

Independent Inquiry into the Care and Treatment of Peter Bryan

Summary of the Report

**A report
for NHS London**

September 2009

Panel members

Jane Mishcon was appointed as Chair of the Inquiry. She is a barrister at Hailsham Chambers whose main area of practice is clinical negligence. She has chaired nine inquiries following homicides committed by psychiatric patients.

The other Panel members appointed were:

- Dr Tim Exworthy, a consultant forensic psychiatrist at Oxleas NHS Foundation Trust.
- Stuart Wix is a forensic nurse consultant at Birmingham and Solihull Mental Health Foundation Trust.
- Mike Lindsey is a former deputy director of social services at Shropshire County Council.

Professor Tom Sensky, a Professor of Psychological Medicine and a consultant psychiatrist, provided expert advice to the Panel.

Statement on anonymisation

The decision to anonymise this Report was made by NHS London and not by the Inquiry Panel.

When the Report was handed to NHS London in early October 2008 it had been expected that the Report would be published as it was written, with the names of all those witnesses we interviewed included. The only reason which has been given to us for not doing so is that anonymisation of such reports is now NHS London's policy, as the practice of naming individuals might otherwise inhibit professionals from giving evidence to such Inquiries. All we can say is that the 62 witnesses who gave evidence to us did so openly and frankly even though they did not know at the time that the Report would be published without their identities being revealed. Those Panel Members who have been involved in other Homicide Inquiries where the reports have not been anonymised have also not encountered any apparent reluctance by witnesses to speak openly.

Unfortunately the anonymisation makes the Report difficult to read fluently, and it is sometimes hard to identify or remember the particular status of each professional. The Report deals with a very complex case in a protracted timeline of over 10 years, and clarity with regard to the roles and responsibilities of those professionals involved is extremely important. The potential confusion in identifying the many professionals we write about may mean that individuals are wrongly identified and thereby are wrongly and unfairly judged. There is also the risk that individuals may not even be able to recognise themselves and therefore will not learn the necessary lessons.

It is also regrettable that those professionals whose involvement with Peter Bryan we praised may not get the recognition they deserve.

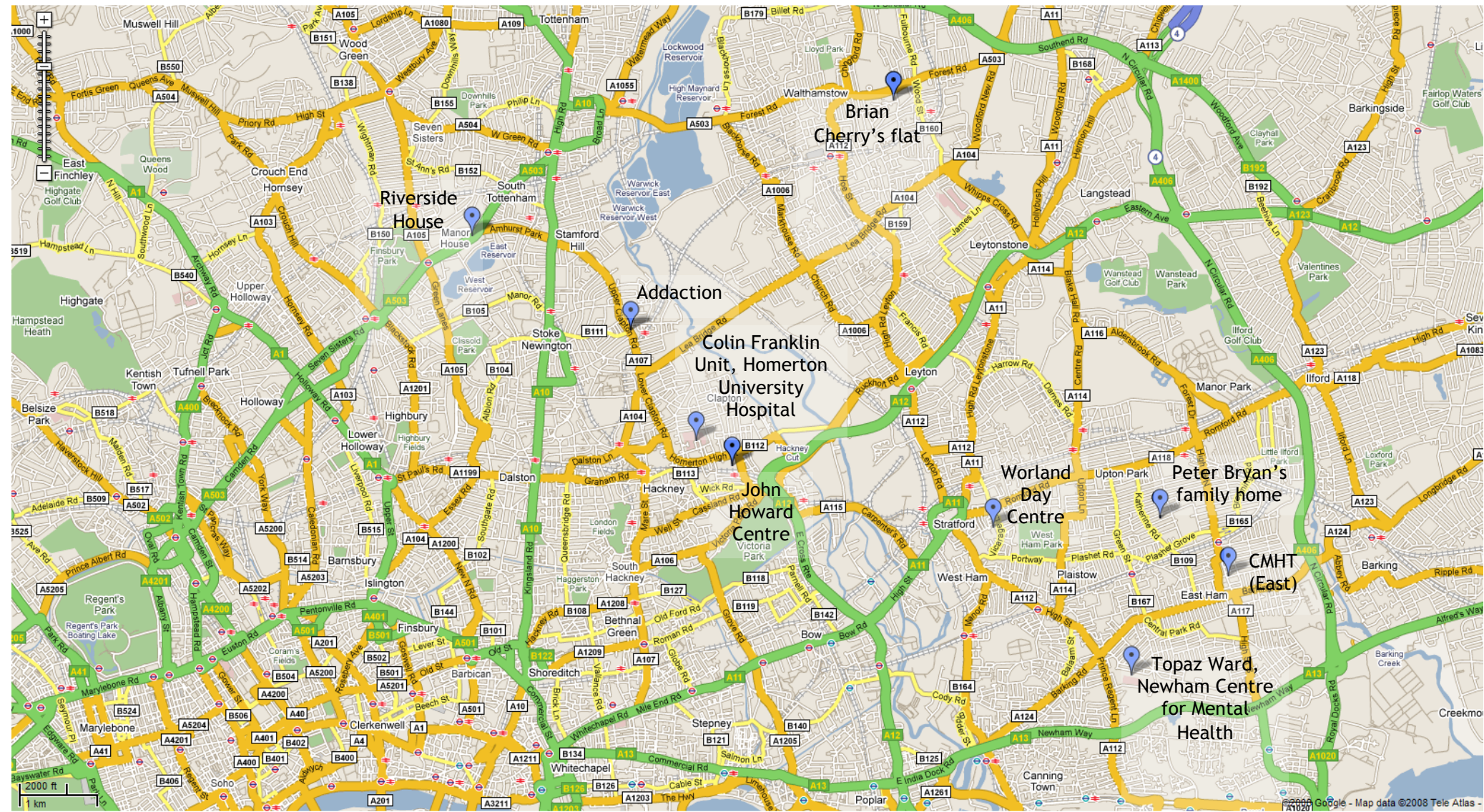
Jane Mishcon

Dr Tim Exworthy

Stuart Wix

Mike Lindsay

Map of Key Locations



Summary of the Report

1. On 17 February 2004 Peter Bryan killed Brian Cherry. It was not the first time that he had killed someone nor was it to be the last.
2. In March 1993 he had killed NS, the 21-year-old daughter of his employer by hitting her over the head with a hammer. In April 2004, just ten days after being transferred to Broadmoor Hospital following the homicide of Brian Cherry, Peter Bryan killed a fellow patient, Richard Loudwell, in Broadmoor Hospital.
3. This Inquiry has investigated only the homicide of Brian Cherry. A separate Inquiry Panel have investigated the homicide of Richard Loudwell.
4. There was no Independent Inquiry following the homicide of NS because such inquiries have only been mandatory since 1994 and in any event are only mandatory when the homicide is committed by a psychiatric patient. Peter Bryan was not a patient of the psychiatric services at the time of the killing of NS.

The Inquiry Panel are only too aware that a great deal of time has passed since the homicide of Brian Cherry, but the Inquiry process has been a long and time-consuming one.

The Panel were unable to start their investigations before the completion of the criminal justice process, and Peter Bryan's trial was not over until 15 March 2005, a year after the homicide.

There was an enormous amount of documentation which had to be read and digested. This included all the police records and witness statements relating to the homicide of NS; the clinical notes (including the nursing notes which were recorded three times a day) for the 7½ years that Peter Bryan was at Rampton Hospital and the six months that he was at the John Howard Centre; all the reports (psychiatric as well as other specialties) from that eight year period; the daily notes (again recorded three times a day) for the two years that he was at Riverside House; the notes for that period made by the Forensic CPN and the Social Supervisor, Social Worker 5; the notes made at Addaction (the drug agency attended by Peter Bryan) and Day Opportunities (rehabilitation service); the police records and witness statements relating to the homicide of Brian Cherry; the records from Belmarsh

Prison where he was originally held on remand following the homicide; the psychiatric reports prepared for Peter Bryan's trial for the homicides of Brian Cherry and Richard Loudwell; the transcript of the submissions and the judge's summing up at the trial; the clinical records and psychiatric/psychological reports from Broadmoor Hospital where he was admitted some two months after the killing of Brian Cherry.

Some of the clinical documents which the Panel received were in disorder and there were many duplicated documents which made them extremely difficult to access and digest. This added many hours to the consideration of them.

During the course of their investigations the Panel also obtained policy documents from the Trust, the Local Authority and the Mental Health Unit of the Home Office¹ relating to the care and treatment of Peter Bryan, which all had to be considered.

The Panel visited Rampton Hospital, the John Howard Centre, Colin Franklin Ward, Topaz Ward, Riverside House and Broadmoor Hospital.

A total of 62 witnesses were interviewed over about an 18 month period beginning in November 2005.

The witnesses included Peter Bryan himself whom the Panel saw at Broadmoor together with his current solicitor, Solicitor 3 (who was later interviewed on her own); Peter Bryan's father and brother; Brian Cherry's two brothers, sister and brother-in law; ten members of staff from Rampton Hospital including Peter Bryan's three RMOs; 15 members of staff from the John Howard Centre, including RMO4, his consultant psychiatrist at the John Howard Centre as well as his supervising psychiatrist for the first six months in the community; RMO5, his community general psychiatrist and supervising psychiatrist after RMO4; the Forensic CPN assigned to him in the community; Social Worker 5, his main Social Worker and Social Supervisor; Solicitor 1, the solicitor who represented him at all of the Mental Health Review Tribunal hearings from the March 2001 hearing at Rampton; various members of staff from Riverside House including the Manager; his drug counsellor; members of staff from Day Opportunities; Home Office 8, Case Work Manager at the Mental Health Unit at the Home Office; the detective sergeant who investigated the murder of

¹ Now the Ministry of Justice

Brian Cherry; one of the arresting police officers; and various former and current members of the senior management staff at the Trust.

Unfortunately the Panel were unable to interview either of NS's parents. They had hoped to do so because they were aware that the fact that Peter Bryan had killed two more people must have caused them great concern and must have brought back painful memories of the death of their much loved daughter.

The Panel interviewed Social Worker 5, RMO5, RMO4, the then Deputy Manager of Riverside House and Solicitor 1 twice each as we had questions for them about matters we had not been able to deal with in their initial interviews, either because time ran out or because new information had been learnt from witnesses who had been interviewed subsequently or because the Panel's views had changed about certain issues as they heard more evidence.

Even though many of the witnesses had not been involved with Peter Bryan for several years, it was striking that almost all of them remembered him well and were able to provide a great deal of anecdotal evidence which helped to build a clear picture of the man they had looked after.

Despite the fact that Peter Bryan had already killed once before, given that he had shown no evidence of violent or threatening behaviour for many years, it is arguable that it could not have been predicted that he would kill again. The Panel are satisfied that the extraordinary nature of the homicide of Brian Cherry could not have been predicted.

There are however many aspects of Peter Bryan's care and management which the Panel consider should have been handled differently and these are dealt with in the Commentary and Analysis section of the report.

The Panel are however acutely aware that they have assessed his care and management with the benefit of hindsight, and with the benefit of access to all known relevant records covering an 11 year period.

The Panel have been critical of several individuals' actions or lack of action. These criticisms should not be taken to imply that, had Peter Bryan been managed as the Report suggests, he would not have committed any further homicide.

Even now there is no clear understanding of Peter Bryan's mental state at the time of - or the motivation for - the killing of Brian Cherry, and without that information it is not possible to say that his death was preventable.

It is not the Panel's task or purpose to make judgments in a judicial sense on clinical competence. Their criticisms do not necessarily reflect inadequate practice in the legal sense, nor are their findings based on the standards of proof which would be necessary for a court of law.

Their aim is different from that of litigation. It is to make findings about the care and treatment afforded to Peter Bryan in order to ensure better and safer practice in the future, and to make recommendations for general guidance.

However, given Peter Bryan's history of having killed NS in a sustained and violent fashion and his diagnosis of paranoid schizophrenia, the best approach to reducing the risk that he might re-offend in a similar manner was to ensure that his care and treatment was of as high a standard as possible. The Panel's criticisms focus on aspects of his care and treatment that were not of a high standard.

However, it must be recognised that even with the best care and treatment, it is never possible to eliminate completely the risk of serious re-offending.

Because the main objective is to illustrate what lessons can be learned from this tragic story, the Panel have at times taken advantage of the benefit of hindsight and also at times have speculated on matters which are inconclusive. They have tried to make it clear when this has been done.

The Panel are aware that Peter Bryan was a particularly complicated individual whose mental illness presented in an unusual way.

If any single lesson can be learned from the analysis of the care of Peter Bryan, it should be that responsibility for managing and treating Section 37/41 Mental Health Act 1983 (MHA)² patients should only be given to professionals who have sufficient experience and training to look after such individuals.

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 sensationalistic features of the killing which occurred only some 3 hours after Peter Bryan had left a psychiatric unit with the approval of his RMO (responsible medical officer) - as well as the fact that Peter Bryan had already killed someone 11 years earlier and killed again shortly after the death of Brian Cherry - the Inquiry Panel are well aware that the public and the media will expect them 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.

What will not have been realised until reading this report, is that the main reason that Peter Bryan was in a psychiatric ward was for his own safety rather than because anyone considered him to be acutely mentally ill.

² 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".'

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.

However despite Peter Bryan not having shown any signs of overt mental illness even when he was first discovered after the homicide of Brian Cherry, it was the general consensus of the four psychiatrists who examined him for the purpose of his trial that he was suffering from a severe mental illness at the time of the killing.

One of the psychiatrists who interviewed Peter Bryan and prepared a report for the Court at his trial for the homicides of Brian Cherry and Richard Loudwell 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.”

RM06, one of Peter Bryan’s former 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 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.

Prior to the homicide of NS, he had not been known to psychiatric services, although after the killing, both NS's mother and Peter Bryan's parents described how he had been exhibiting bizarre behaviour over the preceding months.

The first time that he was assessed by a Consultant Psychiatrist was in October 1993 - seven months after the homicide - while he was on remand in Brixton Prison. It was thought that he was suffering from some form of paranoid psychosis which may well have been a schizophrenic illness. The psychiatrist recommended a referral for admission to Rampton High Secure Hospital so that he could be assessed prior to his court appearance.

The only descriptions of his mental state and behaviour prior to the first homicide came from statements made to the police by 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 member of the psychiatric services 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 the Panel 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) MHA³ (which applies to patients who are subject to Section 37/41) could have prevented the homicide of Brian Cherry, and - as explained in the Commentary and Analysis 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 is now known about the unusual presentation of Peter Bryan's mental illness, it is also likely that any recall would only have been short-lived 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 have been made by the Panel 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.

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

³ 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...recall the patient to such hospital as may be specified...'

There is 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 were the Supervising Psychiatrist and Social Supervisor 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 and treating 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.

The Panel 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 Mr Brian Cherry".

Therefore, even though the Panel 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 illness and (with the benefit of hindsight) personality disorder, were not aware of the difficulties of assessing the risks and dangers he posed.

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.

Rampton Hospital

5. Following the homicide of NS, Peter Bryan was admitted to Rampton Hospital on 17 December 1993 where he continued to display paranoid thinking, but repeated mental state examinations did not demonstrate any other symptoms of schizophrenia.
6. Prior to Peter Bryan's court appearance for the homicide of NS, three highly experienced consultant forensic psychiatrists assessed him but were unable to make a definitive diagnosis. The consultant forensic psychiatrist at Rampton concluded that the inpatient assessment confirmed that Peter Bryan was suffering from mental illness in the form of a paranoid psychosis, the symptoms of which were exacerbated by stress. The Rampton notes thereafter refer mainly to a diagnosis of paranoid psychosis, but they also acknowledge that Peter Bryan probably suffered from paranoid schizophrenia.
7. On 4 March 1994 the sentencing hearing of the criminal proceedings took place at the Old Bailey. Peter Bryan was convicted of the manslaughter of NS on the grounds of diminished responsibility. He was returned to Rampton Hospital under Sections 37 and 41 of the Mental Health Act 1983. This is also known as a Restricted Hospital Order, and a Section 37/41 patient is known as a restricted patient.
8. In May 1994 he was started on antipsychotic medication for the first time. By mid-August 1994 it was decided that the antipsychotic medication should be gradually withdrawn as Peter Bryan was showing no symptoms of mental illness. 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, he was transferred to Hawthorns Villa Ward which at that time was a Pre-Discharge ward.

9. 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, although as already stated, since the homicides of Brian Cherry and Richard Loudwell, Peter Bryan has been given the dual diagnosis of paranoid schizophrenia and personality disorder.
10. By July 1995 there was a gradual but definite deterioration in Peter Bryan's behaviour and therefore he was again given antipsychotic medication, but this time in oral form rather than the depot (injection) medication he had been given previously.
11. For the next year Peter Bryan appeared to push the boundaries with the hospital staff, showing great reluctance to participate in any meaningful treatment programme, but his behaviour gradually improved and towards the end of 1996, he appeared to settle down and thereafter there were no real management problems with him.
12. 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 in a high secure hospital. He attended most of the treatment classes and ward activities that he was supposed to attend.
13. By the spring of 1999, 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.
14. He was assessed by various members of staff from the John Howard Centre who recommended that it would be appropriate to transfer him to an environment of lower security than Rampton Hospital.
15. Despite the decision in 1999 that Peter Bryan no longer needed the high secure environment of Rampton Hospital and the fact that the John Howard Centre agreed in principle to his transfer to a unit, 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 as it often takes this long a period of time before an appropriate bed becomes available and the necessary Home Office authority is in place.

16. On 28 March 2001 there was a Mental Health Review Tribunal (MHRT)⁴ hearing which had been requested by Peter Bryan. Peter Bryan was represented by an extremely experienced solicitor. This solicitor successfully argued that, as no after care plan had as yet been formulated for Peter Bryan, if the tribunal were minded to conditionally discharge Peter Bryan they should adjourn the hearing rather than defer the conditional discharge, but that this should not prevent Peter Bryan being moved to the John Howard Centre in the meantime.
17. The Tribunal concluded that Peter Bryan continued to suffer from mental illness but that, as a consequence of medication, the illness was no longer of a nature or degree warranting liability to detention and that Peter Bryan was entitled to be conditionally discharged from detention.
18. They said that there would need to be a condition that he resided at a suitable hostel which must provide 24 hour day supervision by staff experienced in the care of restricted patients. Other appropriate conditions would include co-operation with medical and social supervision and submitting to random drug testing.
19. As no such arrangements were yet in hand, the Tribunal adjourned the granting of the conditional discharge until appropriate steps had been taken and arrangements made.
20. Because the hearing was adjourned, the Tribunal had not in fact granted a conditional discharge. However 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.

⁴ Mental Health Review Tribunals (MHRTs) are independent judicial bodies that operate under the provisions of the Mental Health Act 1983 and the Mental Health Review Tribunal Rules 1983. An MHRT must contain a suitably qualified legal member, a suitably qualified medical member and a member who is neither medically nor legally qualified but has suitable administrative or social services experience. The Tribunal's main purpose is to review the cases of patients detained under the Mental Health Act and to review the justification for the patient's continued detention. The Tribunal can (a) discharge the patient from detention under the MHA when the legal criteria for detention are no longer satisfied, (b) continue the patient's compulsory detention in hospital or in restricted patients cases (c) discharge the patient subject to conditions ie a conditional discharge (the breach of which may trigger a recall to hospital)

The John Howard Centre

21. On 15 June 2001 the Home Secretary consented to Peter Bryan being granted a period of six months trial leave at the John Howard Centre in Hackney, London. He was transferred to the John Howard Centre on 12 July 2001.
22. The Inquiry Panel have no doubt that it was appropriate to transfer Peter Bryan at this time from Rampton Hospital to the John Howard Centre. Peter Bryan spent 7½ years in Rampton Hospital, which was an average stay for a high secure unit.
23. He had not shown any signs of active psychosis throughout the years that he had been at Rampton, he had responded well to a fairly low dose of 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 had found him likeable although at times immature and manipulative.
24. The Panel were however 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.
25. Almost everyone we spoke to from the John Howard Centre was surprised that he had been transferred straight to Colin Franklin Ward.
26. Colin Franklin Ward was intended as a pre-discharge ward and it 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.
27. JHC Consultant Forensic Psychiatrist 1 (who, as Clinical Director, had developed the ward as part of the John Howard Centre in the late 1990s) told us that this was very important in terms of what it was and its philosophy. He told the Panel:

"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."

28. 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.
29. 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".
30. 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.
31. However, it is the Panel's 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 when it reconvened.
32. The Panel consider that the transfer to the John Howard Centre was appropriate. However, 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, could have been transferred to the bed on Colin Franklin Ward. Peter Bryan should then have been admitted to one of the wards within the secure perimeter of the John Howard Centre.

33. There was also considerable surprise expressed by almost every professional witness about the brevity of his stay in the John Howard Centre.
34. The Panel were told by several witnesses that the average stay in a medium secure unit for a patient transferred from high security is 18 months to two 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.
35. Peter Bryan spent 7½ years at Rampton Hospital. He spent only six months at the John Howard Centre.
36. 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.
37. '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 it became apparent that those responsible for Peter Bryan's care at the John Howard Centre wrongly assumed that a conditional discharge was a 'fait accompli' and that his discharge at the adjourned MHRT was inevitable.
38. However, as is explained in the full Report, it was an exceptional set of circumstances - whereby everything required for Peter Bryan's discharge into the community unexpectedly fell into place - which ultimately resulted in him spending such an unusually short time in medium security, even though the Panel consider that he should have remained at the John Howard Centre for a considerably longer period of time.
39. With the benefit of hindsight, it is likely that Peter Bryan's speedy transit through the John Howard Centre meant that he was not properly rehabilitated prior to his discharge into the community. This was an important factor because Peter Bryan is an individual who is

institutionalised to a considerable degree and who seems to cope better within the structure of a secure unit than with the relative freedom he encountered in the community.

40. 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. The Panel 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, the forensic hostel to which he was discharged from the John Howard Centre.
41. The benefit of hindsight led the Panel 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 curtailed may well have had some bearing on the eventual tragic outcome.
42. 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.
43. However, 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.
44. The Panel was particularly impressed with a detailed report prepared by Psychologist 5, a clinical psychologist at the John Howard Centre, and have expressed their concern in the Commentary and Analysis section of the Report that the findings made in his excellent report were not incorporated in future treatment plans or risk assessments, nor were they put before the MHRT which ordered Peter Bryan's conditional discharge (although it had been intended that they were referred to in the medical report).

Riverside House

45. On 12 February 2002 Peter Bryan was discharged from the John Howard Centre to Riverside House, a nine-bedded residential forensic hostel on the Seven Sisters Road in London N4. It is staffed 24 hours a day and at the time that Peter Bryan was there, was managed by a registered mental health nurse who had considerable experience of looking after residents with a forensic history.
46. It was a condition of his conditional discharge that the forensic team which had cared for Peter Bryan while he was at the John Howard Centre should continue to be responsible for his care for a period of six months following discharge. Therefore the forensic psychiatrist who had been his consultant at the John Howard Centre, RMO4, became his RMO⁵ (Responsible Medical Officer) in the community for the first six months.
47. All restricted patients (patients subject to Section 37/41 of the Mental Health Act 1983) have to have a Supervising Psychiatrist and a Social Supervisor. These are extremely important roles and those appointed have a duty to report regularly about the restricted patients in their care to the Mental Health Unit of the Home Office (now the Ministry of Justice).
48. At the time of Peter Bryan's discharge into the community, RMO4 was also Peter Bryan's Supervising Psychiatrist, and his Social Supervisor was Social Worker 4, an extremely experienced Approved Social Worker (ASW). His Care Co-Ordinator was the Forensic CPN.
49. Social Worker 4 and the Forensic CPN were appropriate allocations for someone with Peter Bryan's forensic history. In particular, Social Worker 4 had appeared before the MHRT which had ordered Peter Bryan's conditional discharge and had obviously impressed them, and they appeared to have been reassured by the fact that he had indicated that he would continue to be directly and closely involved with Peter Bryan in the community.
50. 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

⁵ The term 'RMO' has been used throughout the Report, although strictly speaking it should refer to a consultant in an inpatient setting only. However the term is widely used to describe the consultant responsible for a patient's care in the community

Supervisor to Social Worker 5. This was because Social Worker 4 was going to be managing the duty service which was a new function of the CMHT. Social Worker 5 remained Peter Bryan's Social Supervisor for the next two years until the homicide of Brian Cherry.

51. In the Panel's opinion Social Worker 5 was not an appropriate choice to be Peter Bryan's community social worker and Social Supervisor.
52. 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 within 24 hour drop-in centres.
53. 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 the Panel that he had a caseload of about 25 to 30 at the same time as he was social worker for Peter Bryan.
54. Therefore when he became Peter Bryan's Social Supervisor, Social Worker 5 had had only five months experience as a general social worker.
55. 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).
56. 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.
57. Peter Bryan was the first service user who was subject to Section 37/41 of the Mental Health Act (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.

58. He was not an ASW (Approved Social Worker⁶). The Panel are of the view that an ASW should have been allocated as Social Supervisor for someone with Peter Bryan's forensic history.
59. Having said that the Panel do not consider that Social Worker 5 was an appropriate choice to be Peter Bryan's Social Supervisor, he cannot be blamed for the fact that he was so appointed. The Panel 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.
60. 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 a restricted patient.
61. The Panel consider that Social Worker 5 was too inexperienced to fully appraise the potential risks posed by someone with Peter Bryan's complex presentation.
62. However Social Worker 5 himself believed that he was an appropriate choice to be Peter Bryan's Social Supervisor, and, despite the Panel giving him several opportunities to agree with their 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.
63. He told the Panel that other more experienced social workers' (including ASWs) were reluctant to take on a Section 37/41 patient.
64. The Panel commend Social Worker 5's obvious enthusiasm for his job, but unfortunately enthusiasm is no substitute for experience.
65. However, it has to be said that when more senior members of the social services team were asked for their opinion of Social Worker 5's abilities as a social worker, they expressed no

⁶ 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.

concerns about his work, nor did the Forensic CPN, the Manager of Riverside House or RMO5, his community RMO.

66. Neither the Forensic CPN nor RMO5 were aware of Social Worker 5's inexperience and both believed him to be an ASW.
67. In spite of the Panel's 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.
68. The Forensic CPN was linked to the Community Mental Health Team (CMHT) responsible for Peter Bryan's care throughout the time prior to the homicide of Brian Cherry.
69. 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.
70. 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.
71. He was also not part of the general CMHT. 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.
72. The Kempton Road office is 12.4 miles from Riverside House⁷. 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 office in Kempton Road by any combination of public transport.

⁷ Source: Google Road Maps

73. This made it even more difficult to maintain a close link with Peter Bryan and the Riverside House staff, but Peter Bryan used to make the long trip to Kempton Road on a regular basis. After an initial period when he was seen by either the Forensic CPN or Social Worker 5 every week, he would see them alternately every two weeks. For most of these fortnightly appointments, Peter Bryan would go to Kempton Road to see the Forensic CPN and to the Homerton Hospital (also a considerable distance away) to see Social Worker 5, rather than the professionals visiting him at Riverside House. It is remarkable that Peter Bryan made the journey so regularly.
74. On 17 September 2002 RMO4 handed over the role of Supervising Psychiatrist to RMO5.
75. 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.
76. This was his first post as a consultant.
77. 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.
78. 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 were strictly sectorised, with teams covering defined geographical areas.
79. The sole reason why Peter Bryan ended up on his list in 2002 was because, some ten 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.
80. 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, N4.
81. The Trust at that time did not have a community forensic psychiatric service, which meant that, once a patient was discharged from the John Howard Centre medium secure unit, 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.

82. RMO5 told the Panel 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.
83. His inexperience in managing a restricted 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 that they should address their letters to RMO5 elsewhere.
84. 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.
85. It is clear 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 the Panel that, as an inner-city general psychiatrist, he had considerable experience in managing very difficult, challenging and complex patients with schizophrenia and bipolar disorder.
86. However, the Panel 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.
87. This meant that the two professionals who provided supervision of Peter Bryan with responsibility to report on his progress to the Home Office, RMO5 and Social Worker 5, had no previous experience in looking after a patient who had committed a homicide.

88. This, and the related issue that neither RMO5 nor Social Worker 5 had any real understanding of their roles as Supervising Psychiatrist and Social Supervisor of a restricted patient, caused the Panel their greatest concern.
89. The Panel therefore found that there was a lack of effective management of Peter Bryan in the community.
90. Had Peter Bryan been under the care of a community forensic team, it is likely 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 relapse and re-offending.
91. However, it should not be forgotten that, even in the very specialised forensic setting of Broadmoor Hospital - a high secure environment - Peter Bryan was later able to kill a fellow patient.
92. There is no doubt that Peter Bryan was a difficult and manipulative patient. Despite appearing to be compliant with all the conditions of his conditional discharge, he constantly complained about them, in particular his supervised accommodation and his medication. Almost from the moment that he was discharged into the community, he argued that he should be allowed to live independently and he sought a reduction - if not a complete termination - of his antipsychotic medication.
93. He also made persistent complaints about almost all of the professionals responsible for his care in the community. On two occasions he went as far as making numerous complaints to the NCSC (National Care Standards Commission)⁸ and at every CPA meeting he would arrive with a written agenda of complaints and/or demands which tended to monopolise the meetings. Having to deal with them probably deflected the professionals from carrying out any effective assessment of his mental state or risk.
94. There were occasions when Peter Bryan's behaviour caused the staff at Riverside House to be concerned that his mental health might be relapsing and this was reported to Social Worker 5

⁸ Now the Commission of Social Care Inspection

who then met with Peter Bryan and was of the view that he had no concerns about Peter Bryan's mental health.

95. The Panel were concerned that Social Worker 5 did not have the experience and expertise to properly assess Peter Bryan's mental health.
96. Both he and RMO5 were expecting to see classic and overt signs of schizophrenia if Peter Bryan was relapsing. They were not aware (nor could they really have been expected to have been) that Peter Bryan's presentation was atypical and that any signs of relapse would be subtle.
97. Peter Bryan was 33 years old when he was discharged into the community. Many of his associates were young women in their late teens.
98. He also tended to mix with drug users and women who were perhaps prostitutes. He does not seem to have returned to taking illegal drugs himself (and it is clear that drugs played no part in the homicide of Brian Cherry) but the Panel suspected - and Peter Bryan himself admitted - that he was at times dealing in drugs.
99. It is perhaps not surprising that Peter Bryan was mixing with other people who had been marginalised by society. He had spent eight years out of social circulation while he had been in hospital, and his former associates prior to the killing of NS had been drug users and dealers.
100. However the Panel were concerned that none of the professionals (except his drug counsellor) ever addressed this issue with him and tried to warn him of the potential risks associated with the company he was keeping.
101. It was through one of these young female drug users that Peter Bryan met Brian Cherry.
102. Another major concern of the Panel was the issue of Peter Bryan's antipsychotic medication.
103. 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, explaining Peter Bryan's concerns that his medication was still causing him to have enlarged breasts, despite the change which there had been some months earlier from Stelazine 10 mg to Olanzapine 10 mg daily in an attempt to address the problem.

104. RMO5 was going away for five weeks leave. An appointment was therefore arranged at short notice for Peter Bryan on 28 April.
105. Unfortunately neither the Forensic CPN nor Social Worker 5 were able to attend the appointment on 28 April, 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.
106. 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 had not been on any medication.
107. 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).
108. As from that appointment on 28 April 2003 RMO5 reduced Peter Bryan's medication from 10 mg to 5 mg of Olanzapine.
109. It was not a good time to consider reducing Peter Bryan's antipsychotic medication when RMO5 was going to be away for five weeks. This should only have been done if there was a robust reason for the decision, and the Panel do 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 the Panel that he has what is called 'a body dysmorphic delusional system'.
110. 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.
111. 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 - and 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.

112. Also it had only been some four months since the change of his medication from Stelazine to Olanzapine.
113. On 3 February when RMO5 had reviewed that 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.
114. RMO5 had not seen Peter Bryan since that review as he had been 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.
115. This was yet another example of Peter Bryan being able to manipulate situations by persistent complaints and argument.
116. 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.
117. 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.
118. With the benefit of hindsight, it is possible to detect a subtle change in Peter Bryan's behaviour from about June 2003.
119. 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 halving 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.

120. Peter Bryan also told the Panel that he did not take his medication when he was on overnight leave. He had been regularly going on weekend leave for two or three 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.
121. Towards the end of 2003, the Riverside House notes reveal that there was a noticeable increase in Peter Bryan's erratic behaviour. He complained even more than usual, with many of the complaints being of a paranoid nature. His sleep pattern also appeared to alter with him waking and coming downstairs several times a night.
122. 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.
123. 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 a further test was carried out.
124. As far as the Panel 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.
125. At the end of November 2003 Peter Bryan started working for a cleaning agency two nights a week. He took on this job, not only without the knowledge of the Home Office (who should have been informed prior to him starting work), but initially also without the knowledge of Social Worker 5, his Social Supervisor.
126. At almost exactly the same time, Peter Bryan was allowed to self medicate. 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.
127. The decision to allow Peter Bryan to control his own medication was taken before staff became aware that he had a job. The Panel acknowledge that it would probably have been extremely

difficult to renegotiate this with Peter Bryan when he announced that he had found employment.

128. However, the Panel consider that the combination of these 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.
129. In early December the Forensic CPN and Social Worker 5 had been questioning whether he was relapsing because he was challenging everything at Riverside House and was pushing the boundaries.
130. Five days later Deputy Manager 2 of Riverside House was expressing concerns to the Forensic CPN about the state of Peter Bryan's room and the fact that his sleep pattern appeared to be disrupted, and questions were raised as to whether Peter Bryan was relapsing.
131. Therefore there were now further concerns reported by the staff at Riverside House and yet they do not appear to have had any additional impact.
132. 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.
133. A random urine specimen taken on 29 December revealed the presence of morphine and a second result was inconclusive an hour and a quarter later. 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 common illicit drugs, and the second result was inconclusive, this still should have required an explanation when put in the context of his changeable behaviour and when this was the second positive test within a matter of a few weeks.
134. Despite the recent concerns that he might be relapsing, on 9 January Social Worker 5 wrote to the Home Office requesting permission for Peter Bryan to be moved from Riverside House to a residential hostel which was only supervised from 09.00 to 17.00 hours.
135. By the end of January 2004 the staff at Riverside House were again expressing their concern about Peter Bryan's behaviour. He had complained persistently that property of his had been

damaged while his room had been redecorated and he was demanding compensation. He also accused somebody of stealing £350 from his room with little evidence to suggest that this had actually happened. He had also apparently been stopped and searched by the police and on another night he had come back drunk which was also unusual for him.

136. However what really concerned the Manager of Riverside House the most was the state of his room.
137. In the morning of 22 January Peter Bryan had 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.
138. That evening Peter Bryan returned to the hostel and attended the residents' meeting and was asked to meet with the Manager of Riverside House 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 he would. The Manager recorded in the notes that on entering his room Peter Bryan made a comment that his room smelt and she described his room as in a state of disarray. He was obviously sleeping on the floor and his medicine dosage box was lying on the floor with all his other personal items.
139. The Manager told him 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*".
140. 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.
141. 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.
142. The Manager told the Panel that it was the state of Peter Bryan's room which most concerned her, because previously 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'."

143. Her husband, Riverside 4, explained this phrase to the Panel:

"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'."

144. As a result of her concerns, the Manager decided to discontinue Peter Bryan's self-medication.

145. 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 hearing had been arranged for 1 March 2004 at the John Howard Centre and that Social Worker 5 was expected to attend.

146. This was notification that Peter Bryan was seeking an absolute discharge from the MHRT. The Panel were told by his solicitor 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.

147. If he were to be granted an absolute discharge, he would no longer be subject to conditions or to recall by the Home Office.

148. 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 the Panel that he was not expecting that an absolute discharge would have been granted at that time.

149. In the morning of 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 Deputy Manager telephoned Social Worker 5 he told the social worker 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.

150. 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 42(3) if it were appropriate to do so.
151. It is clear from Social Worker 5's note of the meeting he had with Peter Bryan later that day that Peter Bryan gave Social Worker 5 plausible explanations for all of the concerns which had been expressed about his behaviour.
152. 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.
153. After working through that night, Peter Bryan returned to the hostel at 07.20 the following morning. It was observed by staff that his eyeballs were reddish and when asked if he had slept well he said that he had been taking cannabis. He repeated this three times and asked the member of staff what they thought.
154. 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 his conditional discharge.
155. However it is clear that drugs played no part in the homicide of Brian Cherry.
156. On 28 January Deputy Manager 2 telephoned Social Worker 5 and requested an urgent meeting for 2 or 3 February.
157. 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.

158. 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.
159. 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.
160. 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 House management.
161. Social Worker 5's note of the meeting 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.
162. However the Manager of Riverside House told the Panel that as usual Peter Bryan 'hijacked' the meeting by discussing what was happening about his passport application. She said that RMO5 and Social Worker 5 did discuss Peter Bryan's behaviour at Riverside House with him and advised him to behave and to respect the rules of the hostel.
163. Her recollection was that the meeting only lasted about 20 minutes and she told the panel:
- "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 Peter 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."*
164. 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

invited to express the concerns of Riverside House and to discuss them with the other professionals.

165. If the meeting only lasted 20 minutes, the Panel consider 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.

166. When told about the Manager of Riverside House's description of the meeting, RMO5 said 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."

167. 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 four days beforehand.

168. He told us that on 29 January he had made the decision to increase it 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.

169. In a letter written to Peter Bryan's GP by RMO5 immediately following the meeting, it appears that 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. However RMO5 also expressed the view that the changes in Peter Bryan's behaviour could indicate early symptoms of relapse which needed to be closely monitored and he also recognised that any further deterioration in Peter Bryan's behaviour and mental state could result in recall to hospital.

170. RMO5 planned to review the situation in three weeks time and indicated that he would recall Peter Bryan to hospital if there was any further deterioration.

171. 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.
172. 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 remain 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.
173. At approximately 14.30 on Friday 6 February two male "street crime wardens" and P6 (the mother of P4 - both 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 17 year old daughter P4 against Peter Bryan.
174. 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.
175. The Manager spoke to one of the wardens who said that an incident had taken place involving 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.
176. Peter Bryan returned to the hostel at about 16.00 and the Manager of Riverside House and Deputy Manager 2 informed him about the visit earlier that afternoon.
177. Peter Bryan seemed very shocked and he said that he had gone to P4's 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.
178. 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.

179. 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.
180. 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.
181. 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.
182. The resident then said that that morning he had visited the flat and was told by the family 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.
183. Later that evening the Manager telephoned the Forensic CPN and told him about the allegations which had been made against Peter Bryan. The Forensic CPN 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 of Riverside House to fax over a report on the allegations.
184. 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..."

185. The Panel faced a dilemma concerning the evidence about the weekend of 6 to 9 February.

186. Social Worker 5 told them that the Forensic CPN had 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.
187. 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.
188. When it was 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.
189. Social Worker 5 told the Panel 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 asked why he had not arranged to see Peter Bryan sooner if he had actually spoken to him on the Friday, Social Worker 5 said that they had arranged to see him on the next working day and that they had therefore seen him "*fairly quickly*". He said:
- "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."*
190. 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*".
191. However, when the Panel 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.
192. 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.

193. 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.
194. It is acknowledged that the information was received late on a Friday and both men were off duty, but, given the potential risks involved, the Panel are firmly of the view that it was not good practice to wait until the Monday to interview Peter Bryan about the allegations.
195. The Forensic CPN told the Panel 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 of Riverside House told the Panel that she did not believe the girl's allegations. However she had been sufficiently concerned to advise Peter Bryan not to go on weekend leave to his parents' address.
196. The Forensic CPN told the Panel that he received the call from the Manager of Riverside House at about 7 p.m. and that he remembers that he was already at home.
197. The Panel 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 of Riverside House) 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."

198. While the Panel accept that the Forensic CPN was off duty at the time that he received the call from the Manager of Riverside House, they 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 accepted that he had Social Worker 5's mobile telephone number but also said "*I've never phoned him out of hours.*"
199. The Panel 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 to inform Peter Bryan's Supervising Psychiatrist and/or his Social Supervisor and/or the out of hours service.
200. Even though the Forensic CPN may have been working within the terms (and therefore also the restrictions) of his employment, the Panel are of the view that this attitude is somewhat unprofessional and not conducive to good practice.
201. Had the incident taken place in isolation, the Panel 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.
202. However, the incident occurred just three days after an emergency meeting had been called because there had been concerns that Peter Bryan might be relapsing, and only four days later he had been accused of seriously inappropriate behaviour towards a young woman.
203. This was probably the most serious report of aggressive behaviour on the part of Peter Bryan that had been reported in something like ten years.
204. 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 have 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.

205. 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.
206. 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.
207. The Mental Health Unit at the Home Office (now at the Ministry of Justice) operates a 24 hours emergency service to discuss urgent cases but it is useless if the community teams will not do anything out of their own working hours.
208. The Forensic CPN and Social Worker 5 met with Peter Bryan at the Homerton Hospital on Monday 9 February. 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 P4 and her friend. He said that they had started to play act and had stolen his mobile phone and would not give it back.
209. He admitted '*play acting*' with P4 and "*blowing a raspberry on her stomach*". He denied any sexual activity. He said that he had then left without his phone.
210. 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.
211. 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.

212. 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.
213. 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.
214. It has to be borne in mind that P4's statement to the Police was taken from P4 after the homicide of Brian Cherry and may have been influenced as a result.
215. However, if her description of what happened is true (it can be found in the full Report), it shows that a worrying degree of aggression was used by Peter Bryan towards the girl, as well as indecent behaviour.
216. On Tuesday 10 February Deputy Manager 2 of Riverside House, informed the Forensic CPN 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 'flushed' by one of two cars which were parked across the road facing Riverside House. The cars had contained several men.
217. 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.
218. 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. The Forensic CPN then spoke to Social Worker 5 and updated him about what was happening.

219. The way in which this incident of alleged indecent assault was handled caused the Panel great concern.
220. It was not until five days after the incident - and only 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.
221. The Panel 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.
222. 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
223. The Forensic CPN did inform the police - although only the MAPPa unit (Multi-Agency Public Protection Arrangements) and only after a 'lynch mob' was after Peter Bryan.
224. In particular, they do not seem to have seriously considered recall to hospital under Section 42(3) of the Mental Health Act⁹, despite having threatened Peter Bryan on several occasions that they would do this if his behaviour deteriorated.
225. Recall under Section 42 was one issue which caused the Panel considerable difficulty and over which we deliberated at length.

⁹ 42(3): 'The Secretary of State may at any time during the continuance in force of a restriction order in respect of the patient who has been conditionally discharged... recall the patient to such hospital as may be specified..'

226. The initial unanimous reaction of the Panel was that recall to a secure ward may have been the one factor which might have prevented the homicide of Brian Cherry, and they all felt that Peter Bryan's cumulative behaviour in the weeks leading up to the incident on 5 February 2004 warranted such recall.
227. They initially took the view that it was the inexperience of Social Worker 5 and RMO5 (who were the only people who could have asked the Home Office to arrange his recall) in dealing with Section 37/41 patients which had prevented this happening.
228. However, on questioning witnesses who had the appropriate experience - including Home Office 8, Case Work Manager at the Home Office (now the Ministry of Justice) - it became apparent 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. This is dealt with more fully in the Commentary and Analysis section of the Report.

Topaz Ward

229. Peter Bryan was admitted as an informal patient to Topaz Ward, the acute adult general psychiatric ward at the Newham Centre for Mental Health, in the late afternoon of 10 February 2004.
230. 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."

231. It is clear from these notes that the reasoning behind Peter Bryan's admission to a psychiatric ward was to protect his safety rather than because it was thought that his mental health was relapsing.
232. The Panel consider that it was totally inappropriate to use Topaz Ward as a 'Safe House' for Peter Bryan.
233. Topaz Ward is an open ward with 15 beds. The Panel are 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.
234. However, they 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.
235. 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 the Manager was no longer willing for Peter Bryan to remain there because of the risk to himself and others and it would have been virtually impossible to have found another such hostel at short notice.
236. Therefore the only practical solution was to admit Peter Bryan to the Newham Centre for Mental Health - 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.
237. 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.

238. 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.
239. This appears to have been the only mental state examination carried out while Peter Bryan was on Topaz Ward.
240. The Management Plan was to admit him as an informal patient and to carry out intermittent observations. These were maintained for the first 72 hours.
241. A routine urine drug test was carried out and showed no illicit drugs.
242. 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.
243. 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.
244. It was recorded that if Peter Bryan wanted to leave he should be treated as any other informal patient.
245. 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.
246. This is yet another example of how Peter Bryan responded to control with compliance.

247. On 11 February Social Worker 5 wrote to 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 informed of events as soon as I have more information.

Should you require further information on this matter, please do not hesitate to contact me."

248. It was prompt and good practice on the part of Social Worker 5 to put on hold the transfer to less supervised accommodation at 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.

249. The letter to the Home Office states that a full risk assessment would be undertaken while Peter Bryan was on Topaz Ward. However when interviewed 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 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 I thought a risk assessment should be undertaken ‘just to see’.

250. 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.

251. 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.

252. 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.”

253. 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 their allegations about him and possibly some individuals may want to do some harm on a Ward.

254. This is the first of several entries in the clinical records that Peter Bryan was on Topaz Ward for his own safety.

255. The nurses who were 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.
256. As a consequence, routine mental state assessments were not carried out. He was however kept under close observation for the first 72 hours.
257. Peter Bryan also told us that it was his understanding that he was only admitted to Topaz Ward for his own safety
258. 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.
259. The ward notes record that Peter Bryan remained settled, polite, friendly and no management problem throughout the week that he was there.
260. 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.
261. It is now known 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 of Riverside House who opened it and handed it to the police. The letter is reproduced as it was written:

P. 8
MOUNTAIN GROUNDS HOSPITAL
TOPAZ WARD

to the 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.
Nick & Dennis may well be next
now the two Scotts are
running thing. The problem is
there is not enough accomma-
dation, but well. I still
have my A&K card to play.
Skill 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 twist

and turns, its about
how you cope with them,
still the food is o.k and
time just ticks by;
anyway take care and
if you can look out
for Squash, 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 that
does not matter because
I can not die.

Take care
P.S thank to the Jan I
cooking, to the max.

Transcription

"Dear 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 (a nickname for one of the Riverside residents) may well be next now the two Scotts (Peter Bryan told the Panel 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 around 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 by.

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.”

262. At first when the Panel asked him what his ‘*Ace Card*’ was, Peter Bryan said that it was to ask Solicitor 1 (his solicitor) if he could go before a Mental Health Review Tribunal. However, when it was pointed out 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.
263. 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.
264. However the Panel 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.
265. It is interesting that he wrote about Rampton Hospital still being “*around (his) neck and slowly getting tighter*”, but again it would be merely speculation if the Panel tried to interpret what this remark really meant.
266. 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.
267. The morning shift nursing entry for 17 February describes Peter Bryan as having been calm on the ward.

268. 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 7 (Peter Bryan's Named Nurse), an Occupational Therapist and various medical students.
269. Peter Bryan was not invited to participate in the meeting, apparently because RMO5 felt that there were too many people there.
270. 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 7.
271. 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 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"

272. Nurse 7'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"*

273. 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.

274. All of the key professionals responsible for the care and treatment of Peter Bryan were present at that meeting, namely RMO5, Social Worker 5 and the Forensic CPN.

275. RMO5 and Social Worker 5 should by then have prepared reports for the hearing.
276. 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.
277. 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.
278. Even more worrying was the fact that the Forensic CPN told the Panel 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 asked about the MHRT, he said that it was the first time that he had heard about it.
279. When the Panel asked RMO5 about his report for the MHRT, he told them that he had in fact dictated a draft report in the afternoon of 17 February, following the ward round meeting. He said that he would try to extract a copy of the report from the computer.
280. When seen for his second interview, RMO5 gave the Panel a copy of the draft report which is reproduced in full in the Commentary and Analysis section.
281. 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 the time of handover to the nightshift staff.
282. 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.
283. However, they 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.

284. It was also recorded that RMO5 was going to refer Peter Bryan for an assessment by the forensic service and indeed a letter asking for such an assessment was dictated by him that afternoon.
285. 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.
286. The Forensic CPN told the Panel 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.
287. 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.
288. Social Worker 5 also told the Panel that he had said hello briefly to Peter Bryan that morning and that he had seemed quite normal.
289. The Forensic CPN told the Panel that as far as he was concerned no firm decision had been made by the time of the ward round on the 17 of February. However Social Worker 5 and the Manager of Riverside House made it quite clear to the Panel that the decision had already been made that Peter Bryan would not be returning to Riverside House.
290. Social Worker 5 said 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.
291. The Manager of Riverside House also said that she would not have taken Peter Bryan back as a resident.
292. 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'.

293. Therefore when he left Topaz Ward that afternoon Peter Bryan's future was very uncertain.
294. 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."*
295. Sometime that afternoon, probably just before 15.00, Peter Bryan telephoned the Manager of Riverside House at 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.
296. The Manager of Riverside House explained to Peter Bryan that he would not be able to return to Riverside House and that they would take care of his belongings.
297. Therefore he did not know where he would be going from Topaz Ward if he were not recalled.
298. He was also going to be assessed by the forensic psychiatric service and might yet be recalled and compulsorily detained.
299. Serious allegations of an indecent assault had been made against him and were likely to be investigated by the police.
300. All of these factors would have caused him considerable stress.
301. Stress was an identified key relapse indicator, and Peter Bryan himself had identified stress as being a risk indicator prior to the killing of NS, as well as a feeling that he was being backed into a corner and could not win.
302. 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.

303. When the Panel 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 asked 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.”

304. The Panel 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.”

305. When the Panel 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 butterflies up, but I didn’t know.”

306. At about 15.00 one of the nurses was in the ward office when Peter Bryan approached him and briefly discussed the outcome of the Ward Round Meeting.

307. Peter Bryan told the nurse that he had been informed after the ward round that he could go out if he wanted to. The nurse 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.

308. The nurse told the Panel that Peter Bryan was behaving completely normally and this was confirmed to the Panel by 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 said 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.

309. 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 are 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.

310. 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.
311. 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.
312. The Panel interviewed six 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.
313. There can therefore be no criticism of the decision to allow Peter Bryan to leave Topaz Ward on the afternoon of 17 February 2004.
314. Peter Bryan left Topaz Ward some time between 15.00 and 16.00.

The Homicide of Brian Cherry

315. The account of what happened after Peter Bryan left Topaz Ward is taken from the witness statements of people interviewed by the police, from the Panel's 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 the Panel interviewed him at Broadmoor Hospital.
316. 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.

317. From Stratford Peter Bryan took another bus to Walthamstow and went to Brian Cherry's flat.
318. The Panel 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 re-housed when they had to go into sheltered accommodation. However he visited his parents' home most evenings.
319. 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.
320. Brian Cherry's brother described him as *"A sweet man. Everyone says he was a sweet man. He was really nice."*
321. 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."*
322. 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.
323. 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.
324. 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.

325. 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.
326. 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).
327. 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 so that he could draw out some money from a cash machine for them. They had then used the money to purchase drugs.)
328. Brian Cherry said that he would see her later. Her impression was that he was on his own at the time.
329. P8 had then telephoned Brian Cherry again three times between 18.30 and 18.45 but got no answer.
330. It is likely that Peter Bryan arrived at Brian Cherry's flat on 17 February sometime just after 18.00.
331. Brian Cherry apparently opened the door to Peter Bryan and shortly afterwards, Peter Bryan killed him.
332. 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.
333. 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).

334. 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.
335. P8 asked him what he was doing there and where Brian Cherry was and Peter Bryan told her to go away.
336. When she asked again where Brian Cherry was, Peter Bryan said "*Brian Cherry 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.
337. 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.
338. 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.
339. 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.
340. 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.
341. As the door opened, they saw that the hallway was in darkness. 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.
342. Peter Bryan looked quite startled and shocked to see them and for several seconds there was an awkward silence.

343. 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 okay.
344. 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*".
345. 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.
346. 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.)
347. 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.
348. 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*".
349. 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*".
350. In the kitchen a 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.

351. The contents of the frying pan and the plate were later identified as being tissue from Brian Cherry.
352. Police Constable 1 told the Panel that while they were waiting for the police van to arrive, Peter Bryan said *"I wanted his soul"*.
353. Police Constable 1 was with Peter Bryan for about an hour and a half in total and told the Panel 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."*
354. The police van then arrived and Peter Bryan was taken to Barkingside Police Station where he was taken into custody.
355. 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.
356. 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.
357. For the initial part of the assessment, RMO5 was also present, but was understandably upset by the situation and he therefore left.
358. The Panel 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.
359. Peter Bryan was interviewed by JHC Psychiatrist 2 and Nurse 10 on their own without a police escort or even handcuffs on Peter Bryan.

360. The Panel find it worrying that the clinicians were left alone with an unrestrained suspect who had very recently killed someone in an extremely violent manner.
361. 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.
362. He also said that even though it was a long interview lasting some two hours, Peter Bryan remained very controlled and calm.
363. 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.
364. 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.
365. There was, however, a gradual deterioration in his mental state over the next couple of weeks while he was in prison, and by 8 March 2004 he was becoming agitated and violent and was clearly unwell.
366. His behaviour became so unpredictable that on 15 April 2004 he was transferred to Broadmoor Hospital under Section 48/49 Mental Health Act 1983.¹⁰
367. 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

¹⁰ Section 48: removal to hospital of an unsentenced prisoner 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.

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.”

368. Just 10 days after his arrival at Broadmoor Hospital, Peter Bryan violently attacked a fellow patient, Richard Loudwell, who later died from his injuries.
369. As stated already, there is a separate Independent Inquiry Report into the homicide of Richard Loudwell.
370. 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.
371. 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.
372. On 15 March 2005 there was a sentencing hearing at the Central Criminal Court (Old Bailey).
373. 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.
374. However, because Peter Bryan had 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.

375. He therefore imposed concurrent life sentences which he said should mean the rest of Peter Bryan's natural life.
376. 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.
377. Peter Bryan was returned to Broadmoor under Sections 47/49 of the Mental Health Act 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'.*"
378. 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.
379. 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 a Hospital Order, 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 medium secure unit should be admitted to a ward	Mental Health Trusts

	<p>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.</p>	
10.	<p>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'.</p>	Mental Health Trusts
11.	<p>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.</p>	Mental Health Trusts
12.	<p>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.</p>	Mental Health Trusts
13.	<p>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).</p>	Mental Health Trusts
14.	<p>All responsible authorities (including government agencies and non-government bodies like the Mental</p>	Department of Health Ministry of Justice

	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 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: <ul style="list-style-type: none"> • Clear unified documentation • Cross referencing of any self reporting with 	Mental Health Trusts Local Authorities

	<p>professional assessments</p> <ul style="list-style-type: none"> • 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.	<p>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.</p>	<p>Mental Health Trusts Local Authorities</p>
20.	<p>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.</p>	<p>Mental Health Trusts Local Authorities</p>
21.	<p>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.</p>	<p>Mental Health Trusts Local Authorities</p>
22.	<p>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 responsibilities and those of other professionals involved, and the agency should be fully involved in</p>	<p>Mental Health Trusts Local Authorities</p>

	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

<p>Risk Assessment and Management</p>	<p>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.</p> <p>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.</p> <p>30. The following areas need to be considered with regard to risk assessment of forensic patients:</p> <ul style="list-style-type: none"> • 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 	<p>Mental Health Trusts</p> <p>Mental Health Trusts</p> <p>Mental Health Trusts</p>
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	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. ¹¹	
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

¹¹ From the end of 2008 ASWs will be replaced by Approved Mental Health Practitioners

	<p>they should devise and implement training, CPD and induction programmes aimed at effective management of restricted patients, which should include information about:</p> <ul style="list-style-type: none"> • 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). 	<p>Mental Health Trusts Local Authorities GSCC</p>
39.	<p>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</p>	<p>GSCC</p>
40.	<p>The component in the training of doctors for approval under Section 12 MHA should be extended to include training for managing restricted patients.</p>	<p>Mental Health Trusts S.12 Approval Panels</p>
41.	<p>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.</p>	<p>Mental Health Trusts</p>

<p>42.</p>	<p>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.</p>	<p>Local Authorities GSCC</p>
<p>43.</p>	<p>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.</p>	<p>Royal College of Psychiatrists Royal College of Nurses GSCC Higher Education Authorities</p>
<p>Multidisciplinary Working</p> <p>44.</p>	<p>Local Authorities and Mental Health Services should implement the following, to ensure safe and effective multi-agency working:</p> <ul style="list-style-type: none"> • 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. 	<p>PCTs Mental Health Trusts Local Authorities Police Services</p>

<p>45.</p>	<p>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.</p>	<p>Police Services</p>
<p>Resources</p>		
<p>46.</p>	<p>The supervision of conditionally discharged patients should be acknowledged as an organisational as well as an individual professional responsibility.</p>	<p>Mental Health Trusts Local Authorities</p>
<p>47.</p>	<p>Local Authorities and Health Authorities should appoint and deploy an appropriate number of staff to discharge this responsibility.</p>	<p>Mental Health Trusts Local Authorities</p>
<p>48.</p>	<p>Suitably trained and experienced staff should be given professional supervision and support which may include legal advice.</p>	<p>Mental Health Trusts Local Authorities</p>
<p>49.</p>	<p>Professional supervision should include oversight and agreement of any reports to the Secretary of State, Mental Health Review Tribunals or the Criminal Justice System.</p>	<p>Mental Health Trusts Local Authorities</p>
<p>Family Support</p>		
<p>50.</p>	<p>Steps should be taken to try to ensure that:</p> <ul style="list-style-type: none"> • the victim's next of kin are informed of the homicide of their relation before the identity of 	<p>Mental Health Trusts Police Services</p>

	<p>the deceased is released in the media</p> <ul style="list-style-type: none">• 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	
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