social supervisors occur, it is important that the outgoing supervisor passes to his successor full information about the case and supplements this with oral briefing."*

Social Worker 5 told us that when he first met Peter Bryan, his knowledge of him was based on briefly looking through the notes. He confirmed that he had access to the Rampton Hospital and the John Howard Centre notes.

At one point Day Opportunities 1 of Day Opportunities asked Social Worker 5 for further information about Peter Bryan, and he sent her:

- **The MHRT Decision and Reasons**
- **JHC Psychiatrist 1's assessment of Peter Bryan carried out at Rampton Hospital on behalf of the John Howard Centre dated 13 July 1999**
- **Psychologist 4's psychology report dated 29 September 2000**
- **The Minutes of the Section 117 Discharge Planning Meeting dated 4 February 2002**
- **The CPA Care Plan and the minutes of the CPA meeting dated 2 April 2002**
- **Social Worker 5's Safety and Risk Profile dated 27 May 2002.**

The Panel did not ask Social Worker 5 whether the only clinical assessments which he had read were those of JHC Psychiatrist 1 and Psychologist 4, but would be concerned if they were. However he told us that he had not read the report of Psychologist 5.

The Panel consider that Psychologist 5's detailed report prepared for the final CPA meeting before the MHRT in January 2002 was an essential document for anyone closely involved in Peter Bryan's care to have read. It was thorough and comprehensive, highlighted important areas of risk, and most importantly, produced a clear (and as it turned out, a very accurate) 'relapse signature' which was:

- **Low mood**
- **Irritability**
- **Subtle signs of an increase in paranoid ideation**
- **Illogical statements or disorganised reasoning**
- **Escalating social inappropriateness and sexually disinhibited behaviour**

- **Ideas regarding racism towards him or the expression of racist ideas himself towards others.**

The Forensic CPN said that he remembered seeing Psychologist 5's report and Social Worker 5 confirmed to us that that meant that he would also have had access to the report if it was in the notes. It was in the Community Mental Health Team's notes that we received.

12. Peter Bryan was seen by RMO4 as an outpatient at Homerton Hospital on 15 March who noted that he was mentally stable and that there were no mental health concerns. He appeared to be adapting well to the change in his circumstances.

    The Panel were concerned that there was no record of RMO4's outpatient appointments with Peter Bryan in the various sets of notes available to us. It is not doubted that outpatient appointments were kept by Peter Bryan, but if the records of such meetings were not available to the Panel, it is possible that the clinical information which they should have contained was not available to other members of the community team.

    RMO4 is a consultant forensic psychiatrist. At that time there was no community forensic psychiatric service and the usual practice was for a patient to be handed over to the general psychiatric services immediately on discharge from the John Howard Centre.

    However in the case of Peter Bryan, RMO4 had agreed to continue as his RMO for a period of six months before handing over to RMO5, the general adult psychiatrist who would be his Community RMO. The continuance of the present (John Howard Centre) clinical team for six months following discharge was one of the conditions of Peter Bryan's Conditional Discharge.

13. On 20 March Peter Bryan was visited by the Forensic CPN and Social Worker 5. This was the first time that Peter Bryan had met his new Social Supervisor.

14. On this very first encounter, Peter Bryan wanted to know how long he would be at Riverside House and when he could get his own flat.

15. The Forensic CPN and Social Worker 5 explained to him that it would be a gradual process whereby he would be tested and assessed during the various stages of his progress. He was also informed that he would have to appeal to the MHRT if he wanted to get any of his conditions changed including his residency at Riverside House, and that it was his right to do so every year, but that the support of the professionals looking after him would depend on his progress and risk assessment.

16. On 2 April there was a CPA meeting attended by RMO4, RMO5, Social Worker 5, the Forensic CPN, the Manager and Deputy Manager 1 of Riverside House.

At this stage RMO4 was still Peter Bryan's RMO and RMO5 had been identified as the consultant community general adult psychiatrist who would take over responsibility as RMO after six months. It was good practice that RMO5 was invited to and attended this first CPA following discharge from the John Howard Centre. He had also attended the pre-discharge CPA.

17. Feedback from Riverside House was very positive although it was noted that there had been some difficulties with regard to Peter Bryan testing the boundaries and having problems with motivation.

18. It was noted that he had challenged the Riverside staff regarding the amount of supervision and monitoring he received although recently he had appeared to be more accepting of the reasons and rationale behind this.

19. Some of the issues raised by him highlighted that he still had unrealistic plans for his future care and a lack of understanding about the reasons for his conditional discharge and the level of support which had been set up for him. He wanted to know when he could have his Section 37/41 removed, when he could have overnight leave to his parents' house, and when he could leave Riverside House and get his own flat. He was hoping that this would be in July.

Peter Bryan had only been living in the community for two months and yet was already complaining about the level of supervision at Riverside House. He seemed to believe that within another three months he would be able to live independently in his own flat and he was already asking when his Section 37/41 could be discharged.

This shows a lack of insight into the complexity and seriousness of his mental illness and a lack of understanding of the purpose of a Conditional Discharge. His complaints about the lack of progress towards living independently and the amount of supervision and monitoring he received recurred constantly over the next 22 months, together with persistent requests to come off antipsychotic medication altogether.

20. RMO4 tried to explain to Peter Bryan that these plans were unrealistic and what he would need to do to achieve them. He was also reminded that he had a right of appeal to a Mental Health Review Tribunal.

21. The Care Plan which was formulated was:

1 to reside at Riverside House as part of the conditions of his discharge
2 to be assigned a key worker at Riverside and participate in daily programmes at the hostel
3 regular random drug testing
4 to continue to see (RMO4)
5 (the Forensic CPN) and (Social Worker 5) to see Peter Bryan every two weeks at Riverside or at Kempton Rd.

The meetings with the Forensic CPN and Social Worker 5 hardly ever took place at Riverside House. The Forensic CPN usually saw Peter Bryan at the CMHT office in Kempton Road and Social Worker 5 usually saw him at Homerton Hospital. Both were a considerable distance from Riverside House.

6 (the Forensic CPN) and (Social Worker 5) to visit Peter Bryan's parents
7 to attend the Worland Centre following referral by (Social Worker 5)
8 to attend VITAL drug services following referral by (Social Worker 5).

22. In the section of the Care Plan form for the views of the service user, Peter Bryan commented that he agreed with the Care Plan but made the following comments:

"However the care plan is taken over three month to put into action and still has floors. I am very interested in overnight visit at parent and more important when I will move to own accommodation" (sic)

23. RMO4 saw Peter Bryan at the outpatient clinic on 18 April. It was noted that he continued to remain well in his mental health.

24. The following day Peter Bryan had his first meeting and assessment with the person who was to become his Counsellor at Addaction (the Drug Counsellor), a voluntary drug and alcohol mentoring organisation in Hackney which aims to prevent relapse.

The Drug Counsellor impressed us as a witness and indeed the drug relapse prevention counselling work which he did with Peter Bryan impressed us as well. He saw Peter Bryan regularly over an 18 month period and appears from the records to have been the only person who tried to make Peter Bryan see the risks he faced if he continued to mix with people who were drug users or drug dealers, particularly if they were very young girls.

Peter Bryan clearly had a good relationship with the Drug Counsellor and asked the team to invite him to attend CPA meetings which they did. However the Drug Counsellor told us that he felt that he was just viewed as somebody who was not a psychiatric professional so he really should not be asked any questions about clinical matters. He told us:

"What I would expect, looking back with hindsight, was maybe for someone to say 'If you've got any concerns about Peter, can you please tell me as soon as possible'. There were no (telephone) numbers given to me or anything like that, or 'This is the procedure that we would like you to follow if you are starting to get concerns'."

We asked the Drug Counsellor if he was ever asked by the team if he had any concerns about Peter Bryan and he said:

"Not really. As far as they were concerned Peter was complying and he was turning up to his appointments. The situations that they had found there were difficulties with, they felt they resolved at these meetings, but I do not think they had resolved them, because at the end of the day when we finished, I would leave the meeting with Peter and I would go on the bus and I would get away, and the information that Peter would then talk to me about after the meeting was the information that he should have been saying in the meeting. I had actually got to the point of saying 'Peter, what we are going to have to do is write down what you have got to say by the time you get to the meeting' and so he did start writing things down."

If he had any concerns, the Drug Counsellor should have told one of the team, but if he had perhaps Peter Bryan would have stopped confiding in him.

The Drug Counsellor was concerned that Peter Bryan had been placed at Riverside House because of its geographical position. He told us:

"He was based on Seven Sisters Road - just off the Blackstock Road and that is a notorious sex working area, and it is also quite notorious for crack and heroin. So, the issues were: why had this person been put in this situation where he is surrounded by all these situations, because I found him quite auto-suggestive in some senses. He was quite easily led…I found his social life was revolving around people that were round about 16 to 19 years of age… mainly female."

Although it may have been true that Peter Bryan's placement was in an area where there were many illicit temptations for him, realistically forensic hostels tend to be placed in the more deprived areas of London.

Peter Bryan made life difficult for himself in other ways which concerned the Drug Counsellor who tried hard to set him straight.

"Peter used to make his roll-ups like he was making a joint. So where the average person smokes tobacco and gets a Rizla and just puts some tobacco in it and makes a roll-up and smokes it, Peter would put two Rizlas together and put it all out as if he is making a joint, but the only thing he wouldn't put in is the cannabis or the skunk. He had been pulled a couple of times by the police because to so many looking it clearly looked like he was making a spliff. So my reflection to him was, "Peter, you're setting yourself up. I don't know why you're setting yourself up, but you're putting yourself in a situation where you're going to get confronted". I tried to get him to make a roll-up in a different way so that he could stop drawing attention to himself, because it seemed to be a part of it - and I don't know whether he needed the attention but certainly he was drawing attention to himself with his little behaviours…"

This is a good example of how the Drug Counsellor was dealing with risk management with Peter Bryan on a very practical level.

What was striking to the Panel was that the Drug Counsellor and others at Addaction also saw a very different side to Peter Bryan than most other people who were involved in his care, both when he was in hospital and in the community.

Almost all the witnesses we interviewed from Rampton Hospital, the John Howard Centre and the community described Peter Bryan as somebody who always liked to be 'Top Dog'. Indeed, the Forensic CPN and Peter Bryan himself told us that at Riverside House he was known as 'the Don', although the Riverside staff seem to have been unaware of this.

The Drug Counsellor described him as *"The little boy I used to see"*; also as *"Somebody who was very meek. Even the girls that used to work there (at Addaction) used to call him 'that wee sweet man'. He hardly talks and finds it very hard to even smile, avoids eye contact constantly, who almost felt as if he should be paying for my services. He just didn't feel as if he deserved things."*

He also told us:

"At the time I had a caseload of about 70 people and Peter was the most compliant person I was working with… even the admin workers and some of the other girls at work would say 'He's so lovely'."

The Panel has wondered about these different presentations and it is possible that the people at Addaction saw this different side of Peter Bryan because he did not have to put up a front with them. Also, those at Addaction had no responsibility for imposing rules and restrictions on his behaviour (as Peter Bryan saw the role of the clinical team and Riverside staff). However it is impossible to know whether what the people at Addaction saw was 'the real Peter Bryan' or just another facet of a complex personality.

Whatever the reality, it shows that the Drug Counsellor could have added another dimension to CPA discussions had the community team recognised the worth of his contribution.

25. At a session with the Forensic CPN on 23 May, Peter Bryan was full of complaints about the lack of progress which he blamed on everyone involved in his care. He said that he had been stable

for a long time in Rampton Hospital and should have gone straight from there to Riverside House, instead of going to the John Howard Centre.

26. He said that he did not consider himself a danger to the public and that the homicide had been caused by him becoming ill because he was taking drugs. He went on to say that he now considered himself ready to live in his own flat and that he was hoping that by September he would be ready to, if the professionals hurried up and granted him overnight leave.

27. He also said that the trips he made to museums and other places of interest were merely going through the motions to please the team because he understood that he needed a certain number of such trips under his belt before he would be granted overnight leave.

28. The Forensic CPN noted that a lack of understanding and insight into his illness and the relationship between his illness and his index offence and future risk was very apparent.

Throughout the time that the Forensic CPN was involved with Peter Bryan and had one-to-one sessions with him, Peter Bryan repeated the same complaints about wanting to move into independent accommodation and the lack of progress on the part of his care team. He also constantly blamed his use of illicit drugs for the killing of NS and believed that if he refrained from taking illicit drugs, he would not become mentally ill again.

The Forensic CPN repeatedly noted Peter Bryan's lack of insight into his illness.

29. Just four days after the Forensic CPN noted Peter Bryan's lack of insight, Social Worker 5 wrote his first Social Supervisor's report on Peter Bryan to the Home Office in which he stated:

"He has good insight into his mental health disorder."

Such a statement concerns us because it is completely contrary to what the Forensic CPN had noted just four days beforehand, and therefore there appears to have been no communication between the Forensic CPN and Social Worker 5 about Peter Bryan prior to Social Worker 5 writing his first report to the Home Office.

Given that this was the first Social Supervisor's report that Social Worker 5 had ever written, and that at the time that he wrote it, apart from the CPA meeting on 2 April which

both of them attended, he had only met Peter Bryan on two occasions (the first occasion jointly with the Forensic CPN and the second when he took him to the Worland Centre), we would be concerned if, before embarking on the report, he did not confer with the Forensic CPN who had seen Peter Bryan on six occasions other than the CPA meeting (and of course had met him even before he was discharged into the community). As a CPN the Forensic CPN would be well placed to advise Social Worker 5 on the mental health aspects of Peter Bryan's care in the community.

Also, since Social Worker 5 had no mental health training, he should have shared his draft report with other members of the team before submitting it to the Home Office, especially given that he was commenting on aspects of Peter Bryan's mental health.

30. On 27 May, Social Worker 5 also completed a proforma Safety and Risk Profile in which he stated:

"Relapse indicators show him to resort to drug use when he relapses… Peter is known to succumb to peer pressure on occasions. He is also known to have a manipulative personality and will manipulate situations."

Social Worker 5 was clearly aware from the outset that Peter Bryan was somebody who manipulated situations. Unfortunately, at crucial times when there were concerns about whether or not Peter Bryan was relapsing, his community team allowed themselves to be manipulated by him into accepting his version of events or his explanation of his behaviour. We consider that they should at least have noted how often his version of events differed from that of others, which might have led to them being more wary of accepting his explanations and more alert to the fact that there was a possibility that he might be relapsing.

31. At the next session with the Forensic CPN on 6 June, they discussed precipitating factors leading up to the killing of NS, the homicide itself and Peter Bryan's insight into his illness.

32. He described how after he had come back from Barbados (three to four months prior to the homicide) he was "*unhinged*" after he had seen the injuries which his elder brother had inflicted on his mother. He described the feeling as pacing about the house, not sleeping and feeling angry and wanting to take his anger out on his brother.

33. He said he was smoking three or four joints a day and had no money for food and electricity.

34. On the day of the offence he said that he was feeling agitated, so he went over to a nearby park and while he was there, an Asian man had stolen his hat and had run off with it. He knew who the man was and went round to his house, smashed the man's car windows and took the hat back. When he got back to his house he was feeling very angry and needed money. He decided to get back the £575 that he said that he was owed by the victim's father.

35. He took a hammer with him and went by tube to the shop of NS's parents. He said that as he walked to the shop, he smashed the windows of a house along the way in the hope that he would be arrested by the police.

36. When he got to the shop, NS was on the phone. He asked her three times for the money he said he was owed but she refused, saying that they had not got any money. He said that she slammed down the phone and started to push him. He said that he warned her not to push him, but she said that she hated him and kept pushing him.

37. He said that he then pulled a hammer from his jacket and hit her six times over the head. He said that he had been informed afterwards that he had also hit her brother over the head but he could not remember doing this. Following the attack on NS he said that he saw "*blood and brains everywhere"* which he described as horrific.

With the benefit of hindsight, there are several similarities between this description of the first homicide and events leading up to the killing of Brian Cherry.

Prior to the first homicide, Peter Bryan was not sleeping and described feeling angry and agitated. He took a hammer with him when he went to try to get money back from NS's father. When NS said that there was no money, he pulled a hammer from his jacket and hit her over the head.

Peter Bryan told us when we interviewed him that he had gone to Brian Cherry's flat with the intention of asking him for some money. When he arrived, Brian Cherry invited him in and offered him a cup of coffee, and Peter Bryan asked him for money. When Brian Cherry said that he did not have any, Peter Bryan pulled out the hammer he had just purchased and started hitting him with it.

He also said that on the way to the shop, he had smashed windows in the hope that he would be arrested by the police. One speculative interpretation of the indecent assault which took place at a time when Peter Bryan was being threatened with recall, could well have been an attempt on his part to be "stopped" from carrying out some greater offence.

Again with the benefit of hindsight, the description which P4 gave the police of her trying to push Peter Bryan out of the flat following the alleged indecent assault with him warning her not to push him, is very similar to the description which Peter Bryan gave the Forensic CPN of NS pushing him out of the shop (although according to eyewitnesses this did not happen).

Undoubtedly Peter Bryan's behaviour was becoming more chaotic shortly before the homicide of Brian Cherry, and the Panel would have expected the community team to have scrutinised his behaviour more closely than they did.

However, we acknowledge that closer scrutiny is unlikely to have led the professionals to predict another homicide.

38. Having described how he was feeling prior to the homicide of NS and how he was then quite regularly carrying weapons because of his paranoia, Peter Bryan denied having heard voices or feeling that people were following him or after him in the weeks leading up to the homicide.

Peter Bryan in fact had pretty good insight into his own relapse indicators. He was consistent in describing his feelings and experiences prior to the first homicide, even if he was inconsistent in his description of the event itself.

He always described feelings of anxiety and stress leading to anger and frustration, and always denied any classic symptoms of schizophrenia such as visual or auditory hallucinations.

Unfortunately the team caring for him appears to have been looking for such overt psychotic symptoms as evidence of relapse, and did not pick up on the potential risk to Peter Bryan's mental health posed by stress and anxiety.

However we fully acknowledge that Peter Bryan always appeared to have a somewhat paranoid personality which may have blunted their awareness of signs of increasing paranoia in the weeks leading up to the killing of Brian Cherry.

Both Psychologist 5 and the Forensic CPN identified that Peter Bryan had a persistent underlying paranoia which was probably always simmering below the surface and which meant that he was never completely mentally well, but unfortunately the signs and symptoms which he displayed in the weeks leading up to the homicide were attributed by the community team to his frustration at not getting his own accommodation rather than to a possible worsening of his mental illness.

39. On 12 June Peter Bryan attended an assessment interview at the Day Opportunities Service at the Worland Centre, Stratford with Social Worker 5. During the assessment he asked for help to get back his budgeting skills - he said that he had £1,000 saved but he should have had more.

40. He chose to join the Mental Health Discussion Group and the Photography Group and said that he was interested in going to college and getting some training in the future.

41. He also requested help to deal with stress and anger management. His self-reported trigger points/coping strategies were recorded as being: *"hygiene drops, appearance dazed. Repeat phrases"*.

42. By the end of June Peter Bryan was attending two groups a week at Day Opportunities at the Worland Centre and was also attending Addaction once a week.

43. On 4 July Peter Bryan attended an appointment at the John Howard Centre with RMO4 and Social Worker 5.

44. On 16 July he went for an assessment for dyslexia at the Dyspel Project and the assessment concluded that there was clear evidence that Peter Bryan was dyslexic and that he had clearly underachieved because of his difficulties in learning to read and write and had not yet begun to realise his potential.

45. On 17 July Peter Bryan met with the Forensic CPN and told him about the various activities he was attending and the CPN noted that overall Peter Bryan felt quite motivated and wanted to

demonstrate that he was willing to co-operate with his treatment plans, but that maybe he was trying to take on too much in the belief that this would speed up his move out of Riverside House.

46. Peter Bryan told the Forensic CPN that he had outgrown the hostel and felt resentful that he was there. He complained that Riverside staff had questioned his whereabouts when he came in and were asking him how much he was drinking. They also used to watch him when he had a girlfriend round.

47. On 22 July Peter Bryan had another appointment with the Drug Counsellor at Addaction during which he told him that that morning one of three prostitutes with whom he had been communicating on the Seven Sisters Road had asked him to *"Half her with a bit of hash"* but that he had told her that she should not make such requests because he was not in a position to be taking part in that kind of behaviour.

The Panel questioned why anyone would ask Peter Bryan to supply them with illicit drugs and have always had a suspicion that Peter Bryan might have returned to drug dealing even though it appears that he did not return to taking illicit drugs on a regular basis. We also wondered how and why he had accumulated large sums of cash which he kept in the hostel safe.

When we asked him if it was the case that he had returned to drug dealing, he told us that he did deal in drugs a few times "*but nothing serious*".

It does not appear as though any of his community team were aware that he might have been dealing in drugs despite the fact that he was almost invariably mixing with drug users and young prostitutes.

Young women were constantly turning up at Riverside House, asking for Peter Bryan. One reason why Peter Bryan was so sought after could well have been because these visitors were coming to ask him to supply them with drugs.

The Panel also found it difficult to understand why he needed to buy a car when he did. We did wonder whether it had anything to do with drug dealing.

If in fact Peter Bryan was drug dealing on a regular basis, this had the potential to increase the risk that he would return in other ways to his former criminogenic behaviour, which might have contributed to a relapse.

48. From the beginning of August, Peter Bryan regularly began to leave the hostel at about 21.00 or 22.00 for about an hour. He said that he was waiting for a girl who was around 16 or 17 years of age to pass by on her way home. He said that she lived near the hostel and that he knew her parents as well.

This was probably P4, the young girl who accused him of indecently assaulting her shortly before the homicide of Brian Cherry. Peter Bryan was friendly with both her and her mother, P6, and she lived on an estate very close to Riverside House.

49. On 13 August the Manager of Riverside House received a letter from the National Care Standards Commission (NCSC) informing her that they had received a complaint about Riverside House from Peter Bryan. He had apparently made three visits to the NCSC offices and had made a total of 14 complaints about the hostel and its staff.

50. A meeting was held at Riverside House on 15 August attended by Peter Bryan, Social Worker 5, the Manager and Deputy Manager 1.

This unscheduled meeting appears to have been the first time that Social Worker 5 had seen Peter Bryan since 12 June. There had been an appointment scheduled for 12 July but Peter Bryan told the staff at Riverside House that the social worker had failed to turn up. There was nothing in Social Worker 5's notes to explain why he missed the appointment, nor is there any evidence that the appointment took place.

As this was still within the first six months following Peter Bryan's discharge into the community, the Panel are concerned that he was not being monitored or supported more frequently by his Social Supervisor.

51. At the meeting Peter Bryan said that he was dissatisfied with the hostel and lacked confidence in the management. He complained that some of the residents were using drugs including heroin, and that, as he had dealt with his own drug problem, he did not see why he should have to put up with it.

52. He reiterated other complaints about belongings of his which had gone missing (some of which he had been financially compensated for) and said that he was unhappy at the way that some of the staff spoke to him, for example questioning his sexuality.

53. The Manager and Deputy Manager 1 expressed concerns about Peter Bryan's behaviour and his tendency to be secretive. In particular they were concerned about him going out every night to meet a young girl without letting staff know.

54. They also described an incident in which Peter Bryan had been preparing a meal in the kitchen when something had happened that upset him and he had become angry.

55. They had been concerned because he had a knife in his hand at the time and his eyes had become glazed.

56. They were also concerned that he was deliberately trying to undermine the management of the hostel and had been keeping a list of complaints since he first moved into the hostel and had taken this list to the NCSC.

57. He had also raised his fist to his key worker and had told Deputy Manager 1 that if he did not change her "*she would get some of this*". He also said *"Don't blame me. You know what I can do."* Deputy Manager 1 said that he had taken the threat seriously and felt that he had to take swift action to change Peter Bryan's key worker.

58. At the end of the meeting, Peter Bryan stated that he did not want to stay at Riverside House and that he wanted to move as quickly as possible.

59. At the request of the Manager of Riverside House an urgent CPA meeting was arranged for 20 August which was attended by RMO4, Social Worker 5, the Manager and Deputy Manager 1 of Riverside House. The Forensic CPN was on annual leave.

60. At this meeting, the Riverside staff expressed their concerns about Peter Bryan's recent behaviour and said that they felt that he was showing signs of relapsing.

61. Peter Bryan had an explanation for all of his behaviour which had caused concern. He said that he did not like restrictions or constraints and felt that the team was holding him back.

Peter Bryan tended to have a "scattergun" approach to getting what he wanted and his perception seemed to be that if he persevered with repeating his demands enough times to enough people he would achieve his aims more quickly.

This 'urgent' CPA meeting would have been a good opportunity for the team to make it clear to Peter Bryan that in reality the Home Office dictated what he could and could not do and that he therefore must demonstrate to the Home Office that he was ready to move on, and there was no point in trying to negotiate individually and persistently with the professionals. Unfortunately this was not done.

62. According to Social Worker 5's note of the CPA, at the conclusion of the meeting, RMO4 said that he did not think that Peter Bryan was relapsing, but rather that his current actions and behaviour were just signs of the way that Peter Bryan was.

It is possible that RMO4's comment that the behaviour which had caused the Riverside staff to believe that Peter Bryan was relapsing was 'just the way that he was' influenced Social Worker 5 in his future management of Peter Bryan, in making him attribute less importance to Peter Bryan's increasingly complaining and chaotic behaviour than this behaviour pattern warranted. This is however only speculation.

There were other times when the Riverside House staff were concerned that Peter Bryan might be relapsing but Social Worker 5 seemed to accept Peter Bryan's often very plausible explanations for his behaviour and considered that he was just 'Peter being Peter'.

63. The note also recorded that RMO4 had said that he planned to write to the Home Office but would not ask for a recall, although the Home Office might decide to recall Peter Bryan, based on the content of the letter.

The Panel could not find any letter from RMO4 on the John Howard Centre or the Home Office files following the CPA meeting on 20 August. There were however copies of letters dated 8 August 2002 and 12 September 2002 from the Home Office to RMO4, chasing him for his supervising psychiatrist's report on Peter Bryan which had been due on 22 July 2002.

The implication from Social Worker 5's note about possible recall by the Home Office is that, had RMO4 written a letter to the Home Office following the CPA meeting, that letter might have expressed sufficient concern to prompt action on the part of the Home Office. Failure to send such a letter meant that the Home Office had no record of any concern in August 2002 about Peter Bryan's behaviour and therefore could not bear it in mind in any later consideration about recall they might have to make.

The 'urgent' CPA meeting took place less than three weeks before the 'formal' handover by the forensic psychiatric service to the general service. The Home Office should have been told about it.

RMO4 should also have ensured that RMO5 was aware of the concerns which had been raised, and what RMO4's opinion was as to Peter Bryan's mental state.

In fact it was not until 13 February 2003 - following a letter from the Home Office to the Chief Executive at the John Howard Centre asking them to pursue the matter as RMO4 had not responded to a total of five chasing letters from them - that RMO4 wrote to the Home Office to apologise for his lack of response and to explain that he had handed over his RMO responsibility for Peter Bryan to RMO5 in September 2002.

During the whole six months that RMO4 was Peter Bryan's RMO in the community, the only 'report' which he sent to the Mental Health Unit of the Home Office was a copy of a brief letter dated 22 April 2002 which he had written to Peter Bryan's GP following an outpatient appointment on 18 April.

Given the importance of ensuring that the Home Office are kept up-to-date on the progress of any Section 37/41 patient, this was a serious omission on the part of RMO4 – even more so because his was the only consultant forensic opinion which the Home Office could have had following Peter Bryan's discharge into the community.

The 'Notes for the Guidance of Supervising Psychiatrists' (current in 2002) published by the Home Office state as follows ("*both supervisors*" means Supervising Psychiatrist and Social Supervisor):

> *"41. The Home Office usually asks for reports on the patient's progress from both supervisors one month after conditional discharge and every three months thereafter. In addition, the Home Office expects there to be an annual review of a conditionally discharged patient, undertaken by both supervisors and followed by a report to the Home Office… In some cases, the Home Office may ask for more frequent reports. It is crucial to the safe management of restricted patients in the community that supervisors' reports are delivered regularly and in good time. MHU (the Mental Health Unit) will be assiduous in pursuing any that are not and will write to the Chief Executive of the relevant NHS Trust if reports are not received"*

RMO4's failure to send any comprehensive report was a failure to fulfil his obligation to the Home Office as the psychiatric supervisor of a Section 37/41 patient. As a forensic psychiatrist he should have been aware of his obligations.

RMO4 told us that he had obtained information from the Home Office (now the Ministry of Justice) that between 2001 and 2007 on average they only received about 60% of the expected number of reports from Supervising Psychiatrists and Social Supervisors.

We do not feel that the fact that many other consultant forensic psychiatrists and Social Supervisors failed to fulfil their obligations to the Home Office 'excuses' RMO4, and we still consider that any failure by either supervisor to submit a required report is a serious omission.

64. The Manager of Riverside House noted after the meeting that Social Worker 5 would meet Peter Bryan in future at Riverside House rather than at the CMHT office in Kempton Road, and that all involved in his care would have a meeting at Riverside House to discuss and implement a Care Plan.

In our perusal of the community team notes, we can find only one occasion after this that Social Worker 5 met with Peter Bryan at Riverside House and this was on 5 December 2003 when Social Worker 5 had just discovered through Deputy Manager 1 that Peter Bryan had started work.

He nearly always met him at Homerton Hospital, and often the meeting would entail them having coffee or lunch together in the hospital canteen.

It is extremely important that a Social Supervisor sees his client on a regular basis at his place of residence.

The Notes for the Guidance of Social Supervisors state:

> *"44. There is a certain level of supervision which should be maintained if possible changes in a patient's mental state or behaviour are quickly to be spotted. It is recommended that meetings should take place at least once each week for at least the first month after discharge reducing to once each fortnight and then once each month as the social supervisor judges appropriate. These are considered to be minimum periods… meetings should usually take place on the patient's home territory but some meetings away from the home, perhaps in the supervisor's office, may also prove valuable."*

There were facilities available at Riverside House where conversations could be held in private, and regular visits to the hostel would have allowed regular feedback from the hostel staff, as well as an opportunity to assess Peter Bryan in his residential setting. It may have also afforded the opportunity to pick up more subtle signs of deterioration.

The Panel also consider that the informal setting of a lunch or cup of coffee together, whilst promoting the rapport which is helpful between a Social Supervisor and his client, would not always be conducive to serious discussions about behavioural problems.

It is unlikely that they would be able to discuss anything to do with Peter Bryan's mental illness or his previous offending in a hospital canteen. It is an artificial environment which is acceptable on the odd occasion, as long as it is balanced with more formal meetings.

This is consistent with Social Worker 5 acting more in the role of a 'befriender' or mentor to Peter Bryan rather than the Social Supervisor of someone who had an enduring mental illness, had killed someone and was subject to Section 37/41 MHA.

We can also find no evidence that the care team met with the Riverside staff to implement a Care Plan as had been intended.

65. Following the meeting the Manager of Riverside House met with Peter Bryan and his new Riverside House key worker. They briefly discussed the morning's meeting and Peter Bryan said that he was shocked that he was so close to being recalled back to hospital.

66. His future at Riverside House was then discussed and he was told that he must comply with the rules and expectations of the hostel. He later said that he was going to give it his *"best shot"* and observed *"Though it's like starting from scratch again, it's going to be hard to gain the confidence of others"*.

67. On 27 August Peter Bryan went to his appointment with RMO4 at the John Howard Centre and also went in the afternoon to see the Drug Counsellor at Addaction. Also that day, Deputy Manager 2 (the Deputy Manager of Newton House, the other hostel owned by the Manager of Riverside House and Deputy Manager 1) wrote to the Inspector at the NCSC with a result of his investigation into the complaints made by Peter Bryan, including copies of statements taken from all the Riverside staff involved. His investigation revealed that no evidence had been found to support the allegations.

68. On 3 September Peter Bryan had a one-to-one session with the Drug Counsellor who noted that he presented as being 'a bit down in mood' and had said that he had had problems at the hostel and that they had threatened to send him back to Rampton. They had a long discussion about what had been happening at Riverside House.

69. The Drug Counsellor noted that there was a CPA review on 17 September which he would be attending. He asked Peter Bryan to adopt a new level of honesty as he could not afford to be seen messing around with under 18-year-olds or seeming to be aggressive in any way, as he would just be recalled back to Rampton.

It is clear that Peter Bryan continued to see various women, many of them young girls - probably teenagers. On many occasions the Riverside notes describe different women turning up asking for Peter Bryan, often when he was not there. As we have already said above, the Panel have wondered whether some of them were looking for him in order to buy drugs from him or looking for money from him to buy drugs.

70. The following day Peter Bryan met with the Forensic CPN and they discussed what had been happening. This was their first meeting since the Forensic CPN had returned from annual leave.

71. Although Peter Bryan generally accepted that he had been wrong to go above everyone's heads when making his complaints and that he should be more open with the Riverside staff and discuss his grievances with them, he said that he did not feel that he was in the wrong over a

lot of the incidents and felt that he had been *"put down and treated disrespectfully"* by some of the hostel staff.

72. As an example he accused Deputy Manager 1 of making insensitive remarks to him about his length of sentence, when he tried to compare it to an example in the newspaper of a woman getting a shorter sentence.

73. He also felt that the other residents had a funny look in their eyes which made him feel uncomfortable and were always going into each other's rooms.

74. He minimised the knife incident (which had precipitated the emergency CPA meeting on 20 August) by saying that another resident had sat down at his place in the kitchen which had made him feel angry, resulting in a *"red mist"* coming over him.

What Peter Bryan was describing here could well have been signs of paranoia, and his description of his anger causing a "*red mist*" coming over him should have caused the Forensic CPN to be concerned.

The CPN had noted three examples of potentially paranoid behaviour but appeared to have taken no action other than recording them in his notes.

The Panel was concerned that this might either be an example of how the Forensic CPN's role working with the CMHT meant that he operated in a vacuum with no clear point of referral or, which is of more concern, that this was an example of his operating skills, which meant that he tended to take a passive rather than a proactive role.

We acknowledge that the Forensic CPN had been on annual leave at the time of the emergency CPA meeting when Peter Bryan's recent behaviour had been discussed, but it appears that Peter Bryan had revealed more to the Forensic CPN about how he was feeling than he had to others. This may have been as a result of his session with the Drug Counsellor the previous day when the counsellor had advised Peter Bryan to adopt a new level of honesty.

We are also aware that it was reported at the meeting on 17 September that things seem to have settled down and that there were no ongoing concerns about Peter Bryan's behaviour.

However the Panel considers that it would have been good practice for the Forensic CPN to have reported these signs of paranoia to RMO4 and Social Worker 5 and, in particular, to have raised them at the CPA on 17 September when RMO4 was going to hand over the community care of Peter Bryan to RMO5. As far as we are aware, he did neither.

In the HCR 20 Risk Assessment referred to a little further on, the Forensic CPN did detail the fact that Peter Bryan was expressing suspiciousness toward other residents in the hostel in that they were going into each other's rooms to take drugs and that he had reported that he could tell from their eyes that they were showing some hostility towards him. The HCR 20 was dated 17 September - the same day as the CPA meeting. This potential sign of paranoia should therefore have been mentioned at the meeting.

The Forensic CPN should however be commended for making a point of seeing Peter Bryan during his first week back from leave, and further seeing him again at Riverside House five days later on 9 September.

The CPA meeting on 17 September was always scheduled to be the RMO handover from Dr RMO4 to RMO5. It was therefore an important meeting. Unfortunately RMO5 was unable to be present and was represented by Psychiatrist 8 his SCMO (Senior Clinical Medical Officer) and RMO4 arrived late - after Peter Bryan had already left the meeting. Also Deputy Manager 1 of Riverside House was unable to attend at the last minute but gave feedback on Peter Bryan's progress. Social Worker 5, the Forensic CPN and the Drug Counsellor were present.

The Panel considers that it was most unfortunate that neither RMO5 nor a representative from Riverside House was present at such an important CPA and that RMO4 arrived only after Peter Bryan had already left.

Peter Bryan was extremely upset by their absence and wrote on the CPA Review Form:

"Very concerned that (RMO4) did not attend, and Riverside staff did not attend and it Riverside who suggested that I'm relapsing. And at the end of the day will not attended CPA meeting."**(sic)**

The Forensic CPN told us:

"I did think the CPA was a farce on the 17th"

When he returned to Riverside House that afternoon after the meeting he complained bitterly that he had felt let down as people did not attend his CPA.

After this CPA meeting, Peter Bryan continued to behave as though he thought that RMO4 remained his RMO. The fact that neither RMO4 nor RMO5 attended the CPA meeting when Peter Bryan was present might also have contributed to Peter Bryan's later apparent confusion regarding who was his RMO. It is also possible, however, that Peter Bryan adopted this approach as part of his continuing attempts to push boundaries and out-manoeuvre the clinical team.

75. When RMO4 did arrive at the CPA meeting he reported that Peter Bryan was expressing a lot of anxiety and stress about his index offence and would benefit from further work at the Trauma Clinic at St Bartholomew's Hospital. He said that he would refer him and see him at this clinic and this was added to the Care Plan.

RMO4 never did refer Peter Bryan to the Trauma Clinic (which is for psychological trauma rather than physical trauma). He apparently spoke to the Clinic and it was felt that it would not be an appropriate referral and therefore no letter was written. However, this should have been clarified in the notes.

RMO4 had reported that Peter Bryan was expressing a lot of anxiety and stress which had been documented several times as being relapse indicators.

RMO4 had identified a need for further work. If the Trauma Clinic was not an appropriate referral, an alternative should have been considered in the form of further psychological assessment and/or therapy.

76. The early warning signs/relapse indicators which were given on the Care Plan were: (1) paranoia and suspiciousness (2) drug use, especially cannabis and (3) increased irritability and hostility towards people.

Peter Bryan had been displaying signs of paranoia, suspiciousness and increased irritability in the recent past, and yet these were seen as just features of his personality rather than any possible indication of relapse.

The community team's attitude to such behaviour from Peter Bryan was to repeat itself in the weeks leading up to the homicide of Brian Cherry.

To a very great extent the community team focused on care at the expense of control when it came to their handling of Peter Bryan.

They always seemed to accept his account of events rather than the concerns of others. This led to a perpetuating pattern of initial concern being reduced to an acceptance that he did not pose any risk.

The Panel is also critical of the fact that once again that there was no formal handover from the forensic psychiatric service to the general service.

RMO5 told us:

"He was just transferred to our team."

It appears that there was no transfer of information or specific documents on the handover, nor was there any care plan or risk assessment handed over. We consider that this was not good practice.

Again it would have been helpful if there had been a detailed 'overview' document containing a clear diagnosis, a summarised risk assessment and advice on future management, like the one which is described in the Home Office 'Notes for the Guidance of Supervising Psychiatrists' referred to earlier in the Panel's comments on the discharge from Rampton Hospital to the John Howard Centre.

77. The Forensic CPN had been completing a Risk Assessment Report (using the HCR 20 format) and it is dated 17 September 2002, the day of the 'handover' CPA.

The HCR 20 is a checklist of risk factors for violent behaviour. It consists of 20 items comprised of 10 past (historical) factors, 5 present (clinical) variables and 5 future risk management issues. Each of the 20 factors is given a risk score of 0, 1 or 2.

The HCR 20 Assessment was not universally used in the Trust at that time. The Forensic CPN had been shown this model of risk assessment by the Forensic Nurse Consultant at the John Howard Centre.

The Forensic Nurse Consultant had taken up that post in November 2000 and had initiated some changes in the forensic nursing service, one of which was the use of the HCR 20. He told us:

"I was very keen on the use of the HCR 20, which is an acronym for historical clinical risk assessment, specifically used for assessing violence with mentally disordered offenders. The reason I like it is because it gives you an historical context of the person's offence history, and the current and future presentation of risk. The clinical risk components of it can be utilised to the current and future care planning. It is a useful tool for assessing the impact of mental state on offending."

78. The Forensic CPN gave a score of 14 out of a possible 20 for past risk, 5 out of a possible 10 for current risk and 5 out of 10 for future risk of violence. The Pro-rated Score was 25.3. The assessment rated Peter Bryan as a moderate risk of violence over the next 6 to 12 months.

79. The following extract is the Opinion/Recommendations section of the HCR 20 completed by the Forensic CPN.

"OPINION/RECOMMENDATIONS

Mr Bryan has been rated as a moderate risk of violence over the next 6 - 12 months in the HCR 20. He scored quite high in the Historical Section (14/20) which tends to anchor the risk assessment… this suggests that in the past there is a strong link between violent behaviour, substance misuse and paranoid illness.

As historical factors anchor risk assessment, clinical items are dynamic and changeable and can be moderated to adjust the risk. Although Mr Bryan has some insight in that he had a mental

illness around the time of the Index Offence, he doesn't fully accept that this may have led him to behave violently. He also lacks understanding in how his illness presents itself and the need for medication in the future. More psycho-educational work needs to be done with him around his illness, which should incorporate identifying early warning signs and developing a relapse signature.

<u>*Mr Bryan's mental state appears to have been fairly stable for nearly 7 years while he was in hospital. The last time he showed clear signs of relapse was in 1994 when his medication was stopped for a short time. However, over the last few months he has exhibited some paranoia and hostility towards staff and other residents in the hostel. Even though it was felt by (RMO4) not to be symptoms of relapse, they are of concern and will need further assessing and monitoring by staff over the next few months. These may be early warning signs of relapse or personality trait which are exacerbated by the stress of adjusting to his new environment. If early warning signs are exhibited, then an early mental health assessment will need to be done by his Social Supervisor and RMO with a view to admission to hospital under the Mental Health Act 1983. In the event of relapse, Peter Bryan will need to be admitted initially to a PICU environment due to his propensity to violent behaviour and referred to Forensic Services for a psychiatric assessment."*</u>

This was a good risk management plan. It highlights that Peter Bryan had possible signs of relapse or at least personality traits which needed to be closely monitored and it identifies a need for admission to a psychiatric intensive care unit (PICU) and referral to the forensic service in the event of a relapse.

The passage which we have emphasised by underlining is particularly relevant when considering the events leading up to the homicide of Brian Cherry:

If this recommendation had been followed in late 2003 when there were concerns that Peter Bryan was exhibiting signs of relapse, there is a possibility that it might have prevented the homicide of Brian Cherry.

"Peter Bryan will need to continue to reside at Riverside 24-hour hostel, as he still requires this level of support and supervision. In the community, he will need to demonstrate more openness and show less challenging behaviour towards staff before he is ready for less supportive accommodation. While at the hostel, he would also benefit from a gradual self-

medication programme at some point in order to assess his level of compliance under less supervision.

Peter Bryan should continue with his therapeutic programmes and activities in the community. In particular he should continue with his drug counselling as part of preventative work around his substance misuse issues. Despite being tested negative for drugs over the past few years, the risk of becoming involved in drugs will increase more with a decrease of supervision and the move towards more independence. He should still be tested randomly for drugs by the hostel staff, with an urgent review being set up if he is tested positive.

As there is a strong link between his past criminal activity (robberies, carrying weapons and drug dealing) and his Index Offence, then any evidence of criminal behaviour should be treated with caution by those involved in his care. If there is any evidence of criminal activity, then an urgent CPA review would need to be called and should also involve the police (Mental Health Liaison Officer). There are various options open to the RMO and Social Supervisor, such as admission to hospital for further assessment or contacting the Home Office with a view to recall. If he is arrested for any offences, then it is important that he is charged and that the police and Mental Health Service work in conjunction with each other, as diversion to hospital may be necessary at a later date. This should involve the Public Protection Team at Hackney, to whom Peter Bryan is already known and a referral to the Multi-Agency Public Protection Panel meeting may be necessary.

Before Mr Bryan is considered for overnight leaves to his parents' house, his Social Supervisor and RMO will need to explore further his anxieties around going to his parents' house because of what has happened to him in the past. If it is then decided that he can have some overnight leaves, his parents will need to be involved in the decision-making process, and their needs will need to be assessed further if they are to become involved in his care.

Given the nature and degree of Mr Bryan's Index Offence, if he enters into another relationship with a woman, it is important to assist him in the managing of the relationship and the stresses that it could bring. Due to these factors, the Team should consider a referral to Psychology Services once he enters into a relationship with another woman."

The Forensic CPN very properly forwarded a copy of his report to the other members of the team in November 2002.

80. The covering letter stated:

"Using the HCR-20, it is my opinion that Mr Bryan is a moderate risk of violence over the next 6-12 months, assuming he remains at his current placement and is receiving the current level of support from Mental Health Services. From the Risk Assessment there appears to be two separate but linked patterns of his violence and offending behaviour.

The first pattern of violence is part of his criminogenic traits displayed quite clearly in the past and a long time before he developed a psychotic illness. From the age of twelve years of age, he used violence to obtain money from people when he was involved in Street robberies as part of a gang, which also involved carrying weapons.

The second pattern of violence was linked to his deteriorating mental state in which he was becoming increasingly more paranoid, suspicious and hostile towards others and eventually led to his Index Offence.

His first pattern of violence is very much linked to his past criminogenic behaviour and from a Mental Health Services perspective, there is little that can be offered in reducing the risk in future. That is why it is important to involve the police and for Mr Bryan to be dealt with by the Criminal Justice System if he starts to repeat his offending behaviour again.

With regard to his pattern of violence which stems from his mental disorder, I have suggested a few recommendations that may help to reduce his risk of violence in the future. In brief, the most appropriate strategies to manage and reduce his violence risk, is to continue with adequate monitoring and treatment of his mental disorder and to also continue with the relapse prevention work already being done around his mental health and substance misuse issues.

These dynamic variables are changeable and will need to be reviewed again in eight to twelve months time."

The Forensic CPN's summary of his risk assessment in this covering letter does not accurately reflect the conclusions of the report. He should have referred the reader to the report itself rather than attempt to summarise it in this way. In doing so there was a risk

that the reader would accept his abridged version of risk management without reading what was a lengthy and complicated report.

Overall the Forensic CPN's HCR 20 Assessment was clearly laid out and fairly comprehensive. When the HCR 20 is completed, account should be taken of relevant information from all available sources.

In this report, the sources of information utilised a range of medical and nursing notes as well as the Psychology Report by Psychologist 4 at Rampton Hospital (September 2000).

However, the Forensic CPN does not appear to have used the more recent psychology report of Psychologist 5 (December 2001), a copy of which was located in Peter Bryan's clinical file. He also failed to identify direct sources of information on completing the document.

The Forensic CPN indicated that the risk assessment was to be reviewed in 8 to 12 months time, which did not happen.

Guidance for the use of the HCR – 20 states:

> *"We recommend that risk for violence be reassessed at least every 6 – 12 months or whenever there is an important change in the status of the case."*
>
> (Webster et al, 1997 page 24)

In 2002 the HCR 20 was not widely utilised or understood by other parts of the Trust's psychiatric service including the forensic service at the John Howard Centre. The limited impact of the Forensic CPN's HCR 20 document further highlights his professional isolation from both the forensic service and the general service, because it was done in a vacuum.

This was the only formal Risk Assessment which the Forensic CPN carried out in the two years he was involved with Peter Bryan. The purpose of risk assessment is that it should be an ongoing and dynamic process, so that risk can be continually evaluated against previous risk assessments.

The Forensic CPN should have reviewed and, if necessary, updated his risk assessment 8 to 12 months after this first one. Also, the risk assessment should be an integral part of the Care Plan, but we could find no evidence that the Forensic CPN's HCR 20 Report informed subsequent care plans.

81. From 17 September 2002 RMO5 became Peter Bryan's community RMO.

RMO5 is a consultant in general adult psychiatry and in 2002 was based in Newham. He had taken up that post in July 1999 and was based at the Newham Centre for Mental Health which is on the site of Newham General Hospital.

This was his first post as a consultant.

He described it as *"an incredibly busy job"* in an inner city catchment area. He had a caseload of about 70 patients on enhanced CPA at that time and would also have had responsibility for about 14 or 15 inpatients.

RMO5 had little choice in accepting Peter Bryan as his patient even though he had had virtually no experience in looking after Section 37/41 patients. Mental health services in the community are strictly sectorised, with teams covering defined geographical areas.

The sole reason why Peter Bryan ended up on his list in 2002 was because, some 10 years earlier - before he was sent to Rampton Hospital - he had lived with his parents, and his parents lived in RMO5's catchment area in Newham.

However Riverside House, the hostel to which Peter Bryan was discharged from the John Howard Centre, was not in Newham, RMO5's catchment area, but was a considerable distance away on the Seven Sisters Road.

The Trust at that time did not have a community forensic psychiatric service, which meant that, once a patient was discharged from a medium secure unit such as the John Howard Centre, they were automatically transferred to the general adult psychiatric service. The transfer would be made to whoever was the local general psychiatrist for the patient's catchment area, irrespective of whether or not they were the most suitable psychiatrist to take responsibility for a particular patient.

Home Office 8 of the Mental Health Unit of the Home Office expressed to us the concerns that they had about the Trust's practice of handing restricted patients to the general psychiatric service upon discharge from hospital:

"It is by no means alone as a Trust in doing this, but we would not regard it as a model of good practice for restricted patients in that, after their initial discharge, they are not followed up by forensic services. The Trusts where we have most confidence in their management of conditionally discharged patients are the ones where, initially at least, the patient is followed up in the community by the same team, pretty much, as had been treating them in hospital…

Six months is so short an amount of time as to be irrelevant when you are talking about the timespan for restricted patients. If you came up with an average amount of time that a conditionally discharged patient might spend in the community before absolute discharge, it is normally not less than half a decade.

In those circumstances when I say that they should initially be supervised by a forensic team, I am talking about a period of years rather than months before I would say that a handover to a community mental health service was appropriate.

However, we are aware not only do we have no statutory power in terms of who the supervisor is - that is for the Trust - but the reality is that sometimes Trusts are desperately trying to use their resources just to provide supervisors. Any supervisor is better than no supervisor, as it were.

Within that, where a patient has committed a particularly grave index offence, that increases the argument for a prolonged period of supervision by an experienced forensic team…

As a general proposition, forensic psychiatrists are much better placed to supervise and manage restricted patients in the community because they have a better and broader understanding of risk.

The problem we tend to find with general psychiatrists is that they look purely in terms of the person's diagnosed mental disorder in trying to define risk. They do not look at the

broader risk factors that a good consultant forensic psychiatrist would factor into whether the patient was presenting an increased risk."

In the Panel's view, this is exactly what happened when Peter Bryan's mental state was assessed shortly before the homicide of Brian Cherry.

We consider that there were three major contributing factors here. First, important information regarding Peter Bryan's risks (notably the risks identified by Psychologist 5 in his report, and also later by the HCR20 completed by the Forensic CPN) had not been included in risk assessments, firstly by the forensic team, and subsequently by RMO5 and the other members of the community team. Regarding risk, the focus continued to be on relatively conspicuous relapse indicators.

RMO5 told us:

"That was what was handed over from the forensic team, that the things to look out for were if he became infatuated with a young Asian woman and became very obviously psychotic."

The second factor, related to this, was that there appeared to be relatively little discussion about Peter Bryan among those concerned with his care, with the result that concerns raised by individuals involved in his care were left unresolved and eventually got overtaken by later events.

Thirdly, both RMO5 and Social Worker 5 were inexperienced in dealing with patients like Peter Bryan with a serious forensic history and on a Section 37/41. Their overall approach to Peter Bryan's behaviour was to try to 'normalise' it, to construe it as distinct from either relapse of his illness or his risk of re-offending. Peter Bryan's manipulative behaviour no doubt contributed to this.

However, it is possible that Peter Bryan's behaviour was also encouraged by the failure of those responsible for his care to reach an agreed and consistent appraisal of his behaviour. Had Peter Bryan been under the care of a community forensic team, it is possible that the overall focus of assessment and intervention would have been on controlling his behaviour rather than attempting to normalise it, and the threshold was likely to have been much

lower for construing his behaviour as indicating an increasing risk of his relapse and re-offending.

When the Panel asked RMO3, Peter Bryan's last RMO at Rampton Hospital, what he felt about Peter Bryan being transferred to the general psychiatric service shortly after his discharge into the community, he told us:

"I suppose I would address that question with a bit of bias, in that pretty much all my experience of forensic psychiatry has been high secure forensic psychiatry, so I'm really sensitive and sensitised to risk.

My take would be that this would have to be a forensic case simply because of (a) the severity of the index offence and (b) the potential for history repeating itself.

Forensic bread-and-butter is risk and risk management, more so than general adult services, so my preference would be for him to be a forensic case, at least medium if not long-term."

RMO5 told us that it was not at all usual for him to take responsibility for a forensic patient who had been so recently discharged from the forensic services. He had never before had responsibility for someone who had committed a homicide. He did so with great reluctance.

His inexperience in dealing with a Section 37/41 patient was evident when dealing with his reporting responsibilities to the Home Office. He had to be chased numerous times for his reports, although it is clear that for many months the Home Office's chasing letters were being sent to him at the John Howard Centre (where he had no connection) and it may well be that they were never sent on to him, nor was the Home Office informed by the John Howard Centre or anyone else of RMO5's correct address.

The Panel have some sympathy with RMO5 for finding himself in a situation where he had to accept responsibility for a patient he did not previously know and who had a serious forensic history which he had no experience in dealing with.

We are sure that he is a caring and conscientious general psychiatrist who tries to do his best for his patients. He also was at pains to assure us that, as an inner-city general

psychiatrist, he had considerable experience in managing very difficult, challenging and complex patients with schizophrenia and bipolar disorder.

However, we consider that RMO5's lack of experience in managing and treating forensic patients meant that he was not the best choice for looking after someone like Peter Bryan.

We were concerned when he told us that he was not even aware of the existence of the Notes for the Guidance of Supervising Psychiatrists published by the Home Office, nor was he aware that his role as Supervising Psychiatrist to a restricted patient was any different to that of being the RMO to any other patient.

He should have been sent a copy of the Guidance by the Home Office when he took over as Supervising Psychiatrist. This apparently never happened, but this could be because of the apparent confusion as to who actually was Peter Bryan's Supervising Psychiatrist which we discuss elsewhere.

This meant that the two professionals who provided statutory supervision for Peter Bryan, RMO5 and Social Worker 5, had no previous experience in looking after a patient who had committed a homicide.

RMO5 told us that he was not aware that Social Worker 5 was still working through an agency at the time that he took over responsibility for Peter Bryan, nor that he was an inexperienced social worker. He said that, as a consultant psychiatrist, he was not party to such decisions.

As noted above, the pattern of communication between those responsible for Peter Bryan's care meant that concerns raised were not discussed by all those involved to reach an agreed evaluation and reach a mutual decision as to what should be done.

This applied particularly to those with more forensic and specialist experience - the Forensic CPN, the Drug Counsellor, and the Managers at Riverside House. They had no statutory responsibility and their concerns were not always known by the Home Office.

The Forensic CPN was an experienced CPN who was the only forensic service member involved in the care of Peter Bryan after September 2002, but he was isolated as a

practitioner. He was not really connected to either the forensic or the general psychiatric team, and after he handed over the role of Care Co-Ordinator to Social Worker 5, he had no formal role.

One would have thought that the whole point of having the involvement of a forensic CPN would mean that there was easy access to the forensic service, and it may be that RMO5 viewed the involvement of the Forensic CPN as a kind of 'safety net'. He told us:

"Forensic practitioners work only with mentally ill offenders, and therefore tend to have an expertise in caring for those patients… it is important to bear in mind that I had the benefit of (the Forensic CPN)'s help as a forensic community psychiatric nurse specialist. He was very much involved in Peter Bryan's care throughout."

In reality the CPN was not able to act in such a way. Indeed he told us that when he had concerns about whether or not Peter Bryan was relapsing, he felt that RMO5 and Social Worker 5 *"needed to remove the benefit of doubt for me"*.

This meant that, in the case of Peter Bryan, no one was really making independent decisions about his mental state, but they were each relying on other members of the team to reassure them.

82. Peter Bryan continued to attend his various activities and on 19 October successfully completed a six-week course in computer skills and received a Certificate.

83. On 21 October the Forensic CPN visited Riverside House. First of all he spoke to the Manager of Riverside House who informed him that Peter Bryan's mental state was much more settled and that he was doing quite well. He was seeing his key worker weekly for one-to-one sessions and also met with the Manager of Riverside House monthly with the key worker.

84. She also said that Peter Bryan had been involved with two women over the past few weeks and had admitted to having casual sex with both of them.

Most of the assessments carried out at Rampton and the John Howard Centre had concluded that Peter Bryan was probably still a virgin at that time and had had little sexual experience with women. His attitude to women and sex was immature and the killing of NS

had taken place against a background of what he described as a frustrating sexual relationship with her.

From what we can gather from various accounts in the notes, Peter Bryan's attitude towards women and sex continued to be immature and clumsy, with him believing that he was entitled to some kind of sexual gratification if he either became friendly with a female or if she somehow 'owed' him something.

The Panel is of the view that, in particular since it seems that most of the women whom Peter Bryan associated appeared to be teenagers, prostitutes or drug users - all of whom could lead him back into criminal activity - some consideration should have been given to initiating the psychological counselling that Peter Bryan had requested on various occasions whilst at the John Howard Centre.

We are aware that Psychologist 5 in his report had recommended referral to psychology or counselling services only "*should Mr Bryan enter into a relationship or if there are other sources of stress that threaten the equilibrium he has attained at present*" but it is clear from the notes of the Forensic CPN, the Drug Counsellor and Riverside House that Peter Bryan's relationships with the opposite sex were causing him some stress, whether it was because his attempts to take women to his room were being thwarted by the Riverside staff, or because he was associating with very young girls, or because his sexual advances were being rejected by those whom he considered 'owed him something'.

Many of the tensions between Peter Bryan and those caring for him in the community arose out of situations involving women. We consider that insufficient significance was attached to his interactions with the opposite sex and how sexual frustration and/or sexual rejection might cause him anxiety and stress.

85. The Forensic CPN saw Peter Bryan for about an hour and discussed the symptoms of his illness prior to the killing of NS.

86. Peter Bryan admitted that he was having paranoid thoughts prior to the index offence and that this had continued to worsen while he was in prison and Rampton Hospital. He elaborated this by saying that he thought that the police at the time were going to arrest him and that he thought the neighbours were keeping an eye on him.

87. He also felt that people were looking at him in the street in a funny way. He admitted that he still got these paranoid feelings of people looking at him in the street, but acknowledged that when he was ill this was greatly magnified.

88. He admitted feeling "swamped" by those paranoid feelings which in turn had made him very edgy, irritable and angry. He briefly acknowledged that this had made him more prone to being violent.

89. He also admitted to problems with motivation in the past and that at times he still had them and that in the past he had neglected his personal hygiene and appearance and that this could have been part of his illness. However, he denied having auditory hallucinations or perceptual disturbances of any kind.

When asked about his symptoms of mental illness, Peter Bryan always described feelings of paranoia, anger and stress. He was displaying all of these symptoms in the weeks leading up to the killing of Brian Cherry, but it is fair to say that he displayed such symptoms on and off throughout the two-year period that he was in the community.

The Forensic CPN told us:

"Looking back, I always felt that there was some paranoia. It was whether it was delusional or not, and whether it was indicating he was relapsing which was always a difficult issue. From time to time when they were exacerbated, that was when concerns were raised, but then that was dealt with. It was always simmering in the background…

I always felt he was susceptible to stress - very sensitive to stress - and because of his being in lesser support than in high security, he was exposed, and you are seeing a lot of symptoms coming out in that way that you wouldn't have seen in a more protective type of environment."

The Forensic CPN had got Peter Bryan to acknowledge a great deal, including the underlying paranoia which Psychologist 5 had identified in his report. He is to be commended for the relationship that he managed to build up with Peter Bryan which allowed Peter Bryan considerable freedom of expression.

90. For the rest of the session Peter Bryan went on to discuss some of his grievances with Riverside House and the other residents which the Forensic CPN described in his notes as slightly paranoid and suspicious in nature.

91. He said that he was still angry with the staff for saying that he had relapsed a few months ago when he felt that he had had genuine complaints. He said that he still felt that there was drug taking going on amongst the residents which staff at the hostel did little about.

92. He was also unhappy about having had Asian consultants from Rampton to RMO5, as he felt that they might have negative feelings towards him and a dislike of him because his victim had been Asian. He said that he would like a change of consultant because of this.

93. He said that he was unhappy with RMO4's review of him as he had suggested that he may have shown some signs of relapse and in a way he had colluded with the Riverside staff.

94. The Riverside night staff recorded on 21 October that quite late at night they had overheard a resident telephoning a woman on Peter Bryan's behalf. While the telephone conversation was taking place, Peter Bryan was "watching out" for staff and he appeared embarrassed when staff told him that they knew what was going on. The other resident later informed staff that this woman on the phone was a prostitute who lived or worked in a house nearby.

95. On 31 October Peter Bryan had a meeting with the Manager of Riverside House and said that he was very unhappy with his consultant, RMO4, claiming that he had failed to answer his letter. He also complained that he had failed to grant him overnight leave to his parents' home.

96. The Manager advised Peter Bryan to visit the MIND advocacy service to request someone to act on his behalf in relation to his complaints. She also informed him that she would contact the Forensic CPN to let him know what Peter Bryan was intending to do. She left a message for the Forensic CPN to contact Riverside House.

97. Later that afternoon Peter Bryan asked to see Riverside 4, the Manager's husband, about his complaints. They were:

1. His RMO had not signed his driving licence application
2. His RMO had not signed the two photos

3. His RMO had not signed his passport application

4 His RMO had not considered his request for weekend leaves.

Despite the fact that some six weeks had passed since RMO4 had handed over his RMO responsibility to RMO5, Peter Bryan seemed to be unaware of the change. He continued to complain about his passport and driving licence for a considerable period of time.

There should have been a clear and formal handover from RMO4 to RMO5. In fact neither Peter Bryan (initially) nor the Home Office (for some considerable time) seemed aware that there had been a transfer of RMO responsibility.

98. On 1 November, with the help of the Riverside staff, Peter Bryan contacted the MIND advocacy service and they told him that his details would be passed on and that somebody would get back to him.

99. On 3 November Peter Bryan wrote a letter to Social Worker 5 complaining that he was having problems with RMO4 regarding overnight stays, his driving licence, his passport, his weight and gym.

100. He said that he had written to RMO4 on more than one occasion and had had no reply. The rest of the two-page letter detailed his complaints.

101. The letter concluded:

"I did not feel comfortable on the meeting we had 1:30 p.m. JOHN HOWARD CENTRE 27th August. (RMO4) said "HE CANNOT WORK ME OUT, AND WHERE DO WE GO FROM HERE". Said I was being flipant with (JHC PSYCHIATRIST 3), then started Examining my hand writing. I did not know he was a hand writing expert. He also put me under stress, and then asked me if I am under stress like I am his human toy. Then he did not attend CPA 17th of September 2 p.m. 1 KEMPTON Road EAST HAM. I have not seen or heared from him, 17th September onward. It now 3rd November and I have not see (RMO4) or my community Doctor. So I have decided to complain. As I was told in my tribunal I would see a Doctor once a month. I feel it is him whom is being secretive and has a secret agenda."

This was a typical Peter Bryan letter - full of complaints and accusations.

He tended always to put his thoughts into writing, although that did not stop him from repeating those complaints orally and persistently.

102. On 13 November Social Worker 5 sent the required report to the Home Secretary as Social Supervisor of a conditionally discharged restricted patient. In this report, Social Worker 5 stated:

"Frequency of meeting with the patient since last report:

The Forensic CPN and I see Peter twice each month. He sees his RMO on a regular basis and at the CPAs which are held every 3 months.

In fact, other than when emergency CPAs were called, RMO5 only saw Peter Bryan at the 3-monthly CPA meetings. The statement by Social Worker 5 that Peter Bryan saw his RMO on a regular basis and at the CPAs every three months gives a false impression that Peter Bryan was seen by RMO5 more often than he actually was.

Does the patient show signs of becoming a danger to himself or others?

In August 02, there were some concerns that Peter was expressing thoughts of harming his key worker and making general threats to other staff at Riverside. This was after he reported that his mobile phone had been stolen and he had developed a belief that staff was not listening to him as he had been complaining to them that non-prescribed drugs were being used on the premises. Peter had also complained about these and other matters to the National Care Standards office in Stratford.

If the answer is yes, what action does the supervisor recommend?

A meeting took place between the management staff at Riverside House and me. We looked at all the issues that were affecting Peter including that he wasn't happy living in the home because this impinged on his freedom. A follow-up meeting took place that involved his RMO RMO4, Deputy Manager 1 and the Manager from Riverside House and me. Again Peter talked about what issues he had and both the Manager and Deputy Manager 1 expressed their concerns that included that Peter had made threats to staff because he perceived the home to have some of the characteristics that led to his index offence. For example, that Riverside was

a family run home and Peter had said that the environment was similar to that which led to his index offence.

Although Peter Bryan had some legitimate concerns the home staff were also concerned that Peter was secretive and that he was seeing a young female who was perhaps underage although there was no proof. And this was indicative of his behaviour that led to his index offence. However, neither (RMO4) or me considered that Peter was relapsing and therefore did not warrant admission. It was decided that Peter should be given a chance and supported to work things through, and to approach the staff at Riverside or his RMO, social supervisor or Forensic CPN if he has any concerns about his mental well-being. Since then there has not been any further report about Peter all reports since then have been positive.

REPORT TO THE HOME SECRETARY FROM THE SOCIAL SUPERVISOR OF A CONDITIONALLY DISCHARGED PATIENT

Since the aforementioned incidents Peter has settled down again, and there has been no more reports of concerns by the staff at Riverside. He continues to be compliant with all his conditions and takes his medication as prescribed.

He continues to participate in a wide range of activities, he has sought activities that are positive for his mental health. He continues to have regular contact with both parents and they are happy with his progress. They presently have no concerns about him.

SUMMARY

As mentioned earlier there were some concerns expressed about Peter Bryan's mental health in August that warranted close observation and monitoring. Fortunately he was able to overcome some of his problems with support and guidance from the community team. He now seems to have made a full recovery, and this has resulted in the positive feedback that I have had from staff at Riverside House. He is not considered to be a risk presently and he continues to comply fully with all instructions, his progress continues to be good."

Social Worker 5 sent copies of this letter to both RMO5 and RMO4, although there was no requirement to send one to RMO4. It was helpful that he did so, but it is yet another example of the lack of clarity about the handover arrangements.

103. A letter dated 14 November 2002 (presumably drafted on his behalf by a MIND advocate) was sent by Peter Bryan to the then Chief Executive of the East London and City Mental Health Trust. It read:

"Dear Ms Foley,

I am writing to you because I have to make a formal complaint about my consultant, (RMO4). I am a mental health service patient detained under section 41 of the Mental Health Act and am on conditional discharge living at the above address. I have been living here for the past nine months. I have asked someone to type this letter for me because when I wrote previously to (RMO4) he said he could not read my writing. I am dyslexic which as you are probably aware affects writing as well as spelling and reading.

I have not seen (RMO4) since the summer and I have not been assigned to another community consultant psychiatrist. I am meant to be seen once a month by a consultant psychiatrist. I had a CPA meeting on 17 September but (RMO4) did not attend. A Locum psychiatrist I had never seen before attended.

There are a number of outstanding issues that (RMO4) has not dealt with. He has had my passport photograph and driving licence application since July and I have applied for overnight leaves so that I can visit my parents. This has not been sorted out. I am on antipsychotic medication and also an inhaler for my asthma. This would not be a problem if I stayed overnight at my parents as I am responsible for taking my own medication. (RMO4) also agreed to refer me to a gym for weight training. He has not done this.

I am very unhappy about the way I have been left without proper consultant support which I was supposed to have after I left Colin Franklin Ward, at East Wing Homerton. I would be grateful if you could investigate this for me. I need to have a community psychiatrist who I can see on a regular monthly basis, and which was agreed when I moved."

Peter Bryan was unusual in that he complained that he was not seeing his consultant often enough. However this was entirely consistent with Peter Bryan's overall approach – coming face-to-face with the person responsible for your boundaries is an excellent way of trying to push those boundaries.

Although Peter Bryan was complaining that he had not seen RMO4 since the summer, RMO4 had of course handed over RMO responsibility to RMO5 at the CPA meeting on 17 September. However this is yet another example of the confusion surrounding the handover between the forensic and the general psychiatric services.

RMO5 only saw Peter Bryan at the three monthly CPA meetings (unless there was some perceived urgency). He did not otherwise see him as an outpatient and never saw him on a one-to-one basis.

The Forensic CPN told us that CPAs ran in a typical format. They were half-hour slots and RMO5 would see patients for half an hour every three months. He confirmed that this would have been the format of Peter Bryan's CPA meetings and that he (Peter Bryan) would have been present the whole time, rather than there being a time when the team could discuss his case without him being present.

Although there is nothing particularly unusual about a patient only seeing his consultant psychiatrist at CPA meetings, that is usually only after a considerable period of time when the consultant has seen the patient regularly at outpatient appointments and has had a chance to get to know his patient - and vice versa. Psychiatric supervision of a conditionally discharged restricted patient should, however, demand more frequent contact.

We also consider it to be good practice to allow the community team to discuss the patient with the RMO without the patient being present.

The Home Office 'Notes for the Guidance of Supervising Psychiatrists' current in 2002 stated:

"24. The two most important elements in effective supervision are the development of a close relationship with the patient and the maintenance of good liaison with the social supervisor. However often the supervising psychiatrist decides he needs to see the patient he should see him in a situation in which he can detect deterioration in the patient's mental health behaviour at an early stage. This should include visiting the patient at home from time to time…."

RMO5 did not know Peter Bryan at all when he took over as his RMO, and the Panel considers that it therefore might have been prudent for RMO5 to have arranged at least a few outpatient appointments when he first took over in order that he could hold one-to-

one sessions with Peter Bryan, so that some kind of rapport could be established, and he could better assess Peter Bryan's mental state.

RMO5 acknowledged to us that with the benefit of hindsight, he should have arranged for one-to-one sessions with Peter Bryan. He also never visited Peter Bryan at Riverside House. We fully recognise that RMO5 was a very busy general psychiatrist with a very full case load, but we still consider that at some time in the 18 months during which he was Peter Bryan's community RMO, he should have had some one-to-one sessions with Peter Bryan.

The fact that he did not - and therefore did not have a clear picture of Peter Bryan's 'normal' presentation - may well have contributed to the failure to identify the subtle but progressive changes in behaviour in the weeks leading up to the homicide of Brian Cherry.

104. On 26 November the Home Office wrote to RMO4, remarking that his report had been due on 22 July and that they had sent him chasing letters in August and September which had gone unanswered. The letter stated:

"Whilst we fully appreciate the demands on your time, I must emphasise that the Home Secretary relies on full reports from the supervisors to enable him to monitor the progress of conditionally discharged patients and to carry out his obligations regarding public safety. I should be most grateful, therefore, if you could let me have a full report on Mr Bryan's progress since your letter to his GP dated 22 April 2002. Would you also please note that, whilst we are happy to receive copies of correspondence with the patient's GP, the statutory report should be addressed directly to the Home Office."

Yet again the Home Office was writing to RMO4 despite the fact that RMO5 had taken over as RMO two months previously. This shows that there was a total lack of communication between Peter Bryan's RMOs and the Home Office.

It is regrettable that the Home Office had to chase reports from RMO4, RMO5 and Social Worker 5 time and time again. It is essential that the Home Office is kept informed of the progress or otherwise of a Section 37/41 patient and the required reports should have been provided regularly and on time.

As already set out above, the Notes for the Guidance of Supervising Psychiatrists published by the Home Office stated as follows:

> *"41. The Home Office usually asks for reports on the patient's progress from both supervisors one month after conditional discharge and every three months thereafter. In addition, the Home Office expects there to be an annual review of a conditionally discharged patient, undertaken by both supervisors and followed by a report to the Home Office… in some cases, the Home Office may ask for more frequent reports. It is crucial to the safe management of restricted patients in the community that supervisors' reports are delivered regularly and in good time. MHU (the Mental Health Unit) will be assiduous in pursuing any that are not and will write to the Chief Executive of the relevant NHS Trust if reports are not received"*

We understand that the Home Office now telephones somebody senior in the Trust after they have had to send two chasing letters for the supervising psychiatrist's report.

105. On 27 November Social Worker 5 telephoned to cancel the appointment he had with Peter Bryan that morning. A meeting was arranged for the following day with the Forensic CPN.

106. As soon as Peter Bryan walked into the meeting with the Forensic CPN on 28 November, he handed back the CPA Care Plan which had been formulated after the September meeting, telling the CPN that it was not valid as RMO4 had not been present.

107. The Forensic CPN tried to explore Peter Bryan's feelings about RMO4 further and noted that he appeared quite angry towards him as he said that he had booked appointments to see him and had written to him, only to be ignored. He also stated that RMO4 had his driving licence and passport and he wanted them returned.

108. The Forensic CPN tried to explain to Peter Bryan once again that RMO5 was now his RMO and that the agreement had always been for RMO4 to be his RMO only for the first six months. Peter Bryan found this difficult to acknowledge and went on to give further examples of how he felt RMO4 had treated him badly.

109. He said that he felt angry with him because when he did see him he treated him like a '*guinea pig*' and then got rid of him.

110. He said that RMO4 tried to work him out in his sessions which put him under a lot of stress. He said that he had made an official complaint to MIND about this.

This is, of course, the key role for any psychiatrist. The fact that Peter Bryan made a formal complaint about this shows a lack of insight about his needs for assessment, treatment and supervision as a mentally disordered offender.

This should have been challenged by his care team. The Home Office should have been informed about this complaint rather than the bland reassurances about his compliance they received.

111. He also felt angry at the people who had not turned up for his last CPA and this had included RMO5.

112. When the Forensic CPN tried to explain that RMO5 had nominated a medical colleague to stand in for him, he went on to say that he had not seen him since and that he had expected to and that he was not very happy about it.

113. He then went on to say that he had had enough of Asian doctors and he wanted to change his current RMO to a non-Asian consultant.

114. The Forensic CPN noted that he had the impression that Peter Bryan was beginning to harbour suspicious ideas regarding RMO4 and RMO5 and that he felt that they were trying to harm him deliberately by the lack of treatment they were giving him. This conspiracy theory seemed to have now developed to include all Asian doctors involved in his care - past and present.

115. The CPN noted that it was not clear whether this was delusional and that it would need to be further assessed by his psychiatrist.

116. Peter Bryan apparently still had a fixed idea that his illness was solely down to drugs and that if he stayed clear of drugs he would not relapse again. He also expanded on this to say that he would also like to come off medication in the future as he felt that the side-effect of breast enlargement was down to the medication.

117. Following this session, the Forensic CPN contacted RMO4 and RMO5 to arrange an urgent CPA meeting on 12 December. He also telephoned Social Worker 5 to inform him that when he had met with Peter Bryan the previous day, Peter Bryan had said some things that had raised concerns including that he had a fixation against Asian people and that the Forensic CPN felt

that this could be dangerous because it was this that had caused the index offence. The Forensic CPN informed him that his concern had led him to ask for a meeting with RMO5 and RMO4 which would take place the following week.

Once again it was good practice on the part of the Forensic CPN to have considered the possibility that Peter Bryan's thoughts were becoming delusional and to have alerted the rest of the community team. It was also sensible to inform RMO4 as well as RMO5 and to ensure that the forensic psychiatrist was present at the emergency meeting.

118. On 2 December Peter Bryan had a one-to-one session with the Drug Counsellor at Addaction. He told the drug counsellor that he was getting bored of Riverside House and wanted overnight leave as he was starting to feel trapped or detained where he was.

119. He also said that he wanted to change to a black or white Doctor rather than an Asian doctor. He said that he was afraid that Asian doctors who took on his care were aware that in his index offence he had killed an Asian girl and that this left them with issues in relating to him.

120. He also told the Drug Counsellor that the two girls that he was seeing had been arrested and remanded in prison. The Drug Counsellor asked Peter Bryan to be careful whom he mixed with as he could be going back to a house with one of these girls innocently, but in fact was entering a crack house and the place could be raided by the police and he would then be recalled back to Rampton for associating with known criminals.

121. Peter Bryan also told the counsellor that he had met an Asian woman who had asked him for his telephone number and again the Drug Counsellor warned him to be aware how this could look to others.

It is noteworthy that Peter Bryan was open with the Drug Counsellor about the company he kept and that the Drug Counsellor repeatedly advised him to choose his friends more carefully. He seems to have been the only one of those who were responsible for Peter Bryan's care in the community who seemed to take seriously the risks involved in Peter Bryan mixing with the kind of people he did.

However, this was also clearly directly relevant to the Drug Counsellor's work with Peter Bryan. In order to avoid relapsing into substance misuse, it is helpful to avoid those who are themselves taking illicit drugs.

122. On 12 December the urgent CPA meeting was held at Kempton Road attended by both RMO4 and RMO5, Social Worker 5, the Forensic CPN, the Manager of Riverside House and Riverside 2, (Peter Bryan's key worker at Riverside).

The Panel were impressed that the Forensic CPN had contacted RMO4 as well as RMO5 because of his concerns, and that RMO4 had attended the urgent CPA meeting despite the fact that he had apparently handed over RMO responsibility to RMO5 in September 2002.

If in fact he had not formally handed over RMO responsibility in September 2002, this only adds to the confusion as to who actually was Peter Bryan's RMO at the time.

RMO5 clearly thought that he was Peter Bryan's RMO from September 2002, but as we observe a little later in this commentary, for some time there continued to be some confusion in the minds of Peter Bryan and the Home Office staff as to who actually was his RMO.

123. Relevant extracts from the Forensic CPN's note of the meeting were as follows:

"This was an urgent CPA which had to be called because of Peter 's behaviour over the past few weeks. He had been making complaints about his treatment by (RMO4). He felt that he had been badly treated and treated like a 'guinea pig'. He also expressed his dissatisfaction about having Asian doctors involved in his care and felt that he had been mistreated by them in the past and present.

He was also making unrealistic demands about when he could have a flat on his own as he felt controlled at Riverside and did not feel he needed this level of supervision.

He had also made a complaint about (RMO4) to Mind who he claims has his passport and driving licence and has ignored requests by himself to have them returned.

(RMO4) explored these issues in more detail during the CPA. Although (RMO4) concluded that these were not delusional they were paranoid ideas which would need careful monitoring.

These 'paranoid ideas' continued consistently and persistently throughout the remainder of the time which Peter Bryan spent in the community.

Despite being noted by the professionals as having been raised time and time again, these signs of paranoia appear to have been regarded merely as part of Peter Bryan's personality rather than any underlying persistence of his mental illness.

Nevertheless, even with the benefit of hindsight, it is impossible to discriminate conclusively between these possibilities - that the paranoia was related either to longstanding personality features or to an underlying paranoid illness.

It was clear that Peter expressed unhappiness and anger about being in the "system" and said he feels like he is still locked up. He gave examples of how he felt angry and resentful like when the hostel staff were knocking on his door to get him up in the morning and asking him to declare his whereabouts when he goes out.

When (RMO4) explored Peter's paranoia towards him it was clear that he was misinterpreting what he said and did in his sessions but this was not delusional as he was accepting of explanations e.g. he accused (RMO4) of being hostile and bringing his fist down on the table in the last session –

Medication was discussed. Peter expressed unhappiness of having "enlarged breasts" which he feels are caused by the medication (Stelazine). It was felt by (RMO5) that this was a possible side-effect and plans to introduce Olanzapine before stopping the Stelazine.

Olanzapine was perhaps an unusual choice to replace the Stelazine in an attempt to prevent breast enlargement as it is known to have a considerable likelihood of causing weight gain.

Plan

- *(RMO5) has written to GP to introduce olanzapine 5mgs E/D* (sic). *To review with myself in further 2 weeks and increase olanzapine to 10 mgs.*
- *(Social Worker 5) and myself to visit Peter's sister in Stratford. If everything is satisfactory (Social Worker 5) will write to the Home Office*
- *Riverside staff to discuss Peter's Section 41 Conditional Discharge with him in more detail*
- *to continue with care plans. CPA to be arranged for 3 months."*

124. The Riverside note of the CPA meeting stated:

"Peter expressed his unhappiness with everything around him ie RSH, Consultants, GP etc. After long deliberations the team agreed that staff and his team in general should open up channels of communication while at the same time be vigilant."

125. Peter Bryan had his first overnight leave at his sister's home from Christmas Eve to 26 December 2002. He had a further two nights leave at his sister's home for New Year. He was given his TTO ('to take out') medication to take with him for the days when he was away from the hostel.

126. From then on he had fairly regular overnight leave, each time taking his medication with him.

Peter Bryan told us when we interviewed him that he did not take his medication when he was on overnight leave from the hostel.

127. From the beginning of 2003 Peter Bryan kept up a constant theme of complaints about wanting to come off medication, wanting to move to his own accommodation and the restrictions of living in a supervised hostel.

128. On 7 February 2003 the Mental Health Unit of the Home Office wrote to the Chief Executive of the John Howard Centre because they had received no report from RMO4 on Peter Bryan's mental state and progress since April 2002, despite five written reminders. It was hoped that the matter could be sorted out and that regular reports could be commenced without further delay.

129. On 13 February 2003 RMO4 responded:

"I am very sorry indeed that I have not responded to your letters.
At a CPA Meeting on 17.9.2002 in Newham, it was agreed that (RMO5) would take over from me as the Community RMO.

(RMO5) was represented at that meeting by his colleague, (Psychiatrist 8). I was late in arriving at the CPA and although I missed seeing Mr Bryan I was able to continue in discussions with (Social Worker 5) and (the Forensic CPN).

In view of outstanding issues, which Mr Bryan continued to be concerned about in subsequent months, we convened a further CPA Meeting on 12.12.02 attended by all members of the team, including (RMO5) and I.

I am now dealing with some of these outstanding issues, namely Mr Bryan's application for a driving licence and passport, (the latter about which I have reserved taking early action in order to fully consider all risk matters around Mr Bryan).

The CPA meeting on 12 December was an emergency CPA convened because of concerns about Peter Bryan's behaviour, not because of concerns that Peter Bryan had about outstanding issues.

The Home Office should have been informed of the concerns about Peter Bryan's behaviour and the need to call an emergency CPA meeting. Instead they were led to believe that the meeting was called to deal with such matters as Peter Bryan's application for a driving licence and passport. RMO4 told the Panel that he had in fact temporarily mislaid the application documentation which was why it had not been dealt with.

Once again, I do apologise for the delay in your receiving comprehensive feedback. I am sorry that I did not inform you earlier about the handover of RMOs. I intend to close my involvement formally by week commencing 17th of February 2003 and will write to you about this."

There does not appear to be any 'formal' end to RMO4's involvement in Peter Bryan's care, nor did there appear to be any letter from him to the Home Office after the letter of 13 February.

There still appeared to be some confusion as to when RMO4 ceased to have any formal involvement in Peter Bryan's care. The end of this letter is written by RMO4 as if he were still formally involved in February 2003, and yet he also states in the same letter that he had handed over RMO responsibility to RMO5 in September 2002.

Regardless of the decision having been taken to transfer the role of Supervising Psychiatrist and RMO responsibilities at the CPA meeting on the 17 September, it remained RMO4's responsibility to inform the Home Office of this decision, and to give them the name and full contact details of Peter Bryan's new Supervising Psychiatrist. This could have been done in his letter of 13 February 2003.

130. On 28 March the Mental Health Unit of the Home Office wrote to Social Worker 5 asking him for the further report which was now due concerning Peter Bryan's progress and present condition.

131. The same day they wrote to RMO4 asking him to supply his report which was now due.

The Home Office does not seem to have registered that RMO4 had handed over RMO responsibility to RMO5, despite his letter of 13 February explaining that he had done so in September 2002.

There appears to have been inadequate communication between Peter Bryan's community team and the Mental Health Unit of the Home Office about who was responsible for his care.

In May 2003 the Home Office was still writing to RMO4 asking for his report and in June, September and October 2003 they wrote chasing letters to RMO5, but their letters were addressed to him at the John Howard Centre, which was not where he worked. The John Howard Centre is the forensic medium secure unit in Hackney whereas RMO5 was a general adult psychiatrist attached to Newham Hospital and based in Plaistow.

However, when letters addressed to RMO5 at the John Howard Centre kept being sent, the John Howard Centre should have informed the Home Office that they could not reach RMO5 at that address. We have to assume that this was not done as letters kept being sent to the John Howard Centre.

As already noted above, the Panel is critical of RMO4 for failing to properly notify the Home Office of the change in Peter Bryan's RMO, including giving them the contact details of the new RMO.

However RMO4 actually left the employment of the Trust on 22 April 2003.

132. On 9 April 2003 Social Worker 5 completed a pro-forma Risk Assessment on Peter Bryan. The following are relevant extracts from that document:

"Dangerousness/Risk to Others

Diagnosis: Paranoid Psychosis - Peter was convicted of manslaughter of a young Asian woman the daughter of his employer. He was said to be acting rather strangely. Reports suggest that he had an infatuation with the woman that was not reciprocated. But it is reported that the attack with the hammer took place, after her father refused to pay back £500 he apparently borrowed from Peter. Before the index offence he was reported as having thoughts of persecution, and started walking with a hammer believing that his neighbours were following him and that he was being watched by the police.

Should Peter relapse, he is likely to become paranoid with persecutory thoughts and suspicions - this could lead to him carrying weapons and involved in fights with possible use of weapons

Warning signs or triggers, if any?

Paranoid, persecutory thoughts and suspicions

What intervention has reduced risk behaviour in the past, if known?

Peter is known to relapse very quickly when he doesn't take his medication. Therefore medication should be immediately enforced and monitored and, admission should be considered also depending on the assessed risks at the time. This is of serious consideration particularly if he is around Asian women. The reason for this is that it is believed that Asian women are most at risk because of what is believed to be a preoccupation with Asian women.

Social Worker 5 was not the only one who saw a preoccupation with Asian women as a significant risk factor. RMO5 told us:

"That was what was handed over from the forensic team, that the things to look out for were if he became infatuated with a young Asian woman and became very obviously psychotic."

The Panel can find no hard evidence that Peter Bryan was ever preoccupied with Asian women in general – only with one Asian woman in particular, namely NS.

On the contrary, Psychologist 5 clearly stated in his comprehensive report:

"It is not clear to me that it is significant in terms of specific risk factors that his victim was Asian. It may be significant in this regard that while on remand in Brixton prison Mr Bryan made two apparently unprovoked attacks on fellow inmates. It is becoming clear in the course of this assessment that Mr Bryan has a sexual preference for Asian women and that he is likely to be attracted to Asian women in the future. However, he is also attracted to women from other ethnic groups…"

We are therefore concerned that this is an example of a risk factor which has little basis that has somehow got passed down through risk assessments and perhaps has led to those being responsible by Peter Bryan's care looking for the wrong risk factors.

We are also concerned that none of the professionals appear to have questioned Peter Bryan about Asian women to see whether he was in fact preoccupied with them.

Not only do risk factors need to be reviewed regularly, but their context and basis do as well. This does not appear to have been done.

Management Plan:

Peter to continue living at Riverside, should he show signs of relapse his Social Supervisor and RMO should be informed with a view to admission likely to be a PICU due to the risks he poses to others particularly those of Asian origins. He should be encouraged at all times to take his medication and continue with all therapeutic activities including random drug testing. He

should be discouraged from using cannabis or any other non-prescribed drug. If he is suspected of involvement in criminal activity then all involved in his care and treatment should be informed at once. Work should continue to encourage him to identify early warning signs of relapse.

<u>Vulnerability</u>

Peter is likely to be a risk to others than they to him.

<u>Are there any active symptoms that indicate an increased risk of harm to self or others?</u>

Peter is quite stable at the moment he is fully compliant with his medication and treatment plan. Staff at Riverside residential home report that he is doing (sic) and is not a cause for concerns and neither is he considered a risk to himself or anyone.

There are no concerns expressed by anyone at present. Peter has frequent contacts with the (Forensic CPN) and together with staff at Riverside House we would be able to quickly identify any changes in Peter Bryan's mental state and behaviour."

Unfortunately every time when concerns about Peter Bryan's mental state or behaviour were identified by one of the professionals, he managed to convince them that their concerns were unfounded.

However it has to be remembered that Peter Bryan's behaviour in terms of constant complaints and general frustration and irritability was consistent and persistent, and any changes in his mental state and behaviour were subtle and difficult to interpret.

As had been identified by Psychologist 5 and also by the Forensic CPN, there was an underlying paranoia which was part of Peter Bryan's make up, and we acknowledge that it was therefore extremely difficult to distinguish a subtle change in mental state or behaviour from Peter Bryan's 'normal' personality.

However, we consider that the community team should have questioned whether his paranoid symptoms were behavioural or a sign of relapse on each occasion that they were noted, and that whenever one of the team identified such paranoid thoughts they should

have contacted other professionals involved in his care to enquire whether there were any other concerns which might influence how his behaviour was interpreted.

Nevertheless, even if this had been done, it is unlikely that the clinicians would have been able to reach a definitive answer about the nature and significance of the paranoid symptoms. It is only when these symptoms are considered in the broader context of Peter Bryan's overall behaviour in the weeks leading up to the homicide of Brian Cherry (increasing untidiness, personal disorganisation, and the allegation of sexual assault) that concerns are likely to have emerged regarding the possible increase in his risk of re-offending.

133. On 22 April Peter Bryan completed an 'Early Signs Questionnaire' which the Forensic CPN had given him. It is designed to be given to other patients and family members to evaluate early warning signs observed before the patient had experienced a relapse, but was given to Peter Bryan to evaluate his own estimation of his early warning signs before his relapse which led to his index offence.

134. The final question asked was 'W*ere there additional special feelings that the patient experienced other than the ones above? If "yes", please describe them below and rate them using the 5-point scale.'*

135. Peter Bryan listed the following:

Depressed: ***4***
Stressed: ***2***
Angry at the hole (sic) world: ***5***
What will become of me: ***4***
Black man can not win: ***5: No Black Prime Minister. No one to look up to. Thinking 'fuck'.***

136. Following a subsequent session with Peter Bryan at which these early warning signs were discussed, the Forensic CPN noted the early warning signs as identified by Peter Bryan as:

- *"Being preoccupied with injustices directed towards himself and other black people*
- *feeling restless and agitated, especially at night, for more than four consecutive days*
- *frequent episodes of feeling angry and hostile towards others"*

137. The Forensic CPN noted that he planned to discuss these issues in further detail at the July CPA.

It does not appear as though these issues were discussed at the July CPA nor is it apparent from the notes that the Forensic CPN ever discussed this assessment with Social Worker 5. He should have done, and if he did not, then it is further evidence of a lack of communication between the professionals responsible for Peter Bryan's care in the community about key issues relating to his mental state.

From perusal of the Riverside House and the CMHT notes in the weeks leading up to the killing of Brian Cherry, it seems clear that Peter Bryan must have been feeling all of the emotions he described in his self-assessment.

In particular he was under considerable stress, and on the day of the homicide he was wondering what was going to become of him as Riverside House would not take him back and the police were due to interview him about the indecent assault.

Stress, anxiety about the future, feeling that the whole world was conspiring against him and feeling that he was being backed into a corner were all risk factors which Peter Bryan himself had identified on more than one occasion.

Unfortunately, none of the professionals caring for Peter Bryan at this time seemed to have appreciated that such stress and anxiety might provoke a relapse of his mental health, despite stress having been identified as a risk factor on several occasions by various other professionals.

In the crucial period leading up to the homicide of Brian Cherry, the community team had reverted to identifying early warning signs of relapse as being (a) a return to taking drugs (b) involvement with Asian girls (c) displaying overt psychotic/paranoid symptoms.

Over reliance on the above relapse indicators - in particular (c) - perhaps made them overlook the more subtle signs and symptoms which characterised Peter Bryan's mental disorder, and led them to 'normalise' possible signs of relapse.

138. On 18 April a Care Plan was drawn up at Riverside House as Peter Bryan had gained two stone in weight since he moved into the hostel. He now weighed 15 stone. It was noted that he enjoyed his food, including sweets and ice cream. The agreed objective was that he should go to the gym every Wednesday in order to keep fit and to shed some weight.

139. He was to cook and eat more healthy foods such as fruit and vegetables and to decrease his intake of sugar, carbohydrates and fried food, and should try to cut down on his habit of eating late in the evening and during the night time.

140. Following regular and persistent requests from Peter Bryan to have his medication stopped altogether or at least reduced, on 22 April 2003 the Forensic CPN spoke to RMO5 about the medication issue, explaining about Peter Bryan's concerns that his medication was causing him to have enlarged breasts, despite the change which there had been some months earlier from Stelazine 10 mg to Olanzapine 10 mg.

141. RMO5 was going away for five weeks leave. An appointment was therefore arranged at short notice for Peter Bryan on 28 April.

142. Unfortunately neither the Forensic CPN nor Social Worker 5 were able to attend the appointment, although Peter Bryan was accompanied by Deputy Manager 1 of Riverside House who reported that there were no concerns about Peter Bryan's behaviour or mental state.

143. At the appointment with RMO5, Peter Bryan again raised the issue of reducing or stopping his medication, maintaining (wrongly) that for many years while he was at Rampton Hospital he was not on any medication.

144. RMO5 examined Peter Bryan and concluded that his breasts were somewhat enlarged. (He subsequently wrote to Peter Bryan's GP to ask him to refer Peter Bryan to an endocrinologist).

We are aware that Peter Bryan insists that he was told by the endocrinologist that his enlarged breasts were due to the medication he was taking, but we can find no correspondence from the endocrinologist within the clinical records which confirms or denies this and RMO5 told us that he was not aware of any such opinion - or indeed any opinion from the endocrinologist at all.

145. As from 28 April 2003 RMO5 reduced Peter Bryan's medication from 10 mg to 5 mg of Olanzapine which he took at night-time.

It was not a good time to reduce Peter Bryan's antipsychotic medication when RMO5 was going to be away for five weeks. This should only have been done if there were a robust reason for the decision, and the Panel does not consider that Peter Bryan's complaint about breast enlargement was a robust enough reason. He had been complaining about breast enlargement since he had been at Rampton - and apparently still is at Broadmoor. RMO6 (his former RMO at Broadmoor) told us that he has what is called 'a body dysmorphic delusional system'.

The Panel was also concerned that, just four days after the staff at Riverside House had drawn up a care plan to help Peter Bryan reduce his weight because his unhealthy eating habits had caused him to gain two stone in the 15 months he had been at the hostel, RMO5 was reducing Peter Bryan's medication because of his complaints of weight gain and breast enlargement.

There could well be circumstances when such an approach might be indicated - for example, if RMO5 had judged that Peter Bryan would discontinue his medication altogether unless the dose was reduced, getting him to take a reduced dose would be preferable to his stopping his medication completely. But the Panel was unable to find any explicit rationale of this decision to reduce the medication recorded in Peter Bryan's notes.

Although Deputy Manager 1 was present at the appointment with RMO5, there does not appear to have been any discussion about the extent to which the weight gain was likely to be due to the medication or to the unhealthy eating which had been identified at Riverside House.

The Panel considers that the decision whether to reduce the medication should have been postponed for a period of time to see whether a healthier diet and exercise would change Peter Bryan's physical appearance in order to ascertain whether or not the medication was responsible for any enlargement of his breasts.

If the size of his breasts did reduce with diet and exercise but Peter Bryan still continued to press for a reduction in medication, then RMO5 and the rest of the team would have

known that his persistent "nagging" about reducing/coming off his medication was in fact an indication of a compliance issue rather than a genuine concern about the alteration of his appearance.

Also it had only been some four months since the change of his medication from Stelazine to Olanzapine.

On 3 February when RMO5 had reviewed the change in medication four weeks after it had been instigated, he had told Peter Bryan that, because of his susceptibility to stress and a high risk of relapse, it would not be appropriate to look at a reduction of medication while he was still participating in his community rehabilitation programme, and that therefore the ideal time to look at a reduction would be once his permanent accommodation had been sorted out and that that might be a long way off.

RMO5 had not seen Peter Bryan since that review as he was on sick leave when the March CPA meeting took place. Despite having told Peter Bryan that it would not be appropriate to consider a reduction in his medication before his permanent accommodation had been sorted out, within a matter of weeks he had allowed himself to be persuaded by Peter Bryan to reduce his medication.

This was yet another example of Peter Bryan being able to manipulate situations by persistent complaints and argument.

We were also concerned that, except for the time that he had reviewed the change of medication on 3 February 2003, RMO5 had not yet seen Peter Bryan other than in a multi-disciplinary meeting.

He had attended three multi-disciplinary meetings which had all been headed by RMO4 (the Discharge Planning Meeting on 4 February 2002 at the John Howard Centre, the CPA on 2 April 2002 when RMO4 was still Peter Bryan's RMO, and the emergency meeting on 12 December 2002 when the decision had been made to change the medication to Olanzapine).

The Panel consider that RMO5 should not have reduced Peter Bryan's medication on what was only the second time that he had seen him other than in a multi-disciplinary meeting with RMO4 present.

RMO5 had been reluctant to take Peter Bryan on because he was a Section 37/41 patient, and yet he seemed to forget his forensic history when dealing with him.

It can take several weeks or even as long as about three months for a reduction in antipsychotic medication to show any effect on the patient's mental state.

With the benefit of hindsight, it is possible to detect a subtle change in Peter Bryan's behaviour from about June 2003.

Peter Bryan had been on a therapeutic dose of antipsychotic medication prior to 28 April 2003 and the Panel consider that it is possible that the reduction to 5 mg a day (ie <u>halving</u> the previous 10 mg dose) tipped the balance from keeping his mental state stable to initiating a subtle but continuing deterioration in his mental health.

Peter Bryan also told us that he did not take his medication when he was on overnight leave. He had been regularly going on weekend leave for 2 or 3 nights a week since Christmas 2002, and therefore the reduction in Peter Bryan's medication was probably higher than had been realised or intended by RMO5.

146. Within a week of the appointment with RMO5, Peter Bryan was complaining to the Forensic CPN that he still felt that he should be off antipsychotics entirely and the CPN noted that Peter Bryan had little insight into the need for medication.

147. Peter Bryan subsequently told the Drug Counsellor that he had *'managed to negotiate'* a reduction in his olanzapine from 10 mg to 5 mg a day, but repeated that ideally he would like to come off all medication.

Coming off all medication was a repeated theme of any discussion which Peter Bryan had with every member of his care team.

148. On 12 June the Home Office sent a chasing letter to Social Worker 5 asking for his Social supervisor's report.

149. On 13 June Social Worker 5 sent his report to the Home Office. The following are relevant extracts from it:

"He is seen on a regular basis by (the Forensic CPN). He has regular contact with his RMO, and he attends CPA meetings that are held every 3 months.

Once again this implied that Peter Bryan was seen by RMO5 on regular occasions in addition to the 3 monthly CPA meetings. This was not in fact the case, as, other than on the occasion when he reduced the medication and reviewed it a month later or if an emergency multi-disciplinary meeting was called, RMO5 only saw Peter Bryan at the quarterly CPA meetings and never saw him on a one-to-one basis.

It is interesting to note that Social Worker 5 wrote that Peter Bryan was seen on a regular basis by the Forensic CPN and RMO5 and does not mention himself.

In fact Social Worker 5 did not see Peter Bryan between 11 April 2003 and the CPA on 14 July 2003.

When we asked him why this was the case, he could not give us an explanation. Peter Bryan should have been seen by either the Forensic CPN or Social Worker 5 every two weeks.

The Forensic CPN told us that he was not aware that Social Worker 5 had not seen Peter Bryan during this three month period. This surprised us, since the Forensic CPN also told us that he would regularly read Social Worker 5's notes and there were none between 11 April and 14 July 2003.

This also emphasises the concern that we have that there was at times a lack of communication between the key members of the community team.

There has not been much change in Mr Bryan's presentation since the last report. However despite treatment with medication there remains some residual effect of his illness highlighted in his persistent paranoia particularly with regard to people of Asian origin.

However, in other areas of his treatment, care and development he has made good progress, for example, his overnight stays to his sister's address have now been extended to include overnight stays to his parents' home. It is to be noted that early in his rehabilitation in the community he had decided against visiting his parents because of stress that this had caused him.

Peter continues to push the boundary as far as his need concerned. (sic) He is persistent in asking for move to his own accommodation quickly because he is a "grown" man without seemingly willing to accept that he needs to make further progress as well as there being a need to continue to monitor him in a residential environment as part of his treatment due to some ongoing concerns held by the multidisciplinary team that he may still pose a risk to some Asian members of the community. (sic)

He had some insight into his illness but remains ambivalent about taking medication. One of the reasons is that he feels that a side-effect of the medication is that he has enlarged breasts and because of this he would like to come off his medication.

He doesn't use drugs and seems to have benefited from the drug counselling that he has been receiving. His alcohol intake is not of concern at the time of writing. He seems able to cope with everyday life situations and this is exemplified in recent reports from Riverside House that indicates that he is making good progress.

SUMMARY

As previously stated Mr Bryan progress has been good since he returned to the community from hospital. His mental health remains stable and he complies with his treatment and care plans. He continues to be somewhat demanding at times wanting his medication reduced. A couple of months later he was asking for his medication to be further reduced and requesting that he should be allowed to live in his own accommodation. This highlights his lack of understanding of the importance and significance of his treatment and level of supervision needed.

Social Worker 5 did not specifically inform the Home Office that Peter Bryan's medication had been reduced by RMO5, although it could be said that it was implicit in what he wrote in the foregoing paragraph. However, the Home Office should have been informed of the date and level of the reduction in Peter Bryan's antipsychotic medication.

This also reinforces the fact that RMO5 should have been regularly reporting to the Home Office himself.

The Panel consider that these reports should have been a team effort with input from all of those professionals responsible for the care and treatment of Peter Bryan, but they were not.

The team is uncertain whether this is part of his personality or residual symptoms of his illness. However, members of the multi-disciplinary team will continue to monitor his progress over the coming months in the hope of helping him to develop awareness of the circumstances leading to the index offence and gain more insight and understanding of his illness."

Despite correctly highlighting the fact that the community team was uncertain whether Peter Bryan's attitude to medication and wanting his own accommodation was part of his personality or a residual part of his mental illness, Social Worker 5 and other members of the team nearly always tended to put Peter Bryan's behaviour down to his personality rather than to his mental illness.

They at no time appeared to consider the alternatives: it could have been a gradual under-treatment of his psychosis. It was quite different from his behaviour at Rampton when he had always insisted that he knew that he would have to take antipsychotic medication on a long-term basis - if not for his lifetime.

However, the Panel accepts that attempting to stop his antipsychotic medication was unlikely to succeed in Rampton, but in the community, things were entirely different, not least because of the lack of a unified response to his demands by the clinical team.

The team's attitude to Peter Bryan's behaviour in the weeks leading up to the homicide was crucial to any assessment of risk, and the tendency to believe that his behaviour was just "Peter being Peter " may well have affected his care and treatment at this time.

150. On 14 July 2003 there was a CPA meeting attended by RMO5, the Forensic CPN, Social Worker 5, Peter Bryan, Deputy Manager 1 of Riverside House and his Drug Counsellor.

151. It was recorded that Peter Bryan wanted to move into his own flat as soon as possible and that the team felt that he was ready to move to a 9-to-5 (semi-supportive) hostel.

This was the first time that RMO5 had chaired a CPA meeting for Peter Bryan and the first time that he or Social Worker 5 had seen Peter Bryan since April, and yet from 14 July plans were in motion to move Peter Bryan to less supervised accommodation.

The clinical basis for this decision is unclear and there had been no trial of self-medication yet.

152. Medication was still an issue and Peter Bryan again said that he wanted to come off medication altogether as he felt that it was causing him side-effects and also that he did not need it. It was noted that RMO5 had recently reduced the dosage of his medication to 5 mg Olanzapine and that he would like him to continue with medication until he had been living independently for one year.

153. It was noted in the care plan that at this CPA the role of care co-ordinator was transferred from the Forensic CPN to Social Worker 5, who from then on was both care co-ordinator and Social Supervisor for Peter Bryan.

As we have already stated earlier in this section, the Forensic CPN was not actually attached to either the forensic or the general psychiatric team.

After he gave up the role of Peter Bryan's Care Coordinator, he no longer had a formal role and in many ways became even more isolated.

He made valiant attempts to engage with Peter Bryan and he wrote detailed and comprehensive notes on his sessions with him and on CPA meetings.

However these notes highlighted that Peter Bryan always came with a written Agenda of complaints and to a great extent he managed to control most meetings by the team having to deal with his agendas. He thereby distracted the professionals from going beneath the

surface and evaluating his mental health and behaviour, and made it harder for them to focus their efforts on his care and treatment.

Peter Bryan was able to manipulate the professionals individually to deal with his lengthy and persistent complaints until he succeeded in getting what he wanted, whether it was a reduction in his medication or a move to less supervised accommodation.

It is likely that Peter Bryan's successes in this respect encouraged him to make further demands and to engage in continued manipulation.

Also, despite the fact that at the CPA meetings the whole team (RMO5, Social Worker 5, the Forensic CPN and one of the Managers from Riverside House) was nearly always present, the Panel was concerned that the individual members of the team never spent much time with each other discussing Peter Bryan and the recurring problems of dealing with his issues and coordinating his care. They nearly always discussed matters in Peter Bryan's presence. Their responses to his concerns were therefore piecemeal and/or made under pressure.

On 8 August Peter Bryan gave Social Worker 5 just such an Agenda that he wished to discuss further at their next meeting:

"(1) UNLIMITED LEAVE
(2) OR FRIDAY TO SUNDAY OR MONDAY OF BANK HOLIDAY WEEKEND
(3) REDUCTION IN MEDICATION OR COME OFF ALTOGETHER
(4) If I am to move to half-way house and then one year in flat before I come off medication - I Patchwork (the nickname he called himself) *think it 2 years of medication which is not needed*
(5) Size of my chest and belly and dry mouth
(6) Passport needs sorting out
(7) How do I complain about social worker and CPN
(Social Worker 5) - have not seen in 3 months
(The Forensic CPN) - don't like his ideas and the way he is teaching me relapse prevention"

This was a typical Agenda which Peter Bryan would bring along to meetings, and it is easy to see how any time allotted to such meetings would have been used up in dealing with the issues raised by him, rather than performing any real mental health assessment.

It is interesting to note that one of the subjects Peter Bryan wished to discuss with Social Worker 5 was how he could complain about him!

154. On two separate occasions in mid August one of Peter Bryan's female friends, P5, had caused a disturbance at Riverside House when she turned up demanding to see him and she was not allowed to enter the hostel on the second occasion. She then became very angry and threatening before leaving.

155. Peter Bryan had been upstairs on the second occasion and wanted to know why he had not been called down to see her. He complained that Deputy Manager 1 always sent his guests away and that he was going to complain about how he was treated by him. He said that he had had enough.

156. However the following day he approached Deputy Manager 1 and said that they should sort out their differences, and it was agreed that a care plan would be started to deal with Peter Bryan's visitors and he appeared to be happy with the outcome of the discussion.

157. Deputy Manager 1 then telephoned Social Worker 5 to inform him that he believed that Peter Bryan might be showing early signs of relapse in the light of some of his recent actions/behaviour.

158. The nightshift notes for 20 August state that Peter Bryan returned to the hostel at 21.30 and told staff that he felt that he had been mistreated when one of his visitors was turned away. He said that he was still considering going to the National Care Standards Commission (NCSC) to raise the issue. He was apparently restless overnight talking about the same issue constantly but eventually settled down at 03.00.

159. The following morning staff talked to him about a Care Plan to cater for the visits of his female friends, but Peter Bryan said that he felt he would argue with the plan and was informed that the matter would be discussed with the Managers.

160. The Riverside notes for 22 August show that Peter Bryan came down in the morning and talked about his unhappiness at the way that he felt his visitor had been treated. He said that he had been through the house policies and felt that they needed to be further clarified. He wanted advice on what to do. It was agreed that the options open to him were (1) approaching an

advocacy worker to take up his issue (2) speaking to the Managers at Riverside House to clarify the hostel's policies (3) asking advice of the Care Standards Board. He said that he was happy with the outcome of the discussion and felt that he had *"got it off his chest"*.

161. However that same day Peter Bryan made an official complaint to the NCSC.

162. He made a total of 13 complaints, 5 of which were from the previous year. 3 of those 5 even related to complaints about Riverside House prior to August 2002 when he had made a previous complaint to the NCSC.

163. When Social Worker 5 spoke to Deputy Manager 1 about the complaint to the NCSC, Deputy Manager 1 said that Peter Bryan appeared to be relapsing again and that the pattern of behaviour was similar to his behaviour in August 2002 which had caused concern among the care staff.

164. Deputy Manager 1 wanted Social Worker 5 to organise a CPA meeting so that they could discuss these issues with Peter Bryan.

Once again the Riverside Managers were alert to the potential risks associated with Peter Bryan's behaviour.

165. Peter Bryan went on weekend leave over the August Bank Holiday weekend and when he returned he told staff that he was seriously considering buying a car and had found one for £650.

166. On 3 September 2003 Peter Bryan came down in the morning in a very upset mood and started accusing the hostel staff of giving him medication that was making his chest become "*like women's breasts*".

167. The notes record that even after explaining to him that this issue had been discussed in the last CPA meeting, he was still saying that Riverside House should not be giving him this medication. He asked the hostel staff to telephone his RMO and to make an appointment for him to see the RMO.

168. Social Worker 5 telephoned Deputy Manager 1 that morning and was told about Peter Bryan's intention of buying a car. Deputy Manager 1 also told Social Worker 5 that he suspected that Peter Bryan might be showing signs of deterioration in his mental health.

169. Social Worker 5 said that there was nothing to stop him buying a car, however RMO5 might have some concerns about his driving ability, especially in the light of what Deputy Manager 1 had said about him possibly showing signs of relapse.

170. The social worker said that he would be seeing Peter Bryan the following day and would discuss the car with Peter Bryan and he would also discuss the matter with RMO5 when he was at the hospital.

171. Peter Bryan met Social Worker 5 on 4 September and said that he was well and ready to move from Riverside House. He said that he thought that he was ready for his own place.

172. Social Worker 5 reminded him of the discussion they had had at the last CPA meeting when he was told that his move from Riverside House would have to be planned and structured and done in stages. Peter Bryan said that he did not realise he had to go through "all that".

173. He said that he wanted to complain about the Riverside staff's treatment of him and his visitors. He said that he did not know why residents had to know people for three months before they could visit their rooms. He was also concerned that staff sometimes turned his visitors away without consulting him.

174. Peter Bryan also stated that he had bought a car.

None of the professionals appear to have questioned why Peter Bryan needed a car. It is clear from witness statements given to the police after the homicide that he used to run drug users around in it in order for them to get their drugs.

Also they did not question how Peter Bryan managed to afford to insure and maintain the car and where such finances were coming from.

As Peter Bryan also admitted to us that he did on occasion deal drugs himself, the Panel consider that the community team should have looked deeper into the reasons for this

purchase. Further investigations might have led to the suspicion that he was to some extent in breach of the conditions of his conditional discharge.

175. Social Worker 5 noted that he did not see any signs of relapse and that Peter Bryan looked well. He recorded that he had no issues at present about Peter Bryan's mental health.

On the day of the CPA meeting on 14 July Social Worker 5 had completed a CPA Contact & Crisis Form and under the section 'Crisis Planning' he wrote:

"Early warning signs; relapse indicators; triggers

Non compliance with medication, leading to swift relapse in days. When he is relapsing his eyes bulge, he becomes over concerned about things of little insignificance (sic), he starts to complain frequently about anything as he becomes more paranoid."

Within just a few weeks of recording that one of Peter Bryan's relapse indicators was complaining frequently, Social Worker 5 does not seem to have attached any significance to the fact that Peter Bryan was not only making complaints, but he had once again gone as far as reporting them to the NCSC.

What is striking is that Social Worker 5 did not heed his own warning about risk indicators which he had accurately recorded in an important risk document just a short time before.

It was exactly a year since Peter Bryan's previous complaints to the NCSC had precipitated an urgent CPA meeting at which RMO4 had said that he did not think that Peter Bryan was relapsing, but rather that his actions and behaviour were just signs of the way that Peter Bryan was.

A year later the Riverside House staff were again concerned that Peter Bryan might be relapsing and wanted an urgent CPA meeting to be called, but Social Worker 5 considered that there were no signs of relapse and that he had no concerns about his mental health.

Deputy Manager 1 had more than 20 years experience as a Registered Mental Nurse and also had the experience of running a forensic hostel. He had far more contact with Peter Bryan than Social Worker 5.

Therefore on several occasions, the people who saw Peter Bryan most often considered that he might be relapsing, but those with less experience and/or contact with him did not attach enough significance to the repeated concerns of those with more experience and contact.

The Panel were concerned that Social Worker 5 did not have the experience and expertise to properly assess Peter Bryan's mental health, and there is nothing in his notes to show that he did discuss the matter with RMO5 at this time, despite saying that he would.

There was however the quarterly CPA review on 20 October 2003 at which Peter Bryan's recent complaints to the NCSC were discussed.

176. The CPA meeting on 20 October was attended by RMO5, the Forensic CPN, Social Worker 5, Deputy Manager 1 and Peter Bryan.

177. The Forensic CPN's notes describe a discussion about Peter Bryan's recent complaints to the Care Standards Commission which had been fully investigated with no further action to be taken. It was noted that his main complaint was about a female visitor who had been asked to leave Riverside House because of her abusive behaviour towards members of staff. His complaint was that the staff should have called him as he was upstairs.

178. The Forensic CPN noted that this highlighted Peter Bryan's mild paranoid attitude towards Riverside House and his care and that he felt aggrieved and victimised. He also did not accept that he needed the level of supervision that he had and described this as *"a prison sentence"*.

179. He was reassured that he had made some significant progress and that the team were ready to look at a lower level of supervised accommodation such as a semi-supportive hostel which was staffed from 9 am-5 pm. However Peter Bryan felt that he could manage in a flat on his own.

It was 'all or nothing' with Peter Bryan. He did not accept that he needed any supervision or any medication. He clearly did not have any real insight into these aspects of his management – or indeed into his mental illness.

180. Medication was also discussed. The Forensic CPN noted that Peter Bryan was partially compliant in that he was taking his medication but would like to come off it due to his belief

that it was causing him to have enlarged breasts. It was noted that he had been given an appointment to see an endocrinologist at Homerton Hospital.

181. Social Worker 5's note of the CPA review stated that Peter Bryan was doing well and continued to be motivated and was adhering to his care and treatment plans.

It is noteworthy that the Forensic CPN had identified that Peter Bryan was only partially compliant with medication. Despite the fact that this had been acknowledged by the CPN, Social Worker 5 noted that Peter Bryan was adhering to his treatment plans.

Again this shows that there was no real communication and discussion between those responsible for Peter Bryan's care and treatment.

The Panel were also concerned that any reports which were sent to the Home Office always described Peter Bryan as being fully compliant with his medication.

The fact that he was not completely compliant with medication should have been borne in mind when he was allowed to self medicate the following month.

182. Social Worker 5 also noted that it was agreed that work should be started to move Peter Bryan on from Riverside House to more independent accommodation.

183. On 27 October Peter Bryan asked to speak with Deputy Manager 1 about his care and said that he did not need a care plan for anger management as it was all down to communication.

184. He also requested a meeting with his key worker and co-key worker about his visitors' care plan and said that if it was not dealt with soon, he would not follow the care plan. A meeting was arranged for 30 October.

185. On 30 October Peter Bryan had his meeting with his key worker and co-key worker about his care plan for his visitors. This was apparently resolved.

186. On 3 November Peter Bryan asked to meet with the Manager of Riverside House to discuss issues that were causing him to be unhappy. Peter Bryan had apparently arrived 45 minutes late for his meeting with his key worker and co-key worker on 30 October and did not like the

fact that the Manager of Riverside House had asked him to apologise for being late. He also felt that the meeting was rushed.

187. He said that he was not happy with the way that his care team dealt with his problems at the CPA meeting on 20 October and that afterwards he had felt that nobody cared.

188. On 10 November Peter Bryan set off the fire alarm at 07.30 by trying to burn unwanted paper in his room. He was told that he should not do that again as it put his own life and others at risk.

This act of burning paper in his room can be interpreted several ways other than mere thoughtlessness. It could be that he was trying to draw attention to himself or that he was becoming slightly chaotic or reckless.

It is noteworthy that when he was in Belmarsh Prison after the homicide of Brian Cherry and before he was sent to Broadmoor Hospital, Peter Bryan started fires in his prison cell. He was clearly unwell then.

189. On 12 November the Home Office wrote to RMO5 acknowledging receipt of copies of his letters to Peter Bryan's GP dated 29 April 2003, 16 July 2003 and 18 September 2003. The Home Office reminded RMO5 of his obligation to provide them with reports on Peter Bryan's progress at quarterly intervals, sending copies to the supervising social worker on each occasion. The letter mentioned that the content for such a report was outlined in the notes which were enclosed with the Home Office letter. RMO5 was reminded that the next report was due on or before 18 December 2003.

190. The same day the Home Office wrote to Social Worker 5 chasing his report which had previously been requested on 20 June and 2 October.

The Panel were concerned that RMO5 and Social Worker 5 seemed quite unaware of the importance of their duty to report to the Home Office at three monthly intervals, and that the Home Office had to chase them repeatedly.

RMO5 also did not seem to know what the format was for such a report, as when he did finally respond to the chasing letters from the Home Office, he merely sent them copies of letters that he had written to Peter Bryan's GP on three occasions in 2003.

There is now detailed guidance on the information requirements for reports on conditionally discharged patients which can be found in annex A to the current guidance for Social Supervisors and section 10 of the current guidance for supervising psychiatrists[10]. Had this guidance been available at the material time, it may have helped to ensure that the Mental Health Unit obtained all the relevant information about Peter Bryan.

191. On 17 November Peter Bryan had an appointment to see the Forensic CPN at the CMHT office. The CPN noted that Peter Bryan still lacked insight into his need for treatment and supervision and continued to protest about staying at Riverside House. He was also constantly questioning what the team was doing for him. He felt that he should be living independently and that he did not need supportive housing.

192. It was also noted that his compliance with his medication was again partial. He insisted that he would take his Olanzapine until the doctor told him otherwise, but would like to come off it altogether. He still felt that the medication was causing him to grow breasts and pointed out that other patients at the hostel had the same symptoms.

193. He expressed his despondency about being turned down for job applications because of his past and he did not feel that there was much hope of him getting work. However he also denied applying for work.

194. It was noted that his weekend leave to his parents' home appeared to be going well and that no problems had been reported. In the past two months he had been going on leave most weekends and was self-medicating during the three nights that he was on leave.

Warning bells should have been ringing at this stage that Peter Bryan might not be fully compliant with his medication regime and was going on regular weekend leave during which time he was responsible for taking his medication for three nights.

[10] www.mentalhealthunit.com/mhu%20guidance-social-supervisors%2020070601.pdf
www.mentalhealthunit.com/mhu%20guidance-supervising-psychs%2020060601.pdf

As already stated, Peter Bryan himself told us that he did not take his medication when he was on leave.

195. Following a discussion he agreed to try a self-medication programme at Riverside House. The Forensic CPN's plan was to discuss a self-medication programme with the hostel and to see Peter Bryan again in a month's time.

196. The following day the Forensic CPN contacted Deputy Manager 2 (who had been the Deputy Manager of Newton House but had recently become a Deputy Manager at Riverside House) and they agreed to start Peter Bryan on self-medication.

197. On 19 November Peter Bryan was asked by the Deputy Manager of Riverside House for a random urine specimen which later tested positive for amphetamines. Peter Bryan challenged this and therefore the test was repeated within an hour with the same result. He said that he wanted it to be tested again later.

There is no note which shows that any further test was carried out.

As far as we are aware, this was the first time since he had been living in the community that Peter Bryan had tested positive on any random drug test and therefore it should have been treated seriously.

Social Worker 5 was of the impression that the second test had proved to be negative, but the Panel could not find any reference to this in the Riverside notes.

198. On 21 November Peter Bryan was visited by his solicitor, Solicitor 1, and left with him for his weekend leave, having collected his TTO medication.

Solicitor 1 had visited Peter Bryan because he had made an application for a further Mental Health Review Tribunal (MHRT) to apply for an absolute discharge. Once he had such an absolute discharge, Peter Bryan would no longer be subject to conditions or to recall by the Home Office.

However, from about this point on there is a noticeable increase in erratic behaviour reported in the Riverside notes.

Peter Bryan's sleep pattern appeared to alter with him waking and coming downstairs several times a night; he complained even more than usual, with many of the complaints of a paranoid nature.

The Panel are aware that it is perhaps only with the benefit of hindsight that the significance of this behaviour becomes apparent, but its cumulative effect should have been noted and its significance assessed.

199. Peter Bryan returned to Riverside House the following Monday morning, 24 November, and advised the Manager that he now had a cleaning job which he had started over the weekend. He was apparently working for a cleaning agency 15 hours a week.

200. The Forensic CPN was contacted by the Riverside staff and the CPN stated that Peter Bryan should have informed his Social Supervisor, Social Worker 5, before starting work. He also said that he would organise a Professionals Meeting on 15 December.

201. The Forensic CPN contacted Social Worker 5 to inform him that Peter Bryan had started a job and Social Worker 5 confirmed that he was not aware of the fact, but that he would speak to Peter Bryan about it. The work was apparently overnight until 07.00 and they discussed the possible difficulty that this could create for compliance with his care plan, although Social Worker 5 noted that they did not object to him working as long as it was within the DSS guidelines. He also noted that he planned to speak to Peter Bryan to discuss this issue and also the issue of moving on.

Social Worker 5 did not in fact speak to Peter Bryan until 1 December. The Panel consider that Social Worker 5 should have spoken to Peter Bryan straightaway, given that he had started work, not only without the knowledge of the Home Office, but also without the knowledge of his Social Supervisor.

The 1997 Home Office 'Notes for the Guidance of Social Supervisors' which was current at the time stated:

> *"40… The patient should consult the supervisor when considering any significant change in circumstances, for example a new job… Careful consideration of risk should precede any such proposal and the supervisor should advise the patient against taking any step which, in the supervisor's view, would involve an unacceptable degree of risk."*

It was never clear exactly where Peter Bryan was working. Some people seemed to think that it was at the Excel Centre in Docklands whereas there are also references in the notes to it being at Earls Court.

The Panel are concerned that Social Worker 5 did not appear to have contacted Peter Bryan's employers either to verify where he was working (or even if he was working). He was however working through an agency.

There is also no evidence that Peter Bryan's employers were aware of his forensic background. We do however acknowledge that this raises the issue of confidentiality as to what information can be disclosed.

The Home Office 'Notes for the Guidance of Social Supervisors' stated:

> *"48. Both the social supervisor and the supervising psychiatrist will have detailed information about the patient's case. However, many other people may become involved with the patient in the community and the supervisors will need to consider whether certain information about the patient should be disclosed to such people. Except where medical information is concerned, it will usually be the social supervisor who has to make such decisions.*
>
> *49. Decisions about disclosure of information should be taken by social supervisors in the light of their knowledge of the case and their professional judgement and in cases of doubt they will almost certainly find consultation with their line managers helpful. In general, information about the patient should be disclosed only with the full knowledge and agreement of the patient and information should only be given against the patient's wishes when there are strong overriding reasons for doing so. Such reasons may include the patients known propensity for offending in circumstances which arise from the accommodation, workplace or some types of job…."*

Peter Bryan was also working at night, although once again no-one seems to have checked that he was actually working through the night rather than being up to anything else. However the Panel have seen pay slips which show that he did work but on only a few occasions.

The Panel is also concerned that no-one appears to have considered the risk to female workers who very often do such cleaning jobs, and where there is often only low supervision during the night shift.

We consider that Social Worker 5 should have visited Peter Bryan's place of work and vetted the situation, to ensure both Peter Bryan's well-being and the protection of the public.

202. The Manager of Riverside House noted that Peter Bryan had been resting throughout the evening of 24 November after having been working through the previous night. He was also to start the first stage of his self-medication that night.

The Panel consider that it was unwise to start Peter Bryan on self-medication at the same time as he started work for the first time in many years. It made it difficult to assess whether any changes in his behaviour were down to non-compliance or the change in his routine.

The decision to allow Peter Bryan to control his own medication was taken before staff became aware that he had a job. The Panel acknowledges that it would probably have been extremely difficult to renegotiate this with Peter Bryan when he announced that he had found employment.

However, the Panel considers that the combination of two new factors – self-medication and employment - should have meant that more safeguards were put in place and, in particular, there should have been closer scrutiny of Peter Bryan's actions and behaviour.

203. On 25 November the Drug Counsellor had a session with Peter Bryan at Addaction. He told the counsellor that he had been doing OK and had not touched any drugs. He said that he had had a scare when the random drug test had shown positive for amphetamines but said that the Riverside staff thought that it was just the medication he was on showing up in the test.

There is nothing in the Riverside notes that state that the staff thought that the positive result was probably related to medication, but the Panel acknowledge that none of the Riverside staff they interviewed believed that Peter Bryan was taking illegal drugs at this time or indeed at any time.

204. The Drug Counsellor discussed the issue of Peter Bryan's relationships with street girls because he thought that Peter Bryan was a *'walking risk assessment'* and that if something happened with any of these girls he would get a recall back to a special hospital.

Once again the Drug Counsellor seemed to be more alert to the risks from Peter Bryan's association with young prostitutes and drug users than anyone else.

205. At 00.15 that night Peter Bryan told a member of the Riverside staff that he was going out for a few minutes and was asked to hold on for a moment so that she could open the middle door for him. He then asked why the door was locked and was told that it was for security reasons so that no one would be able to come in, even if they had the keys to the front door.

206. Peter Bryan then said that he was fed up with the system of locking doors since this was not a prison. He went upstairs for a short time and then came back down to go out. When he came back later it was noted that he was restless.

207. At 03.15 he came downstairs to the lounge and when he was asked if everything was all right, he replied that '*Nothing was all right.*' He said that the member of staff on duty should tell the Manager or whoever was on duty in the morning that he was not happy with the way that they locked the door.

208. He said that he was very upset and talked about how the Manager had not allowed his friend P8 into his room. He said that two other residents were allowed to take their girlfriends into their rooms, but when it came to him he was refused. He said that his care plan needed to be changed.

209. It was noted that he settled down in his room at 03.35 but that when the fire alarm went off at 06.30 he did not respond. A member of staff even went to alert him, but he did not come down stairs.

210. The following morning Peter Bryan asked to have a meeting with the Manager of Riverside House about allowing his visitors to his room. She explained to him that once he had brought his girlfriend on a regular basis and the staff and fellow residents had got to know her, she would have no problem letting her go to his room. However at present he was bringing different girls to the hostel and she explained that Riverside House was not a halfway house.

211. She also explained that there was a risk factor in not knowing who was coming into the home and the effect that this may have on other residents.

212. Later that night Peter Bryan left Riverside House at 23.15 saying that he was just *'popping out'* and was asked to call the member staff on duty if he was going to be late back. He telephoned at midnight saying that he would be back soon and he returned at 00.30 and went to his room.

213. At 01.20 he came downstairs again, said that he was just going out and went out until 04.30. When asked if he had gone out to do his job he said that he had not, he had gone to see P8.

The Panel believe that P8 was probably the young woman through whom Peter Bryan met Brian Cherry. She was a self-confessed habitual drug user who used to take money from Brian Cherry to fund her habit.

Again there is no evidence that anyone considered the significance and potential risk of Peter Bryan associating with such young women.

The risks were considerable – the victim of his index offence was a young female; inappropriate sexual behaviour was a recognised risk factor; so were drug taking/dealing and association with a criminogenic culture.

It was also extremely unusual for him to leave the hostel in the early hours of the morning and yet nobody seems to have discussed this with him at any time.

214. On 27 November Social Worker 5 telephoned Riverside House and spoke to Deputy Manager 1 who informed the social worker that Peter Bryan had started work as a cleaner working the night shift from midnight until 07.00 twice a week. Social Worker 5 asked if he was working within the 14 hour guideline and was told that he was, but that the work was with an agency.

215. Social Worker 5 requested a meeting at Riverside House to address this issue and any other issues that the hostel might have and a meeting was set for 5 December at midday.

216. Deputy Manager 1 also told Social Worker 5 that Peter Bryan had gone on leave to his mother's home and had gone from there to his place of work, thereby breaking his overnight stay conditions and he did not tell anyone. Deputy Manager 1 also said that Peter Bryan seemed to be a little agitated recently but that these issues could be discussed at the meeting.

217. On 1 December Social Worker 5 telephoned Peter Bryan to remind him of the forthcoming meeting on 5 December to discuss his employment. Social Worker 5 noted that Peter Bryan told him that he could not attend the appointment because he had been asked to work on the night of 4 December. The Social Worker reminded him that he was subject to conditions and that they would have to meet to discuss him working and other issues and that this was his priority. He told him that he needed to get his permission before he could take up employment and that he should have been consulted.

218. Social Worker 5 also informed him that he considered his attendance at the meeting a priority and therefore he could not give him permission to work the night beforehand because he would need to be alert at the meeting. He said that he would pass on his decision to the Riverside staff.

Peter Bryan had again clearly overstepped the boundaries he had been set, not only by starting his job without permission, but also by breaking the terms of his weekend leave at his parents' home. On this occasion, Social Worker 5's response had been appropriately firm and uncompromising.

219. Peter Bryan responded by putting down the phone.

220. During the night of 2/3 December Peter Bryan came down from his room at 22.00 to take his medication and have something to eat and then went back to his room. At 02.30 he came down again for something to eat, and again came down at 04.09 for more food. When asked if he was all right, he said that he was.

221. At 05.20 he brought down his hair clippers and said that he wanted to have a haircut. He was up and down in the kitchen taking chocolate but it was noted that he seemed to be okay.

This was a new pattern of night-time habits which constituted a change of behaviour. Disturbed sleep can be a sign of a relapse of mental health.

It should have been recognised at the very least as part of a general pattern of deterioration in Peter Bryan's behaviour.

222. During the evening of 3 December Peter Bryan was called to take his medication at 22.20 but did not come down until 22.35 and went into the dining room. He was asked to come to take his medication first because the night staff wanted to be able to sleep in the office, but he would not listen to their explanation and loudly responded that staff *'should give him a break and should not push him around'*.

223. When he was ready to get his medication he asked if he could have it then and was told he could and was given it. A few minutes later when the office door had been shut by the staff, he asked if they could check in the diary if he had any appointments for the following day or whether it was not possible to check because the night staff were sleeping in the office. They said there was no problem and checked the diary for him and told him that he had no appointments. It was noted that the member of staff was calm with him.

224. About 30 minutes later he went into the kitchen and apologised for being rude to the member of staff. He said that that was the way he behaved, that at first he would appear to be angry but once he had thought it over he would calm down.

225. He said that he wanted to move on, that he could not understand why they were keeping him at Riverside House. He said that perhaps the Manager wanted him to go back to taking drugs but said that he could never go back to drugs. He said that it was no wonder that two residents that had left had gone back to taking drugs because she did not let them move on.

226. On 4 December Peter Bryan had a very unsettled night and told members of staff that he was a bit worried about his meeting the following day. He said that he was just eager to leave Riverside House and have his own flat.

227. On 5 December Peter Bryan had his meeting with Social Worker 5, the Manager of Riverside House, Deputy Manager 1 and his co-key worker. The Riverside notes say that all relevant issues were discussed.

228. Social Worker 5 noted:

'Suspect he may be relapsing.

1. *Breaking down - challenging almost everything wanting his own way as to visitors and who comes and what time.*

2. *Not registering he is on licence –*
   challenging whether he should consult with me or let me know what he is doing. Walks away when advised about rules.

(Manager) - suggest he is difficult (?)

Pushing the boundaries, gets angry, wants a break, persistent complaint.

Pushing boundaries - wishes to move on. Manipulating.

No more 117 money (?)

Move to Glenarm Road. Some ground rules -- staff would monitor

Visitors -- Peter would need to comply with rules. Drug test. Let staff know he is staying out overnight

Must inform staff of visitors. Staff have right.

Work 11 -- 7 a.m. in Earl's court. Gets tired

Feel stressed, frustrated, limited especially about visitors.

Peter doesn't see why he should not have any visitors. He should have visitors when he wants.

Peter told and agreed not to continue to challenge rules and (the Manager) told Peter Bryan he needs to comply with rules.

Moving on -- Glenarm Road -- Peter Bryan does not want to pay

Peter felt he could move on -- frustration about moving on

Other blood urine test negative

Emphasise that he needs to let us know he admits to responsibility

His expectation

Smooth, what is expected of him, imagine like Riverside but less rules. Much more stable. Agrees that staff have helped'

229. On the evening of 9 December the Manager had a discussion with Peter Bryan about self-medication as she was going to allow him to take his dosage box to his room as from that night. His care plan was amended accordingly.

230. Peter Bryan returned to the hostel after work at 08.30 on 11 December, did his laundry and chatted to staff. At 10.00 he was visited by his two female friends, P6 and her daughter P4. They stayed for 10 minutes before leaving the house with Peter Bryan.

231. That evening Peter Bryan informed staff that he had taken his medication before leaving at 21.00 for his night shift. He returned at 07.15 the following morning.

232. The Riverside notes show that that morning Peter Bryan made several comments about a member of staff's appearance and also '*came close to the personal space'* of the member of staff who recorded the note.

233. Peter Bryan then left Riverside House for his weekend leave and was due back on the Monday. However he returned at 13.30 and was observed to be sleeping on the sofa. He finally left an hour later for his weekend leave.

234. Social Worker 5 telephoned and spoke to the Riverside staff and they asked him what was happening about Peter Bryan moving on. He said that he was still waiting for an answer. He was also asked if Peter Bryan could go on leave to Glenarm Road (a 9 to 5 supervised hostel also under the management of the family of the Manager of Riverside House) pending his move there and said that he would have to get permission from the Home Office.

235. Social Worker 5's records show that on 12 December he had a discussion with the Forensic CPN and they suspected that Peter Bryan might be relapsing as he was challenging almost everything at Riverside House. He was pushing boundaries and was not listening to advice.

236. He was also working at night and Social Worker 5 noted that he had advised him before about working as this could cause him a degree of stress. It was noted that otherwise there were no problems with Peter Bryan's mental health although it would be necessary to monitor his progress.

Despite these concerns plans continued to transfer Peter Bryan to less supervised accommodation.

237. On 15 December Peter Bryan had an appointment with the Forensic CPN at the CMHT office.

When he had been informed by the Riverside staff on 24 November that Peter Bryan had started work, the Forensic CPN had said that he would organise a Professionals Meeting for 15 December. Unfortunately this was not done and there was therefore no opportunity to 'pool' any concerns or observations about Peter Bryan which might have enabled them to see the larger picture.

238. The CPN noted that Peter Bryan continued to be sarcastic at times in his attitude towards his care and treatment.

239. Peter Bryan informed the Forensic CPN that he had seen the specialist endocrinologist at Homerton Hospital the previous week and that the specialist had told him that his antipsychotic medication (Olanzapine) had caused his breasts to become enlarged. He said he had been given three options - to reduce the medication, to stop the medication or to have surgery.

The Panel found nothing in any of the records which stated that the endocrinologist had confirmed that Peter Bryan's medication had caused breast enlargement.

240. This had reaffirmed Peter Bryan's belief that he was a "*guinea pig*" and that he had been over medicated by RMO5. This belief was fixed despite being reminded that his medication had been changed as well as reduced and that he was on a minimal dose.

Once again the Panel consider that Peter Bryan's comments should have rung alarm bells about his compliance with medication.

241. Peter Bryan said that he was now working 15 hours a week cleaning at Earl's Court. He said that he was meeting the employment officer the following day to find out if this would affect his benefits. He said that if it did, then he was going to work full-time and come off benefits.

242. When advised by the Forensic CPN that he should discuss this matter with his Social Supervisor first to see if this affected his supervision and care plans, he did not see why he should do so. He was strongly advised to discuss the matter with Social Worker 5 and the Forensic CPN informed him that he would be discussing it with Social Worker 5 after the meeting.

243. Peter Bryan was aware that Social Worker 5 was looking at low support accommodation at the Glenarm Road Project. He said that he was not happy to go there as he wanted his own flat.

244. Peter Bryan informed the Forensic CPN that he had tested positive for a class A drug twice a month ago but he denied taking any drugs and was very concerned about this result and how it would affect him. The Forensic CPN said that he would look into it further as he had been unaware of this result.

245. Following the meeting with Peter Bryan, the Forensic CPN telephoned Social Worker 5 who told him that Peter Bryan had tested positive for a class A drug, but that when the test had been repeated it had been negative. He said that the first test appeared to have been done incorrectly. Peter Bryan had been informed but appeared not to have understood what this meant. The Forensic CPN said that he would contact Riverside House to explain.

As we have indicated above, there is nothing in the Riverside notes to show that the second drug test was negative or that the first test was done incorrectly. However it is fair to say that there is no evidence that Peter Bryan had returned to his former habitual drug use, although statements given to the police after the homicide by some of his young female associates seemed to imply that he smoked the occasional 'spliff' with them.

One thing that is clear, however, is that illicit drugs were not a feature of the homicide of Brian Cherry.

246. On 15 December the Forensic CPN rang Riverside House to request a random drug screen for Peter Bryan and said that if it was negative, there was no need to contact him. This was then discussed with the Manager of Riverside House who advised that the drug screening should be referred back to the Forensic CPN for him to arrange. A message was left with the Forensic CPN to ask him to ring Riverside House about this.

247. Social Worker 5 also noted that day that, once he had been transferred to the less supervised hostel at Glenarm Road, Peter Bryan wanted to move out in eight months but that the Manager of Riverside House had told him not to have that in mind because that was the attitude which had affected him at Riverside House because he had a fixed time in his mind to move on.

248. That evening at 22.20 Peter Bryan said that he was going out and was asked if he had taken his medication. He said that he had. He went out and returned about half an hour later, spent a short time in the dining room before retiring for the night. He was called by a member of staff the following morning at 08.40.

249. In the afternoon of 16 December Peter Bryan was visited by P4 and a little girl aged about four years. They spent about 20 minutes in the dining hall and the rest of the afternoon Peter Bryan remained in the hostel. The Manager of Riverside House had a one-to-one talk with him and it was noted that he was going to tidy his room the following day. The notes state that he appeared 'fine'.

250. That evening Peter Bryan went out at 22.35 with two other residents. Before he went he informed staff that he had taken his medication. He returned half an hour later but went out again at 23.45 saying that he would telephone if he was not coming back. In fact he returned 10 to 15 minutes later and went to his room.

251. He came downstairs again at 03.30 and put some clothes on to wash. When he was told that it was not his washing day he said that he had made a mistake.

252. The morning shift note records that Peter Bryan was seen in the house at 10.15 on the morning of 17 December but that, prior to that, there had been no response from his room and therefore two members of staff had checked his room which had been empty. When asked about this, he said that he had told the night staff that he was going out at 06.30.

253. When seen at 10.15, he said that he had no time to tidy his room and he left the hostel at 11.00 saying that he would be back at 18.00.

254. Deputy Manager 2 telephoned the Forensic CPN that afternoon and discussed drug screening and whether the CPN could arrange a random drug test. The Forensic CPN said that it could be arranged with the Addaction team and his drug worker as long as he was screened before 5 January 2004 in time for the CPA review.

255. Deputy Manager 2 advised the Forensic CPN that Peter Bryan had been up all night, that he was in a rush that day and that his bedroom was very untidy and disorganised. The Forensic CPN questioned whether he was relapsing and wondered if he could be screened for drugs that day. He was told that Peter Bryan had said that he would be out until 18.00.

Deputy Manager 2 had noted and reported two significant factors to the Forensic CPN - the fact that Peter Bryan's sleep pattern appeared to be disrupted and that his bedroom was very untidy and disorganised, which was unusual for him.

The Forensic CPN had appropriately questioned whether Peter Bryan was relapsing and suggested drug screening. However these concerns do not appear to have been communicated to either RMO5 or Social Worker 5. They should have been.

Only five days earlier on 12 December, Social Worker 5 and the Forensic CPN had been questioning whether Peter Bryan was relapsing because he was challenging everything at Riverside House and was pushing the boundaries.

There were now further concerns reported by the staff at Riverside and yet they do not appear to have had any additional impact.

The issues all seem to have been considered individually and none of the professionals seem to have taken an overview of the cumulative effect of these changing behaviours. Had they done so, it might have heightened their suspicion that Peter Bryan was relapsing

256. In the morning of 18 December Riverside staff helped Peter Bryan clean and tidy his room, and it was noted that this would continue another time.

257. That evening he went out with a fellow resident and returned at 22.00. He informed staff that he was going to take his medication. He watched television until midnight and then went to bed, but the notes record that time and again he was up and down between his room and the lounge throughout the night, eating food from time to time. He finally settled down at 04.00.

258. The following afternoon he left for his weekend leave at his parents' home. At 21.00 that evening his friend P5 came to visit him but was told that he was away until Monday and she left. At 23.30 another female arrived at the hostel looking for him and was also told that he would not be back until Monday, and she then left.

259. On 19 December RMO5 wrote to the Home Secretary at the Mental Health Unit of the Home Office:

"1.*Patients Name: MR PETER BRYAN…*

5. Length of time since patient's conditional discharge: ***1 year 10 months***

6. Frequency of meeting with the patients since last report: **patient not seen by Psychiatrist**

7. Does the patient showed signs of becoming a danger to himself or others: ***No***

Since the last report there has been no CPA meeting arranged for Peter Bryan. However I have had discussions with his care coordinator (Social Worker 5). Mr Bryan has continued to remain stable in his mental condition and has displayed no symptoms of his illness. He is compliant with his medication.

In fact Social Worker 5 had only seen Peter Bryan once since the last CPA meeting on 20 October 2003.

Despite there having been concerns expressed by Deputy Manager 2 to the Forensic CPN only two days previously which had led the CPN to question whether Peter Bryan might be relapsing, this does not appear to have been communicated to RMO5 nor even to Social Worker 5.

There is also no mention of the fact that Peter Bryan had been started on self-medication. The Forensic CPN's concern about Peter Bryan's 'partial' compliance with medication also does not appear to have been communicated to RMO5.

The current plan is to transfer Mr Bryan to a hostel, which provides less supervision than the present one. A hostel has been identified on Glenarm Road in Hackney. This is the first phase of a planned eventually discharged into independent living in the community (sic)

In the meanwhile Peter Bryan has also started employment in a part-time capacity as a cleaner.

There was no mention of the fact that he had started employment without the knowledge of or permission from his Social Supervisor or Supervising Psychiatrist nor of the fact that he was working a night shift. These facts should have been reported to the Home Office.

I will be reviewing Mr Bryan in January at his CPA, but in the meanwhile he continues to be supervised by his care coordinator, (Social Worker 5). If any need arises he will be seen urgently. In his current state there are no reasons to recall Peter Bryan to the hospital."

260. Also on 19 December Social Worker 5 wrote his Social Supervisor's report to the Home Office:

"Peter was detained under Section 37/41 in 1993 for manslaughter on the grounds of diminished responsibility. He was given a conditional discharged (sic) by the Mental Health Review Tribunal on 11.01.02 and he was moved to Riverside House on 10.02.2 where he has continued to reside.

Mr Bryan continues to be seen regularly by (the Forensic CPN) and myself. He also has regular contact with his RMO particularly with regard to his medication. Mr Bryan attends all meetings arranged to look at his care and treatment including CPAs and meetings organised by staff at Riverside House.

Mr Bryan continues to be compliant with his treatment and care plan, including those he has instigated himself, for example he has recently through his own volition signed up with our day opportunities employment project, so that he could get back to work. Despite this there remains the impression that Mr Bryan's paranoia about people of Asian origin still remains and

there is a feeling amongst the multidisciplinary that the persistence of his paranoia places some members of the Asian community at risk although this is deemed to be low.

However, recently there were concerns that Mr Bryan was showing signs of relapsing because he was challenging home policy, wanting his own way, particularly with regard to his friends visiting the home. It appears that Peter wanted his friends to be able to visit him any time regardless of the policy of the home. He is seen as someone who pushes the boundary and doesn't see the need to consult with his social supervisor or care coordinator for example he started work part-time without consulting with his care team.

Social Worker 5's report does inform the Home Office that Peter Bryan had started work without consulting his care team.

A meeting was called recently to discuss these and other issues that relate to Mr Bryan's care, during the meeting Mr Bryan stated that he was frustrated having to live in such restrictive condition (sic). Mr Bryan was made aware of the reasons for this that it was his own action that placed him in such a situation. The meeting concluded with Mr Bryan agreeing to comply with home policy and to abide by the rules. In his defence he agreed that the support he has received from the multi-disciplinary team has helped him significantly and he would now like to move on to become more independent.

The team agreed that Mr Bryan has done as well as he can at Riverside House and that we should look to move him to more independent type accommodation to see how he respond (sic). This is of course subject to Home Office approval and a formal request to move Mr Bryan to a low support accommodation will be made once an appropriate placement is identified.

SUMMARY

Despite some of the problems identified above the multi-disciplinary team agrees that Mr Bryan has done quite well since his discharged from hospital (sic) he has started a part-time job as a cleaner 2 nights each week working a total of 13 hours. This has helped his confidence and his self-esteem; I have informed Mr Bryan and the home that he should not work more than these hours in any one week. Mr Bryan remains compliant with treatment and care plans, he is on a self-medicating plan and this has been going well, he still has reservations about

taking his medication mainly due to him developing enlarged breast (sic) for which he has been seeing a specialist at Homerton Hospital, Hackney.

He has made good use of his home overnight leave, he has requested overnight leave over the Christmas period dates are 24 to 29 -- 03 and 31 to 02 -- 04 which has been granted. Plans are to be made to move him to a low support accommodation at 112 Glenarm Rd, Hackney E5. This is managed by the owners of Riverside House. This is seen as a natural progression for Mr Bryan but any move is subject to Home Office approval. Mr Bryan has agreed to discuss with the home staff and his key worker any issues that he has relating to his stay. He knows what is expected of him and has agreed to abide by all the policies and procedures of the home before any move is agreed and approved by the Home Office and his multi-disciplinary team."

This report does mention most of the issues and concerns which the Panel considers it was necessary to communicate to the Home Office, but the interpretation of those issues is benign and does not convey the true picture of Peter Bryan's reluctance to accept the conditions imposed by the MHRT, nor does it highlight the more erratic behaviour of the past few weeks.

Once again it also gave the impression that Peter Bryan was seen by RMO5 and Social Worker 5 on a much more regular basis than he actually was.

261. Peter Bryan returned to Riverside House at 21.00 on 21 December and retired to his room at midnight. However once again he kept coming down stairs intermittently, either for food or to smoke. He settled down around 03.00. He then came down at 06.00 and put his clothes into the washing machine. He later told staff he was going out to help his lady friend push start her car.

262. The nightshift notes for 22 December show that Peter Bryan did not sleep much throughout the night and that he said that he was not tired. He had something to eat at 04.00 and went back to his room at 08.00.

263. In the afternoon of 23 December Peter Bryan returned to the hostel at 16.00 with a female visitor who remained in the lounge. They then both left at 16.50, and Peter Bryan left with his self-medication TTOs as he was about to go on Christmas leave for three nights.

264. Peter Bryan returned after his leave at 21.15 on 27 December and told staff that he could not find his room keys and demanded duplicate ones. He was given duplicate keys but he handed them back rudely, saying that he needed the proper keys to open his door.

265. He was asked to exercise some patience because the keys were the right ones and the member of staff used the same keys to open his door. He then said that maybe he had been rushing because he needed to go out and he left at 22.30. He returned at midnight and apologised to the member of staff, saying that he had acted '*in the heat of emotion*'.

266. Once again it was noted that Peter Bryan was up all night and had breakfast at 07.00.

267. At 08.30 on 28 December Peter Bryan came downstairs and told staff that he had dreamed that he was fighting a dog and had woken up kicking the wall and punching it. He said that he had kicked out one of his toenails.

This was the first time that a dream had been noted in the Riverside records for Peter Bryan and it is perhaps significant that the dream was one that involved some element of violence.

Peter Bryan told us that in 1993 before the homicide of NS, when he was on drugs he had had hallucinations of a black dog chasing him.

Despite recent concerns about the possibility of a relapse in his mental state, it does not appear as though any particular significance was attached to the report of this dream, and it does not appear as though any of the other professionals involved in Peter Bryan's care were informed about it.

The Panel is however aware that they have the benefit of hindsight which might make them attribute more importance to the dream than anyone considering it at the time. We have seen no reference to hallucinations about a dog chasing Peter Bryan in any of the clinical records.

Peter Bryan had also described to the Panel how at various times when he was not well or when he was angry, he would get pins and needles and clicking in his ankles.

When we questioned him as to whether he was experiencing such sensations towards the end of 2003, he told us that he was.

In response to us asking whether he was also experiencing any other symptoms at all, he said:

"Agitated. Butterflies. Nervousness."

He told us that he had talked to one of the other residents at Riverside House about these symptoms and that his friend had told him:

"Behave yourself. Just hold it down – you are nearly at the gate. You are nearly at the gate. You can get through the gate. You can make it.' So I listened to him – but it didn't work out for me".

When we asked him if he had mentioned his feelings to anyone else, Peter Bryan said:

"I didn't trust anyone else to be honest."

It is obviously unfortunate that Peter Bryan did not tell any of the professionals about the symptoms he was experiencing at this time as this would have been likely to have reinforced their suspicions that his mental health was relapsing.

It is however important to remember that none of the professionals were told of this highly significant development.

268. That evening Peter Bryan went out at 21.30 and returned at 22.00 and told staff he was going to take his medication. He later watched television until midnight and then went to bed. He came down at 03.00 for a cigarette and asked if he could start doing his laundry. He was told he could start at 05.00 at the earliest which he did. He also started cleaning his room.

269. The following evening Peter Bryan went out with another resident at 21.50. At 00.30 he called the hostel to inform staff that they were both fine and that he would make sure that the other resident was all right. They both returned at 01.20.

270. Once again it was noted that Peter Bryan came down three times during the rest of the night and settled only at 05.00.

271. He was up and about at 08.00 the following morning and appeared cheerful and alert. New wooden slats were fitted to his bed by members of staff.

272. A random urine specimen taken at 09.00 revealed the presence of morphine and a second result was inconclusive an hour and a quarter later. It was noted that he had not been followed to the toilet for the drug test.

This was the second 'positive' drug test within a short period of time, and although the result was for morphine rather than one of the more usual illicit drugs, and the second result was inconclusive, this still required an explanation when put in the context of his changeable behaviour.

273. Peter Bryan was reminded by Deputy Manager 2 of his CPA on 5 January and he said that he thought that he would be ready to move in September 2004 and that he had no issues for discussion at the CPA except about moving on.

274. In the afternoon of 31 December Peter Bryan left for leave at his parents' home. He returned in the afternoon of 2 January 2004.

275. The following evening he went out at 22.20 and telephoned at midnight to say that he was running late and he then returned at 01.00. He had some food and told staff that he did not need to go to bed as he was waiting for another resident who was still out. He had a long chat with the resident until 04.00, then had some more food before going to his room at 04.30. He came down again at 05.30 saying that he could not sleep as he was worried about his forthcoming CPA. He finally went to his room at 06.30 and stayed there until 08.30.

276. When he came downstairs the member of staff on duty asked him how he was and he replied that he was not okay because he could not understand why he was still in Riverside House when he had been told that it was time for him to move on. He started talking about other former residents who had their own flats just after coming out of prison.

277. He also said that perhaps his team was waiting to him to do something so that he could go back to prison. He also mentioned his index offence and said that he was sorry for what he had done but he felt that he was still being punished.

With the benefit of hindsight one can see the start of references by Peter Bryan to Rampton Hospital and to his care team wanting him to re-offend.

Although these references are recorded in the Riverside notes, it is only when one sees them in the context of the other changes in his behaviour that they take on any real significance.

278. That evening Peter Bryan went out again with another resident at 21.30 and telephoned at midnight to say that he would be late. He returned at 01.20 and went straight to his room. At 03.00 he came downstairs to have a cigarette and then came down again at 05.30 to put his laundry in the washing machine. He came down again at 07.30 with more laundry.

279. On 5 January the CPA review took place attended by RMO5, the Forensic CPN, Social Worker 5 and Deputy Manager 1 of Riverside House.

280. The Forensic CPN's note records that the main themes discussed were Peter Bryan working, moving on from Riverside House, illicit drugs and medication.

281. It was noted that over the past three months his mental state had been stable with no areas of concern observed. The feedback from Riverside House was positive and he was attending his groups in the community.

It does not seem as though the Forensic CPN reported the concerns that he had discussed with Deputy Manager 2 to RMO5 nor did either he or Social Worker 5 appear to report the concerns that they had had about the possibility of a relapse.

It is also surprising that the feedback from Riverside House was positive, when only a matter of some three or four weeks beforehand there had been concerns about Peter Bryan pushing the boundaries, having a disrupted sleep pattern and his room being uncharacteristically untidy.

Once again there appears to have been no pooling of information between the professionals involved and an opportunity to discuss what appears to have been an ongoing concern that Peter Bryan might be relapsing was lost.

282. Peter Bryan said that he was working as a cleaner for under 15 hours a week mainly on the night shift. He expressed his wish to move on to semi-supportive accommodation in Glenarm Road as soon as possible. He was told that there should be a vacancy in a couple of months and that Social Worker 5 and RMO5 had written to the Home Office about this.

283. It was reported that again on 30 December 2003 there had been a positive result of amphetamines, however the trace was not very clear on the drug testing strip and RMO5 felt that it might be a false positive. Peter Bryan adamantly denied taking illicit drugs and was concerned what the test was showing. It was agreed to discuss this further with the Drug Counsellor at Addaction in order to come up with a more accurate way of testing such as sending a sample to a laboratory.

There is no record in the Riverside notes of a further positive result of amphetamines on 30 December 2003. The only record of a positive amphetamines test result which the Panel can find in the notes was on 19 November 2003 as highlighted above.

If in fact there had been a further positive amphetamine test result, this should have been taken far more seriously than it was, and RMO5 should not have concluded that this was probably a false-positive result.

284. Peter Bryan was still unhappy about being on medication due to his concerns regarding his enlarged breasts. He said that he had had an appointment with a specialist and was due to go to see him again on 22 February. He said that he was awaiting an opinion.

285. RMO5 again reminded Peter Bryan that his dose of Olanzapine (5 mg) was very low and that he would not consider taking him off medication altogether until he had been living independently for at least a year.

The Panel acknowledges that RMO5's decision that he would not consider taking Peter Bryan off medication altogether until he had been living independently for at least a year was good practice.

286. The plan noted by the Forensic CPN was that they would continue with the current care plan; the Forensic CPN would discuss alternative drug testing with the Drug Counsellor; RMO5 had written to the Home Office regarding semi-supportive accommodation and Social Worker 5 would liaise with Glenarm Road about funding and a placement referral.

287. After the CPA meeting, Peter Bryan returned to Riverside House at 20.15 and had a one-to-one session with his co-key worker about the meeting.

288. He said that he did not know what else to do because he was still being punished and that was the only way that he could look at things. He also wrote a letter of complaint about his care team and asked his co-key worker to ask staff in the morning to find out who was the person in charge over the Forensic CPN and RMO5.

289. He went out for a short time with another resident and then returned and went to bed at midnight and spent the rest of the night in his room.

290. At 08.30 the following morning Peter Bryan spoke to Deputy Manager 2 and asked him to provide him with details of how to report the Forensic CPN and RMO5 to their superiors. He said that he was not satisfied with the outcome of the previous day's CPA meeting - that he was waiting for his passport and there had been a delay in moving out of Riverside House. Peter Bryan had come to the office and Deputy Manager 2 asked him to close the office door, but he said that he wanted everyone to hear.

291. At 11.00 the Forensic CPN returned Deputy Manager 2’s call and was told that Peter Bryan wanted to put in a formal complaint about RMO5, the Forensic CPN and Social Worker 5 because he was very unhappy about the previous day’s meeting, particularly about their responses to his concerns about medication and accommodation.

292. The Forensic CPN said that Peter Bryan could make a complaint to the Community Mental Health Manager at Kempton Road but that if his concerns were about his discharge conditions, he should discuss them with his legal representative and should be reminded of his right to appeal against his conditional discharge.

293. He also said that he felt that Peter Bryan was drawing attention to his mental state and, as he had been on self-medication, he questioned if he had been taking his medication. If he had

not, then staff should continue to observe him for changes in his behaviour and signs of paranoia.

In fact Peter Bryan told the Panel that he did not take his medication when he was on weekend leave, and he had therefore not been taking his medication for at least two or three nights a week for some 12 months, as he had been having regular weekend leave since the previous Christmas.

He also told us that when he was self medicating he would not take his medication all the time, but would take it if he *"felt a bit edgy"*.

The Drug Counsellor also told us that Peter Bryan had told him that he used to spit out his medication when it was given to him by the Riverside staff, although Peter Bryan denied this when we asked him about it.

After the homicide, a bottle containing about 10 white tablets was handed to the police by P4's father. The bottle had apparently been left by Peter Bryan in their flat shortly before the indecent assault incident. He had apparently told P4 that he was thinking of scrubbing the label off and selling them as Ecstasy.

We were later told that the tablets had been analysed and they were Olanzapine. These may well have been some of his weekend TTO tablets which he had accumulated.

On any view, however, the fact that his medication had been halved as from April 2003 to only 5 mg Olanzapine per day, and the fact that for three days a week he was not taking any medication at all, is likely to have had an adverse effect on the stability of Peter Bryan's mental health.

The Panel also considers that more significance should have been attached to the fact that Peter Bryan now wanted to complain officially about all three of the professionals involved in his care and treatment.

This could have been an indication that his paranoia was becoming more pervasive, and the fact that he was prepared to take his complaints to a higher level was also an indication of his perception of his relationship with his care team at that time.

294. That evening Peter Bryan appeared low in mood. He collected his laundry from the washroom and prepared some food which he ate and then informed staff that he had had his medication and was going to bed.

295. He came downstairs at 00.35 and put some laundry in the washing machine and went straight back to his room where he remained for the rest of the night.

296. In the morning of 7 January Peter Bryan informed the member of staff on duty that he was not happy with the CPA and when the member of staff advised him to take it easy and have patience, he responded saying *"I think you're talking a lot of nonsense"*.

297. The Forensic CPN spoke again to Deputy Manager 2 that afternoon and advised him that if Peter Bryan was still not happy staying at Riverside House then he could contact a solicitor through MIND to appeal against the conditions which formed part of his conditional discharge. Peter Bryan later discussed these matters with the Manager of Riverside House.

In fact, Peter Bryan had already been in touch with his solicitor, Solicitor 1, and had set in train such an appeal which was due to be heard on 1 March - just 12 days after the homicide of Brian Cherry - although the date had not yet been notified to anyone.

298. Peter Bryan went out for a couple of hours that evening, returning at 23.35 and went to his room shortly afterwards. He came downstairs at 04.15 and put some washing in the washing machine and then went back to his room. He was down again at 06.30 and checked his laundry and interacted with staff and went back to his room at 6.55.

299. It was noted that that morning he was up and about and appeared cheerful. He played pool with members of staff and did not report any problems.

300. In the early evening the Manager of Riverside House met with him and explained that at present he needed to get confirmation from the Home Office about moving on to other accommodation which was being taken care of by Social Worker 5. She informed him that Glenarm Road had no bed available at present.

301. On 9 January 2004 Social Worker 5 wrote to the Home Office:

"I am writing to request permission for Mr Bryan to be moved from his current address at Riverside House a high support residential home to a more independent low support accommodation. This is because Mr Bryan has made significant progress since his conditional discharged (sic) in Jan 02.

The multi-disciplinary team is of the opinion that Mr Bryan is ready to move on and should be given an opportunity to live more independently to see how he cope (sic) living in a different and more independent environment. There would be staff on site at the new home 112 Glenarm Rd, Hackney, E5 but only between 9 a.m. and 5 p.m. the remainder of the time they would be on-call.

If this new arrangement is agreed, Peter could be moved within the next two weeks. Please let me know of your decision as soon as possible so that arrangements could be made to move Mr Bryan.

Should you require more information about Mr Bryan or the new placement please do not hesitate to contact me."

The concerns that Peter Bryan might be relapsing which had been expressed by Deputy Manager 2, the Forensic CPN and Social Worker 5 himself only a matter of some two or three weeks previously are not mentioned in this letter to the Home Office. They should have been.

The Panel also questions whether it was appropriate to seek Peter Bryan's transfer to low support accommodation when there had been such recent concerns about his behaviour. The comment in the letter that it might be possible to move Peter Bryan to Glenarm Road within the next two weeks is inconsistent with the Manager of Riverside House's remark to Peter Bryan just two days before the letter was written that there was no bed available at that time at Glenarm Road. Once again the various professionals do not appear to have been communicating properly with each other.

302. On receipt of Social Worker 5's letter, Home Office 4 of the Mental Health Unit of the Home Office sought the permission of a senior caseworker, Home Office 6, to move Peter Bryan to less secure accommodation. Home Office 6 responded:

"The move does not seem a particularly ambitious one but I would feel much happier endorsing it if we had more concrete evidence of the "significant progress" made by B. since discharge. I would feel more comfortable if we had had more comprehensive reporting but feel that we at least need (RMO5)'s confirmation that the risk to members of the Asian community remains low and this move will not increase the risks. We should also double check whether there are any concerns about drug taking. B. appears to have made a clean break but it is not clear whether he is still closely monitored in this area. Condition 6 (which required drug testing) appears to have been linked to a particular drug programme and it is not clear whether this is still required. I raise this concern only because B. has been described as pushing boundaries, having underage girls and other "friends" to his room and complaining when this is objected to. We should clarify whether these friends are known drug users and whether it is likely they will have more access to B. at the new accommodation. Please write to (RMO5) and let me see the draft."

This was an appropriately cautious response from Home Office 6 which does show at least that some of the concerns about the kind of people with whom Peter Bryan associated had been highlighted to the Home Office and noted by them. It also illustrates how the Home Office's decision making was hindered by the lack of regular reporting to it by Peter Bryan's supervisors.

303. Peter Bryan returned to the hostel at 09.00 on 9 January and spent some time chatting to staff before going up to his room where he spent the morning. He remained at the hostel until he left at 18.00 with his self-medication tablets to go on leave for the weekend.

304. Peter Bryan returned from weekend leave at 11.00 on 12 January and the Manager of Riverside House gave him a new supply of medication and also informed him that a new carpet would be fitted in his room that day. He said that he felt very tired.

305. That day he received information in the post about a painting and decorating course at the John Laing Training Centre which was due to start on 19 January.

306. Following the new carpet being fitted in his room, members of staff offered four times to help Peter Bryan to clean and tidy his room. On the last occasion he declined saying that he had had a busy day and was tired. He also remarked that to keep asking him was bordering on intimidation.

This was a somewhat paranoid response to an offer to help tidy his room and should perhaps have been given more significance.

307. He spent the afternoon sorting out his laundry and cooking an evening meal and he then played pool with another resident. It was noted that he appeared cheerful.

308. At 19.45 he advised staff that he was popping out for 4 hours and would return about 23.00 which he did. It was noted that he appeared to be in an unhappy mood and told the member of staff on duty that when he had been out that evening, the police had stopped and searched him. He said that they were harassing him as if he were a drug dealer. He came back with the stop and search paper and angrily threw it on the floor. The on call Manager was informed.

Again Peter Bryan's response to having been stopped by the police had a somewhat paranoid element to it, and was the second such response that day.

Documents were provided to us by the Police which state that on 13 January 2004 Peter Bryan was stopped by a police officer at 20.50 in the stairwell of a block of flats on the Woodberry Down Estate. They had been patrolling the block in response to numerous complaints about illegal drug use in the block.

[We assume that this incident must be the same as the one described by Peter Bryan on 12 January. If it is not it is even more concerning that there were two occasions in 24 hours when the police had cause to stop and question him.]

Peter Bryan was apparently the only person in the block at the time and was sitting on the stairs drinking a bottle of super malt. He claimed to know nothing about people using the flat for drugs and said that he had only "*come out of the cold for a quiet drink*".

He was searched for drugs and nothing was found. It was noted that he was compliant throughout the search and left the block of flats afterwards.

It was also noted that Peter Bryan indicated that if he had done anything wrong he would have jumped out of the window. He was on the fifth floor at the time.

Again the benefit of hindsight causes the Panel to be concerned that Peter Bryan was drinking on his own on the fifth floor of an apparently empty block of flats which was thought by the police to have been used for drug dealing.

However we acknowledge that those caring for Peter Bryan were probably unaware of the full facts of him being questioned by the Police.

309. Peter Bryan went to bed at 11.35 and came down at 02.00 to check his clothes. It was noted that he was observed nodding his head in the kitchen.

310. He took some chocolate and a spoon and went back to his room. At 06.40 he went back down to check his clothes in the laundry room and then went back upstairs.

311. On 13 January he met with the Care Standards Inspector.

312. On 14 January Peter Bryan said that his clothing had been damaged by paint and that a sum of money had been stolen from his room when it was being painted.

313. The Manager of Riverside House explained to Peter Bryan that at the previous week's residents' meeting there had been a discussion about him taking responsibility in giving permission to allow the painting of his room to be done while he was on weekend leave. He said that he had brought back two items of clothing that had been damaged by paint and the Manager said that she would not deal with that issue that day. Apparently Peter Bryan had discussed the same matter with the staff team on duty and also with the Care Standards Inspector when she had visited him the previous day.

314. That afternoon the Manager received a telephone call from the Mental Health Office at the John Howard Centre to say that Peter Bryan had requested a form to complete about his Section 37/41 to be sent to the Home Office. The Manager gave the administrator the telephone number of Social Worker 5 as Peter Bryan's Social Supervisor.

This was the first indication recorded in the notes that Peter Bryan was intending to appeal against his conditional discharge.

315. Deputy Manager 2 also offered to tighten up Peter Bryan's bed because he had complained that part of the fittings had come loose. Peter Bryan declined the offer and asked if his bed could be dismantled as he said that he preferred to put the mattress on the floor and sleep on just the mattress. Deputy Manager 2 discussed this with the Manager and then explained to Peter Bryan that his bed could not be dismantled as it was a standard of care to provide him with a proper bed. He said that he had expected this response and made no further comment about it.

316. On 14 January, Social Worker 5 was sent a letter by the Mental Health Assistant at the John Howard Centre, informing him that Peter Bryan's MHRT was to be heard on 1 March 2004.

317. On 15 January Day Opportunities 2 e-mailed Social Worker 5 as he had not heard from him. He informed him that Peter Bryan had told him that he was starting on a Painting and Decorating training scheme from 19 January and that he might not be able to attend Day Opportunities from the following week. Day Opportunities 2 wanted to know if this was acceptable in terms of his Section 37/41. He ended the e-mail:

'Although I understand Peter's need to maintain his independence, I am concerned that Peter has been making arrangements around employment and training without consultation, leading him away from MH services with professionals in terms of his legal status'.

Day Opportunities 2 very properly and very perceptively highlighted in his letter the fact that Peter Bryan was organising his life - without prior permission from the professionals or the knowledge of the Home Office - in such a way that it was leading him away from mental health services, probably in contravention of the conditions of his Section 37/41 status.

318. Social Worker 5's e-mailed response was:

"I returned your call but you were out got your message there is nothing wrong with Peter doing the course however I would need to speak to him to see if there could be a compromise but I am off until next Tuesday will contact you on my return."

Once again Social Worker 5's attitude to Peter Bryan was fairly 'laid back' and he did not appear to share the concerns that Day Opportunities 2 had expressed in his letter.

319. On 15 January Peter Bryan attended the residents' meeting at Riverside House and raised his concerns about his clothes having been damaged by paint while the painters were in his room and also that items were missing from his room. The Manager explained that these were issues that had already been dealt with outside of the meeting.

320. He then raised the issue of his weekly grocery shopping and said that his shopping was checked by the Manager and he felt that he had been singled out. The Manager explained that she had spoken to him in the past that the money given to him was to buy food items of his choice but instead he was buying soft drinks, crisps and energy drinks and that she had to make sure that he had a staple diet.

321. Peter Bryan then asked to leave the meeting and then came back into the sitting room where the meeting was being held, showing a tablet which he said that he had found on the staircase. He refused to hand it back, saying that he was going to take it to the Care Standards Commission.

322. Peter Bryan left the hostel at around 19.45 and one of the members of staff reported that he had pushed the door leading to the staircase towards her. He returned to Riverside House at 20.45 and told the Manager that he had brought the tablet which he then handed over to her. He then said he still needed to go out to meet up with another resident and left at 21.00. He returned at 01.20 and went to bed shortly afterwards, where he remained for the rest of the night.

The Riverside note describes several worrying behavioural features which, when put together with all the other examples of difficult behaviour which had been recorded over the previous few weeks, should have caused concern.

323. In the afternoon of 16 January Peter Bryan had a one-to-one session with his Riverside co-key worker and he told her that he had had a quarrel with the Manager because he had asked for compensation for the damage to his personal property and the money that had gone missing from his room. He said that he just thought that he should inform her of what was going on.

324. He collected his TTO medication and left the hostel for his weekend leave.

325. He returned early in the morning of 19 January and left the house at 07.30 for his 08.30 appointment at the John Laing Training Centre.

326. He returned to the hostel that afternoon and was reminded by Deputy Manager 2 to bring his dosage box to the office later to restock his weekly medication and to sign his self medication chart. They then played a game of pool together and Peter Bryan said that he was having a *"shitty day"*. He then said that he was working that night.

327. At 21.15 he went to the hostel office shouting at staff and saying that he had asked them to call him at 20.00 and that his medication should be ready for him. The member of staff on duty explained to him that he was supposed to be with staff when his medication box was being filled and they also reminded him that the Manager had spoken to him about this the previous week. Peter Bryan then said that the Riverside staff were not organised and that he did not need to be taught how to put the medication in the box. He then said he would report the hostel to the Home Office and that the staff were making him late for work. He then had his medication and left, but before he left he could be heard shouting in the lobby as he was going out.

328. He returned to Riverside house at 07.05 and went to the office asking what last night was about and why a member of staff had to be present while his medication was being put into his dosage box. The member of staff explained to him what she had explained the previous night. He came back to say that he did not understand and she therefore took the medication policy and read it to him and advised him to speak with the Manager when she came in. He then said that he understood and he did not need to see her. He was then overheard to say that this was a lot of nonsense.

329. On 20 January 2004 Peter Bryan wrote a letter to the Manager of the CMHT at Kempton Road:

"(CMHT Manager),

I have been trying to get out of Riverside Hostal now for 21 month at the taxpayer expense of 9.36 (sic) *pounds a week. However my team based at 1 Kempton Road on a very go slow track. I am not happy about the following:*

1. (RMO5)

(1) Regarding medication I think this doctor is over medicating me.

(2) Will not reduce or take me off medication

(3) Every time I ask him to sign my passport he say he has done so and by the time it gets to the passport office, it is out of time to process my passport. He also keep talking about the seriousness of my offence as if I was never part of the community. And I can not stop thinking he is personalizing the crime, as for apart from reducing the medication he has done nothing but shout me down. 3 meeting before one can move on and still 20/01/04 I am still at Riverside.

(The Forensic CPN) - as followers (sic) - it has taken him 19 ie nineteen month to get me on self-medication and apart from about 6 week or 10 week going over relapse prevention I cannot see how he is helping me. All the time his approach is go slow because to the seriousness of the offence. I have to keep on telling him I am doing my best to respond to rehabilitation.

(Social Worker 5) - to me he just keep on agreeing with (the Forensic CPN), (RMO5) (incorrect spelling) what ever they decide he just runs along with it.

Please could you find out why it take like twenty month to sort out a passport. As I phoned them 20/01/04 and they said it has been cancelled once again.

Hope to here from you soon Peter Bryan"

It is perhaps significant Peter Bryan does not appear to know the correct name of his RMO RMO5. It could just be that his dyslexia affected the way that he spelt the RMO's name, but even when he was interviewed by the Panel, he kept confusing the various names of the psychiatrists who had been responsible for his care.

This letter to the manager of the CMHT also appears to show that Peter Bryan had lost faith and patience with all three key members of his community team. As always he was focused on his desire for less supervised accommodation, to come off medication and to get his passport.

Following swiftly after his application to appeal against his conditional discharge, this letter was further evidence of Peter Bryan's mounting frustration about his future which was obviously causing him some anxiety and stress.

330. On 21 January Peter Bryan came downstairs at 7.40 and said that he was going to his training course.

331. Later that day the Manager of Riverside House telephoned the Forensic CPN to express her concerns about Peter Bryan's recent behaviour and told the CPN that she felt that he could be relapsing. She said that over the last couple of weeks she had noticed significant changes. She said that he had become more hostile to and suspicious of staff at the hostel and had expressed more grievances about things that had been done to him.

332. She gave an example of the fact that Riverside House had had decorators in recently and Peter Bryan made a complaint that they had spilt paint on his jumper and damaged his stereo for which he was demanding compensation. She said that the jumper had a lot of paint on it as if somebody had deliberately poured paint directly over it and that this possibly suggested that Peter Bryan could have done this himself.

333. None of the other residents had reported any damage to their property and there was also no obvious damage to his stereo.

334. Peter Bryan had also accused somebody of stealing £350 from his room and was demanding compensation for this. Again there was little evidence to suggest that this had actually happened.

335. She also reported that his room was messy and disorganised with clothes and other items thrown across the floor. His medication box was also thrown on the floor. She said that his room was always tidy and clean and that this marked a contrast to how it was normally.

336. She also reported that he had come back drunk on one of the nights of the previous week which was also unusual for him.

337. The Forensic CPN said that he would inform Social Worker 5 of the situation and would arrange for one of them to see Peter Bryan as soon as possible. In the meantime he advised the

Manager to put staff back on dispensing his medication and to cancel his self-medication programme until after he could be reviewed.

338. The Forensic CPN then called Social Worker 5 and updated him.

Both the Manager's reporting of her concerns about Peter Bryan's changed behaviour and the Forensic CPN's response are commendable.

It was however another six days before Peter Bryan was seen by Social Worker 5. The Panel consider that efforts should have been made to have seen him within 48 hours at the most. Once again the Riverside staff appear to have been sensitive to subtle changes in Peter Bryan's behaviour and immediately and appropriately passed on those concerns.

However the Panel note that it was the Forensic CPN whom the Manager usually contacted about any concerns rather than Social Worker 5 who was of course Peter Bryan's Social Supervisor and Care Co-coordinator. It could have been because the Forensic CPN was more responsive and accessible than Social Worker 5. He was also known to her from other cases.

339. Peter Bryan came back at 16.15 and went out again half an hour later with another resident. At 18.00 a female visitor called to see him and left immediately.

340. Peter Bryan rang the hostel at 21.20 and informed staff that he would be returning late. When asked how late he said around midnight. He returned at midnight and informed staff that he was drunk.

341. On 22 January 2004 Home Office 4 of the Home Office wrote to RMO5:

"I am writing with regard to the recent letter I have received from (Social Worker 5) in which he has requested permission from Mr Bryan to move to independent accommodation.

Before this can be considered, I would be grateful for your comments on whether Mr Bryan's risk to the Asian community remains low and that this move will not increase the risks.

I would also be grateful if you could confirm whether there are any concerns about Mr Bryan's drug taking and whether he is still closely monitored in relation to this. Condition six of his conditional discharge relates to compliance with a substance abuse programme but it is not clear whether this is still required. Mr Bryan has been described as previously pushing boundaries, by wanting his friends to visit at any time regardless of home policy, and it would be helpful if you could confirm whether Mr Bryan's friends are known drug users and whether it is likely that they will have more access to him at the new accommodation."

At this stage it does not seem to have been considered whether a move to accommodation only staffed from 9-5 was still appropriate given that Peter Bryan had been taken off self-medication. He usually took his anti-psychotic medication at night-time, and there would therefore be no means of checking whether he was still compliant. They could have considered whether to change Peter Bryan's time for taking the medication but the Panel considers that no thought appears to have been given to this potential problem.

342. In the morning of 22 January Peter Bryan left the house at 07.10 for IT training. Thinking that he was still in the hostel, members of staff checked his room at 09.00 to see if he was in. There was no response. They went in and found that his room was in a state of disarray with evidence that he was not using his bed to sleep on as his mattress was on the floor.

343. Peter Bryan returned to the hostel and attended the residents' meeting and was asked to meet with the Manager after the meeting. She said that she would like to meet in his room. At first he did not agree but he then said that it was all right. The Manager recorded in the notes that on entering his room he made a comment that his room smelt and she described his room as in a state of disarray. His dosage box was lying on the floor with all his other personal items.

344. The Manager said that the state of his room was a health and safety issue and that as the Manager of the hostel she felt that he was not responsible enough to be on the self medication programme. She said that she was going to take his medication to the medication cupboard in the office. He replied "*Do what you have to do*".

345. The Manager recorded that during their conversation she observed Peter Bryan to be making reference to Rampton Hospital, saying that even his clothing reminded him of the time he spent at Rampton. She had not heard him say anything like that before.

346. He also said that he was unhappy at Riverside House and fed up with not being discharged as he felt that he had met all that was asked of him and nobody in his care team was doing anything.

347. Peter Bryan showed the Manager his diary which had a spot of paint on it and she said that he should have put his belongings in the cupboards. He then went on to talk about compensation for other personal items - clothing and a music centre which had been damaged and also a sum of money which was missing.

348. The Manager explained that she was not going to take any action on this matter and Peter Bryan said that he was not happy with either her or Deputy Manager 1 asking about his welfare. The Manager explained to him that she had concerns and would be informing his Social Supervisor the following day and would request an urgent meeting.

349. Peter Bryan then said that he would sort out his room if it made the Manager happy and maybe then he could have his medication back. The Manager asked him why he did not take up the offer made by the Riverside staff to assist with sorting out his room. He was also asked if his behaviour meant that he wanted to go back into hospital.

The Manager told the Panel that it was the state of Peter Bryan's room which most concerned her, because before he had always been meticulous about how he kept everything. She said:

"It was because it was a big, big change. It was a big change because of becoming a 'schizophrenic bedroom'."

Her husband, Riverside 4, explained this phrase to us:

"When we were working in the hospitals, often you would see a patient who would gradually break down over many months - when they were on a drug-free trial for example - and often the first indication you would have - their hygiene would deteriorate a little bit - but the first real deterioration you would have is their bedroom. It would be chaotic and we would call it 'a schizophrenic bedroom'."

350. Shortly after the Manager left his room, Peter Bryan came downstairs and put his clothes in the washing machine even though residents had been asked not to use the washing machine after 20.00 so as to avoid any disturbance to other residents who were sleeping downstairs.

351. He apparently continued with his laundry throughout the night. He went out briefly at 07.00 and then returned and continued doing his laundry. He left the hostel at 07.50 saying that he would be back around 16.00.

352. While he was out the Forensic CPN telephoned and asked him to contact him on his return.

353. Peter Bryan returned to the hostel around 13.30 and after a short period of time he went out again. On his return he sorted out his laundry.

354. The Manager had called the Forensic CPN that morning and he called her back in the afternoon.

355. She aired her concerns about Peter Bryan's behaviour and also explained that she had handed back responsibility for his medication to the Riverside staff as at present he was not taking enough responsibility to continue being on a self-medication programme.

356. The Forensic CPN informed the Manager that he had spoken to Social Worker 5 and updated him on what had been happening. Social Worker 5 had an appointment to see Peter Bryan on 27 January and the Forensic CPN was also going to visit him at Riverside House on 2 February.

357. At 19.00 Peter Bryan left the hostel with his TTO medication for his weekend leave. He informed the Manager that he had cleared up his room.

The Panel are concerned that Peter Bryan was allowed to go on weekend leave without having been seen by either Social Worker 5 or the Forensic CPN following the Manager's report of her concerns that he might be relapsing.

They are also critical of the fact that RMO5 does not appear to have been informed of the Manager's concerns.

358. Peter Bryan returned at 20.50 on 25 January and handed over his medication box. He went to bed at midnight and was up three times during the night to smoke a cigarette.

359. Peter Bryan left the hostel at 07.55 for the John Laing Training Centre and returned at 17.00. He asked the Manager of Riverside House if he could go on leave from Wednesday 28 January and was told to speak to Social Worker 5 about this. He also advised staff that he was would be working that night.

360. He was reminded by Deputy Manager 2 of his appointment to see Social Worker 5 and the Forensic CPN the following morning and was encouraged to keep this appointment if possible. He responded that he could not keep his appointment. He was therefore advised to contact Social Worker 5 and the Forensic CPN before cancelling and was asked to let Deputy Manager 2 know the outcome of this but said he would not do this to help them out.

361. Later Deputy Manager 2 asked him how his room was and he said that it was in a mess and the Deputy Manager offered to help him tidy it up, but he declined.

362. He left the hostel at 20.45 for work, taking his medication with him. He returned at 10.15 the following morning.

363. On 26 January a letter was sent to Social Worker 5 by the Mental Health Act Assistant at the John Howard Centre informing him that Peter Bryan had appealed against detention and that the Tribunal had asked that Social Worker 5 should prepare a Social Circumstance Report which should be submitted at least three weeks prior to the date of the hearing.

Social Worker 5's report should therefore have been submitted to the Tribunal no later than 7 February 2004. In fact no report was ever submitted.

When the Panel asked Social Worker 5 why he had not prepared any report for the MHRT, he told us that Peter Bryan had informed him that he had withdrawn his application, although on questioning he said that he had never checked to find out if this was the truth. RMO5 told us that he was aware of the pending hearing and was not under the impression that it had been withdrawn.

In fact it had not been withdrawn. This was confirmed to us by Solicitor 1.

364. The letter stated that the hearing had been arranged for 1 March 2004 at the John Howard Centre and that Social Worker 5 was expected to attend.

This was notification that Peter Bryan was seeking an absolute discharge from the MHRT. We were told by Solicitor 1 that he had seen Peter Bryan on 21 November 2003 when they had filled in an application for legal aid for the hearing.

Brian Cherry was killed just 12 days before the MHRT was due to hear Peter Bryan's application for an absolute discharge.

However Solicitor 1 told us that he would have been *"astounded"* if an absolute discharge had been granted.

365. At 09.30 on 27 January the Forensic CPN telephoned Riverside House and Deputy Manager 2 discussed Peter Bryan's recent behaviour with him. The CPN said that Deputy Manager 2 should update Social Worker 5 and when the Manager telephoned Social Worker 5 he said that he had been telephoned by Peter Bryan at 10.15 who had said that he felt very tired. Social Worker 5 had told him that he must see him at the Homerton Hospital at 13.00 that day.

366. Deputy Manager 2 told Social Worker 5 about the state of disarray in Peter Bryan's room and his refusal of Deputy Manager 2's offer to help him tidy it; his drunkenness the previous week; the fact that he was not taking good care of his self-medication which therefore had now been taken over by staff; his recent conversations with members of staff which at times had been confrontational and non-cooperative; also his request to have leave from Wednesday of that week.

367. Social Worker 5 said that he had the choice of recalling Peter Bryan to hospital if it were appropriate.

This statement shows that Social Worker 5 was aware of the option of recalling Peter Bryan to hospital under the provisions of Section 37/41 if it were appropriate to do so.

368. Social Worker 5's note of his meeting with Peter Bryan at Homerton Hospital on 27 January states:

"We discussed some of the issues that (Deputy Manager 2) informed me about. The impression that Peter gave is that everything was okay. However I informed Peter that if he continued to break or question the rules that I would consider recalling him to hospital. He stated that

anything is better than Riverside House. I reminded him that I could and would not move him until I get permission from Home Office. Peter was still not happy.

Please see further note taken at meeting of Peter's complaints:

1. *Peter is unhappy and dissatisfied about being at Riverside*

2. *Damage caused by decorators include hi-fi, picture artwork, clothes, diary. Money £375 missing from room.*

Karaoke machine Mic holders damaged.

Handed in £600 at one time but was told they were not insured, that he should take to bank. Decided not to put £375 in as they were not insured

Peter complained that (the Manager of Riverside House) has searched his shopping.

3. *Peter denied being drunk last Wednesday*

4. *Reason sleep on mattress is because slats on cot keep getting broken. These have been repaired several times. So feel more comfortable just sleeping on a mattress.*

5. *Reason for room in a state is because he is rebelling against the home for not paying him compensation*

6. *Peter state that he likes to keep his meds in sight so he can remember to take it. He denied not taking his meds.*

7. *He is not going to Day Opps, because he is doing course.*

8. *Peter denied being angry and agitated that R asked him for his payslips*

9. *Peter earns £69.00 per week. Need to contact benefit office."*

It is clear from this note that Peter Bryan gave Social Worker 5 plausible explanations for all of the concerns which had been expressed about his behaviour.

Social Worker 5 appears to have accepted these explanations to some extent as he did not record any particular concerns at this stage about Peter Bryan's mental state, although he did express some to the Forensic CPN the following day.

369. At around 18.15 Peter Bryan met with the Manager and briefly talked to her about his meeting with Social Worker 5. He said that he had discussed the conditions of his Section 37/41, his medication and the expectations and rules of Riverside House.

370. Peter Bryan informed her that he had received a telephone call from the agency and that he had agreed to work that night. The Manager explained to him that she had observed that he had had very little rest that day after working the night before and discussed the health and safety aspect of working all night and the risk factor of him being very tired.

371. They then had a general discussion about his employment which at that time was two nights a week, returning to the hostel around 07.00 - 07.30 in the morning and she emphasised that it should not affect his daily appointments.

372. That morning he had returned around 10.30 saying that he had got caught up, and the Manager advised him to return in time the following morning. She noted that he seemed to be slow in getting around and was dragging his left leg.

373. Peter Bryan returned to the hostel at 07.20 the following morning and was reminded of his appointment in the diary.

374. It was observed by staff that his eyeballs were reddish and he said that he had been taking cannabis. He repeated this three times and asked the member of staff what they thought.

The fact that it appears as though no one did a drug test when Peter Bryan said that he had been taking cannabis shows that they did not take him seriously. It should have prompted some response. If it were true that he had been taking cannabis, he would have been in breach of one of the specific conditions of this conditional discharge.

Again it is speculation on the part of the Panel, but it is possible that Peter Bryan's behaviour was an attempt to challenge the professionals to investigate matters further or that he was becoming more disinhibited about hiding behaviour which had in fact been going on for some time.

375. At 14.00 on 28 January Deputy Manager 2 telephoned Social Worker 5 to update him on Peter Bryan's behaviour the previous night and that morning. He requested an urgent meeting for 2 or 3 February.

376. Social Worker 5 said that he had asked Peter Bryan not to work more than two nights a week and not during the nights before any daytime appointments. He said that he would try to attend the meeting with the Forensic CPN at Riverside House on 2 February at 10.00.

377. The Forensic CPN discussed with Social Worker 5 his meeting with Peter Bryan on 27 January. The social worker said that he had some concerns about Peter Bryan's mental state as he continued to express paranoid ideas about items of his being damaged and money being stolen from his room.

As noted above, Social Worker 5 did not record any such concerns about Peter Bryan's mental state in his notes. He should have done, as anyone who might have had to take over in his absence would need to know of any such concern.

378. They agreed to see him jointly after the Forensic CPN had seen him on 2 February at Riverside House. The Forensic CPN said that he would also arrange for RMO5 to assess Peter Bryan's mental state.

This was good practice to arrange a joint meeting and to ask RMO5 to assess Peter Bryan's mental state.

379. When Peter Bryan returned to the hostel later that afternoon he appeared to be in a cheerful and friendly mood and played pool with members of staff. After taking his medication at 22.00 he went to his room where he remained for the rest of the night.

380. On 29 January one of the members of staff made a note of a one-to-one session they had had with Peter Bryan on 19 January when Peter Bryan stated that his care team both at Riverside

House and in the community did not want him to move on. He mentioned his index offence and said that he could see why some people re-offend because the system wanted them to do so.

This was another reference by Peter Bryan to his forensic history and re-offending which, with the benefit of hindsight, has potential significance.

381. He was advised not to think about the past but to work towards the future. He said that he had done everything that was expected of him and would do whatever they asked because that was what his care team wanted.

382. Also on 29 January Deputy Manager 1 noted that, since he had met with the Forensic CPN and Social Worker 5 earlier in the week, Peter Bryan had been avoiding him and when he had asked him that morning why he was doing so, he had said that he did not trust the Deputy Manager, did not want to talk to him at all and that he had *"stabbed him in the back",* but he would not elaborate.

383. On 29 January the Forensic CPN telephoned RMO5 to inform him of Peter Bryan's recent behaviour and RMO5 agreed to see him at Kempton Road on 2 February. He also advised that Riverside House should increase his medication from 5 mg Olanzapine to 10 mg.

384. The CPN then telephoned Deputy Manager 1 at Riverside House and asked him to bring Peter Bryan to Kempton Road on 2 February and also to increase his medication to 10 mg.

385. Deputy Manager 1 told the Forensic CPN that Peter Bryan appeared to have some kind of grievance against him but he would not say what it was. He was ignoring him and refusing to speak to him. Deputy Manager 1 said that he was aware that if Peter Bryan was becoming paranoid towards him then that this would increase the risk of Peter Bryan becoming violent towards him.

386. That evening the hostel staff were told by Deputy Manager 2 of what measures they should take should Peter Bryan's mental state give concern. They were told to give him space if he became provocative or excited, not to get drawn into an argument or conflict with him but to alert the Manager and on duty social worker. He could also be referred to the emergency clinic during normal hours.

387. If he made any threats or suggestions of violence, they should alert the emergency services. Otherwise they should continue to involve him by reference to his care plans until he was seen by his clinical team on 2 February.

Warning staff in such a way was an indication of the seriousness of the concerns that the Riverside management had about Peter Bryan's behaviour at the time. However Deputy Manager 2 told us that Peter Bryan was not the only patient whose behaviour had prompted him to give such advice.

388. That night Peter Bryan returned at midnight, took his medication and had some take-away food before going to bed at 00.30. He came down at 06.00, prepared himself breakfast and left the hostel at 07.45 for his daily activities.

389. He returned to the hostel at 16.30, collected his TTO medication and left at 18.30 for his weekend leave at his parents' home.

390. The emergency meeting took place on 2 February 2004 attended by RMO5, Social Worker 5, the Manager of Riverside House and Peter Bryan. The Forensic CPN was unable to attend because he was unwell.

It is unfortunate that the Forensic CPN was not able to attend. He was the one who had arranged the meeting as a result of the concerns which had been expressed to him by the Riverside management.

As it was an important meeting we will record all of the available notes which describe what took place.

391. Social Worker 5's note is as follows:

"Room -- Peter stated room is always messy -- but extra messy.

Medication – relapsing

Peter stated that he doesn't like staying at Riverside Hse

Concerns remain about his behaviour and how he perceives things to be

We have to be satisfied that he is well.

Confrontational

Peter stated that he fell out with (Deputy Manager 1)

Sleep deprivation -- reduce confrontation

Peter will have to make an effort.

I advised Peter that he would have to start complying and to keep his room cleaned and to comply with the home. He said that he would do his best but he is not happy. Peter doesn't think he is relapsing. I told him that there are signs and I am becoming concerned and that if it continues I would have to recall him to hospital."

Social Worker 5's note appears to reflect some concern that Peter Bryan might be relapsing. He clearly notes that any continuation of concerning behaviour would mean a recall to hospital.

392. The Manager of Riverside House wrote:

"Peter attended his emergency meeting this a.m. with his care team. Issues discussed were his behaviour within the home.

Medication discussed no change.

Moving on from R S H. it was explained to Peter that if he fails to comply with the home rules it would be necessary to recall him to hospital while awaiting a placement in another community home and this would set him back rather than going forward to moving on. Home Office in relation to his community placement also the condition of his discharge they have to be informed of any changes and agree to the action. If Peter is recalled to hospital it may take four to five months or longer to find suitable accommodation.

Passport discussed it appears that his social worker may have failed to give it to his consultant to sign. (Social Worker 5) to act on this issue straight away.

Drugs. The team felt that Peter was not taking any street drugs. Results showed negative from the screening done by an outside agency.

Peter expressed throughout the meeting that he was not happy living at RSH.

Action plan for Peter to avoid having any conflict and adhere to the rules of the home.

Agency work. Only to work on Monday night and Friday night. Any change in his programme he should inform his social worker and social supervisor.

A meeting to be followed up in 4 - 6 weeks time."

The Manager of Riverside House told us the following about the emergency CPA meeting:

"When I arrived at the Centre, (Social Worker 5) and Mr Bryan had not arrived. I was in the room alone with (RMO5) and I discussed with him my concerns and the reasons for asking for the emergency CPA meeting.

(Social Worker 5) and Mr Bryan then entered the room and the meeting commenced. (Normally the team would meet first before seeing the patient). Mr Bryan immediately began discussing with (Social Worker 5) the progress or otherwise of his passport application. (Social Worker 5) informed Mr Bryan that he had just discovered his form in his pile of papers on his desk, which Mr Bryan had previously been led to believe had been applied for several months previously. (Social Worker 5) apologised to Mr Bryan mislaying the form and said he would progress it.

I recall Mr Bryan had a broad smile on his face at this turn of events and to me appeared happy as if he had 'had one up' on the team.

(RMO5) and (Social Worker 5) then discussed with Mr Bryan his behaviour in the home and advised him to behave and to respect the rules, and they told him that he could not move on until the Home Office gave permission.

The meeting then came to an end. I was in the centre for 20 minutes in total at most. To my recollection, mental state, risk factors etc. were not discussed.

In my meeting with (RMO5) before the CPA meeting I raised the possibility of increasing or reviewing Mr Bryan's medication. My recollections are hazy now, but I do recall coming away feeling deflated, and thinking 'What a waste of time'.

My agenda for asking for the meeting was the hope that he would have been admitted to hospital or at the minimum his medication would be reviewed. On reflection I feel I should have insisted that Mr Bryan's mental state and changing behaviours should have been addressed, but the issue of the passport seemed to change the whole mood of the meeting. I believe I was not asked to speak during the meeting and made no verbal contribution to the meeting."

If this description of the meeting is correct, it causes the Panel great concern. This was an emergency meeting, convened because of serious concerns about Peter Bryan's mental state and/or behaviour, and at the very least the Manager of Riverside House should have been allowed to express the concerns of Riverside House and to discuss them with the other professionals.

If the meeting only lasted 20 minutes, the Panel considers that this was too short a time in which to ascertain the likely causes of Peter Bryan's recent behaviour, and to assess whether or not this behaviour heralded a relapse of his mental health.

When we recounted the Manager's description of the meeting to RMO5 he told us that he recalled it as being a fairly long meeting. He said:

"I don't think that any meeting with Mr Bryan was short or brief. I have always had a long meeting. I always felt it was important to clarify each and every complaint, because his nature was such that, unless you clarified everything, he was so paranoid that he always complained. So I felt it was important that it was clarified with him with everybody present to make sure it wasn't due to any psychotic symptoms."

393. Following the meeting RMO5 wrote to Peter Bryan's GP on 4 February:

"I reviewed Peter urgently on the 2nd of February 2004. This review was arranged at the request of (the Forensic CPN), who was himself unfortunately unable to attend. (The Manager of Riverside House) and (Social Worker 5), his care coordinator attended the meeting along with Peter.

The background to this meeting was that there was an increasing concern that there have been certain changes in Peter's behaviour. It was felt that his room was messier than usual and also he had been complaining that his clothes and a music system was damaged by paint during a spate of redecorating which went on at Riverside House. This was in contrast to the experiences of most of the residents who did not feel that anything that had happened (sic). In addition Peter also complained that a certain sum of money had disappeared from his room. In addition Peter's tablets were found on the floor of his room next to the mattress and although there was no clear evidence to suggest that Peter had actually stopped taking his medication, the managers felt it was appropriate that Peter stops self-medicating. In addition the staff clearly experienced that Peter was pushing the boundaries with them and at times taunting them about having taken cannabis. In addition concerns were also raised that he went out at nights to work as a cleaner thus disrupting his biological cycle.

During the review all the factors were clarified. It is certain that Mr Bryan has not used any drugs although it would be beneficial to continue with the random testing to be arranged by the specialist drug unit, as the hostel randomised testing process is not working properly.

The Panel does not know how RMO5 could be <u>certain</u> that Peter Bryan had not used any drugs. There had been possibly two recent positive drug tests for amphetamines and one for morphine and Peter Bryan had been saying that he had taken cannabis.

Secondly a lot of the problems appear to be related to Mr Bryan's continue frustration at living with the hostel (sic). This have been recorded from before as Mr Bryan has always felt that he would like to move on to an independent accommodation as soon as possible. It is very difficult to convey to Mr Bryan that there is due process involved which involves decisions making directed by the Home Office (sic). Mr Bryan appears to be aggrieved that residents who have come to Riverside House after him have been sent to the Community much before him. He feels that he has spent two years in the Residential home and thinks that this is an extension of his prison sentence. He also feels that the Managers of the Riverside House are

particularly harsh towards him but is unable to comprehend that he has to abide by rules and regulations of the hostel.

Again, the serious concerns expressed by the Riverside staff were attributed by RMO5 to Peter Bryan's frustration at living at Riverside House and Peter Bryan's explanations for his behaviour appear to have been accepted by the community team.

With regard to his employment he said that he cannot work during the day time as this jobs are already taken (sic) so his only option is to work at night. So far he has not agreed to working only on weekends as suggested by the hostel staff. He feels that working is important to him and in his own way it is an act of redemption to his offence.

There is no obvious evidence of any psychotic symptoms in terms of delusions or hallucinations. However the very fact that there have been changes in behaviour noticed as mentioned earlier could indicate that these are early symptoms of his relapse. As no firm conclusions could be drawn at the point when the review took place it's a state that needs to be monitored closely. What was concluded at the time of the review was that Mr Bryan put in an effort to comply with the rules and regulations of the hostel and work with the staff at making up to the breakdown in the relationship. He will be reviewed in three weeks time at which point if there is a further deterioration in his behaviour and mental state this would result in recall to the hospital. If the breakdown in the relationship with the staff was irrevocable that this would result in Mr Bryan having to be found another residential placement and in this event as it takes time he would have to be recalled to hospital when a placement is being found."

In this letter, despite attributing Peter Bryan's recent behaviour to his frustration at remaining at Riverside House, RMO5 very properly recognised that the changes in Peter Bryan's behaviour could indicate early symptoms of relapse which needed to be closely monitored.

He also recognised that any further deterioration in Peter Bryan's behaviour and mental state could result in recall to hospital.

The Panel consider that it was good practice for RMO5 to write this letter to Peter Bryan's GP, but they are of the opinion that a copy of the letter should have been sent to the Home Office at the same time.

The Panel were however concerned that at the emergency meeting RMO5 decided not to increase Peter Bryan's medication despite having advised such an increase just 4 days beforehand.

He told us that on 29 January he had made the decision on the telephone after the Forensic CPN had told him about the concerns that the Riverside staff had that Peter Bryan might be relapsing, but that when he saw him on 2 February he felt that it was not necessary.

However RMO5's letter to the GP on 4 February had concluded:

"There is no obvious evidence of any psychotic symptoms in terms of delusions or hallucinations. However the very fact that there have been changes in behaviour noticed as mentioned earlier could indicate that these are early symptoms of his relapse."

If RMO5 did have concerns that the changes in Peter Bryan's behaviour could be early symptoms of relapse, he should have increased the dosage of medication.

He also planned to review the situation in three weeks time and indicated that he would recall Peter Bryan to hospital if there were any further deterioration.

In the panel's view, three weeks was too long a period of time to wait to review the situation if RMO5 had concerns about Peter Bryan's mental health and yet had made the decision not to increase his medication.

Although it is perhaps only with the benefit of hindsight that it can be seen that Peter Bryan's mental health was probably relapsing at this time, the Panel remains critical of Peter Bryan's treatment. The key point is that, given his history and the concerns expressed about his recent behaviour, the focus of treatment at this time should have been to continue monitoring him closely and attempting as far as possible to minimise the risks of relapse.

394. The Riverside House nightshift notes for 2 February record that Peter Bryan left the hospital at 21.00 in the company of a friend and returned at 23.45 and requested his medication. He told his co-key worker that his care team had said that he should behave or he would be recalled. He also said that they wanted him to spend at least another six months in Riverside House. He was advised by his co-key worker to work with his care team and Riverside staff and things would be better for him.

395. According to the Riverside House notes, on 4 February the Forensic CPN spoke with Deputy Manager 2 to update himself on what had happened at the 2 February meeting that he had not been able to attend.

If this note is correct, the Panel do not understand why the Forensic CPN did not speak to Social Worker 5 to find out what had happened at the meeting. Deputy Manager 2 was not even present at the meeting. Social Worker 5 was Peter Bryan's Social Supervisor and the Forensic CPN was meant to be working closely with him.

This would be yet another example of a lack of 'joined up' working between the professionals involved in the care and treatment of Peter Bryan.

However the Forensic CPN assured us that he remembers discussing the meeting with Social Worker 5 on 3 February when he returned after his sick leave and told us that he cannot understand why Deputy Manager 2's note was worded that way.

When we asked Peter Bryan whether he felt that the Forensic CPN and Social Worker 5 were doing everything they could to try to help him he told us:

"They done their best but kept pushing the ball into each other's court."

396. Deputy Manager 2's note also recorded that the Forensic CPN was going to meet with Peter Bryan and Social Worker 5 at 11.00 on Monday 9 February in the canteen at Homerton Hospital.

397. The nightshift note on 4 February described how staff had observed Peter Bryan talking to himself although he also interacted with staff about his training course.

This was the first (and only) note in the Riverside records of Peter Bryan talking to himself although there had been a note on 12 January that he had been seen nodding to himself. Only with the benefit of hindsight might this have any significance. This could have indicated that Peter Bryan was hearing voices.

398. It was noted on 5 February that Peter Bryan left with another Riverside resident at 20.30 and returned at 21.50. He then took his medication and went to bed at 22.40.

399. At approximately 14.30 on Friday 6 February two male "street crime wardens" and P6 (the mother of P4 - both she and her daughter were friends of Peter Bryan) turned up at Riverside House looking for Peter Bryan who was not in at the time. They informed the Manager that a serious allegation had been made by P6's daughter P4 against Peter Bryan.

400. As Peter Bryan was not there, the full details were not revealed and a meeting was arranged for Monday 9 February when he would be present.

401. The Manager spoke to one of the wardens who said that an incident had taken place with the 17-year-old girl P4 in a flat on the nearby estate. He said that the girl and her mother wanted to see Peter Bryan at Riverside House on the evening of 9 February.

402. Peter Bryan returned to the hostel at about 16.00 and the Manager and Deputy Manager 2 informed him about the visit earlier that afternoon.

403. Peter Bryan seemed very shocked and explained that he had been to the flat in question prior to coming back to Riverside House that afternoon to collect his mobile phone and that P6 had shouted at him to go away.

404. When asked if he wanted to discuss what had happened the previous night, he said that he had gone to the flat to watch DVDs and that while he was there his mobile phone had gone missing and it might have fallen out of his pocket. He said that there was then an argument and he had left the flat and had returned to Riverside House. At the time he had not felt bothered as he planned to collect his mobile phone that afternoon.

405. The Manager advised Peter Bryan not to visit the estate over the weekend and to stay at Riverside House rather than going to his parents' home for weekend leave as planned.

This decision presumably illustrates the level of concern that the Manager had at that time.

406. The Manager also received a telephone call from the wardens on the estate requesting that Peter Bryan should not come to the estate and this message was passed on to Peter Bryan.

407. Shortly after this meeting one of the Riverside residents asked to speak to the Manager and was obviously very angry with Peter Bryan. He said that he had gone the previous evening with Peter Bryan to the flat of the girl in question (P4) and said that prior to their visit, Peter Bryan had telephoned P4's mother to ask if P4's father was around as she lived with her father. The mother had informed Peter Bryan that P4's father was visiting another member of the family.

408. The resident said that when they arrived at the flat, the first question that Peter Bryan had asked P4 was if her father was around, even though he already knew from her mother that he was not. He explained to the Manager that he had felt very uncomfortable being in the flat with P4 and her friend who was around the same age ie. 17 years old. He said that he had told Peter Bryan that he was not feeling well and therefore he was leaving and that Peter Bryan had encouraged him to go. He said that on Peter Bryan's return to Riverside House he had knocked at his door to tell him that his mobile phone had gone missing.

409. The resident then said that that morning he had visited the flat and was told by the family about the allegations against Peter Bryan. He said that apparently after he had left, P4 had gone into the bedroom and Peter Bryan had 'come on' to her, feeling her breasts and private parts. She had asked him to leave the flat but he had refused and so she had produced a knife. After some time Peter Bryan left the flat.

410. He said that the family were afraid to get the police involved because the girl in question had protected herself with a knife. He said that he felt so angry towards Peter Bryan he felt like fighting with him.

411. The Manager noted that she had informed Peter Bryan's Social Supervisor of the incident **(in fact she telephoned the Forensic CPN not Social Worker 5)** and the Forensic CPN was going to inform the public protection office in Newham as Peter Bryan might be on their list. She noted that the Forensic CPN also planned to meet with Peter Bryan on Monday 9 February.

Once again the Manager contacted the Forensic CPN rather than Social Worker 5, presumably again because he seemed the most accessible member of the team.

However, Social Worker 5 was Peter Bryan's Social Supervisor and therefore had formal responsibility to report any serious concerns to the Mental Health Unit of the Home Office which might lead to a decision to recall Peter Bryan to hospital. He should have been informed on the Friday evening by someone.

412. The Forensic CPN noted that he had received a telephone call late on Friday evening from the Manager who had informed him of an incident that had taken place the previous night and that Peter Bryan had allegedly sexually assaulted a 17-year-old girl at a block of flats near the hostel. He noted that Peter Bryan had known the girl and her mother for about two years and often went to see them.

413. The Manager had told him that two security guards from the housing estate had come to Riverside House with the alleged victim's mother wanting to speak to Peter Bryan about what had happened. As Peter Bryan was not in the time they had said that they would be back on Monday to see him.

414. The Forensic CPN noted that he had informed the Manager to tell them to go to the police and to report the incident and also to try to discourage them from coming to the hostel as it was very unpredictable what might happen.

415. He said that he would contact Hackney Public Protection Team and give them details of the incident and the alleged victim and he asked the Manager to fax over a report on the allegations. He also noted that he planned to see Peter Bryan on Monday 9 February with Social Worker 5.

416. His note for Monday 9 February begins:

"Informed (Social Worker 5) of incident and gave him copies of written documentation from Riverside of what had happened.

We met with Peter at the Homerton Hospital…"

The Panel faced a dilemma concerning the evidence about the weekend of 6 to 9 February. Social Worker 5 told us that the Forensic CPN contacted him on the evening of Friday 6 February to inform him of the incident and to arrange a joint meeting with Peter Bryan on Monday 9 February.

He made no note of this telephone call, but he may well not have been in the CMHT office and therefore would not have had access to the notes.

When we pointed out to him that the Forensic CPN's notes record that the CPN only contacted him on the Monday morning, he was still adamant that he had been telephoned by the Forensic CPN on the Friday evening.

Social Worker 5 told us that, after the Forensic CPN had informed him about the allegation, he had spoken to Peter Bryan on the Friday evening to arrange to see him with the Forensic CPN on the Monday. When we asked him why he had not arranged to see Peter Bryan sooner if he had actually spoken to him on the Friday, Social Worker 5 told us that they had arranged to see him on the next working day and that they had therefore seen him *"fairly quickly"*. He told us:

"I would argue that we were concerned, maybe not in the degree that you are thinking of, but we were concerned enough in order to meet with him as quickly as possible on the Monday."

He accepted that one way of putting it was that the incident had caused him *"a small degree of concern but not a large degree of concern"*.

However, when we subsequently put Social Worker 5's version of events to the Forensic CPN, he was adamant that he had not telephoned Social Worker 5 on the Friday evening, but only on the Monday morning. He said that he and Social Worker 5 already had a meeting with Peter Bryan pre-arranged for Monday 9 February. This is in fact confirmed by a note to that effect that Deputy Manager 2 had made on 4 February.

The Panel are bemused by this discrepancy about when the Forensic CPN informed Social Worker 5 of the allegation, and neither the Forensic CPN nor Social Worker 5 would shift

their position, despite the fact that it would probably be more favourable to each of them if they agreed each other's contention.

Whatever the truth of the matter is, the Panel are seriously concerned that, despite a very serious allegation of an indecent assault having been made against Peter Bryan just four days after the emergency meeting on 2 February, no attempt was made by the Forensic CPN or Social Worker 5 to see Peter Bryan immediately.

We acknowledge that the information was received late on a Friday and both men were off duty, but, given the potential risks involved, we are firmly of the view that it was not good practice to wait until the Monday to interview Peter Bryan about the allegations.

The Forensic CPN told us that the Manager of Riverside House was not concerned about Peter Bryan's mental health or his management but simply wanted advice as to what to do about the security guards turning up, and it is fair to say that the Manager told us that she did not believe the girl's allegations. However, as noted above, she had been sufficiently concerned to advise Peter Bryan not to go on weekend leave to his parents' address.

The Forensic CPN told the Panel that he received the call from the Manager at about 7 p.m. and that he remembers that he was already at home.

We were disturbed by the Forensic CPN's assertion that the reason that he did not contact Social Worker 5 or anyone else on the Friday was because:

"He was off duty, (RMO5) was off duty, I was off duty.

What I am saying is there is a crisis plan in place. With all patients who are in 24-hour hostels, there is a crisis plan in place if people have concerns about their mental state. Depending on where the hostel is, they call the out of hours team out to that hostel and they go and assess them. That's quite clear and (the Manager of Riverside House) is clear on that and everyone is clear on that, because we don't work Saturdays, Sundays, and out of hours.

(The Manager) phoned me on Friday evening and I was off duty, as I said, and not offering an out of hours service. She didn't think Peter was relapsing. She wasn't concerned about anything, and all she was concerned about was the security guards turning up.

I said to her that I'm out of hours and I'm not on duty at all. No one from us can see him out of hours. I'm actually at home. I'm not supposed to go out and visit people at weekends and out of duty. I'm not contracted to do that. I'm not supposed to do that. There is an out of hours service."

We accept that the Forensic CPN was off duty at the time that he received the call from the Manager of Riverside House, however we are surprised that he did not feel that he could, at the very least, telephone Social Worker 5 to inform him about the allegation that had been made against Peter Bryan. He told us that he had Social Worker 5's mobile telephone number but also said *"I've never phoned him out of hours."*

We are also concerned that the Forensic CPN readily accepted the Manager's assessment of the situation instead of forming his own opinion independently. He should have appreciated the significance of the allegation when viewed in the context of Peter Bryan's risk profile and the recent concern as to whether or not his mental state was relapsing. In these circumstances it was not sufficient to keep the information to himself over the weekend and not inform Peter Bryan's Supervising Psychiatrist and/or his Social Supervisor and/or the out of hours service.

Even though we appreciate that the Forensic CPN may have been working within the terms (and therefore also the restrictions) of his employment, we feel that this attitude is somewhat unprofessional and not conducive to good practice. In particular it does not conform to the Nursing and Midwifery Council's Code of Professional Conduct 2002 which states under Section 4 that:

"4.3: You must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients".

Had the incident taken place in isolation, we may not have been so critical of the decision to wait until the Monday to see Peter Bryan. Both the Forensic CPN and Social Worker 5

would have been off duty at the time that the Manager of Riverside House rang the CPN on the Friday evening, and at the time there was no forensic CPN out of hours' service.

However, the incident had occurred just three days after an emergency meeting had been called because there had been concerns that Peter Bryan might be relapsing, and the following day he had been accused of seriously inappropriate behaviour towards a young woman.

This was probably the most serious account of aggressive behaviour on the part of Peter Bryan that had been reported in something like 10 years.

Inappropriate sexual behaviour had been one of the risk factors identified at an earlier stage in the care and treatment of Peter Bryan and should have rung alarm bells about possible relapse. Irrespective of that, an allegation had been made that a member of the public had been put at risk, and whether or not the allegation was true, some steps should had been taken to protect the public, by arranging to see Peter Bryan as soon as possible and by ensuring that he stayed at Riverside House over the weekend where his behaviour could be closely monitored.

The Panel are also critical of the fact that even on Monday 9 February Social Worker 5 did not consider it necessary to inform RMO5 or the Home Office about the allegations that had been made.

Paragraph 68 of the Home Office Notes for the Guidance of Social Supervisors provides:

"If a social supervisor is concerned about a conditionally discharged patient's mental state or behaviour, the concern should first be discussed, if possible, with the other professionals involved in the case, particularly the supervising psychiatrist."

Paragraph 69 states:

"If the social supervisor has reason to fear for the safety of the patient or of others, he should contact the supervising psychiatrist immediately.

The consultant may decide to initiate local action to admit the patient to hospital without delay with the patient's consent.

Whether or not such action is taken, and even if the supervising psychiatrist does not share the social supervisor's concern, the social supervisor should report to the Home Office at once so that consideration should be given to the patient's formal recall to the hospital."

The Panel are strongly of the view that both RMO5 and the Home Office should have been informed about the incident at the earliest possible opportunity. This would have been Friday 6 February. They were not informed until Tuesday 10 February.

Home Office 8, Case Work Manager, Mental Health Unit of the Ministry of Justice (formerly the Home Office) told us:

"We would expect to be informed immediately - and immediately would mean preferably on the 6th. Even if it occurred at midnight, we operate a 24/7 out of hours service precisely for things such as emergencies and crises involving conditionally discharged patients.

With something of that nature, I would expect to have been notified immediately, even if that meant phoning the out of hours service."

The Mental Health Unit at the Ministry of Justice operates a 24 hours emergency service to discuss urgent cases but it is useless if the community teams cannot do anything out of their own working hours.

417. At around 19.00 on the evening of Friday 6 February Peter Bryan informed staff that he was working that night and he left the hostel at 21.00.

Given that many cleaning staff are female, the Panel consider that steps should have been taken to ensure that Peter Bryan did not attend work until the allegation of indecent assault had been further investigated. If Social Worker 5 was informed about the allegation on 6 February, then this would have been his responsibility.

418. He returned at 22.40 and told staff that his agency had given his 'shift' to somebody else as they could not confirm with him during the day that he would manage to do the shift. They had tried to contact him on his mobile phone as usual, but could not reach him as his mobile phone was not with him at the present time. He had some food and retired to his room for the night at 23.00.

419. He came down the following morning at 11.30 and left the hostel at midday saying that he had something to do with his car. It was noted that he said nothing more about what had happened the previous day.

420. He returned at 13.15 and spent the afternoon at the hostel except for a few short trips into the community. He played pool with other residents. He spent the evening at Riverside House, took his medication and was noted to appear 'chatty in mood'. He went to bed at 01.40 after watching a movie on television.

421. On Sunday 8 February Peter Bryan remained in his room for most of the day and then prepared a light meal for himself and spent the evening in the lounge watching television. It was noted that he appeared pleasant in mood.

422. He asked the Manager of Riverside House if he could have a urine test as he wanted to make sure that his urine was clear. She explained to him that he should know what to expect if he was not taking street drugs and also explained that the drug screening tests were expensive to use.

423. They then discussed his prescribed medication and he informed her that he was taking it on a regular basis.

424. They also spoke about the allegations which had been made about the previous Thursday night and that he was to discuss it with the Forensic CPN the following day.

425. Peter Bryan remained in the hostel throughout the evening, watching television and interacting with other residents.

426. On the morning of Monday 9 February the Manager of Riverside House received a telephone call from the Forensic CPN (still described by her in the notes as Peter Bryan's Social Supervisor) and they had a general discussion about the allegation made against Peter Bryan and also the risk factors. The Forensic CPN asked the Manager of Riverside House to fax through her notes written on 6 February when she had heard details of the allegation, and she did so.

427. The Forensic CPN and Social Worker 5 met with Peter Bryan at the Homerton Hospital later that day. He admitted going to the girl's flat with another resident but said that he had gone in on

his own and had watched DVDs with the girls. He said that they had started to play act and had stolen his mobile phone and would not give it back.

428. He admitted *'play acting'* with the alleged victim P4 and *"blowing a raspberry on her stomach"*. He denied any sexual activity. He said that he had then left without his phone.

429. He said that he was aware that he had been accused of something by the girl the next day, but he did not know what.

The following is the girl, P4's, version of events in her statement to the police.

From police records it is apparent that P4 reported the incident to the police on 5 February, the same day as the incident occurred. Police officers attended that day but she was not in at the time, so a note was left for her to contact them. She did not contact them again until 20 February although she said that she had tried to telephone them prior to that date.

It might have made a difference if the police had been more active in investigating P4's complaint as they would then have had access to Peter Bryan's previous convictions and would have been aware of his forensic history.

Also, if the police had been involved at an earlier stage and had taken the allegation seriously, it may have influenced whether or not Peter Bryan was recalled to hospital under compulsory detention rather than admitted as an informal patient.

It has to be borne in mind that the statement was taken from P4 after the homicide of Brian Cherry and may have been influenced somewhat as a result.

However, if her description of what happened is true, it shows that a worrying degree of aggression was used by Peter Bryan towards the girl.

430. Her account was that at about 21.00 on 5 February she was outside her home with a friend when Peter Bryan and two friends approached and asked where her father was. When she said that she did not know, Peter Bryan asked if he could come in and use their DVD player as he

had just got a new DVD and wanted to see if it worked. She said that he could and they all went in to her flat.

431. She went into her bedroom with her friend, Peter Bryan and one of his friends. One of Peter Bryan's friends had already left. His other friend left shortly afterwards saying that he did not feel comfortable being there without her father present.

This part at least is consistent with what the resident told the Manager of Riverside House.

432. At that point P4 and her friend were sitting on the bed and Peter Bryan was standing up. He then started coughing in P4's face -something he knew annoyed her - so she stood up. He then grabbed hold of her wrists and threw her on the bed.

433. He put both of his knees on to her arms so that she could not move and then slapped her face. She told him to get off her but he would not move. She felt she could not breathe and was getting agitated. She managed to get one hand free to push him away, but as she did so he grabbed both her hands with one of his hands and then started biting her. She again told him to get off her, but he would not move and slapped her around the face again.

434. When he finally let go, she realised that one of her fake nails had broken and the nail was bleeding so she went into the bathroom to wash it. Peter Bryan followed her into the bathroom, came up behind her, cupped his hand under the water and threw water in her face. She turned round and slapped him and he said "*Don't mess around with me. You don't know what I'm capable of.*" She said "*I don't care what you're capable of. Get out of my way*".

435. She then pushed past him and went into the kitchen and started to rinse out a cup which she had left on the side earlier. Peter Bryan followed her into the kitchen, walked up behind her, put his left hand across her face covering her mouth so that she could not scream and then put his right hand down her trousers (they had an elasticated waistband) although he had not yet touched her knickers.

436. At this point she felt really scared and picked up a knife that was on the side in the kitchen. Peter Bryan said *"Don't mess about with that"*. She said *"Get out of my house"*.

437. Peter Bryan grabbed her hand again and made her drop the knife. She started punching and kicking him and he just stood there covering his face with his hands. She ran into her bedroom

and picked up a pot of cream and threw it at him as he was coming towards her and it went all over him and the floor. He still kept coming towards her, so she picked up some wood that was in her room and hit him on the face and shoulder. The piece of wood broke, so she picked up one of the bits of wood and hit him again.

438. He ran into the bathroom and she shouted at him to get out of the house. He came back again, so she hit him again. At this point her friend grabbed the bit of wood and told P4 to stop hitting Peter Bryan. P4 told her to let go of the piece of wood which she did.

439. Peter Bryan then shouted *"Stop hitting me. You don't know what I'm capable of"*.

440. P4 managed to push him towards the front door, still hitting him, and pushed him out, saying *"Get out of my house"*. He left saying *"You better mind yourself"*.

It is only to be hoped that if any of the professionals or the Home Office had been aware of this version of events, they would have seriously considered Peter Bryan's immediate compulsory recall to a locked ward.

441. The Forensic CPN noted that as Peter Bryan was denying that anything untoward had happened, they had told him that they would be discussing the incident with RMO5 and the Police Public Protection Team so that they could investigate the incident in more detail.

442. Social Worker 5 noted that Peter Bryan would remain at Riverside House until Social Worker 5 had heard from the Home Office, but that he was fully aware that Social Worker 5 was considering recalling him to hospital and that he would be discussing the matter with RMO5.

In fact neither the Forensic CPN nor Social Worker 5 informed RMO5 or the Home Office of the incident that day, although we acknowledge that the main responsibility to do so lay with Social Worker 5 as Peter Bryan's Social Supervisor.

It is the way in which this incident was handled which causes the Panel the greatest concern.

It was not until the following day - when threats had been made against Peter Bryan - that any steps were taken that showed that this matter was being taken seriously – and then

only because there was a risk of danger to Peter Bryan, rather than any risk from him to others.

We were alarmed at the seeming lack of concern on the part of the professionals responsible for the care and treatment of Peter Bryan on hearing that he had been accused of sexually inappropriate behaviour towards a 17-year-old girl so soon after they had convened an emergency meeting to discuss the possibility that he was relapsing.

Neither Social Worker 5 nor the Forensic CPN:

(a) arranged to see Peter Bryan immediately to assess his mental state
(b) informed RMO5 or the Home Office of the allegations
(c) gave instructions that Peter Bryan should remain at Riverside House and should not go out into the community

The Forensic CPN did inform the police - although only the MAPPA unit (Multi-Agency Public Protection Arrangements) and only after the 'lynch mob' were after Peter Bryan.

When we asked Social Worker 5 why they did not inform RMO5 on 9 February he told us:

"Because we felt that PB's mental health was stable we went through the process of contacting the Multi Agency Public Protection Team for them to carry out an investigation, but the reason for that is, there are always allegations being made. There are constant allegations being made about various clients that we manage, and those allegations, for example, how would you put it – if this allegation was unusual in PB's case, although he has had a history it was unusual, and therefore we needed for it to be investigated by the MAPP team.

Now if during the period of their investigation another allegation comes up or something happens, in a sense unless you are within the multi-agency CMHT, it is difficult to know how it actually works. You are always making decisions, and it's very difficult to know.

No decisions that you make are the right ones. They're the ones that if nothing happens they appear to be the right ones. If something happens, unfortunately they are wrong

ones, but we have to make these decisions, and on that day the decision that was made was in the knowledge that PB's mental health was stable but an allegation was made"

In particular, they do not seem to have seriously considered recall to hospital under Section 42 MHA[11], despite having threatened Peter Bryan on several occasions that they would do this if his behaviour deteriorated.

Peter Bryan told us that he was aware of the talk about him being recalled and that he *"wouldn't have minded"*.

Recall under section 42 was one issue which caused the Panel considerable difficulty and over which we deliberated at length.

Our initial unanimous reaction was that recall to a secure ward may have been the one factor which might have prevented the homicide of Brian Cherry, and we all felt that Peter Bryan's cumulative behaviour in the weeks leading up to the incident on 5 February 2004 warranted such recall.

Paragraph 74 of the Home Office 'Notes for the Guidance of Social Supervisors' current in 2004 states:

> *"Whether the Home Secretary decides to recall a patient depends largely on the advice of a medical practitioner about the health of the patient and about the degree of danger which the particular patient might present. Where the patient in the past has shown himself capable of serious violence, comparatively minor irregularities in behaviour or failure of co-operation would be sufficient to raise the question of a possible need for recall…Each case is assessed on its merits in the Home Office and a decision is reached after consultation with the doctor(s) concerned and with the social supervisor."*

The equivalent paragraph (now paragraph 71) of the 2007 Guidance for Social Supervisors now begins:

> *"Whether the Secretary of State decides to recall a patient depends partially on the advice of a medical practitioner that the patient's mental condition requires treatment in hospital. Such opinion is not final, however."*

[11] S. 42(3) MHA: The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under subsection (2) above by warrant recall the patient to such hospital as may be specified in the warrant.

and ends:

> *"However, the decision will always give precedence to public safety considerations."*

The Panel is pleased to see this important revision to the Guidance.

We initially took the view that it was the inexperience in dealing with restricted patients of Social Worker 5 and RMO5 (who were the only people who could have asked the Home Office to arrange his recall) which had prevented this happening.

However, on questioning witnesses who had the appropriate experience, we discovered that it may not have been easy to have arranged Peter Bryan's recall to a secure ward, even if steps had been taken to facilitate it.

We asked Social Worker 4 whether he would have done anything differently if he had been Peter Bryan's Social Supervisor at the time of the incident, and he told us:

"It is hard to say. I can think of a similar case where I did actually try and have someone formally detained but where the consultant did not feel that he met the criteria for detention under the Mental Health Act and I was thinking more in terms of public safety rather than mental ill-health. It was a very similar situation and in the end I got him recalled through some other means, but it was a very long and complicated drawn out process with the Home Office."

When we asked Home Office 8 of the Ministry of Justice (see page 451) whether the circumstances would have caused him to recommend that Peter Bryan should be recalled he said:

"It would cause me to consider recall but, in order to recall, whilst case law allows us lawfully to recall where we disagree with the assessment by the psychiatric and social supervisors, we nonetheless still have to have sufficient evidence that it can be reasonably interpreted that the patient meets the criteria for compulsory detention under the Mental Health Act.

Therefore the questions I would have been asking in considering recall would be first about the nature of the allegation of the indecent assault. There are several questions. Is there any evidence that his mental state has deteriorated or that he is relapsing? Secondly, is the indecent assault in itself evidence of a relapse or deterioration? Thirdly, even if the indecent assault were proven, is it linked to his mental disorder?…

If the social and psychiatric supervisors stuck to their assessment as we have it in the fax and the record of the phone call, then I cannot see that we would have the evidence lawfully to recall under Section 42. There would be clear and unequivocal views from both supervisors that the person was not deteriorating, they were mentally well, and this unsubstantiated allegation of indecent assault had led to his admission to hospital purely for his own protection. There were no issues of increased risk surrounding his mental disorder.

It may be that a detailed and more questioning conversation with the supervisor may have brought a different assessment but that is obviously pure speculation."

When we put it to him that, only a matter of weeks beforehand the Home Office had received the 19 December 2003 report from Social Worker 5 which had mentioned concerns that Peter Bryan might be relapsing, Home Office 8 responded:

"At that time, as I think I said earlier, it should have been pursued.

Unfortunately, at the time of the allegation, all the information that we had was very reassuring in terms of his mental state. The Caseworker unfortunately took that reassurance at face value rather than looking at it critically in the context of other recent information that we had had.

If at the time I had been contacted and they had said 'We think there is some concern about his presentation and he may be relapsing, and also there was an allegation of indecent assault', then I would be minded to recall."

The Panel consider that the Home Office should have been told that there was concern about Peter Bryan's behaviour which had made the community team question whether he was relapsing at the same time as they were informed that there had been an allegation of

indecent assault. All of this information should have been relayed to the Home Office on the evening of 6 February.

Had all of that information been promptly passed on, it is more likely that Peter Bryan would have been recalled.

However, the Home Office, even if it had been informed promptly of the new concerns about Peter Bryan, would have had some difficulty in evaluating the level of risk posed by him.

The lack of regular reporting by RMO4 and later by RMO5 and to a lesser extent by Social Worker 5, together with the lack of balanced reporting in those reports which the Home Office did receive, meant that it had little in the way of context by which it could critically appraise the recent behaviour of Peter Bryan.

This meant that the Home Office was more dependent on the views on 10 February of RMO5 and Social Worker 5 and was less able to engage in any possible debate about the merits of recall or appropriate alternative courses of action. These concerns of the Panel underscore the criticisms expressed earlier about the poor reporting record of the two community RMOs.

We have been told by the Ministry of Justice that in 2003-4, 130 or 11% of the 1169 restricted patients living in the community were recalled to hospital. In 2007-8 this had risen to 203 or 14% of the 1446 restricted patients living in the community.

As we have said above, the Panel is of the view that the recall of Peter Bryan to hospital as a detained patient may have prevented the homicide of Brian Cherry at that particular time.

However, given the particular dangerousness of Peter Bryan which has been learned with the benefit of hindsight, his recall as a detained patient at the beginning of February 2004 could not have guaranteed that he would not have killed someone (perhaps Brian Cherry) following his discharge at a later stage.

There is a discrepancy between the evidence that the Forensic CPN and Social Worker 5 gave us about the meeting they had with Peter Bryan on 9 February.

The Forensic CPN told us that it was agreed at the meeting that Peter Bryan needed to be in hospital and that Social Worker 5 as the Social Supervisor was going to discuss recalling Peter Bryan with RMO5 at the regular CMHT allocations meeting that afternoon.

The Forensic CPN's note of the meeting on 9 February records that Peter Bryan was told that they would be discussing the matter with RMO5 and the Police Public Protection Teams (MAPPA) so that they could investigate the incident in more detail. However neither RMO5 nor MAPPA were informed until the following day after the Forensic CPN and Social Worker 5 had been told about the incident of the men in a car waiting outside Riverside House to 'get' Peter Bryan.

Social Worker 5 told us that it was not until the following day when he heard about the 'lynch mob' which was looking for Peter Bryan that he seriously considered admitting Peter Bryan to hospital and even then it was not because he had any concern about Peter Bryan's mental state. He told us that he saw the incident of the indecent assault as purely a police matter rather than any cause for concern about Peter Bryan's mental health deteriorating.

He told us that on the Monday:

"I was not overwhelmed by what was going on but I was becoming increasingly concerned. (I was) not concerned enough to phone (RMO5) and in part this was again the information we received from Peter Bryan."

443. The Riverside notes record that Peter Bryan returned to the hostel at 16.30 on 9 February and told staff that the meeting had not gone well regarding the recent allegations and that he could be recalled to hospital. He said that the Forensic CPN was looking into the matter and that he had advised him not to meet the wardens from the estate. He was therefore going to stay indoors for the rest of the day.

444. Peter Bryan also told the Manager that he was feeling scared by the recent events.

445. He remained at Riverside House for the rest of the evening, took his night medication and went to his room where he remained for the rest of the night.

446. The following morning he came downstairs at 09.15 and played pool with staff. He said that he did not have much on that morning but that he planned to visit the training centre that afternoon for an update on his CV.

447. The Forensic CPN telephoned the hostel at 09.40 and asked for the daily progress record sheets which noted the events surrounding the allegation to be faxed to him. He also asked for the name and address of the girl making the allegation and this was provided by Peter Bryan. The Forensic CPN said that he would pass on those details to the Police Public Protection Team.

448. At 10.20 Peter Bryan left Riverside House saying that he was going to the training centre and would be back soon. He returned at 12.20.

449. When the Forensic CPN telephoned again at 12.45 Deputy Manager 2 informed him of an incident that had happened the previous night. He said that when he was leaving the hostel at 22.00 his car had been 'flashed' by one of two cars which were parked across the road facing Riverside House. The cars had contained several men.

450. That morning this incident had taken on more significance because one of the Riverside residents had told a member of staff that he had been one of the men sitting in the cars and that the others had wanted him to point out Peter Bryan as they had planned to pick him up to take him somewhere to kill him. They had also planned to enter Riverside House by using the resident's key to access the hostel. They were apparently going to put Peter Bryan into the boot of one of the cars to take him away, *'sort him out'* and kill him. The resident was very upset and apparently demanded to leave Riverside House because of this.

451. The Forensic CPN then talked to the Manager who expressed her concern about Peter Bryan's safety and also the risk element towards other residents and members of staff. They both agreed that the police should be informed and the Manager contacted Stoke Newington police station and gave a statement over the telephone. It was agreed that a police officer would visit Riverside House that afternoon.

452. The Manager noted that Peter Bryan was pleased that he was not being recalled.

453. The Forensic CPN then spoke to Social Worker 5 and updated him about what was happening.

454. Social Worker 5's notes record the following entries on 10 February 2004:

"10.2.04 informed by (the Forensic CPN) that some people went to Riverside House to confront Peter re: the allegation of indecent assault against the young 17-year-old girl. I informed (the Forensic CPN) that I intend getting Peter into hospital immediately for his safety. (The Forensic CPN) agrees with this plan. I suggest to (the Forensic CPN) that I would speak to (RMO5) today, and let him know the situation and my plan to move Peter to hospital."

"10.2.04 T/C to (RMO5) informed him of what (the Forensic CPN) told me and my plan to move Peter to hospital for his safety and for a risk assessment. (RMO5) reluctant because there is no relapse but told him I could not take risks with Peter because the girl's friends could hurt him. (RMO5) advised that I speak to (the Topaz Ward Manager) because Peter is unlikely to be admitted to John Howard Centre or Crystal Ward. I suggested Bevan (Ward) but unlikely as no signs of psychotic illness. Agreed to ring Topaz Ward."

When we asked Social Worker 5 about his note that RMO5 had been reluctant to admit Peter Bryan to hospital he told us:

"He was disinclined to admit full stop – and because of that – and it's not (written) here but I remember because I always paint it as a scene from a movie in trying to do something to get this man in hospital who is not showing any signs of relapse. So how do I get him into hospital? What I had to do was threaten that I'm not going home tonight unless he is admitted to hospital"

"10.2.04 T/C to (the Topaz Ward Manager) advised him of my discussion with (RMO5) and plans to admit Peter informally for his safety and to do a risk assessment because of allegation and people going after him. (The Topaz Ward Manager) stated that he was reluctant to take him because he is 37/41 and advised that he goes to a locked ward. Informed him that this wasn't possible because Peter was not showing any signs of relapse but there was a risk to him from family of the girl so he had to come in and (RMO5) agrees with me. (The Topaz Ward Manager) said he would speak to the MHA office to get advice and let me know."

"10.2.04 discussed the situation with (the Forensic CPN) and (Social Worker 6). Consulted the supervisor's Handbook and (Social Worker 6) authorise cab fare. T/C to (the Topaz Ward Manager) he agreed that Peter could come in. T/C to Riverside House informed (the Manager) that if Peter is there to tell him that I would like him to come into hospital informally. To let him know that he is not being recalled that it is for his safety. I requested (the Manager of Riverside House) call cab immediately if Peter agrees. (The Manager) spoke to Peter and I ask her to call me when cab leave with him."

"10.2.04 T/C to Home Office 4 Home Office to inform her of decision to get Peter to hospital informally. Promised to fax letter by tomorrow and keep her inform (sic)."

"10.2.04 T/C from (the Manager of Riverside House) to tell me that Peter Bryan has left in a CAB. Promised to keep (the Manager) informed of events."

"10.2.04 T/C to duty nurse he is aware of action to admit Peter to Topaz Ward informally."

"10.2.04 T/C from (the Topaz Ward Manager) to let me know that Peter has arrived in taxi and driver is asking for £25 plus for fare. Advised (the Topaz Ward Manager) that we would pay and ask him to send cab driver to CMHT office."

The Panel consider that allowing Peter Bryan to go unaccompanied in a taxi to a psychiatric ward was not acceptable practice. However it shows that Social Worker 5 was not concerned about Peter Bryan's mental state at that time.

Topaz Ward

1. Peter Bryan was admitted as an informal patient to Topaz Ward, the acute adult general psychiatric ward at Newham Centre for Mental Health, in the late afternoon of 10 February 2004.

The Panel consider that it was totally inappropriate to use Topaz Ward as a 'Safe House' for Peter Bryan.

Topaz Ward was an open ward with 15 beds. The Panel is concerned that it was a mixed ward and no thought appears to have been given to the risk that Peter Bryan might pose to the female patients on the ward, given that he had recently been accused of indecently assaulting a young girl.

However, we acknowledge that there was probably nowhere else that Peter Bryan could go unless he satisfied the criteria for compulsory detention or was recalled under Section 42(3) of the Mental Health Act (see footnote page 380).

It was a condition of his conditional discharge that he should reside in a 24 hour supervised hostel, staffed by individuals experienced in the care of restricted patients. Riverside House met that criteria, but it would have been virtually impossible to have found a placement at another such hostel at short notice.

Therefore the only practical solution was to admit Peter Bryan to Homerton Hospital – to either the locked Crystal Ward if he were detainable under the Mental Health Act or to Topaz Ward if he did not meet the criteria for compulsory detention.

However, any readmission to hospital suggests that the patient is under increased risk of some kind and this may indicate that they present a potential risk to the public, even if the patient's RMO considers that the patient is mentally stable.

The Panel consider that the Ministry of Justice should treat all cases where a conditionally discharged patient is admitted to a psychiatric ward – for whatever reason – as an urgent case which requires immediate consideration of whether or not the patient should be compulsorily detained under the power of recall.

The presumption in such cases should be that the patient should be recalled unless there are compelling reasons as to why he should not.

2. That evening SHO3 carried out an assessment and completed the Admission Summary/Assessment form. He recorded that the reason for the admission was "relapse", that Peter Bryan had a diagnosis of paranoid psychosis/paranoid schizophrenia and that on the previous Thursday he had been accused of indecently assaulting a 17-year-old girl. It was noted that there was currently no paranoid ideation, delusions or hallucinations and that he had been compliant with medication.

3. SHO3 carried out a mental state examination and recorded that Peter Bryan was talkative, made good eye contact, that his speech was clear, coherent and communicative, that his mood (subjective) was 6/10 and his affect (objective) was euthymic. There was no paranoid or suicidal ideation and no FTD (formal thought disorder) and there were no signs of delusions or hallucinations and he had insight.

   This appears to have been the only mental state examination carried out while Peter Bryan was on Topaz Ward.

   The Admission Information Form gave the Forensic CPN as Peter Bryan's Care Co-ordinator. This was incorrect. There was no mention of Social Worker 5.

4. The Management Plan was to admit him as an informal patient and to carry out intermittent observations.

5. A routine urine drug test was carried out and showed no illicit drugs.

6. A Risk Assessment was carried out by one of the ward staff, Nurse 7, which gave the following indicators of risk.

   "Peter is likely to become paranoid with persecutory thoughts and suspicions if he relapses. He then may lead him to carry offensive weapons and involved in fights possible using the weapons (sic)".

7. Warning signs or triggers were stated to be:

"Paranoid, Persecutory thoughts and Suspicions"

8. It was further noted that:

"He relapses very quickly when he is non-compliant with his medication. Administration of medication and monitoring of pharmacological effects. Admission to psychiatric units depending on risk factors, especially if he is around Asian women with whom he has a pre-occupation."

9. The Management Plan in the Risk Assessment was:

"(1) to be cared on strict INTERMITTENT OBSERVATIONS ensuring of his whereabouts all the time

(2) to be encouraged to take his medication on all times, and observe and monitor pharmacological effects and adverse effects

(3) to carry out regular checks whenever he leaves the Ward and returning back

(4) random drug screening

(5) engage him with ward/OT activities

(7) (sic) inform the team (MDT) if he is suspected of any criminal activity

10. It was further noted under the heading 'Vulnerability':

"He is likely to be at Risk to others than they to him." (sic)

11. The nursing Progress Notes have the following Admission Summary timed at 21.30 on 10 February:

"Peter is a 33 year Afro Caribbean gentleman admitted to Topaz ward informally however he is on Section 37/41 in the community. Peter was transferred from Riverside Residential Care Home for relapse, evidenced by incident on Thursday 5/2/04 when he was accused of indecently assaulted a girl of 19 years old (sic). Peter was diagnosed as suffering from Paranoid Schizophrenia and was convicted of the manslaughter of a young Asian woman who was the daughter of his employer. He attacked her with a hammer because the father refused to pay back £500 to Peter. Before the offence he was reported experiencing persecutory

delusions walking with a hammer and believing his neighbours were following him and police watching him. On the ward Peter appears settled and was assessed orientated to ward."

12. The nightshift notes record that Peter Bryan appeared settled in mental state and calm in mood. He had his night-time medication before he retired to bed and he appeared to have slept well.

13. The following morning the notes record that a telephone call had been made to clarify Peter Bryan's status and it was noted that he was on Section 37/41 in the community but that this was an informal admission and that he had agreed to come to Topaz ward and had not been recalled by the Home Office.

14. It was recorded that if Peter Bryan wanted to leave he should be treated as any other informal patient.

    In fact it seems that Peter Bryan was told not to leave the ward despite being an informal patient, and he did not attempt to leave the ward until he was given permission to do so on the afternoon of the homicide.

    This is yet another example of how Peter Bryan responded to control with compliance.

15. The notes record that Peter Bryan spent part of the morning in his room and then spent the rest of the morning shift in the Day Area where he was observed reading the newspaper. He appeared calm. He remained settled for the remainder of the day, interacted well with the ward staff and was no management problem.

16. Care Plan 1 (which was a pro forma plan which merely required the patient's name to be inserted and a choice to be made of what was to be observed, assessed and reported on) dated 10 February was:

    "Client's problem: 72 hour assessment of social, mental and physical state.

    Agreed Goal: to obtain a comprehensive picture of Peter's social, mental and physical state and use it to formulate an individualised plan of care.

Agreed Action Plan: to orientate Peter to the ward environment, staff and fellow patients. To provide a safe and therapeutic environment.

The nursing staff to build a therapeutic relationship with Peter based on trust, empathy and warmth

The nursing staff to observe, assess and report on the following:

A. Altered thoughts +/or sensory perceptual alterations.
B. Mood and activity levels.
D. verbal/Physical aggression.
G. Diet and fluid intake
J. Compliance with medication.
L. Physical state"

17. On 11 February Social Worker 5 wrote to Home Office 4 at the Home Office:

"Further to our conversation yesterday, I am writing to inform you that Mr Bryan was admitted to the Newham Centre for Mental Health informally on the 10.02.04.

This situation arose following an alleged incident of indecent assault on a girl of 17 years old. Mr Bryan has denied the allegation, but apparently some friends or relatives of the girl went to the residential home where he lives yesterday to "sort" him out. Fortunately Mr Bryan was not at home at the time. So far the police have not been informed, but we have taken steps to inform the Multi-Agency Public Protection team (MAPP). Following discussion with his RMO (RMO5), a decision was made to admit him informally for his own safety.

A full risk assessment of Mr Bryan will be undertaken while he is on the ward. Any indication of risks will be forwarded to you.

In light of the above allegation coming to my attention, I intend to put on hold my previous application to move him to a low support accommodation. I would also like to take this opportunity to seek permission to move Peter to another appropriate residential home that offers 24-hour support before he is discharged from hospital. I will keep you inform of events as soon as I have more information.

Should you require further information on this matter, please do not hesitate to contact me."

It was prompt and good practice on the part of Social Worker 5 to put on hold the transfer to Glenarm Road. It would clearly not have been appropriate to have continued to progress Peter Bryan's transfer to low support accommodation in the light of recent events. It also shows that Social Worker 5 did have some concerns about Peter Bryan's alleged behaviour.

The letter to the Home Office states that a full risk assessment would be undertaken while Peter Bryan was on Topaz Ward. However when we interviewed him Social Worker 5 accepted that on 9 February when he and the Forensic CPN saw Peter Bryan, he had felt that Peter Bryan's mental health was stable and he would not have asked for a risk assessment. He could not explain to us what had happened between 9 February and the following day when he admitted Peter Bryan to Topaz Ward that had made him change his mind about the necessity for a risk assessment other than to say:

"At that point I felt it was necessary that whilst he was in this environment that I thought a risk assessment should be undertaken 'just to see'."

From Police documentation which was provided to us, it seems that the Public Protection Unit was contacted by the Forensic CPN on 11 February who told them that Peter Bryan was now in Topaz ward on the psychiatric wing of Newham Hospital as a voluntary patient "*pending his recall to Rampton Special Hospital*".

It seems strange that the Forensic CPN would have said this (and he denies that he said this). Despite having threatened Peter Bryan with the possibility of recall, it does not seem as though recall was seriously being considered and recall would most likely have been initially to the psychiatric intensive care unit (PICU) at Newham Hospital. It is most unlikely that he would have been recalled to Rampton Hospital.

18. On the morning of 12 February it was noted in the ward notes that the Forensic CPN had telephoned to report that Peter Bryan had been accused of sexually assaulting a woman at the hostel where he had been living **(which was not correct)** and that she was going to press charges and that the nursing staff should be aware that the police might visit Peter Bryan on the ward. The Forensic CPN had also stated that it had been reported that some strange men

had been seen around the hostel and that they wanted to kidnap Peter Bryan and take him to a lonely place and beat him and kill him.

19. The Forensic CPN requested that the nursing staff should be cautious about who visited Peter Bryan on the ward and that all visitors should be vetted.

20. A nursing entry that afternoon described a one-to-one session with Peter Bryan who stated that he was reflecting on his behaviour when he was at the hostel and felt that he should have acted more calmly and should not have lost his temper. He also spent time watching television in the company of other patients and appeared calm.

21. A later entry described him as "*showing a bright face*" and that there was no sign of aggression towards others. He appeared to have slept well although he stated the following morning that he had had some difficulty sleeping.

22. Just after midday on 13 February RMO5 saw Peter Bryan on the ward round. It was noted:

"Doesn't feel did have any sex with the lady (who is alleging)

Not happy that had to spend two years in Riverside.

Has been charged by a lady (indecent behaviour)

Doesn't want to go back to Riverside.

Not taking any drugs.

Told him that will not have visitors.

Feels like hands are tied."

23. A nursing note a couple of hours later stated:

"Peter seems settled on the Ward, no psychotic symptoms have been observed. Adequate diet and fluid intake. No management problems. Seen in the Management round and he was

informed as to why he is on TOPAZ ward. It is for his "SAFETY" as there (sic) allegations about him and possibly some individuals may want to do some harm on a Ward.

The nursing entry: Peter had visitors and was informed before they came on to the ward. Happy to see his visitors. Request for a fax to be sent to his accommodation this was done. Received a T/C from staff at the home states that Peter should not send anyone to the home to get his belongings and that they will be coming on Monday to see him. Peter did not express any anger. Spent time in day area. All well."

This is the first of several entries in the clinical records that Peter Bryan was on Topaz Ward for his own safety.

The nurses whom we interviewed were all clear that it was their understanding that Peter Bryan was on the ward for his own safety and not because he was mentally unwell.

As a consequence, routine mental state assessments were not carried out. He was however kept under close observation for the first 72 hours.

Peter Bryan also told us that it was his understanding that he was only admitted to Topaz Ward for his own safety.

24. Peter Bryan's Named Nurse wrote the following in the Care Plan Evaluation/Review Record:

"Following observation in the last 72 hours Mr Bryan has not displayed any altered thoughts, physical/aggression behaviour. Adequate diet and fluid intake and presented no management problems. It is therefore of my opinion that the Care Plan number 1 be discontinued."

25. A new Care Plan 2 was devised dated 13 February:

"Needs/Area of Concern: Peter has a diagnosis of paranoid psychosis.

Goal: To monitor Peter's mental state while on a Ward. If he is displaying any psychotic ideation.

Intervention: (1) staff to monitor if he displays any paranoid ideation

(2) named nurse to have a one-to-one with him at least 15 minutes every two days

(3) Peter to express his feeling to allocated Nurse if he feels unwell."

26. There is a Care Plan 3 which was also dated 13 February:

"Needs/Area of Concern: Peter is on Topaz ward due to his own "SAFETY".

Goal: to provide a safer environment while his (sic) on the ward.

Intervention: (1) staff to monitor the visitors that come to see him while on a Ward

(2) staff to encourage him to provide some information if he feels threatened whilst on the ward

(3) staff to encourage him to meet occasionally to discuss about issues that arise on the ward and outside about his safety."

27. There is also a Care Plan 4, the date of which appears to have been altered to 10.2.04:

"Needs/Area of Concern: Placed on intermittent observation

Goal: to monitor his well-being while on the ward as he is a new patient

Intervention: (1) to monitor his mental state

(2) staff to observe the environment in which Peter is placing himself

(3) to be observed every 15 minutes due to the new environment"

Social Worker 5 told us that he visited Peter Bryan briefly on the same day as RMO5 and that there was nothing significantly different about him and he appeared to be fine.

28. The Riverside House notes for 13 February record that Peter Bryan rang the hostel at 18.00 and sent a fax requesting that one of the residents should clear out his room. Deputy Manager 2 noted that he had advised Peter Bryan to speak to the Forensic CPN first and to make all arrangements in writing and through the Manager.

29. It was noted that the Manager was planning to visit Peter Bryan the following Monday to collect his keys etc and to make arrangements to remove his property from his room.

30. The night shift notes on Topaz Ward record that Peter Bryan remained settled and spent time in the smoking room before retiring to bed around 23.00. He appeared to have slept throughout the night.

31. He remained settled on 14 February and appeared bright in mood. He was visited by his family. The nightshift notes also record him to be settled in mood and friendly on approach. He retired to bed after eating an Indian take-away and watching a football match. He slept well.

32. Throughout 15 February he remained settled and compliant and interacted well with both staff and patients. He remained on intermittent observation for his safety. No psychotic behaviour was observed and he was no management problem. He spent the day on the ward and was apparently polite and pleasant. His mental state was noted as being stable and he reported that he felt fine.

33. A note timed at 19.50 that evening stated that at that time he was listening to music in the quiet room. He declined a one-to-one session with one of the nurses.

34. The night shift records states that Peter Bryan was apparently awake until 02.00 and had expressed some anxiety over the fact that the Manager of Riverside House was to visit that day. However he settled after that and slept. Intermittent observations were maintained through the night.

35. On 16 February Home Office 4, a case worker in the Mental Health Unit at the Home Office, wrote a note to her casework manager, Home Office 7:

"B has allegedly been involved in an incident of indecent assault on a 17-year-old girl, which he has denied. Friends and relatives of the girl went to confront B but he was not at home.

The police have not been informed, but steps are being taken to inform MAPPA. A decision was made to informally admit him and full risk assessment will be undertaken + any indication of risk will be forwarded to us. In the light of this, the S/W has asked that the application for independent accommodation be put on hold but has asked for B to be moved to another appropriate 24-hour support residential home (which I assume is so that an assault on B cannot be carried out). I have spoken with (RMO5) who has said that they had admitted him for observation only. He is not displaying any psychotic symptoms & his treatment has not been changed. It does not seem that another placement has been identified and I assume that this would be for the team to sort out. I would be grateful for your advice on how to progress with this."

The Panel are of the view that the casework manager should have been asked for his advice immediately on receipt of the information about the indecent assault. This had been received on 10 February and should not have been left for six days.

Home Office 8 agreed with us:

"It is a clear error. Even prior to the changes we brought in, any admission to hospital or any indication of potential serious offending should immediately have been brought to (Home Office 7)'s attention.

That is a clear error by the caseworker who, on receipt of the information on the 10th should have passed the case up to (Home Office 7). There were two reasons. First of all, there was the voluntary admission to hospital which, in itself, should have triggered the case going to her casework manager. Secondly there is the allegation which we understood at the time had not actually been reported to the police, because that was the information that we had from the Social Supervisor - but there was the fact that an allegation had been made and this should have been passed up to the casework manager.

If I were in that situation and received the case, I would initially have phoned the Social Supervisor as the one who obviously had some knowledge about it having contacted the caseworker. I would then have sought to speak to (RMO5) by telephone."

Home Office 8 told us that, partly as a result of this case, the Mental Health Unit of the Home Office had undertaken specific refresher training for all case working staff on what to do at certain trigger points. The Panel were reassured by this.

36. On 16 February Peter Bryan spent most of the day in the communal area watching television. The notes record that he was settled and that no psychotic symptoms were observed and that he complied with his treatment. He posed no management problem.

We now know that on 16 February Peter Bryan posted the following letter to a fellow resident at Riverside House. It arrived after the homicide of Brian Cherry and his distinctive handwriting was recognised by the Manager who opened it and handed it to the police. We have reproduced the letter as it was written:

P. B
NEWHAM GENERAL HOSPITAL
TOPAZ WARD

Hello P.A.
Hope you are fine and
keeping well. Well (the Manager) got her
way, but I can not stop
thinking who will be next.
NICKADEMUS may well be next
now the two Scots are
running thing. The problem is
their is not enough accomma
dation, but well I still
have my ACE Card to play.
Still if I am not happy
with it I can still play
my best card of all
sit and wait and see
what around the corner.
Life is full of thret

and turns, its about
how you cope with them.
Still the food is o.k and
time just ticks bye.
Anyway take care and
if you can look out
fore SaSQash, Tell him
keep out of trouble
and hold it down.
Life is still not going
to be easy its like
Rampton is still around
my neck, and slowly
getting tighter but it
dose not matter becaus
e I can not die.

Take care
[illegible]

P.S thank to the Jam I
cooking, to the max.

"Dear PA

Hope you are fine and keeping well. Well (the Manager) got her way, but I cannot stop thinking who will be next. Nickademus **(a nickname for one of the Riverside residents)** ***may well be next now the two Scott*** **(Peter Bryan told us that this word was 'Scouts' and referred to two other Riverside residents)** ***are running thing. The problem is there is not enough accommodation, but well, I still have my ACE card to play. Still if I am not happy with it I can still play my best card of all. Sit and wait and see what round the corner. Life is full of twist and turns, it's about how you cope with them. Still the food is okay and time just ticks bye.***

Anyway take care and if you can look out for Squash **(another resident),** ***tell him to keep out of trouble and hold it down. Life is still not going to be easy, it's like Rampton is still around my neck, and slowly getting tighter but it dose not matter because I can not die.***

Take care

Patchwork

PS thanks to the Jam **(Jamaican)** *I cooking, to the max."*

At first when the Panel asked him what his *'Ace Card'* was, Peter Bryan said that it was to ask his solicitor, Solicitor 1, if he could go before a Mental Health Review Tribunal. However, when it was pointed out by us that he had already set the Tribunal in motion and it was to take place on 1 March, just 13 days after he wrote the letter, he said that it meant that he wanted his passport to get out of the country.

On further questioning, Peter Bryan accepted that it was possible that when he wrote this letter he already had in his mind that he might do something such as he did the next day.

However we acknowledge that Peter Bryan has been considered an inconsistent historian who often says what he thinks the questioner wants to hear, and it is by no means clear that when he referred in the letter to his *'ACE card'* and *'If I am not happy with it I can still play my best card of all'* that he was referring to the homicide which occurred the following day.

It is interesting that he wrote about Rampton Hospital still being *"around (his) neck and slowly getting tighter"*, but again we would be merely speculating if we tried to interpret what this remark really meant.

It has to be remembered that no-one saw this letter prior to the homicide, and Peter Bryan did not talk to anyone in anything like those terms in the days leading up to the killing.

We showed the letter to RMO5, the Forensic CPN and Social Worker 5 and they all said that, had they seen this letter at the time that it was written, it would have caused them some concern and they would have questioned Peter Bryan about its meaning.

Unfortunately no-one saw what he had written and no-one was aware of the thoughts which were in his head at that time.

37. The night shift entry describes Peter Bryan as settled and friendly on approach and that his mood appeared to be stable. He was said to be interacting appropriately with other patients and staff. He watched television until just after 01.00 and then retired to bed and slept well.

38. The nurse who made that entry, Nurse 7, told the police later that he remembered that Peter Bryan was up again between 02.00 and 03.00 reading a newspaper and again at about 04.00 when he had a cigarette with him, but he had not recorded this in the notes.

39. He told us that the newspaper that Peter Bryan was reading was the Sun and he took it to his room with him. When Nurse 7 retrieved it later, he noticed that there was an article in it about the man in Germany who advertised on a 'cannibal website' for somebody whom he could kill and eat.

The 'German Cannibal' was convicted and sentenced on 30 January 2004 and there had been considerable media coverage of this story then and prior to that when the trial was covered, but we cannot find any reference to this story in the Sun newspaper or any other newspaper around 16 February 2004. However it may have been an old newspaper which Peter Bryan was reading.

When we asked Peter Bryan whether or not he had been influenced by the story of the 'German Cannibal', he denied that it had influenced him at all.

40. The morning shift nursing entry for 17 February describes Peter Bryan as having been calm on the ward and that he had not expressed any concerns about Care Plan 3.

41. There was a Ward Round Meeting that day to discuss Peter Bryan attended by RMO5, Psychiatrist 8, SHO4, the Forensic CPN, Social Worker 5, the Topaz Ward Manager, Nurse 8 (Peter Bryan's Named Nurse), an Occupational Therapist and various medical students.

42. Peter Bryan was not invited to participate in the meeting, apparently because RMO5 felt that there were too many people there.

43. There are two records of the Ward Round Meeting, one a pro forma with handwritten notes prepared by SHO4 and the other a typed note prepared by Peter Bryan's Named Nurse, Nurse 8.

44. SHO4's note states:

"Nursing Report: well. Settled. No problem as such.

(The Forensic CPN) → Police investigating allegations. Also reports that Peter in last 2/12 getting paranoid.

(RMO5) says no psychotic symptoms apparent. Peter Bryan said relationship at Riverside broke (?). (RMO5) feels he is improving and may be beneficial to find alternate accommodation. His safety is of concern.

(The Topaz Ward Manager) mentioned about proper Care Plan.

Not present at interview today (not called)

Vulnerability: yes

Plan: 1. (RMO5) said if any concern about safety of staffs etc may need to go to Crystal Ward.

2 (Social Worker 5) to look for alternate accommodation.

3. John Howard to assess him.

4. (The Forensic CPN) will find from Police about outcome of investigation

5. Visitors need to be restricted/monitored

6. If he wants to go out - up to him

He need to consent about his safety"

45. Nurse 8's note of the Ward Round Meeting was:

"Peter's care was discussed as to why he ended up on TOPAZ ward. (The Forensic CPN) informed the Ward round that there had been a breakdown of relationship between Peter and the residential home [Riverside House]. He went further to say that there is an ongoing investigation in regards to an alleged incident, which happened at the neighbour near where Peter reside. Furthermore, (the Forensic CPN) said that the Family of the victim were interviewed by the police as well as the service users. This made the service users unhappy about Peter, as they didn't want to be involved. (The Forensic CPN) said that the police might be coming soon to interview Peter.

(The Forensic CPN) pointed out, that Peter had not displayed any aggressive behaviour or taking illicit drugs probably in the last 2 years. He is self-medicating and working for 3 days in a week, which may have contributed to what happened. (The Topaz Ward Manager) asked about the plan for PETER BRYAN and how long are we going to keep him here for his safety bearing in mind that he is informal patient on an ACUTE WARD.

The team pointed out that since his admission he had been settled, calm and complying with medication. The patient's status was discussed while on the Topaz Ward. (RMO5) informed the team that it was discussed with Peter and he is aware that he is informal but he is here because of his safety. Therefore, it is up to him if he leaves the ward, he will be responsible for his safety.

PLAN:

- *(RMO5) agreed to refer Peter to John Howard Centre for assessment*
- *(The Forensic CPN) informed the meeting that he will give feedback to the ward as to the progress of the investigation and when the police will be coming to interview Peter*
- *(Social Worker 5) informed the meeting that he is going to try to look for another residential accommodation as soon as possible. This will enable Peter to move out of the ward"*

The Panel consider it quite extraordinary that there was no mention at the ward round meeting of the fairly imminent MHRT which was scheduled for 1 March - just 12 days later.

All of the key players in the care and treatment of Peter Bryan were present at that meeting, namely RMO5, Social Worker 5 and the Forensic CPN.

RMO5 and Social Worker 5 should by then have prepared reports for the hearing.

Peter Bryan was seeking an absolute discharge from any conditions which would mean that he could live freely and independently in the community and would no longer be subject to conditions or recall to hospital.

There had been recent concerns which must have affected any recommendations which RMO5 and Social Worker 5 would wish to make to the Tribunal, and yet these matters were not discussed at all.

Even more worrying was the fact that the Forensic CPN told us that he had no idea that Peter Bryan had made an application for an MHRT and that there was a hearing in only a few days time. When we asked him about the MHRT, he told us that it was the first time that he had heard about it.

When we asked RMO5 about his report for the MHRT, he told us that he had in fact dictated a draft report in the afternoon of 17 February, following the ward round meeting. He told us that he would try to extract a copy of the report from the computer. There was no copy of any report in the notes.

On the first occasion that we saw him, RMO5 told us that as part of the report to the tribunal, his normal practice was to go and see the patient to carry out a detailed mental state examination, and that he was planning to see him the next day to carry out the examination.

When we saw him on the second occasion, RMO5 gave us a copy of the draft report. He told us that the fact that he was dictating this report was one of the reasons why he did not see Peter Bryan on the day of the ward round.

He told us that it was very much a first draft - *"I just wanted to get thoughts in my head on to tape"*- and that after it had been typed up by his secretary, he would have amended it and *"it would have been fleshed out a bit more"*. However in principle his conclusions would have remained the same.

We pointed out to RMO5 that the report as it stood was not a very robust one if he was trying to prevent Peter Bryan being granted the absolute discharge which he was seeking at the MHRT. There was no mention of the fact that RMO5 had that very day requested a forensic assessment. That in itself would probably have been enough to prevent an absolute discharge until the outcome of that assessment was known.

RMO5 told us:

"All I can say is these are some of the thoughts I had at the time. I just wanted to make sure that I got a start on the report."

When we pointed out that the tribunal hearing was only 11 days away and it seemed as though he and Social Worker 5 were not even discussing it, RMO5 said:

"I couldn't answer why we weren't. I don't think there was any reason not to, or that it wasn't considered."

He accepted that it would have made a tremendous difference to the whole management of Peter Bryan if he were to be granted an absolute discharge and that it was important to be sure that both he and Social Worker 5 were putting in as robust a report as they possibly could.

RMO5's draft report is set out below:

Department of Psychiatry
Newham Centre for Mental Health (NCfMH)

17 February 2004

Our ref: SB/jk/08 90 32

AN UPDATE REPORT ON MR PETER BRYAN(d.o.b. 04. 01. 69)

Mr Bryan was transferred to John Howard Centre in July 2001.

On 11th January 2002 he was conditionally discharged by Tribunal.

In February 2002 he was placed at Riverside House, which is a 24hrs-staffed facility. For the initial six months of his discharge from John Howard Centre he was being followed up by (RMO4)'s Team. He was then transferred to my care. For the large part of his follow up, his social supervisor and care coordinator has been (Social Worker 5) and he was also monitored by(the Forensic CPN) and I have also seen him regularly for CPA's review during which staff member from the Riverside house has attended.

During this period there had been a number of recurrent things, which are needed to be addressed:

1} MEDICATION:

Mr Bryan has consistently requested to come off the medication. His argument is that whilst he was in Rampton Hospital he had been off the medication for a while and he was quite well and had been restarted on the medication because he had been a bit boisterous on a few occasions. However the reports from the time suggest that Mr Bryan had become paranoid and increasingly irritable and this had prompted his medication being restarted. He also complained of the side effect from the medication in the form of gynaecomastia, which is enlargement of the breast. This could feasibly be a side effect of the type of medication, which is trifluoperazine, and hence this was changed. Given the fact that Mr Bryan was on a low dose of the trifluoperazine he was also placed on a low dose of olanzapine, which is 5mgs as he also complained of weight gain on the olanzapine, which is again a likely side effect.

His request to come off medication continues to be ongoing preoccupation with Mr Bryan and he has been informed that considering the number of changes that likely to take place in his life if he were to live independently. It was very important that he had the safety net of the medication and any review would take place after he has had a reasonably lengthy period of stability in the community at least for a year.

2} FRUSTRATION:

Frustration had been in 24hrs staff facility. Mr Brian has also consistently expressed his frustration at being Riverside House. He likens there is still a continuous of his prison sentence and has wanted to move into his own accommodation fairly quickly. On a related mood he has always carried complaints about the residential placement. These complaints have usually related to matters about visitors. Mr Bryan has often felt that his visitors were treated differently although on clarification with the staff at the Riverside Housing his presence it clearly would appear that the staff were following the normal policy and procedures of the hostel.

3} DRUG AND ALCOHOL ABUSE:

This was a very important part of his care plan that he receives counselling for his drug abuse, which he attended regularly and he was also subjected to regular drug tests which were always negative apart from (1) which was marginally positive for amphetamines, but was confirmed by sending it to Lab and this was in fact negative. In this instance Mr Bryan's behaviour has been very encouraging.

As such Mr Bryan was making adequate progress and plans were place for him to move to a hostel with decreased supervision. This would have provided a halfway house, which he is moving into the community completely independently. Mr Bryan continued to show his frustration that things are not moving as quickly as he wished them to. However more recently there were increasing concerns expressed by the staff at the hostel.

In November it was reported that Mr Bryan had started working as a cleaner. Which in itself was quite positive, however this meant that he worked night and this would impact on his sleep wake cycle. Prior to this, a programme was started to get Mr Bryan to self medicate as this would be required if he were to go to a less supervised place. The staff reported that in January Mr Bryan had started to complain that the painters and decorators had deliberately spilled paint on his music system and his clothes. This was unusual as he was the only resident who made this complaint. In addition he also believed that £300 of his money had been stolen from his room. This issue raised particular worries as loss of money or money being owed to him had played a major part in his original index offence. Moreover there were increasing incidents when Mr Bryan was pushing the boundaries at the hostel. He was seen urgently at the Community Mental Health Team and it was decided that he would be monitored for two more weeks and if necessary he would be admitted to hospital.

However certain events over took any planned decision-making as Mr Bryan was accused of allegedly sexually assaulting a 17-year-old girl. From the information available there are certainly some worries that Mr Bryan visited a young girl making sure that her father was not around. As the accusation of the alleged incident naturally a very serious one and also there were increasing concerns that as a result of this incident Mr Bryan himself might be a victim of violence. He was admitted informally to Topaz ward.

CONCLUSION:

Mr Bryan has a previous history of paranoid schizophrenia, which is well controlled with medication. Despite his protestations that he doesn't require medication, there is evidence from previous report to suggest that there is definite change in his behaviour when he is off medication. Although admittedly during this period of observation over one and half years that I have known him he has not displayed any obvious symptoms of psychosis. More recently his behaviour would suggest that it would be prudent to take a cautious view that all of a sudden, the changes in his behaviour are significant enough to taken seriously. In addition in the light of his previous history the recent allegations also need to be taken seriously. It is hard to differentiate whether they bear any direct relationship with his previously diagnosed illness or they manifestation of poor social judgement. However in order to put principal of safety first. For the time being Mr Bryan requires to be in hospital while his mental state is closely observed. Given the reason of events I would like to recommend that Mr Bryan is not unconditionally discharge from his Section.

Yours sincerely

(RMO5)
Consultant Psychiatrist

RMO5 did not go to see Peter Bryan following the ward round. He did however accede to Peter Bryan's request for permission to leave the ward and said that he could do so as long as he took responsibility for his own safety and returned to the ward by hand over time to the nightshift staff.

The Panel are of the view that RMO5 should have seen Peter Bryan that day, especially if he were going to allow him leave for the first time since he had been admitted to Topaz Ward.

However, we acknowledge that, even if RMO5 had seen Peter Bryan, it is unlikely that he would have changed his mind about allowing him to leave the ward that afternoon. Everyone who saw Peter Bryan that day said that he was behaving perfectly normally and was not displaying any signs of any deterioration in his mental state nor was he showing any anxiety.

It was also recorded that RMO5 was going to refer Peter Bryan for an assessment by the forensic service and indeed a letter was dictated by him that afternoon:

"Dear Colleague,

I would like to refer Mr Bryan for an assessment. He was transferred to my care in January 2002 by (RMO4). He had been transferred from Rampton on a Section 37/41 to John Howard Centre but had been conditionally discharged. His index offence was manslaughter due to diminished responsibility.

Since his discharge he has been living at Riverside House in Hackney. More recently there have been increasing concerns regarding his behaviour and this has culminated in his being admitted informally to Topaz Ward following an incident of alleged sexual assault on a 17-year-old girl.

I would be very grateful for an early report."

Two witnesses told us quite independently that the referral for a forensic assessment was because it was necessary to support a placement in another forensic hostel now that it was not possible for Peter Bryan to return to Riverside House.

However all of the key professionals were adamant that this referral for a forensic psychiatric assessment was because there were concerns about Peter Bryan's mental state, although this is not consistent with the rest of the evidence.

When RMO5 was asked whether the forensic assessment was requested because he was very worried that Peter Bryan was a high risk or to reassure him that his lack of concern was justifiable, RMO5 accepted that it was more the latter reason.

He also agreed with the suggestion that if the alarm bells had been louder, he would probably have initiated a forensic assessment much earlier, despite the difficulties in getting one.

46. Following the ward round, the Forensic CPN went to see Peter Bryan and had a chat with him about what had been discussed at the Ward Round Meeting.

The Forensic CPN told us that there was nothing untoward about Peter Bryan. He was quite relaxed and he was not showing any signs of thought disorder and was not agitated. He just wanted to know what was going on and what had happened in the ward round.

The Forensic CPN told him that it was likely that he would have to remain in hospital for quite a while. They also discussed the allegations that had been made and the fact that the police were probably going to come to see him on the ward and that a forensic assessment would have to be made.

Social Worker 5 also told us that he had said hello briefly to Peter Bryan that morning and that he had seemed quite normal.

However it is likely that Peter Bryan was feeling considerable stress and anxiety at this time.

He was back in hospital in a psychiatric ward, serious allegations had been made against him which were going to be investigated by the police, he was under threat of recall as a compulsorily detained patient and he did not know where he was going to go from Topaz Ward if he were not recalled.

The Forensic CPN told us that as far as he was concerned no firm decision as to where Peter Bryan would go had been made by the time of the ward round on the 17th of February. He told us:

"Certainly at that stage it hadn't been decided that he was no longer going back to Riverside. No one had made that decision at all, not that I was aware of anyway."

However Social Worker 5 and the Manager of Riverside House made it quite clear to us that the decision had already been made that Peter Bryan would not be returning to Riverside House.

Social Worker 5 told us that it had already been agreed that he would not return to Riverside House once he was admitted to Topaz Ward. He said that he had made the decision because he was concerned that Peter Bryan could be attacked by the people who

were looking for him, or that members of staff or other residents of Riverside could be at risk from them.

The Manager of Riverside House also told us that she would not have taken Peter Bryan back as a resident.

Once again there appears to have been no communication or collaboration between Social Worker 5 and the Forensic CPN over this decision and RMO5 appears to have been 'out of the loop'.

We know that Peter Bryan telephoned the Manager of Riverside House at about 14.30 to 15.00 on the 17th of February just before he left Topaz Ward and told her that there was a shortage of beds on the ward and that he would have to come back to Riverside. She explained to him that he would not be able to return.

So when he left Topaz Ward that afternoon his future was very uncertain.

He did not know how long he was going to have to stay on Topaz Ward until alternative accommodation was found for him, and it was clear to him that he was viewed as a 'bed blocker' by the nursing staff. He told the Panel:

"They were saying to me that I'm taking up somebody's bed and I might as well go back to Riverside. They made me feel like I'm no use any more."

He was going to be assessed by the forensic psychiatric service and might yet be recalled and compulsorily detained.

Serious allegations of an indecent assault had been made against him and were likely to be investigated by the police.

All of these factors would have caused him considerable stress.

Stress was a key relapse indicator identified by Psychologist 5 and others, and Peter Bryan himself had identified stress as being a risk indicator prior to the killing of NS, as well as feeling that he was backed into a corner and could not win.

He was only 12 days away from the MHRT at which he had been going to ask for an absolute discharge from Section 37/41, but he must have felt that his chances of achieving an absolute discharge were fading fast.

When we asked Peter Bryan if that afternoon he felt he was being backed into a corner with no real way out of it, he said "*Definitely*". When we asked him if it made him angry or just anxious or both, he replied:

"I don't know about angry but I was a seasoned professional because I'd done manslaughter before, so I just take it all in my stride."

We asked him if that meant that because he had committed manslaughter before and because he had nowhere else to go, he might as well do it again, he answered:

"It's not that I wanted to do it again. It just happened that way."

Even though, with the benefit of hindsight, it is regrettable that Peter Bryan was given leave from the ward on 17 February 2004, the Panel is of the view that it was not inappropriate to allow Peter Bryan to leave the ward that afternoon, given the circumstances which prevailed at that time.

He was an informal patient and that meant that he was free to leave the ward at any time, although he had been advised not to leave the ward during the previous week and he had complied with that advice.

His mental state and behaviour whilst he had been on Topaz Ward had not caused any concern and it must also be remembered that he was really only in hospital for his own safety.

Therefore there were no grounds to invoke section 5 (2) or section 5 (4) MHA to prevent him leaving the hospital.[12]

[12] Section 5(2) MHA: 'If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner in charge of the treatment of the patient that an application ought to be made for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in hospital for a period of 72 hours from the time when the report is so furnished'

We interviewed 6 people who saw Peter Bryan on Topaz Ward on the day of the homicide, and all of them confirmed that he was acting quite normally and showed no obvious signs of mental disorder.

There can therefore be no criticism of the decision to allow Peter Bryan to leave Topaz Ward on the afternoon of 17 February 2004.

47. Sometime that afternoon, probably just before 15.00, Peter Bryan telephoned the Manager of Riverside House and told her that staff on the ward were saying that there was a shortage of beds and that he would have to come back to Riverside House.

48. The Manager explained to Peter Bryan that he would not be able to return to Riverside House and that they would take care of his belongings.

49. At about 15.00 one of the nurses, Nurse 9, was in the ward office when Peter Bryan approached him and briefly discussed the outcome of the Ward Round Meeting.

50. Peter Bryan told the nurse that he had been informed after the ward round that he could go out if he wanted to. Nurse 9 had not been aware of this decision and therefore went to check the ward round summaries. Having clarified that it had been agreed that Peter Bryan could go out if he wanted to, it was agreed that he could go out as long as he was back on the ward by hand over time.

Nurse 9 told us that Peter Bryan was behaving completely normally and this was confirmed by Social Worker 6, a Senior Practitioner in Social Work, who was a member of the same CMHT as Social Worker 5. She happened to be in the ward office as she was visiting one of the other patients on Topaz Ward and she told us that she remembered Peter Bryan coming in to ask if he could leave the ward. She described him as quiet and unassuming with no signs of being unwell.

Section 5(4) MHA: 'If, in the case of a patient who is receiving treatment for mental disorder as an in-patient in hospital, it appears to a nurse of the prescribed class –

(a) that the patient is suffering from mental disorder to such a degree that it is necessary to his health or safety or for the protection of others to him to be immediately restrained from leaving the hospital; and

(b) that it is not practicable to secure the immediate attendance of practitioner for the purpose of furnishing a report under subsection (2) above,

the nurse may record that fact in writing; and in that event the patient may be detained in hospital for a period of six hours from the time when that fact is so recorded or until the earlier arrival at the place where the patient is detained of practitioner having power to furnish a report under that subsection.'

When we asked Peter Bryan whether or not he told anyone what was going on inside his head at that time, he replied:

"I didn't know what was going on inside me. I was all butterflied up, but I didn't know."

51. Peter Bryan left Topaz Ward some time between 15:00 and 16:00.

The Homicide of Brian Cherry

The account of what happened after Peter Bryan left Topaz Ward is taken from the witness statements of people interviewed by the police, from our own interviews with the arresting police officers, from the Court transcripts at his trial in March 2005, from accounts given by Peter Bryan to various professionals and from Peter Bryan himself when we interviewed him at Broadmoor Hospital.

1. On leaving the hospital Peter Bryan took a bus to Stratford where he went in to a branch of the builders' merchant Jewson and purchased a claw hammer, a Stanley knife and a screwdriver. The till receipt was timed at 16.22 and a CCTV camera showed Peter Bryan leaving the store at 16.27.

It is perhaps significant that Peter Bryan described the store to us as "*the weapons shop*". He told us that he had purchased these tools so that he was prepared '*if there was going to be any fighting*'.

When we asked him if he had any intention of going to Brian Cherry's house when he left the hospital that day, Peter Bryan told us:

"I can't say that I did. I just jumped on any buses that came along."

On further questioning as to whether he had the intention to kill him, once he had purchased the tools and had found himself at Brian Cherry's home, he said:

"What I thought I was going to do - I was going to stay around Mr Cherry's house, go out, maybe kill somebody and come back to Mr Cherry's, but it didn't work out that way."

Peter Bryan then admitted that he had had thoughts about harming someone else that day, and when asked again whether killing someone was really what he was talking about the previous day when he wrote the letter about his 'ace card', he said:

***"I guess it might have been, yes"*.**

Solicitor 3, Peter Bryan's solicitor who was with him during the interview with the Panel, very properly pointed out that earlier he had said that the 'ace card' was his Tribunal and that he should not be led and should say only what he remembered. He then said:

"Yes, but I do think I was - I had that in my mind, but I had already tried it with my solicitor and I had already tried it with (the Forensic CPN), tried it with the Tribunal, you know, I've got all these cards but I couldn't play them at the time."

It is impossible to do anything other than speculate as to what the letter that Peter Bryan wrote the day before the homicide of Brian Cherry really meant. It would be wrong to attach too much meaning to it because of the influence of hindsight.

It is also noteworthy that his interview with the Inquiry Panel was the first time that Peter Bryan appears to have stated that it was his intention to harm someone that day. In previous interviews with psychiatrists and psychologists, he had said that he went to Brian Cherry's house with the intention to rob him.

Before we interviewed Peter Bryan he had also been interviewed by the Inquiry Panel investigating the homicide of Richard Loudwell in Broadmoor. He told them that it seemed as though *"my life had a momentum by itself"*.

When we asked him what he meant by that, he said:

"It's like I've done the deed - bad things - and before I know it…my brain starts going off in different directions."

We asked him if it was affecting him the day he killed Brian Cherry and he said:

"It's like a rolling ball, just a rolling ball picking up snow, and it picks up momentum and I can't slow it down."

He said that he was quite conscious of what was happening in the back of his mind but said: *"I don't think I could stop it. That's the problem. I've got my own destiny haven't I?"*

As we have already said, we are aware that Peter Bryan is not always an accurate historian and will often say what he thinks others want to hear. All we can do is report what he told us.

2. From Stratford Peter Bryan took another bus to Walthamstow and went to Brian Cherry's flat.

We were told by Brian Cherry's family that he was a 45 year old man who had been living alone in a Council flat for about four or five years. Prior to that he had lived with his parents, but had been rehoused when they had to go into sheltered accommodation. However he visited his parents' home most evenings.

Although he suffered from epilepsy, he had been in work, but he suffered an accident in which his thumb was severed and had to be reattached with microsurgery. Following the accident he was made redundant and also received compensation, which we were told amounted to about £8,000. From then on he received severe disability allowance, which was most likely because of his epilepsy which apparently became much worse after the accident.

Brian Cherry's brother described him as *"A sweet man. Everyone says he was a sweet man. He was really nice."*

His sister's husband told us:

"He was just a big softie really. He had his moments. He didn't deserve what happened to him."

The family told us that they felt that they had received very little support following the death of Brian Cherry. Other than having a Police Liaison Officer assigned to them up until the trial, about whom they were extremely complimentary, very little else was offered to them.

They said that they would have welcomed the offer of some form of counselling and were particularly upset that they learned about their brother's death for the first time when they saw the reports in the media.

If this account is correct, the Panel consider that more should have been done to support the family and to protect them from the intrusion of the media, which they apparently found extremely upsetting.

Peter Bryan had apparently met Brian Cherry through a young girl, P8, whom he had befriended some two years previously. They had met through her friend P7 who was a friend of one of the residents in Riverside House.

According to her witness statement to the police, P8 was a habitual user of drugs, mainly crack cocaine. She had known Brian Cherry for over a year and it was clear that he was infatuated with her. He believed that she was his girlfriend although there was never any sexual relationship between them. She admitted that she took advantage of this fact and his loneliness to extract money from him to pay for her drug habit.

She would visit him with her friend P7 about four times a week at any time of the day and he would allow them to drink and take drugs in his flat.

She said that Brian Cherry would give her more than £100 a week. She would tell him that it was for minicabs because she was banned from driving. She understood that the money came from compensation that he had received for an injury which he had suffered and his disability benefit. She believed that he had given her something between £4,000 and £5,000 in total over the period that she had known him. He never asked for anything in return.

P8 said that on the first occasion that she and Peter Bryan had met, in P7's flat in the summer of 2002, Peter Bryan had given P7 £20 for drugs for P7 and P8. They both bought drugs later that night and smoked them in P7's bedroom. Peter Bryan was present and stayed a couple of hours.

She said that Peter Bryan gave her and/or P7 £20 on most occasions when he met them and that he knew that it was for drugs. She said that he gave them the money because he knew that they would not agree to meet him unless he was going to give them money for drugs. He apparently would ask what he would get in return for giving them all that money and they would tell him that he was just their friend, nothing else.

Once Peter Bryan had bought his car, he would drive them to get drugs, give them £20 and the girls would smoke the drugs in his car. P8 said that, as far as she knew, Peter Bryan did not use drugs himself.

P8 told the police that in the summer of 2003, Peter Bryan had telephoned her and told her that he had booked a hotel near where he lived in Seven Sisters Road. He asked P8 to come to the hotel alone without P7. He did not say why but P8 believed that he wanted sex.

She in fact took P7 to the hotel with her and Peter Bryan kept telling P7 to leave and pushed her out of the room. P8 stayed in the room with Peter Bryan and tried to get some drugs from him. At some stage before P7 returned, Peter Bryan asked P8 to give him a 'blow job' in return for all the money he had given her. She refused and said that she was not like that.

At some stage during the evening P7 and she smoked a 'rock' and Peter Bryan took a 'rock' and said that he was going to sell it.

Some months later, Peter Bryan went to Brian Cherry's house to pick P8 up and drove her to Riverside House. He had sneaked her into his room to smoke drugs and then a friend of his gave Peter Bryan a key from the same hotel that he had previously invited her to. They went there because P8 was not allowed to stay in his room at Riverside.

At the hotel Peter Bryan asked P8 to lie down on the bed and she told him that she did not want to and said that she wanted to go home. He asked why she had agreed to go to the hotel and she told him that she was there to smoke drugs. Peter Bryan then drove her back to her house.

P8 told the police that Peter Bryan had been to Brian Cherry's flat with her on three occasions (although between her two witness statements she describes four occasions).

The first time she said was just before Christmas 2003 (but as that was only two months before the homicide that date is unlikely to be correct) when he had picked her up in his car from Brian Cherry's flat and he had driven her and Brian Cherry to the bank so that Brian Cherry could get some money for her. In one statement P8 said that Peter Bryan had not actually gone into the flat on that occasion, but in another statement she said that he had. (It is likely that this was the occasion mentioned above when Peter Bryan then took P8 back to Riverside House.)

She had introduced Peter Bryan as a friend of hers. She told Brian Cherry that Peter Bryan was going to arrange for her to get a room and that that was what she needed the money for.

A couple of days afterwards Peter Bryan went with P8 and P7 to Brian Cherry's flat and on that occasion P8 got more money from Brian Cherry to buy drugs.

The next occasion she said was about two months before the homicide. Peter Bryan had gone to Brian Cherry's flat with P8 and P7. P8 had been smoking crack cocaine that day and asked Peter Bryan to go with her into Brian Cherry's bedroom. She told Brian Cherry that she wanted to see Peter Bryan privately otherwise Brian Cherry would have followed her into his bedroom. Once in the bedroom she stole £50 from Brian Cherry's bag.

A few days later the three of them visited Brian Cherry's again. Peter Bryan told P8 that he wanted to speak to her and asked her to go into Brian Cherry's bedroom. They did so and Brian Cherry and P7 remained in the living room. Peter Bryan pushed P8 against the bedroom door but she managed to push him away and told him that he was out of order and told him to leave the flat which he did.

There was apparently another occasion when Peter Bryan went to Brian Cherry's flat on his own, apparently looking for P8. Brian Cherry had let Peter Bryan into the flat. At that time P8 had left some of her belongings at Brian Cherry's flat because she had been evicted from where she had been living. Brian Cherry told P8 that Peter Bryan had looked through her bags and her underwear.

It is likely that Peter Bryan arrived at Brian Cherry's flat sometime just after 18.00 on 17 February 2004.

P8 told the police that she had telephoned Brian Cherry that evening at 18.00 and told him that she would be coming to his flat soon to pick up her cigarettes. (Earlier that day she and a friend P9 had gone out with Brian Cherry to so that he could draw out some money from a cash machine for them. They then used the money to purchase drugs.)

Brian Cherry said that he would see her later. Her impression was that he was on his own at the time.

P8 telephoned Brian Cherry again three times between 18.30 and 18.45 but got no answer.

3. Brian Cherry apparently opened the door to Peter Bryan and shortly afterwards, Peter Bryan killed him.

Peter Bryan gave the Panel the following version of events:

"I found my way to Mr Cherry's address and I knocked on the door and he said 'Come in'. So I came in, went to the toilet and put the hammer in my trousers and put the bag in the bathroom.

I went into the kitchen with him. He was talking about 'He ain't seen (P8) all day and where is she and do I want a cup of coffee?' and I said 'no, no', and I was thinking to myself 'Look at this guy. He's living like a' – how can I put it? – 'roughish life, and every money he gets he gives it to (P8). I just thought to myself 'I'm going to ask him for some money.'

So he walked into the TV room. I asked him for some money and he said he doesn't have any, so I pulled out the bolster –the hammer – and just started hitting him with it. I could have lost that fight two, three times actually because I've got a scar on this finger where he bit me, and then he tried to grab my legs, but I was too wild I guess, like a wild animal. He stopped breathing – no, he didn't stop breathing, he kept breathing – so I kept kicking his head in and then I saw this blob of meat on the floor. I thought he was dead so I picked it up, washed it, put it in a pan with a knob of butter and cooked it up, like scrambled egg, and I pulled out my super malt because I went to the off-licence before I went to Mr Cherry's house.

I opened my super malt and then started drinking it and eating what I know now was Mr Cherry's brains, and then he started breathing again, like the life was still in him, so I went over there and hit him a few more times.

I was thinking to myself 'This feels good. This is letting all the tension out'. So I picked up the Stanley knife and I started cutting him into bits. That's as far as I got because the police came – no, (P8) came."

4. At about 19.30 P8 arrived at Brian Cherry's flat. She had been driven by a friend P9 who remained in the car while she went in to the flat to get the cigarettes and some more money from Brian Cherry.

5. P8 rang the doorbell to Brian Cherry's flat but got no answer. She could hear movement inside the flat and so she pushed the front door open (it had been damaged previously and did not shut properly unless it was double-locked.

6. Immediately she opened the front door she smelt disinfectant which she had never smelt there before.

   NS's mother had told the police after the death of her daughter that shortly before the homicide, Peter Bryan had smelt strongly of disinfectant as if he had been washing his face with it.

7. As she walked into the flat, Peter Bryan came out of the front room. He had no clothing on the upper half of his body and he was sweating. He had what looked like a kitchen knife in his hand.

8. P8 asked him what he was doing there and where Brian Cherry was and Peter Bryan told her to go away.

9. When she asked again where Brian Cherry was, Peter Bryan said "*Brian is dead*". He went towards the front door as if to close it, and P8 momentarily looked into the front room and saw Brian Cherry lying on the floor, naked. He was lying on his back and his right arm had been dismembered and was lying a few inches from his body.

10. P8 tried to act as normally as she could and told Peter Bryan that she was leaving, saying "*I'll see you later*". She then left the flat and Peter Bryan closed the front door behind her.

11. She later went to her mother's house and told her what she had seen. She said that she was afraid to call the police because she thought that there was a warrant out for her and she would be arrested. (She was in fact arrested later but never charged with any offence) Her mother called the police.

Peter Bryan admitted to us that he was very fond of P8 but was not sure if he saw Brian Cherry as any sort of rival for her affections.

When we asked him why he did not try to get away once he knew that P8 had discovered what he had done and had left, he replied:

"I hadn't finished cutting him up, and it felt so soothing when I was cutting him up."

12. Police Constable 1 and Police Constable 2 were on duty in a police car when at approximately 19.45 they received a call to go to Brian Cherry's flat.

13. On arriving at the block of flats they approached the front door of Brian Cherry's flat and knocked loudly on the door, identifying themselves as police officers. After repeatedly knocking three or four times, they got no response and therefore they forced entry to the property.

14. As the door opened, they saw that the hallway was in darkness. There was an overwhelming smell of disinfectant.

15. Almost immediately they were confronted by Peter Bryan who was bare-chested and just wearing denim jeans and trainers. He was sweating profusely and his arms from the elbows downwards were covered in dried blood and his jeans and trainers were heavily bloodstained.

16. Peter Bryan looked quite startled and shocked to see them and for several seconds there was an awkward silence.

17. At first the police officers assumed that he was probably the man who had been injured and asked him if he was all right and if he had been injured. He replied that he was OK.

18. The police officers then asked him if he lived at that address and when he said that he did not, they asked him what he was doing there. He said that he had broken in to the flat - that he had knocked on the door and pushed his way in and that there had been "*a bit of a struggle*".

19. Police Constable 1 told Peter Bryan to stay where he was and to keep his hands where he could see them and Peter Bryan apparently remained calm, quiet and responsive. Police Constable 2 went to search the rest of the flat and found Brian Cherry's body in the living room.

20. At this point two other police officers arrived and Police Constable 2 explained that there was a lifeless body in the room he had just come out of. Police Constable 1 then went into the room and saw that both Brian Cherry's arms and his right leg had been completely severed from his body and his head was completely covered in blood. The left leg appeared to be partially cut off as well. (The post-mortem discovered that an attempt had also been made to decapitate the body.)

21. There was a Stanley knife lying under the severed leg and another kitchen knife on a chair leading out of the room. Just above the head there was a claw hammer. All these instruments were bloodstained. A later search revealed a saw behind the living room door, although there was no obvious blood staining on this, and a blood stained Stanley Screwdriver on the draining board by the sink in the kitchen.

22. When Peter Bryan was asked if he had severed the limbs, he calmly replied that he had. When asked whether Brian Cherry had been alive when he had arrived, Peter Bryan replied: *"Yes. He opened the door to me when I knocked"*. When asked if he had killed Brian Cherry, Peter Bryan replied: "*yeah"*.

23. Peter Bryan was then arrested and placed in handcuffs. While they were waiting for a police van to arrive, he said unsolicited "*I did it, yeah… I don't know why I did it"*.

24. When one of the police officers went into the kitchen, he watched her go in and said with a slight smirk: "*I ate his brain with butter. It was really nice"*.

25. In the kitchen the police officer found a plastic plate to the right of the cooker on which there appeared to be flesh with human hair coming from it. On the cooker was a frying pan containing a white substance with a yellow tinge to it which appeared to have been cooked.

The contents of the frying pan and the plate were later identified as being tissue from Brian Cherry.

Police Constable 1 told the Panel that while they were waiting for the police van to arrive, Peter Bryan said "*I wanted his soul*".

Police Constable 1 was with Peter Bryan for about an hour and a half in total and told us that Peter Bryan was very calm and very cooperative throughout. He made no attempt to escape and he described him as being as compliant as anybody he had ever had to arrest or even question. He told us:

"When we had time to reflect on it afterwards, it was quite chilling really – quite chilling how calm he was."

When we asked Police Constable 1 whether there was anything at all that he saw that day in Peter Bryan's behaviour (other than what he had done to Brian Cherry) that would have led him to think that Peter Bryan suffered from a mental illness, he answered:

"It was his demeanour…there were a lot of things going through our heads at the time but when I sat down and thought about it, it was just how he was so cool and calculated and very expressionless that I see that there were things going on inside his head. Obviously I'm not in a position to judge, but there was certainly something. I have never met anybody like that…he was very cool and calculating. He was very blasé about everything – that it was just – I'm not saying something you do every day - but it was something that he thought was not wrong in any way - what he had done."

Police Constable 1 also told us:

"I had the impression he was very very institutionalised – very. He was used to being told what to do - used to being asked questions.

When we asked if he had any impression that Peter Bryan was quite pleased to have been discovered and arrested, Police Constable 1 said:

"Yes. Yes…I just had the impression that he wanted the police to arrive and he wanted us to be there…"

When we asked Peter Bryan if he was surprised when the police arrived he told us:

"I was a bit taken aback but I was also at peace because they had a green medicine bag with a white cross on it, and it felt like I was at peace then."

26. The police van then arrived and Peter Bryan was taken to Barkingside Police Station where he was remanded in custody.

27. At 01.44 on 18 February a principal Forensic Medical Examiner, attended Barkingside Police Station to examine Peter Bryan.

28. The Forensic Medical Examiner certified that Peter Bryan was fit to be detained and that in his opinion he was fit to be interviewed in the presence of an appropriate adult. However he advised the police that as Peter Bryan had had serious mental health issues, they should consider asking his known psychiatrists to carry out a mental state assessment before any interview was carried out.

29. On 18 February Peter Bryan was interviewed and assessed by JHC Psychiatrist 2, Locum Consultant Forensic Psychiatrist at the John Howard Centre and Nurse 10, Senior Nurse Manager at the John Howard Centre.

30. The purpose of the interview was to assess whether Peter Bryan was fit to be interviewed by the police and to go through the criminal justice system, or whether he needed to be in hospital.

31. For the initial part of the assessment, RMO5 was also present, but was understandably upset by the situation and he therefore left.

    We were told that what had upset RMO5 was that Peter Bryan appeared very much the same as he always had, despite having recently killed someone in particularly horrific circumstances.

32. Peter Bryan was interviewed by JHC Psychiatrist 2 and Nurse 10 on their own without a police escort or even handcuffs on Peter Bryan.

    We find it worrying that the clinicians were left alone with an unrestrained suspect who had very recently killed someone in an extremely violent manner.

However JHC Psychiatrist 2 told us that despite being alone with Peter Bryan so soon after such a violent homicide, neither of them felt in any way uncomfortable or intimidated by him.

He also said that even though it was a long interview lasting some two hours, Peter Bryan remained very controlled and calm. He told us:

"It was an awfully long assessment…but there was a good reason for that. I wanted personally – and I know that (Nurse 10) felt similarly – to give this man as much opportunity as possible to demonstrate any symptoms that he had, and the way to approach that we felt was to let him talk – to let him talk himself into demonstrating illness if it was there…

We did everything in our power to elicit evidence of active psychosis, and there was not much there."

Apparently it was only the strange use of some words which made them question whether Peter Bryan was suffering from any mental disorder at the time. He said that their *"solace made him feel at peace"* and he described standing next to a woman at a bus stop on his way to Brian Cherry's flat and thinking that this woman's *"aura was very nice"*.

Nurse 10 told us that when he was talking about the woman's aura, she got this instinctive feeling that that woman was probably the luckiest person alive. She also said that at the end of the interview when she thanked him for answering their questions he said to her: *"Your aura is very nice and you make me safe"*.

JHC Psychiatrist 2 also said that Peter Bryan seemed quite aware of what he had done. He told us:

"He had clear ideas about his level of responsibility, and that was best summarised by his particular statement when he said words to the effect of 'I'll be nuttered off for life for this'.

What I understood by that was that he knew very well that he would be detained indefinitely in a psychiatric hospital for what he may or may not have done, and he was very clear about that…

The way he said it – the casual way he said it – implied to me that it was less about feeling mentally ill and more about the reality, the practicality, of what had happened – or not happened – and what he thought the likely outcome would be given his history. I think it was a practical, quite flippant, statement really. I don't think he was saying 'I'm so ill that I'm going to be in hospital for my own treatment of my illness.' It didn't have that feeling to it."

JHC Psychiatrist 2 told us that he wanted to know what the pattern of Peter Bryan's relapse was – what he was like when he was really ill - and that before he had left RMO5 had helped him with this:

"He gave us the impression certainly that when Mr Bryan was ill he was very actively ill and it was very overt. That is what I understood from our discussions."

We now know that it is not correct that Peter Bryan was actively and overtly psychotic when he was mentally ill, but this was the problem for RMO5. He had never seen Peter Bryan when he was known to be mentally unwell – in fact very few people had – and therefore he did not know what to look for.

Both JHC Psychiatrist 2 and Nurse 10 concluded that Peter Bryan was fit to be interviewed and did not need a bed on a psychiatric ward.

33. Peter Bryan was subsequently interviewed by the police, charged with the murder of Brian Cherry and remanded in custody, initially at Pentonville Prison and then on 23 February he was transferred to Belmarsh Prison.

One of the people we interviewed was Solicitor 3, who was the duty solicitor on call the night that Peter Bryan was arrested and who was asked to attend the police station to represent him. She was told that he had a history of mental health problems.

She interviewed Peter Bryan the morning after the homicide, and she also was allowed to be alone with him without a police chaperone. She described her first impression of him to us:

"I thought it was inappropriate that he was so calm in all the circumstances, because the first thing I was thinking was if it was safe to me to sit with him, and also was it safe for me to start asking him about what had happened in case that set him off if he was very volatile or anything like that.

He wasn't. He was slow. He was very polite – as he always has been. He was groggy."

She made the following note of the interview:

"He said he had a hazy recollection of all the events and could only remember getting on a few buses. Mr Bryan said all of his recollection was hazy and it was as if he was remembering when he was extremely drunk.

Mr Bryan was clearly struggling to remember what had happened. He was recalling what appeared to be a number of images which were disorganised and disjointed. He appeared to have absolutely no insight into what he had done. He appeared to be heavily medicated or extremely tired. He appeared very groggy and took a long time to answer some questions. He could only say that there was no reason why he had attacked Mr Cherry and that something had come over him and he had not been in control at all…

My advice to him was not to answer questions at the police station. I was very conscious of the fact that he was groggy and he appeared to me to be mentally ill. He certainly wasn't right. I was concerned he would change instructions when he became more lucid and it wasn't safe to put anything on record yet."

Solicitor 3 told us that she was at the police station when RMO5, JHC Psychiatrist 2 and Nurse 10 arrived. She had been told that they were going to come to assess whether Peter Bryan was fit to be detained by the police and told us that she was pleased because she felt that he was unwell and that they would know what they were doing.

She said that she thought that he was unwell because it was inappropriate that he was calm and unconcerned at what had happened and his responses were slow. She said:

"It wasn't anything more extreme. It wasn't that he was talking about voices or had displayed bizarre behaviour."

She also said that Peter Bryan had told her that, after he had attacked Brian Cherry (and she believed that he was referring to a time after Brian Cherry was already dead) Brian Cherry kept saying *"Make me, make me"*.

These were very similar words to those that Peter Bryan believed NS said to him at the time that he killed her.

She also told us:

"After he had described hitting this person with a knife and going back to him and hitting him again and he was talking to him saying "Make me, make me", he was also talking about smells and blood… He was comforted by the blood and he said 'I needed more blood'. I thought that was quite indicative of the fact that he wasn't well."

Solicitor 3 spoke to JHC Psychiatrist 2 and Nurse 10 after they had interviewed Peter Bryan and made the following note:

"…The doctors said immediately that they thought he was fit to be interviewed. I accepted this but asked the doctors whether or not they felt he could be sectioned under the Mental Health Act. To my amazement they said no. They had carried out an assessment and found him to be calm, composed and lucid and nothing to suggest that he needed to be in hospital…

I asked him (JHC Psychiatrist 2) whether the fact that he had long-term severe mental health problems and that he was alleged to have committed a murder less than 24 hours ago, the details of which the police had given to the doctors, did not suggest that he was in need of treatment. (JHC Psychiatrist 2) would only concede the offence was probably connected to his existing mental illness but that he felt there was no need for him to go to hospital at this particular time. (JHC Psychiatrist 2) said his memory was good and that

he was aware of where he was and was able to discuss his thought processes and his state of mind at the time that the offence was allegedly committed. He said that he gave a clear account and could remember some details…"

Solicitor 3 told us that she asked them to consider transferring Peter Bryan to a hospital because the stress of being in custody might lead to a deterioration in his condition, and that, although they agreed with her, they did not feel that his condition warranted being in hospital at that time.

Solicitor 3 remained Peter Bryan's solicitor for some considerable time and saw him many times after that first encounter, both in prison and in Broadmoor. She accepted that when she saw him on later occasions he was more obviously unwell than on that first occasion. She said:

"He appeared to me to be unwell, but he was more subtly unwell – if I can put it like that – when I saw him at the police station… it was the fact that he was so calm. I have read what happened with both of them and they are both very violent attacks, and I can't see that in him at all. I have never seen anything like that behaviour."

It is clear that Solicitor 3 had concerns about Peter Bryan's mental state immediately after the homicide which made her question the opinion of the psychiatric professionals, but it has to be remembered that their duty was to assess whether or not he was fit to be interviewed by the police.

Although we fully understand Solicitor 3's concerns, we do not in any way seek to criticise the decision made by JHC Psychiatrist 2 and Nurse 10.

Their professional opinion was that at that time he was not showing any signs of mental illness that would warrant an admission to hospital. He was therefore sent to prison.

There was, however, a gradual deterioration in his mental state over the next couple of weeks while he was remanded in prison charged with murder, and by 8 March 2004 he was becoming agitated and violent and was clearly unwell.

His behaviour became so unpredictable that on 15 April 2004 he was transferred to Broadmoor Hospital under Section 48/49 Mental Health Act 1983.[13]

The following is taken from a psychiatric report prepared for the Court by Psychiatrist 9:

"He was remanded to HMP Pentonville on 20th February 2004 when he was described as co-operative but in a 'sombre' mood. He was then transferred to HMP Belmarsh on 23rd February 2004 when he was recorded as being irritable and guarded and presenting with persecutory ideas regarding the staff from the Riverside Hostel and also the community mental health team. On 8th March 2004 he punched a member of staff. On 13th March 2004 a noose was found in his cell, and he was transferred to the intensive care suite for the next three days. On 23rd March 2004 he set a fire in his cell and on 29th March 2004 he spat at a prison officer. He is documented in the Inmate Medical Record as having repeatedly attempted to assault staff, behaving unpredictably, and being managed via a controlled unlock with the use of shields. He is described as being unsettled, talking to himself and shouting out loud. On 29th March 2004 his dose of Olanzapine was increased to 10 mg daily, but compliance to medication was deemed inconsistent. (Psychiatrist 10), Consultant Psychiatrist at HMP Belmarsh referred him to Broadmoor High Security Hospital, and on 2nd April 2004 he was assessed by (Psychiatrist 11), Consultant Forensic Psychiatrist and Clinical Director to Broadmoor Hospital. (Psychiatrist 11) found him to be perplexed and frightened, staring menacingly, with evidence of thought disorder, and stating that he recognised somebody outside of his cell, who had been following him "since the beginning of time". (Psychiatrist 11)'s opinion was that he was mentally unwell and recommended urgent transfer to Broadmoor Hospital under section 48/49 of the Mental Health Act 1983."

Peter Bryan was transferred to Broadmoor High Secure Hospital on 15 April 2004. Just 10 days after his arrival at Broadmoor Hospital, Peter Bryan violently attacked a fellow patient, Richard Loudwell, who later died from his injuries.

There is a separate Independent Inquiry report into the homicide of Richard Loudwell.

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[13] Section 48: removal to hospital of a prisoner on remand if the Secretary of State is satisfied that that person is suffering from mental illness or severe mental impairment of the nature or degree which makes it appropriate to him to be detained in hospital for medical treatment and that he is in urgent need of such treatment

Section 49: the Secretary of State, if he thinks fit, may by warrant further direct that that person shall be subject to the special restrictions set out in section 41 MHA.

Peter Bryan was charged with the murders of Brian Cherry and Richard Loudwell and in October 2004 an application was granted to join the two indictments so that the two counts of murder could be tried together.

In preparation for the trial, four psychiatrists (two for the prosecution and two for the defence) provided reports for the court expressing their opinion that Peter Bryan was seriously mentally ill, and the prosecution subsequently acknowledged that at the time of both homicides Peter Bryan was suffering from a severe mental illness and accepted his plea of not guilty to murder but guilty of manslaughter on the grounds of diminished responsibility.

On 15 March 2005 there was a sentencing hearing at the Central Criminal Court (Old Bailey).

Normally, a conviction for manslaughter gives the sentencing judge some discretion and he can impose a discretionary life sentence, a determinate sentence of imprisonment or a hospital order under the Mental Health Act.

However, because Peter Bryan had already previously been convicted of a serious offence, he was subject to the "two strikes" rule under Section 109 of the Powers of Criminal Courts (Sentences) Act 2000, and the judge had no option but to impose an automatic life sentence in respect of each homicide.

He therefore imposed concurrent life sentences which he said should mean the rest of Peter Bryan's natural life.

Having given the life sentences, the judge was then required to set the minimum period of imprisonment that the offences would have warranted had a determinate sentence been passed. This was held to be 35 years.

Peter Bryan was returned to Broadmoor under Sections 47/49 of the Mental Health after the trial. His RMO at Broadmoor, RMO6, had recommended this on the basis that *"his risk can only safely be managed in a 'special hospital'."*

Peter Bryan appealed against the 35 year tariff which had been imposed and the Court of Appeal presided over by the Lord Chief Justice reduced the minimum term to 15 years because of the fact that the killings were committed when Peter Bryan was suffering from a severe mental illness, but the Court indicated that it was unlikely that Peter Bryan would ever be released.

Because Peter Bryan is both a restricted patient under the Mental Health Act and subject to a sentence of life imprisonment, a Mental Health Review Tribunal cannot release him. He is entitled to ask the tribunal to review his case, but the only options open to them are (i) to continue his detention under the Mental Health Act or, (ii) if they find that his mental disorder no longer warrants detention in hospital, to remit him to prison to continue serving his sentence. If he is no longer subject to detention in hospital, the Parole Board can consider his release, but only after the expiry of the minimum 15 year period. However, until such time as a Mental Health Review Tribunal considers that Peter Bryan's mental disorder no longer requires detention under the Mental Health Act, his case cannot be referred to the Parole Board, even if the 15 year period has expired.

Recommendations

The Panel have made various recommendations as a result of their findings in this Inquiry. They found nothing that was particularly idiosyncratic to the case of PB and therefore consider that the lessons which are (hopefully) to be learned are applicable to all settings where professionals are responsible for the care and treatment of Section 37/41 restricted patients.

The recommendations are therefore addressed to all such responsible multi-agency organisations nationwide in the hope that they will assist in lessons being learned by everyone who has deal with these difficult and challenging individuals.

Area of Practice	Recommendation	Responsible Body
General		
1.	Every community general psychiatrist can expect at some time to have to take responsibility for a section 37/41 patient. Trusts should give consideration to ensuring that training for fulfilling the responsibilities for Section 37/41 patients is incorporated into the personal development plans of all consultant psychiatrists and that their competency in this subject is monitored regularly in their appraisals.	Mental Health Trusts
2.	The required reports to the Ministry of Justice should cover all of the details set out in the 'Proforma for Reports on Conditionally Discharged Restricted Patients' annexed to the Ministry of Justice Guidance for Social Supervisors and the Guidance for Supervising Psychiatrists.	Mental Health Trusts Local Authorities
3.	A restricted patient's Supervising Psychiatrist and Social Supervisor should share the content of their statutory reports with each other and other members of the CMHT before submitting the report to the	Ministry of Justice

	Ministry of Justice.	
4.	The Supervising Psychiatrist and Social Supervisor should visit the patient at home in accordance with paragraph 24 of the current Ministry of Justice 'Guidance for Supervising Psychiatrists' and paragraph 34 of the 'Guidance for Social Supervisors'.	Mental Health Trusts Local Authorities
5.	Any professional who is involved in the care of a section 37/41 patient who becomes aware of an event involving that patient which is potentially relevant to risk should inform the patient's Supervising Psychiatrist and Social Supervisor who should ensure that the Ministry of Justice are informed promptly.	Mental Health Trusts Local Authorities
6.	Trusts and Local Authorities should ensure that their employees' contracts allow for any necessary action to be taken even if it is outside normal working hours.	Mental Health Trusts Local Authorities
7.	Any decision to admit a conditionally discharged restricted patient to a psychiatric ward – as an informal patient or otherwise – should trigger an assessment by a forensic psychiatrist as soon as possible.	Mental Health Trusts
8.	As suggested in paragraph 23 of the current Guidance for Supervising Psychiatrists, identification of the hospital to which a patient may be recalled should always form part of the discharge plan. If it not so specified, recall should be to the hospital from which the patient was discharged, unless there are compelling reasons to do otherwise.	Mental Health Trusts Ministry of Justice
9.	Any patient coming from a high security hospital to a	Mental Health Trusts

	medium secure unit should be admitted to a ward other than a pre-discharge ward and within the secure perimeter of the medium secure unit unless there is a clear clinical reason to do otherwise.	
10.	Consideration should be given to sharing the care of restricted patients in the community between the forensic and general adult services in accordance with the 'Hybrid' model as described by the Department of Health in 'Best Practice Guidance: Specification for Adult Medium-Secure Services, 2007'.	Mental Health Trusts
11.	A transition protocol should be developed between the forensic and general adult services, which specifies the criteria for hand-over and follow up of patients discharged from medium secure services. Such criteria should determine the type of hand-over and follow up a patient requires based on individual need and the issue of public protection.	Mental Health Trusts
12.	On every hand-over the diagnosis of a restricted patient should be reviewed specifically to include co-morbidity (in particular personality factors and substance misuse). The diagnosis should subsequently be reviewed regularly.	Mental Health Trusts
13.	A restricted patient's supervising psychiatrist should see the patient in sufficient one-to-one sessions to establish rapport and build trust and to learn enough about the patient to detect deterioration in their mental health or behaviour at an early stage and to formulate an effective risk assessment. (See paragraph 24 of the Guidance).	Mental Health Trusts
14.	All responsible authorities (including government	Department of Health

	agencies and non-government bodies like the Mental Health Act Commission or its successor) should revisit their Guidance to ensure that they reflect the new emphasis upon public protection, risk assessment and staff safety set out clearly in the Code of Practice for the Mental Health Act 2007.	Ministry of Justice
Ministry of Justice Framework		
15.	Whenever a patient is admitted to a psychiatric ward – for whatever reason – the Mental Health Unit at the Ministry of Justice should be informed immediately.	Mental Health Trusts
16.	The Ministry of Justice should treat all cases where a conditionally discharged restricted patient is admitted to a psychiatric ward – for whatever reason – as an urgent case which requires immediate consideration of whether or not the patient should be compulsorily detained under the power of recall. The presumption in such cases should be that the patient is recalled unless there are compelling reasons not to do so.	Ministry of Justice
CPA		
17.	Care plans should always reflect multi-professional working and should incorporate all relevant professional assessments. These care plans should be monitored and reviewed on a regular basis.	Mental Health Trusts Local Authorities
18.	The CPA processes should not be over reliant on self-reporting by the patient, and should include: • Clear unified documentation	Mental Health Trusts Local Authorities

	• Cross referencing of any self reporting with professional assessments • Evidence of a review of the risk assessment and risk management plan • Clear recording and outward communication of the roles and responsibilities of the Supervising Psychiatrist, Social Supervisor and Care Co-ordinator • Contingency plans for relapse and recall	
19.	A CPA document should be prepared on handover at every stage of the mental healthcare pathway, which contains the information as set out in paragraph 15 of the 2007 Ministry of Justice 'Guidance for Supervising Psychiatrists', (the "Guidance") and this document should be placed on the patient's file.	Mental Health Trusts Local Authorities
20.	All important arrangements for the support of a patient in the community – such as (in PB's case) drug counselling and rehabilitative activities – should be put in place prior to the patient's discharge from a medium secure unit. If this is not possible, the risks must be explicitly considered within the discharge plan.	Mental Health Trusts Local Authorities
21.	Any information indicative of risk should be recorded and shared between professionals caring for the patient and should inform discussions at any subsequent CPA review.	Mental Health Trusts Local Authorities
22.	Where a non-statutory agency (such as a drug agency) is involved in a restricted patient's care plan as a requirement of their conditional discharge, there should be a clear division of the agency's	Mental Health Trusts Local Authorities

	responsibilities and those of other professionals involved, and the agency should be fully involved in any CPA meeting and in any care planning and risk assessment. There should be prior agreement for collaborative working.	
23.	The criteria for re-admission and/or recall of each conditionally discharged patient should be agreed at an early stage and recorded by the community team and regularly reviewed.	Mental Health Trusts Local Authorities
24.	Consideration should be given to the national standardisation of CPA documentation in accordance with the 2008 CPA Guidance.	Department of Health
Mental Health Act Specific		
25.	Where possible the patient's RMO should personally attend the MHRT of any restricted patient, but in particular any MHRT at which a section 37/41 patient's discharge from hospital into the community is likely to be the outcome.	Mental Health Trusts
26.	Trainee specialist registrars (now STRs) should be supervised by the consultant at all MHRTs until their supervisors consider them to be competent to represent the clinicians on their own at any such Tribunal.	Mental Health Trusts
27.	A patient's clinical team should have strong reasons before supporting the discharge of a section 37/41 patient from any unit before such time as unescorted leave has been successfully implemented.	Mental Health Trusts

Risk Assessment and Management		
28.	A formal risk assessment (such as an HCR-20) should be carried out as part of the discharge plan from a secure unit, which should then be handed over to the community team.	Mental Health Trusts
29.	The Risk Assessment should be printed on coloured paper so that it can be easily recognised and accessed in the patient's clinical notes.	Mental Health Trusts
30.	The following areas need to be considered with regard to risk assessment of forensic patients: • There is a need for a single evidence-based risk assessment format, with associated training and multidisciplinary input • Risk assessments should be completed by members of at least two professions within the team and shared with the remainder in draft form before completion • There should be a formulation of the individual's risk which should be tied in with the known historical risks with a clear indication as to what, if anything, has changed • The risk assessment should form an integral part of the CPA process and documentation • The risk assessment document should be regularly reviewed and updated and the patient and any carers should be involved in the process of its formation and review • The risk assessment document should be easily	Mental Health Trusts

	identifiable within the clinical record for ease of access.	
Guidance for Supervisors of Restricted Patients		
31.	A revision of paragraph 45 of the current 'Guidance for Supervising Psychiatrists' is recommended in respect of the formal handover process, to ensure that when such handover occurs it is recorded and the Mental Health Unit at the Ministry of Justice is informed of any change of supervising psychiatrist and notified of the identity and contact details of the new supervising psychiatrist. It is necessary to clarify who should inform the Ministry of Justice of any such change. It is recommended that it should be the outgoing supervising psychiatrist.	Ministry of Justice
32.	Section 6 of the current Guidance should be revised to cover any transfer between teams, not just discharge from hospital.	Ministry of Justice
33.	The Ministry of Justice should consider giving guidance as to what competencies and experience are required for any Supervising Psychiatrist or Social Supervisor.	Ministry of Justice
34.	The Ministry of Justice should revise their Guidance to Social Supervisors to include a requirement that local authority Social Supervisors should be Mental Health Approved Social Workers (ASWs) as a minimum	Mental Health Trusts

	requirement and where possible should have at least two years experience as an ASW. [14]	
35.	The Ministry of Justice – after consultation with other government departments and interested parties – should revise the Notes for the Guidance of Supervising Psychiatrists and Social Supervisors to take into account the findings, recommendations and lessons learned from this and other recent homicide Inquiries relating to mentally disordered offenders.	Ministry of Justice
36.	The Ministry of Justice should review paragraph 53 of the 'Guidance to Supervising Psychiatrists' in the light of the findings in this case, and should consider whether they should expand the circumstances concerning a restricted patient which would warrant immediate notification to the Mental Health Unit.	Ministry of Justice
37.	Consideration should be given to unifying the two Guidances into a single document to ensure consistency and integrated working.	Ministry of Justice
Professional Training and Continuing Professional Development (CPD)		
38.	Trusts and Local Authorities have a responsibility to ensure that all their employees who might have to take responsibility for a section 37/41 patient have sufficient and appropriate skills to do so. Therefore	Royal College of Psychiatrists Royal College of Nurses PCTs

[14] From the end of 2008 ASWs will be replaced by Approved Mental Health Practitioners

	they should devise and implement training, CPD and induction programmes aimed at effective management of restricted patients, which should include information about: • Sections 37/41 • The powers of the Secretary of State for Justice under section 42 MHA in respect of patients subject to restriction orders, including the power of recall to hospital. • The responsibilities and duties of a Supervising Psychiatrist and Social Supervisor. • When and how to write reports to the Ministry of Justice. • The Ministry of Justice Guidance for Supervising Psychiatrists and Social Supervisors • Relevant legislation • Multi Agency Public Protection Arrangements (MAPPA).	Mental Health Trusts Local Authorities GSCC
39.	The General Social Care Council (GSCC) should consider reintroducing a post-qualifying training module in Forensic Social Work to ensure specialist social workers are able to make the fullest contribution in services for mentally disordered offenders	GSCC
40.	The component in the training of doctors for approval under Section 12 MHA should be extended to include training for managing restricted patients.	Mental Health Trusts S.12 Approval Panels
41.	Section 12 and CPD training should be provided for doctors on the implications of section 37/41 and additional training and CPD for psychiatrists on how to effectively manage restricted patients.	Mental Health Trusts

42.	ASW (Approved Social Worker) and AMHP (Approved Mental Health Professional) training should include specific training for the role of Social Supervisor, in particular, training for the role in relation to recall and the Social Supervisor's duties to the Ministry of Justice. In addition it should form part of the continuing professional education of ASW's/AMHP's.	Local Authorities GSCC
43.	Training bodies for psychiatrists, nurses and social workers should review their curricula to ensure that they include core competencies for working with mentally disordered offenders.	Royal College of Psychiatrists Royal College of Nurses GSCC Higher Education Authorities
Multidisciplinary Working **44.**	Local Authorities and Mental Health Services should implement the following, to ensure safe and effective multi-agency working: • Newly appointed staff should have observation visits to teams and units with whom they will be collaborating. These should include MAPPA. • Established staff should have regular opportunities to meet with teams from all agencies involved in the care of mentally disordered offenders, including MAPPA, to discuss common issues and working practices. • Multidisciplinary training opportunities should be provided to ensure all professionals keep up to date with best practice and current thinking.	PCTs Mental Health Trusts Local Authorities Police Services

45.	The Police Services should review the way that their local MAPPAs respond to allegations of a serious nature made in respect of an individual who is believed to be a restricted patient. Where such a patient has previous convictions for violence, the allegation should be investigated as a matter of urgency.	Police Services
Resources		
46.	The supervision of conditionally discharged patients should be acknowledged as an organisational as well as an individual professional responsibility.	Mental Health Trusts Local Authorities
47.	Local Authorities and Health Authorities should appoint and deploy an appropriate number of staff to discharge this responsibility.	Mental Health Trusts Local Authorities
48.	Suitably trained and experienced staff should be given professional supervision and support which may include legal advice.	Mental Health Trusts Local Authorities
49.	Professional supervision should include oversight and agreement of any reports to the Secretary of State, Mental Health Review Tribunals or the Criminal Justice System.	Mental Health Trusts Local Authorities
Family Support		
50.	Steps should be taken to try to ensure that: • the victim's next of kin are informed of the homicide of their relation before the identity of	Mental Health Trusts Police Services

	the deceased is released in the media • support and counselling are offered to the immediate family and/or the carers of the victim and the perpetrator, if necessary with the option of such support being provided from outside the Mental Health Trust responsible for the care and treatment of the perpetrator • there is a co-ordinated approach by Mental Health Trusts, Local Authorities and Police Services to protect the families of the victim and perpetrator from media intrusion	

APPENDICES

Appendix A – Terms of Reference

North East London Strategic Health Authority
Independent Inquiry into the Care and Treatment of Peter Bryan

Commissioner

The Inquiry is commissioned by North East London Strategic Health Authority on behalf of Newham Primary Care Trust and Newham Social Service Department with the cooperation of the Metropolitan Police. It is commissioned in accordance with the guidance published by the Department of Health in circular HSG (94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community*.

Terms of Reference

1. To examine the relevant circumstances surrounding the treatment and care of Peter Bryan by the NHS, Local Authority Social Services and other agencies, both public and private; from the point that discharge planning commenced at Rampton Hospital in order to effect transfer to the Regional Medium Secure service at John Howard Centre, East London and The City Mental Health Trust, to the date of his admission to Broadmoor.

2. To examine the appropriateness, quality and adequacy of any assessment, including assessment of risk, care plan, treatment or supervision provided having regard to:

- His past social history
- His previous psychiatric diagnosis and history
- His use of alcohol and illegal substances
- His history of violence to others
- His actual and assessed risk of potential harm to himself and others including the response by services to signs of relapse and deterioration in his mental health
- His actual and assessed health and social and support needs
- The alleged sexual assault by him whilst under the care of health and social care services in North East London
- The extent to which Peter Bryan's 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

- The extent to which his care and treatment plans were based on assessed risk and were drawn up, carried out, monitored and reviewed
- The extent to which his care and treatment plans were effectively drawn up and communicated to all agencies involved with Peter Bryan's care from the point of discharge planning at Rampton Hospital to the date of his index offence and his subsequent arrest
- The extent to which Peter Bryan complied with his care and treatment plans.

3. To examine the adequacy of the liaison, co-ordination, collaboration, communication and organisational understanding between and within the various agencies. In particular whether all relevant information was effectively passed between the agencies involved; forensic and general mental health services, mental health, social care, criminal justice services and other relevant agencies and whether such information as was communicated was acted upon adequately.

4. To examine the adequacy of the communication and collaboration between the statutory agencies and any family of Peter Bryan.

5. To review relevant documentation including all health and social care case notes, notes used in criminal proceedings and investigative processes relating to the matter.

6. To prepare an independent report for North East London Strategic Health Authority on behalf of Newham Primary Care Trust and Newham Social Service Department, including key and appropriate recommendations that will contribute to the continuous improvement and development of local service models and practice.

Sharing of Information

This Inquiry will be running alongside a second Independent Inquiry concerning Peter Bryan, commissioned by North West London Strategic Health Authority. Information obtained by this Inquiry may be shared with the second Inquiry, where in the opinion of the Chair it is reasonably necessary for the purposes of the second Inquiry to do so. Similarly, the Chair may

request the Chair of the second Inquiry to share information with this Inquiry on the same basis.

15th July 2005

Appendix B – List of interviewees

Rampton Hospital

Lecturer at Acorn	Lecturer representing Acorn Further Education Department in 2001
Nurse 1	Clinical Nurse Specialist, Hawthorns Villa
Nurse 11	Staff nurse, Hawthorns Villa
Nurse 3	Peter Bryan's Named Nurse on Hawthorns Villa
Psychologist 4	Clinical Psychologist
Psychologist 7	Clinical Psychologist
RMO1	Consultant Forensic Psychiatrist and Responsible Medical Officer
RMO2	Consultant Forensic Psychiatrist and Responsible Medical Officer
RMO3	Consultant Forensic Psychiatrist and Responsible Medical Officer
Ward Manager at Rampton	Ward manager, Hawthorns Villa

East London and the City Mental Health Trust (now East London NHS Foundation Trust)

Day Opportunities 1	Project Worker, Day Opportunities
Day Opportunities 2*	Care Co-ordinator, Day Opportunities
Day Opportunities 3	Specialist Employment and Training Support Worker, Day Opportunities
Forensic Social Worker 1	Forensic Social Worker
Forensic Social Worker 2	Forensic Social Worker
JHC Consultant Forensic Psychiatrist 1	Clinical Director of the John Howard Centre
JHC Psychiatrist 1	Honorary Specialist Registrar in Forensic Psychiatry
JHC Psychiatrist 2	Specialist Registrar to RMO4 and later Locum Consultant Forensic Psychiatrist
JHC Psychiatrist 3	Specialist Registrar in Forensic Psychiatry to RMO4
Modern Matron	Modern Matron for Acute Services (Inpatients), Newham Centre for Mental Health
Nurse 10	Senior Nurse Manager, John Howard Centre
Nurse 4	Staff Nurse, Colin Franklin Ward
Nurse 5	Peter Bryan's Primary Nurse, Colin Franklin Ward
Nurse 7	Staff Nurse, Topaz Ward
Nurse 9	Staff Nurse, Topaz Ward
Occupational Therapist 1	Occupational Therapist, John Howard Centre
Occupational Therapist 2	Basic Grade Occupational Therapist, John Howard Centre
Psychologist 3	Chartered Clinical Psychologist, Specialist Addiction Unit
Psychologist 5	Consultant Clinical Psychologist
RMO4	Consultant Forensic Psychiatrist and Peter Bryan's First Community RMO and Supervising Psychiatrist
RMO5	Consultant General Adult Psychiatrist and Peter Bryan's Second Community RMO and Supervising Psychiatrist
Robert Dolan	Chief Executive, East London NHS Foundation Trust
Service Manager at the John Howard Centre	Service Manager, John Howard Centre
Sheila Foley	Chief Executive, City and East London NHS Trust
SHO3	Senior House Officer, Topaz Ward
The Borough Director	Borough Director for Mental Health in Newham
The Forensic CPN	Forensic Community Psychiatric Nurse
The Forensic Nurse Consultant	Forensic Nurse Consultant, John Howard Centre

The Topaz Ward Manager	Topaz Ward Manager

Newham Social Services

Interim Head of Adult Services	Assistant Head of Human Resources, Newham Local Authority
Social Worker 4	Aproved Social worker and Peter Bryan's First Community Social Supervisor
Social Worker 5	Social Worker and Peter Bryan's Second Social Supervisor
Social Worker 6	Senior Practitioner in Social Work

Riverside House

The Manager of Riverside House	Manager of Riverside House
Riverside 4	Husband of the Manager and Mental Health Worker at Riverside House
Deputy Manager 1	Deputy Manager
Deputy Manager 2	Deputy Manager
Riverside 1	Key Worker

Police representatives

Edmonton Murder Squad Lead Investigator	Edmonton Murder Squad Lead Investigator
Police Constable 1	Police Constable

Other interviewees

Peter Bryan	Patient
Home Office 8	Casework Manager, Mental Health Unit, Home Office
RMO6	Consultant Forensic Psychiatrist and one of Peter Bryan's RMOs at Broadmoor Hospital
Solicitor 1	Peter Bryan's Solicitor
Solicitor 3	Peter Bryan's Criminal Lawyer
The Drug Counsellor	Project worker, Addaction

The job titles described refer to each person's position at the time of their involvement with Peter Bryan.

The Panel also met with four members of Brian Cherry's family and two members of Peter Bryan's family.

**The Panel were sad to learn that (Day Opportunities 2) died in the course of the Inquiry.*

Appendix C – List of witnesses mentioned in the report

HMP Brixton

Psychiatrist 1	Consultant Forensic Psychiatrist
Psychiatrist 2	Consultant Forensic Psychiatrist
Psychiatrist 4	Consultant Forensic Psychiatrist

Independent consultant psychiatrists

Psychiatrist 3	Consultant Forensic Psychiatrist
Psychiatrist 6	Consultant Psychiatrist, Local Secure Services, Brent and Harrow

Independent consultant psychologist

Psychologist 3	Chartered Clinical Psychologist, Specialist Addiction Unit

Rampton Hospital

Lecturer at Acorn	Lecturer representing Acorn Further Education Department in 2001
Nurse 1	Clinical Nurse Specialist, Hawthorns Villa
Nurse 11	Staff Nurse, Hawthorns Villa
Nurse 3	Peter Bryan's Named Nurse on Hawthorns Villa
Psychiatrist 5	Locum Staff Grade Psychiatrist, Personality Disorder Unit
Psychiatrist 7	Associate Specialist, Personality Disorder Unit
Psychologist 1	Assistant Psychologist
Psychologist 2	Consultant Clinical Psychologist
Psychologist 4	Clinical Psychologist
Psychologist 7	Clinical Psychologist
Rampton Psychiatrist 1	RMO2's Senior Registrar
RMO1	Consultant Forensic Psychiatrist and Responsible Medical Officer
RMO2	Consultant Forensic Psychiatrist and Responsible Medical Officer
RMO3	Consultant Forensic Psychiatrist and Responsible Medical Officer
Ward Manager at Rampton	Ward Manager, Hawthorns Villa

John Howard Centre

Acting Ward Manager	Acting Ward Manager
Forensic Nurse Consultant	Forensic Nurse Consultant
Forensic Social Worker 1	Forensic Social Worker
Forensic Social Worker 2	Forensic Social Worker

Forensic Social Worker 3	Forensic Social Worker
JHC Psychiatrist 1	Honorary Specialist Registrar in Forensic Psychiatry
JHC Psychiatrist 2	Specialist Registrar to RMO4 and later Locum Consultant Forensic Psychiatrist
JHC Psychiatrist 3	Specialist Registrar in Forensic Psychiatry to RMO4
Nurse 10	Senior Nurse Manager
Nurse 2	Senior Nurse
Nurse 4	Staff Nurse, Colin Franklin Ward
Nurse 5	Peter Bryan's Primary Nurse, Colin Franklin Ward
Nurse 6	Nurse
Occupational Therapist 1	Occupational Therapist
Occupational Therapist 2	Basic Grade Occupational Therapist
Psychiatrist 8	Psychiatrist and member of Dr Bhandari's team
Psychologist 5	Consultant Clinical Psychologist
Psychologist 6	Psychologist
RMO4	Consultant Forensic Psychiatrist and Peter Bryan's first Community RMO and Supervising Psychiatrist
RMO5	Consultant General Adult Psychiatrist and Peter Bryan's second Community RMO and Supervising Psychiatrist
Service Manager	Service Manager
SHO1	Senior House Officer
SHO2	Senior House Officer

Newham Centre for Mental Health

Forensic CPN	Forensic Community Psychiatric Nurse
Modern Matron	Modern Matron for Acute Services (Inpatients)

Newham Social Services

Interim Head of Adult Services	Interim Head of Adult Services, Newham Local Authority
CMHT Manager at Kempton Road	CMHT Manager, Kempton Road
Social Worker 1	Senior Social Worker
Social Worker 2	Social Worker
Social Worker 3	Social Worker
Social Worker 4	Approved Social Worker and Peter Bryan's first Community Social Supervisor
Social Worker 5	Social Worker and Peter Bryan's second Social Supervisor
Social Worker 6	Senior practitioner in social work

Day Opportunities

Day Opportunities 1	Project Worker
Day Opportunities 2	Care Co-ordinator
Day Opportunities 3	Specialist Employment and Training Support Worker

Riverside House

Manager of Riverside House	Manager of Riverside House
Deputy Manager 1	Deputy Manager
Deputy Manager 2	Deputy Manager
Riverside 1	Key worker
Riverside 2	Key worker
Riverside 3	Daughter of Manager and member of Riverside House staff
Riverside 4	Husband of Manager and Mental Health Worker at Riverside House

Topaz Ward

Nurse 7	Staff Nurse
Nurse 8	Peter Bryan's Named Nurse
Nurse 9	Staff Nurse
SHO3	Senior House Officer
SHO4	Senior House Officer
Topaz Ward Manager	Ward Manager

Police

Police Constable 1	Police Constable
Police Constable 2	Police Constable
The Edmonton Murder Squad Lead Investigator	Edmonton Murder Squad Lead Investigator

Home Office

Home Office 1	Case Worker
Home Office 2	Case Worker
Home Office 3	Case Worker
Home Office 4	Case Worker
Home Office 5	Case Worker

Home Office 6	Senior Case Worker
Home Office 7	Casework Manager
Home Office 8	Casework Manager

Members of the public

P1	Friend of Peter Bryan
P2	Friend of Peter Bryan
P3	Friend of Peter Bryan
P4	Alleged abuse against perpetrator
P5	Friend of Peter Bryan
P6	Mother of P4
P7	Friend of P8
P8	Discovered homicide scene
P9	Mother of P8
P10	Friend of P8
Patient at Ramton Hospital	Patient, Rampton Hospital

Broadmoor Hospital

Psychiatrist 9	Specialist Registrar and author of a psychiatric report
Psychiatrist 11	Consultant Forensic Psychiatrist
RMO6	Consultant Forensic Psychiatrist and one of Peter Bryan's RMOs

Solicitors

Solicitor 1	Solicitor
Solicitor 2	Solicitor
Solicitor 3	Peter Bryan's Criminal Lawyer

Management at East London NHS Foundation Trust (formerly City and East London NHS Trust)

Borough Director	Borough Director for Mental Health in Newham
Sheila Foley	Chief Executive, City and East London NHS Trust
Dr Robert Dolan	Chief Executive, East London NHS Foundation Trust
JHC Consultant Forensic Psychiatrist 1	Clinical Director of the John Howard Centre

Others

Drug Counsellor	Peter Bryan's Drug Counselor at Addaction
Forensic Medical Examiner	Forensic Medical Examiner at the police station following the homicide
Psychiatrist 10	Consultant Forensic Psychiatrist, HMP Belmarsh
GP	Peter Bryan's GP
Mind Advocate	Mind Advocate
Brian Cherry	Second victim of Peter Bryan
Richard Loudwell	Third victim of Peter Bryan
NS	First victim of Peter Bryan
NS's brother	First victim's brother
NS's father	Father of first victim
NS's mother	Mother of first victim
Peter Bryan's father	Peter Bryan's father
Peter Bryan's mother	Peter Bryan's mother
JB	Subject of previous inquiry