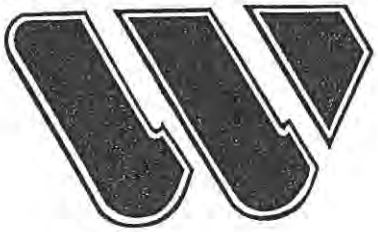
WESTERN

HEALTH AND SOCIAL SERVICES BOARD



The Brian Doherty Inquiry

Report of the Inquiry Team to the Western Health and Social Services Board

October 1995

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A. EXECUTIVE SUMMARY

Brian Doherty discharged himself Contrary to Medical Advice from the Tyrone and Fermanagh Hospital on the same day that he abducted and killed Kieran Hegarty. He was convicted of manslaughter and kidnapping and sentenced to life imprisonment for manslaughter and ten years for kidnapping on 15 May 1995. On 16 May 1995, the Western Health and Social Services Board announced its intention to initiate a full independent review of the circumstances surrounding the admission and discharge of Brian Doherty to and from the Tyrone and Fermanagh Hospital with particular reference to the applicability of the provisions of the Mental Health (Northern Ireland) Order 1986, to make recommendations on operational policy and related changes in management, and to prepare a report of any relevant findings or recommendations arising out of this review for the Western Health and Social Services Board and the Mental Health Commission. The Western Health and Social Services Board will report its conclusions to the Minister for Health. The Inquiry Team was chaired by Professor George Fenton and it consisted of four people from the disciplines of Psychiatry, Mental Health Nursing, Social Work and Youth and Community Work.

Brian Doherty had contact with twenty different caring agencies over a ten year period prior to the killing. These included special schools, children's homes, a training school, various young offender institutions, the Probation Service, and various hospitals. All the relevant records were obtained and scrutinised, including the RUC records. Some seventeen people involved in his care were interviewed as well as his mother and the parents of the victim.

He had breathing difficulties at birth with possible temporary lack of oxygen to the brain. His subsequent early development was normal. **[This sentence has been removed in order to meet the Board's duty of confidentiality.]** He was a slow learner with problems in reading and writing and special difficulty with numeracy. His tested intelligence level was

at the top end of the mental handicap range. The educational retardation led to his being placed in a special school and accompanying behaviour problems resulted in his spending most of his school and teenage years in institutions because he was unmanageable at home. These included a residential school, a training school and a mental handicap hospital. Over the years his behaviour has been characterised by immaturity, inability to learn from previous experience, difficulties in social and personal relationships, as well as reckless and irresponsible behaviour that seems to be motivated by a need to draw attention to himself and to boost his fragile self esteem by impressing or frightening other people. He seemed to have difficulty in distinguishing between fantasy and reality and had an unhealthy preoccupation with violence. He often dressed up as a paramilitary, although there is no evidence that he had direct connections with any such organisations. This led people involved in his care to be seriously concerned that he was putting himself at risk of being shot by the security forces in error. Prior to the killing he was not considered as a serious danger to other people, being perceived as a social nuisance.

There is no evidence of a formal mental illness and the diagnosis is a severe personality disorder of the dissocial type and mild mental handicap. Following his discharge from Muckamore Abbey Hospital, this dual diagnosis caused placement problems. He was regarded as too "bright" for the mental handicap service, while the adult mental illness service viewed him as someone with untreatable personality and social problems in the absence of a frank mental illness. In the absence of "ownership" by any of the available caring services no coherent long term care and supervision plan was formulated, with the result that the various agencies reacted in response to crisis rather than in a planned way. His erratic and chaotic lifestyle, wandering around the country, created serious difficulties in engaging him in any form of therapy. The uncertainty about his placement either in the learning difficulties services or the adult mental health service contributed to

this, possibly compounded by a feeling of therapeutic futility amongst the professionals involved.

Prior to his discharging himself from the Tyrone and Fermanagh Hospital against medical advice on the day of the killing, his mental state was carefully assessed by the Senior Registrar Psychiatrist on duty. She did not consider that he was suffering from a frank mental illness and found no evidence that failure to detain him would create a substantial likelihood of serious physical harm to himself or to other persons. She advised him to remain in hospital for further assessment and to be seen by the Consultant. He refused to do so. An attempt to secure emergency accommodation for him by the ward Social Worker was unsuccessful. He reported his intention to go to a "squat" in Londonderry.

Following the event there was considerable discussion about whether he could have been detained under the Mental Health (Northern Ireland) Order 1986. The view expressed by the Tyrone and Fermanagh psychiatrists is that he could not have been detained because the Mental Health Order specifically excludes people with personality disorder unless accompanied by other forms of mental disorder. The Northern Ireland Mental Health Order definition of severe mental impairment, "a state of arrest or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned", would seem to exclude Brian Doherty from consideration because his impairment intelligence was mild rather than severe. The Code of Practice states clearly that it is not meant to restrict the definition to persons whose intelligence level as measured by psychological tests falls below a particular figure. Assessment should take into account the total impairment of intelligence and of social functioning. The Inquiry Team are of the view that Brian Doherty could have been detained using the Code of Practice criteria, if he had been considered at risk of causing harm to himself or other people. These

ambiguities require clarification and mental health workers should be familiar with the Code of Practice guidance.

The vast majority of mentally disordered people live safely in the community and the event we are dealing with is extremely rare. The Inquiry Team can find no evidence that prior to the killing, he was a serious danger to other people. Indeed, his irresponsible, impulsive and reckless behaviour put himself at risk rather than other people.

However, there are no grounds of complacency. Through Brian Doherty had a great deal of dedicated care over the years from a range of agencies, the Inquiry Team have identified a number of weaknesses and ambiguities in the provision of care that need to be addressed in order to improve quality and co-ordination. In hospital, there are a number of medical and nursing care arrangements that need to be reviewed and revised. The co-ordination of care between hospital and community and across community care disciplines needs to be rationalised, with a compatible information system between mental health and social services. There is a strong case for defining a group of at risk patients, who because of severe personality disorder, limited intelligence or chronic psychosis put themselves and others at risk through violent or seriously irresponsible behaviour. Such people lead chaotic lifestyles and are difficult to supervise or engage in treatment. We suggest that such patients should form a special supervision group to be cared for by a specialist multidisciplinary team with a limited and protected caseload, led by a forensic psychiatrist with access to regional secure unit beds.

A review of the Northern Ireland Mental Health Order is necessary to resolve the ambiguities that this case has highlighted, to consider the merit of introducing an additional category of mental disorder, namely severe personality disorder, and a supervised discharge order. Staff training in the interpretation and use of the Mental Health Order should be an ongoing

commitment. The need to promote greater involvement of the local community in mental health services is highlighted.

The Inquiry Team make the following recommendations:

1. (i) All new inpatients should be seen by the consultant responsible for their care or a senior psychiatrist deputising for him/her within three days of admission, unless the patient has been examined by the consultant or senior deputy at an outpatient clinic or in the community in the one/two days prior to admission.

(ii) Management should arrange the consultants' contract to allow more frequent review of inpatients' progress according to the patients' needs.

(iii) All potential discharges Contrary to Medical Advice should be discussed with the consultant psychiatrist responsible for their care or a senior deputy.

(iv) All individuals who discharge themselves Contrary to Medical Advice should be offered an early outpatient clinic review.

(v) There should be a recorded review of all patients who discharge themselves at the next multidisciplinary team meeting in order to formulate an aftercare plan and liaise with the relevant community services.

(vi) A detailed mental state assessment and care plan should be entered in all newly admitted patient's casenotes. This should be updated at least once per week.

(vii) When patients who have been detained for assessment are regraded as voluntary patients, there should be a detailed written record of the reasons for regrading.

(viii) There should be an immediate review of the implementation of the named nurse procedures.

(ix) The nursing staff should be reminded of their responsibilities in relation to record keeping (UKCC Standards for Records and Record Keeping, 1993).

2. (i) The importance of team working between hospital, community and primary care needs emphasis and constant review.

(ii) A multidisciplinary panel with representatives from all the relevant mental health, mental handicap, social work, probation and education services, should be established to consider the most appropriate care package for at risk patients where there is uncertainty as to which agency should be the one to take the lead caring role. An appropriate chairperson for such a panel would be a forensic psychiatrist. The main role of this panel would be to resolve interagency disputes and uncertainties about the "ownership" of people who did not fit into the standard services on offer.

(iii) The group of patients who do not fit into the conventional services should be carefully defined and referred to the co-ordination panel for allocation to the relevant caring agencies.

3. (i) The Mental Health Services and other relevant disciplines in the Western Board area should co-operate to identify patients using defined criteria for at risk patients for inclusion in the supervision group. A specialist team led by a forensic psychiatrist with access to

back up medium secure unit beds should be established. The specialist team should be multidisciplinary in nature.

(ii) Each supervision group patient should have a key worker, usually a specially trained community psychiatric nurse with a very limited caseload and the facility to refer to other members of the team with special expertise.

(iii) The key workers should follow patients across Health and Social Services Board boundaries until responsibility is formally transferred to a local specialist team.

(iv) Compulsory supervision will be necessary from time to time using a supervised discharge order. This will require new legislation.

(v) A compatible information system between mental health and social services should be established to facilitate greater continuity of care.

4. (i) The Department of Health and Social Services (Northern Ireland) should review the 1986 Mental Health Order with the aim to introducing an additional category of mental disorder, namely severe personality disorder. This could follow the wording of the English Mental Health Act 1983 (Section 3) "... such treatment is likely to alleviate or prevent a deterioration of his condition".

(ii) All staff likely to use powers under the Mental Health Order (NI) 1986 should have received induction training in its use.

(iii) In addition, there should be regular refresher training in the use of the Mental Health Order (NI) 1986.

(iv) Training should include full knowledge of the additional guidance contained in the Guide to the Order and the Code of Practice.

(v) In all instances where a voluntary patient is discharging him or herself Contrary to Medical Advice, consideration should be given to the desirability of using powers to detain for assessment.

(vi) All staff likely to use powers under the Mental Health Order (NI) 1986 should have ready access to legal advice concerning any aspects where they are unsure of the interpretation of the Order.

5. (i) We would recommend to the Western Health and Social Services Board that our report is made public.

(ii) The report presents an opportunity to engage the public in discussion of wider issues relating to mental health and the role of professionals working within this field.

We would recommend that the Western Health and Social Services Board take the lead in promoting greater community involvement in mental health services.

B. INTRODUCTION

1.0 Why was the Inquiry Team established?

On 15 May 1995, Brian Martin Doherty, was sentenced to life imprisonment for the manslaughter of Kieran Hegarty, and to ten years for the kidnapping of Kieran Hegarty. Brian Doherty had discharged himself, Contrary to Medical Advice, from the Tyrone and Fermanagh Hospital in Omagh on the same day that he abducted and killed Kieran Hegarty.

On 16 May 1995, the Western Health and Social Services Board announced its intention to initiate a full independent review. A copy of the Western Board's Press Release is contained within Appendix 1.

The Western Board appointed Professor George Fenton as Chairperson of the Inquiry Panel, together with three other members, Mr Eamonn Deane, Mr Stanley Herron and Mr Brendan Mullen. Further details of the members of the Inquiry Team are contained within Appendix 2.

2.0 Terms of Reference

The full terms of reference for the Western Board's review were:

1. to review and examine the circumstances surrounding the admission and discharge of Brian Doherty to and from the Tyrone and Fermanagh Hospital with particular reference to the applicability of the provisions of the Mental Health Order (NI) 1986,

2. to make recommendations on operational policy and related changes in management arrangements arising from the experience learned from

this incident. Such recommendations should also include any identified action,

3. to prepare a report on any relevant findings or recommendations arising out of this review for the Western Health and Social Services Board and the Mental Health Commission by 30 September 1995. The Board will report its conclusions to the Minister by 31 October 1995.

Following initial investigations, the Inquiry Team soon felt it necessary to broaden the scope of the review so that a fuller picture of Brian Doherty and his history, with particular regard to the treatment and care he had received from various agencies throughout his life, could be made. In view of this and the scale and complexity of the review, as Chairperson of the Inquiry Team, Professor Fenton requested that the deadline for the receipt of the Inquiry Team's report be extended. This request was considered and granted by the Western Board and the deadline was extended to 21 October 1995.

3.0 Thank Yous and Acknowledgements

We wish to extend our thanks to everyone who willingly agreed to give evidence to us about their involvement with Brian Doherty. We particularly wish to thank Mrs Doherty, Brian Doherty's mother, and Mr and Mrs Hegarty, parents of Kieran Hegarty, for meeting with us at what must be a most traumatic time for both families - we would wish to place on record that the Inquiry Team is very grateful to them for giving evidence to us.

We would also wish to extend our thanks to Mrs Janet Hall, who has acted as Administrator and Secretary throughout the Inquiry.

4.0 Methods of the Inquiry

At the beginning of our Inquiry we requested and obtained access to various records relating to Brian Doherty which were held by any agency we could identify as having had contact with him. This included hospitals, social services departments, the Royal Ulster Constabulary, the Northern Ireland Court Service, children's homes, training schools, and reports from forensic psychiatrists.

As we read the records it became clear that there were a number of factual witnesses from whom we wished to hear evidence. These witnesses were sent a letter (see Appendix 3) inviting them to meet with the Inquiry Team. No one refused to meet with us and a full list of those from whom we heard evidence and the organisations they came from or represented, where appropriate, is contained within Appendix 4. We have also set out in Appendix 5 a bibliography of all source materials which the Inquiry Team had access to during the course of their investigations.

We initially met on two occasions, 21 July 1995 and 11 August 1995, in order to set out our agenda and method for carrying out our investigations. We then met with witnesses on 5, 11, 12, and 18 September 1995 - these meetings were held in various venues within the Western Health and Social Services Board area. We further met on 2, 3 16 and 23 October 1995 in order to structure and write our report.

We will not be making public any of the evidence that has been submitted to us either orally or in writing, apart from that which is disclosed within the body of this report. We should also like to make it clear that we make our findings on the basis of the evidence that we have received. Our comments and recommendations which appear in the report are based on those findings.

C. NARRATIVE

5.0 Story of Brian Doherty

5.1 Early Years

Brian Doherty was born on 13 March 1974 in Strabane Hospital. He was the youngest of four children, having three sisters, two, three and five years older. His mother, Cecilia, claims that he was deprived of oxygen at birth and that this has impacted on his behaviour ever since. She further claims that this caused one side of his face to have a swollen appearance for the first two years of his life.

At primary school Brian Doherty was assessed as "borderline educationally subnormal" (ESN) in September 1980 aged 6 years. Three years later on 5 September 1983 , he was admitted to Belmont House Special School because of a "severe reading problem" and "no real concept of number". It was noted that whilst his classroom behaviour was generally good that he was "constantly in trouble during break". His copy-writing was perfect and he was especially good at art work, winning second prize in a nationwide art competition for special schools. He and his mother appeared on breakfast television to receive his award.

[Two sentences have been removed in order to meet the Board's duty of confidentiality.] Brian Doherty's behaviour appears to have steadily worsened as he became older. Yet whatever behavioural problems he presented they were apparantly capable of being dealt with at home and at school at that time.

5.2 Aged 11 - 13 Years

In July 1985 Mrs Doherty asked Strabane Social Services for help in dealing with her disruptive son, Brian. He was becoming involved more regularly in incidents which were giving cause for concern - "set the back shed on fire" ; "involved in a violent incident with another child and may have cut him with a knife"; "violent at home, spitting in milk, breaking glass, leaving on the gas"; "defecating in his own back yard and urinating through neighbour's letter boxes". He had been given a warning by the RUC about disorderly behaviour - stoning buses carrying "Orangemen" from the 12th July march. It was noted that he had a preoccupation with death and one incident was recorded when he brought home the remains of a maggot-ridden dog that he had earlier stabbed to death with a knife having impaled the animal on a piece of wood with nails through it. The same report notes that "he won't come home at night and recently seems to have walked into the reservoir in a dangerous quarry."

A social worker visited the Doherty home several times and there were discussions with Mrs Doherty about her needs. In late summer of 1985 Brian Doherty (Senior) left for England and this was a significant step towards the final break-up of the marriage.

In November 1985 it was agreed by all concerned, including Brian Doherty, that a period of assessment in Harberton House would "prove to be useful".

For a few weeks prior to his admission to Harberton it appears that he was receiving medication from his GP to calm him down.

Despite a careful preparation process undertaken by the social worker with Brian Doherty, he absconded from Harberton House, one day after his admission on 12 December 1985. He was returned to Harberton and

continued there for assessment until February 1986, with a two-day break at home for Christmas during which time he was extremely disruptive.

In a progress report on 6 January 1986 his houseparent at Harberton noted that:

"Throughout Brian's stay in Harberton I have found him to be a "strange" and difficult little boy to work with and this has also been expressed by other members of staff. Prior to his care he was an extremely difficult and uncontrollable boy who did extreme things. While in care where there is the structure and consistent controls we have managed to contain his behaviour, although any other progress or change has been slow; for Brian to respond, I feel will take time."

In this report's recommendations three options were outlined:

1. "That Brian remain in Harberton House for a stated period of time to allow work to continue.
2. Should Brian return home now a high level of social work involvement is essential.
3. If the home placement should break down then a referral to Lissue Hospital would seem appropriate."

Whilst he remained anxious to return home from Harberton House, his school progress report noted that, "Brian's behaviour seems unaffected by the stay in Harberton," and "Though Brian's behaviour is unsatisfactory at times it shows none of the quirks which contributed to his move to Harberton. It is normal rather than abnormal misbehaviour."

In January 1986 he was assessed by an educational psychologist who noted that his attainments were very poor:

"Reading - sight vocabulary of about a dozen words
Number - Belfast Junior Arithmetic Test - Arith. Age - 6 years."

As a result he recommended management training carried out by Lissue Hospital or Harberton House with mother and child in residence. There is no record of such training having taken place and no apparent reason why it did not.

Brian Doherty stayed in Harberton for another few weeks during which time his most extreme behaviour was pretending to be in the IRA, wearing a hood.

On 7 February 1986 an assessment review of Brian Doherty's progress was held. This concluded that:

1. "Mrs Doherty would be permitted to withdraw Brian from care although serious concerns remain about the lack of change in the home situation.
2. A high level of fieldwork support will be provided because of the ongoing concerns.
3. If the home situation breaks down, a future admission to care would be on a formal basis."

On 24 February it was noted that since his discharge from Harberton House to his mother's care that his behaviour hadn't presented any difficulties - "However, he did go to a local quarry recently which was frozen over."

Regular social work visits continued throughout the next several months and Brian Doherty's improved behaviour remained consistent. On 26 September, following another month without significant incident, it was agreed that social work involvement would be closed. It was emphasised to Mrs Doherty that social work staff would remain at her disposal "at any time, including on standby during the night or at weekends. This has been agreed with Cecilia (Mrs Doherty) and Brian. Case closed."

5.3 Aged 13-14 Years

Between September 1986 and February 1987, Brian Doherty was at home. However, his behaviour at home deteriorated. So much so that Social Services were again requested to intervene. His behaviour at school continued to be reasonable and it was agreed that the best option was to transfer him to Greystone Hall boarding School in Limavady, thus allowing his mother respite during the week and Brian Doherty to be home at weekends. This was put into effect on 3 April 1987. It was noted on 29 May 1987 that "Brian is in Greystone Hall for the foreseeable future, although the issue of dealing with his emotional needs is far from resolved. His behaviour is being contained for the present." There appears to have been a period of some stability yet within a year of his admission to Greystone Hall it was noted in a class report that "He will throw objects at the slightest provocation and is a distinct danger to the safety of his classmates."

Yet, there seemed to be sufficient optimism about his potential for improved behaviour when he was sent on a children's holiday scheme to a family in the United States during the early summer of 1988. However, he had to be brought home early because of shoplifting and aggressive behaviour towards another child.

During that summer of 1988 there was a marked deterioration in his behaviour. He became more aggressive and violent; physically abusing his mother; throwing furniture, cups, knives and a hammer at his sisters; kicking holes in every door in the house. His mother had been through major surgery a short time before and could not cope physically or emotionally with this level of stress.

For some relief his mother urged him to visit his father in England - this visit was for a short period and his father sent him home because of his

misbehaviour. His father alleged that Brian Doherty climbed onto the roof of his flat and fired from an air pistol down at passers-by in the street below. When he came back from England, he took to roaming the streets at night and eventually in September with a combination of his increasingly disturbed behaviour and the school refusing to have him back it was clear that the situation was out of hand.

A case conference was held on 12 September 1988 and the following was agreed:

1. "The child needs specialist assessment before any detailed planning can be undertaken. He should be referred to the Senior Medical Officer for assessment of birth trauma factors. Referral to the Adolescent Psychiatry Unit at the Royal Victoria Hospital should be pursued.

2. Social Worker will attempt to persuade Brian to return to Greystone Hall and to negotiate with Mrs Doherty about his care at weekends.

3. In the event of the home situation breaking down, the use of residential care for weekends can be considered as an interim measure."

It appears that no action was taken on the suggested referral to the Adolescent Psychiatry Unit.

Brian Doherty was admitted to voluntary care in Harberton House on 24 September 1988 but ran away and made his way back to Strabane on foot through the fields. He claimed to have found a shotgun and this caused Social Services to request the RUC to remove him to a place of safety on 28 September 1988. He was admitted to St Patrick's Training School, Belfast. During his first few days in St Patrick's he was involved in numerous fights and a case review was held on 4 October. This concluded that Brian Doherty should be referred to Child and Adolescent Psychiatry within a short period of

time and that there was a need for a psychological assessment to be carried out. This psychological assessment was duly implemented within several weeks, however, it appears that two years had elapsed before the psychiatric referral was acted upon

On 14 October 1988, an application for an Interim Order of Detention to facilitate "a fuller assessment to be made to determine Brian's future" was made by his social worker. This application was granted on 21 October 1988 and a further Interim Order was made on 18 November by the Juvenile Court. In an assessment made in November it was recorded that, "Brian is below average intelligence and is verbally defective. He can only read words but cannot read sentences ... He needs specialist individual (educational) attention."

At the request of St Patrick's Training School, a clinical psychologist assessed Brian Doherty's intellectual, social and emotional development on 21 November 1988. He concluded that, "Brian is of very low ability ... Most certainly he presents management problems and is likely to do so in the years ahead ... Brian's preoccupation with paramilitary activity ... gives cause for concern ... there might be some danger of him ending up in the wrong place at the wrong time and thereby placing himself at some risk ... He copes very poorly in the peer group situation ... I believe he will remain a long-term care and management problem even in adulthood ..."

Strabane Social Services convened a case conference about Brian Doherty on 22 November 1988. This assessed Brian Doherty's progress in St Patrick's Training School, reviewed the situation at home and began planning for future educational and social needs. It was noted that since going into St Patrick's that Brian Doherty had spent three weekends at home. The first of these had not worked out well but the more recent weekends had. The clinical psychologist expressed the view that secure accommodation was not a viable proposition for Brian Doherty. It was agreed that in years to come he

would need sheltered employment and support to retain his independence in the community. It was further agreed that the Western Education and Library Board be asked to consider future options - Ardmore and Glencraig as placements for Brian Doherty, in the interim the most suitable option available was a return to Greystone Hall. It is not clear whether these suggested further options had been followed up or whether the interim arrangement became the long term arrangement by default.

At a further case conference on 12 December 1988 it was agreed that Brian Doherty should go back to Greystone Hall on 4 January 1989 on a residential basis. Brian Doherty's behaviour in St Patrick's Training School continued to cause concern and was described as "unsettled and elusive". It was agreed that the Western Health and Social Services Board should withdraw any pending court proceedings for a Training School Order and if there was any breakdown in these arrangements over the Christmas period that he be returned to the Training School using a Place of Safety Order.

When the interim Place of Safety Order expired on 16 December 1988, Brian Doherty appeared at Strabane Petty Sessions. No application was made for a Training School Order and he was released home. He created a scene outside the Court demanding that his mother bring him a toy gun.

His father sent him an air pistol for Christmas and he injured his mother behind the ear with this gun. The police were called in to assist and took the gun from him. His behaviour became increasingly "bizarre" over late December 1988 - January 1989 period. He stole a bicycle on which he travelled up the wrong side of a motorway and was arrested. He created mayhem at home to such an extent that his sisters left the house.

He went back to Greystone Hall on 9 January 1989 and by the 18 January his behaviour was described as very difficult to control:

" - found on numerous occasions in out-of-bounds area of the school;
- water thrown around the changing room in the local swimming pool;
- sought by the police when having absconded from the swimming pool;
- on the school roof almost daily;
- verbal abuse to other pupils;
- absent from school grounds to purchase cigarettes;
- a disturbing influence upon other pupils who copy his behaviour."

Brian Doherty was expelled from Greystone Hall on 26 January 1989 as the litany of incidents continued to mount. Of particular concern was an incident when he, "twisted a towel around a younger pupil's neck and tried to lift the pupil off the floor. The timely intervention of a member of staff prevented what could have been a case of death by asphyxiation."

His case was reviewed on 1 February 1989 and it was agreed that "staying at home is not viable, he has the house under siege. He is not only a danger to himself and others but there is also danger from outside sources." It was also noted that there were no (alternative forms of education) facilities available in Ireland to meet Brian Doherty's needs.

He was placed in St Patrick's Training School on 26 January 1989 but absconded on 3 February 1989. He broke into a house and was arrested on 9 February and charged with breaking and entering. He was remanded to Lisnevin Secure Unit on 10 February and stayed there until 21 March when he received a Training School Order and was transferred to St Patrick's Training School again.

5.4 Aged 15-18 Years

Brian Doherty found it very difficult to settle in St Patrick's Training School and absconded several times. For one of these periods he was absent for a week and during that time "was running around Strabane completely out of

control. He had shaved his head and was knocking on people's doors in the early hours of the morning wearing a balaclava".

In June 1989 the Social Services closed Brian Doherty's case as he was no longer their responsibility as he was under a Training School Order. Brian Doherty continued his frequent abscondings from St Patrick's Training School and on one occasion broke windows in a house. He was arrested and charged with this offence and was remanded for a further period to Lisnevin Secure Unit (7 August 1989). He was assessed by a second clinical psychologist from the Adolescent Psychology and Resource Centre in September 1989 who stated, "The major consideration in Brian's case is the danger of his absconding from an open setting and placing himself once more at risk in the community ... an application was made to the Admissions Panel of St Patrick's Training School with a view to Brian being accepted into their secure unit ... (he) has been offered a place, subject to the Court's approval. He will be able to remain in the Unit, subject to regular review, as long as he is perceived to remain at risk to himself and others in the community."

Brian Doherty was discharged from Lisnevin Secure Unit and transferred to Slemish House at St Patrick's Training School (closed observation unit) on 6 October 1989. Initially he responded very well to his new surroundings, so much so that at two further court hearings in Strabane in October 1989 and Dungannon in March 1990, he was discharged and allowed to continue in the care of Slemish House. In his report to the Strabane Juvenile Court, the clinical psychologist noted that, "Brian ... has made considerable progress in terms of his social interaction, self care skills and educational ability." His improvement was such that his Christmas leave at home was incident-free. In April 1990 when he was then 16 years old, Brian Doherty joined Routeways Youth Training Programme at the Rupert Stanley College in Whiterock, He experienced difficulty relating to the others on the course and in the impact of two different approaches to discipline - one from Slemish

House and the other Youth Training Programme. He continued to go home at weekends and whilst his overall behaviour had improved immensely he began to over eat.

In September 1990 it was alleged that whilst attending the Rupert Stanley College in Whiterock for literacy and numeracy skills development, that Brian Doherty was involved in an incident in the nearby cemetery in which he frightened two youngsters. The following day a group of 40 older children chased Brian Doherty and it was agreed that in future he should be escorted to and from the College. However, the next day after being duly escorted he left the building at lunch time without permission and was eventually tracked down by the police in Larne attempting to board the ferry to travel to his father in Nottingham.

It was decided to have Brian Doherty psychiatrically assessed. The clinical psychologist referred him to the Young People's Centre. The Child and Adolescent Senior Registrar saw Brian Doherty on 31 October 1990 and reported that, "I could find no evidence of psychotic symptoms or paranoid ideation ... I would suggest that planning for his future support and care might involve a referral to the Mental Handicap Service as he will undoubtedly need continued support and supervision and would benefit from access to the special facilities which they can provide."

In November 1990 a Consultant Psychiatrist in Mental Handicap from Muckamore Abbey Hospital interviewed Brian Doherty. He reported that, "...I do not think that the general mental handicap services would have anything to offer him and I do not think that it would be helpful to consider him to be mentally handicapped." Brian Doherty continued in the care of Slemish House and a programme of home leave was developed.

During the new few months, Brian Doherty absconded several times from Slemish House and during these interludes had been involved in joy-riding,

glue sniffing, drinking and fighting. In February 1991, he again absconded clad only in his pyjamas and having secreted a 6" screwdriver in his rectum. He went to a woman he had befriended in the Turf Lodge estate, West Belfast. She became very frightened when he developed an erection whilst her young daughter was present. The clinical psychologist involved in his current care noted at a case conference in February 1991 that, "Brian's profile is now shifting ... he is going for bigger thrills and is not aware of the gravity of the situation ... (Brian) has a concept of being a prisoner of war - he is now shifting his ideas ... out into the community, ie. a "hood" or paramilitary factor (and in particular one who can evade capture by the police)." The case conference agreed to refer him to Muckamore Abbey Hospital for a full assessment.

The consultant psychiatrist from Muckamore Abbey was asked for his advice about the desirability of Brian Doherty being discharged home and attending a Youth Training Programme scheme. Following his interview with Brian Doherty on 26 Feburary 1991, he concluded that, "I think that his unclear view of what is expected of an adult male ... requires more attention and active care than could be provided by his mother and a Youth Training Programme scheme. I would suggest that it would be wise to review the present plan to discharge him home and that the appropriate agencies be involved to construct a longer term plan."

This recommendation appears to have been ignored and Brian Doherty continued in Slemish House and, "made considerable progress to the extent that after spending "a number of successful weekends" at home the decision was taken to return him to the care of his mother on a full-time basis. This was to be effected with the support of a placement on Youthways, Londonderry. This support was withdrawn at the last minute as staff in Youthways felt they did not have the specialist training he required. However, it was decided to place him in a Youth Training Programme in Strabane and return him home. During his weekend at home he went to

Donegal and was arrested by the Gardai for committing a burglary in the Downings area for which he received a six month suspended sentence.

During one of his trial periods at home he had been involved in a serious incident assaulting a youth and damaging his bicycle. As a result of this and the incident in Donegal he was recalled to St Patrick's Training School to await a further assessment from the consultant psychiatrist at Muckamore Abbey Hospital. A case review noted "This assessment may result in Brian being placed in Muckamore under the Mental Handicap label. While this seems a regrettable and backward step it may well be a better alternative to a prison sentence which appears to be the likely outcome at his next court appearance".

The consultant psychiatrist from Muckamore Abbey saw Brian Doherty on 13 June 1991 along with his mother, the clinical psychologist and staff from St Patrick's Training School. It was agreed that he should be admitted to Muckamore Abbey Hospital on a formal Order under the Mental Health Order (NI). In a letter to the Northern Ireland Office, the consultant psychiatrist said "Brian would seem to be severely mentally handicapped within the meaning of the Mental Health (NI) Order 1986 and in addition shows seriously irresponsible behaviour by absconding, violence and inappropriate association while at home". The admission to be in late August. In the interim Brian Doherty continued his frequent abscondings from St Patrick's Training School and on one occasion was apprehended by staff on the Monagh Road, West Belfast, quite drunk.

5.5 Aged 17 Years

Brian Doherty was admitted to Movilla 'A' a locked semi-secure ward in Muckamore Abbey Hospital on 30 August 1991. His admission as a detained patient was for a two week initial assessment period. The stated reasons for admission were:

1. Routine assessment
2. History of absconding
3. General observation.

He was very unhappy in Muckamore Abbey Hospital and wrote a letter on the 10 September 1991 requesting a return to St Patrick's Training School or back home. On 12 September 1991 he was detained for treatment on the grounds of severe mental impairment.

Brian Doherty absconded on 16 September 1991, escaping on a visit to a community centre. It is not entirely clear how he spent all of the next few weeks. He travelled to Donegal and was seen in Bundoran on 20 September - then he made his way to England and visited his father in Leicester on 28 September. This was an unsuccessful visit and he made his way home again. He was arrested in Larne by police and was handcuffed whilst trying to evade capture. He had a 'package' in his coat with a cartridge and powder in it and became very disruptive when these were retrieved. His image of himself as a Rambo-style character on the run from the police was taking more potent forms. He was returned to Movilla under nurse and police escort on 8 October 1991 and on his return grabbed a pass key and attempted to escape through the front door of the villa.

He again attempted to abscond on 11 October and was very violent when apprehended by staff. He was placed in seclusion for a few hours and was seen by the consultant psychiatrist who noted that, "we have reservations about keeping him here in Muckamore because:

a) we suggest that he may not be seriously mentally handicapped
b) he has shown such determined and violent measures to try and get out
c) he does not identify with any of the other residents.

Other factors:

a) we have not had an opportunity to reassess him on an adult scale

b) the logical conclusion of the current situation would be considering special hospital."

These matters were discussed at a case review held in St Patrick's Training School on 15 October 1991 On the same day Brian Doherty was tested by the clinical psychologist at Muckamore Abbey Hospital, using the Wechsler Adult Intelligence Scale. In his opinion Brian Doherty was suffering from mental handicap, within the meaning of the Mental Health Order 1986. The results placed him "on the borderline between mild and severe mental handicap - full scale IQ69". The case review concluded that St Patrick's Training School had nothing more to offer him and that he should continue in Muckamore Abbey Hospital for a further period of one month. It was acknowledged that he could only stay in the Training School system until the Training School Order expired in June of the following year. Fears were expressed about his forthcoming court case and whether he may receive a custodial sentence to the Young Offenders' Centre. It was agreed that contact be made with Strabane Social Services.

On 6 November 1991 there was a case review held in Muckamore Abbey Hospital between St Patrick's Training School and Muckamore Abbey staff. It was noted that Brian Doherty's behaviour had improved since the absconding in October and that he was progressing satisfactorily. It was agreed that close contact with St Patrick's Training School should be phased out. Christmas leave for Brian Doherty was discussed but no decision was made other than to keep it as a possible goal at the end of a structured programme. The Training School Order was discussed and it was agreed that it should be left in place until his eighteenth birthday "in case there was a further episode of absconding which lasted more than 28 days in the near future".

When Brian Doherty's case came before the court in Strabane on 21 November 1991 it was adjourned until 16 January 1992. He continued to progress in Muckamore Abbey Hospital and was allowed home leave for Christmas, travelling independently. He returned to Muckamore Abbey Hospital on 28 December as arranged and then having declared that he was glad to be back, absconded on 31 December. He was returned to Muckamore Abbey Hospital on 6 January 1992 having had " a lot of alcohol on board" and been aggressive and abusive to the police.

Again when he went to court on 16 January 1992 the case was adjourned until 12 March 1992. One charge was dropped but charges of theft and assault were to continue. A planned programme was prepared to allow more home leave - his mother said, "he acts differently when at home on leave than when he is absconding". In a review held on 6 February it was noted that he had "no concept of time yet has a good memory for directions. He is impulsive and has problems with his fantasy world. He would require a period of training before being discharged but otherwise there is no absolute indication for hospital care."

Brian Doherty went home on trial leave for a few days on 14 February 1992. Although his mother saw him onto the train to return to Muckamore Abbey Hospital and staff were waiting for his arrival, he did not arrive. He got off the train in Portrush and went back to his sister's house in Omagh. When she rang Muckamore Abbey Hospital he ran away. He continued "at large" and on 5 March the Probation and Juvenile Branch at the Northern Ireland Office wrote to the consultant psychiatrist at Muckamore Abbey Hospital:

"Ignoring any time when Brian was absent without authority from St Patrick's Training School or Muckamore Abbey Hospital his Training School Order is due to expire on 20 March 1992. You indicated that, at present anyway, you did not require the total time at large without authority to be calculated to assist you with his further treatment.

In view of this and your intention to discuss Brian's case with the Western Health and Social Services Board, no further action will be taken by this Division unless so requested by you.

Since, even after the Training School Order has expired, St Patrick's have a continuing responsibility for Brain's supervision until he reaches his 21st birthday, I would be grateful if you keep them informed of any significant developments."

For the next several days and weeks Brian Doherty managed to evade any attempts to recapture him or persuade him to go back to Muckamore Abbey Hospital. By failing to return to Muckamore Abbey, by the 15 March 1992, his Compulsory Detention for Treatment lapsed and he was discharged. On 18 March 1992 his mother again sought help from Strabane Social Services in dealing with Brian. He had by now just turned 18, it was unclear whether he was mentally handicapped or not and who, if anybody, should take responsibility for helping him to cope. Since he had been a recent resident of Muckamore Abbey Hospital, he was referred to the social worker in the Mental Handicap Team who contacted hospital mental handicap services for information. In his report of 20 March 1992, the consultant psychiatrist at Muckamore Abbey Hospital records that Brian Doherty:

"made a considerable advance in his social skills whilst at St Patrick's Training School and made a small further advance during the short period of time at Muckamore. He was not listed as being a person with special needs because of his mental handicap. If further treatment is thought to be required an approach should be made to the appropriate local services who may then decide if a referral is necessary."

The court case due to be heard on 12 March 1992 was adjourned again until 9 April 1992. Brain Doherty's Training School Order expired on 20 March 1992.

5.6 Aged 18 Years

As he entered the world of adulthood (March 1992), Brian Doherty had experienced a variety of institutions and systems for children in care. Now, as an adult, he was facing into the world with a court case pending in the near future and an ever growing reputation for being troublesome and a nuisance who acted bizarrely.

He appeared at Strabane Magistrate's Court on 9 April 1992 charged with assault and theft. He was given a one year probation order and the Probation Service were then perceived to be the lead organisation in dealing with him. He was seen by his probation officer once per week for the first three months of the twelve month period, then at regular intervals for the remainder of the Order. During this time he attended the Probation Service Community Support Programme. He had great difficulty in participating in group discussions and often made inappropriate demands on the probation officer's time. He had no concept of time and this was combined with a propensity for making "out-of-the-blue" statements which implied inside knowledge of the workings of paramilitary organisations and gave a sense of strangeness.

During the summer of 1992 Brian Doherty "took to his bed" spending days on end in his bedroom and wandering the streets at night. At the request of his probation officer arrangements were made for him to attend an outpatients clinic at Gransha Hospital but he failed to attend. In October there was an alleged "flashing" incident and this prompted a request from the consultant psychiatrist, Gransha Hospital, for a home visit from the social worker for mental health.

In November he went to visit his father in Leicester and was arrested there by the police and charged with criminal damage (breaking into a car). He was given a conditional discharge and returned home on 18 November 1992. A domiciliary visit from the consultant psychiatrist at Stradreagh Hospital was arranged at the request of his General Practitioner, prompted by his probation officer. This took place on 20 November 1992 and the consultant psychiatrist concluded, "I would hesitate to put his name on the mental handicap register ... The future for this young man is grim ..."

On 4 December 1992 Brian Doherty was referred as a formal patient to Gransha Hospital by his General Practitioner. This referral arose from his violent reaction to his mother buying him trainers and a shell suit. These were not the type he wanted and he smashed dishes and attacked his mother. He was brought to the hospital, handcuffed and accompanied by three RUC officers. He was initially detained for assessment but was reviewed by a consultant psychiatrist the following day and regraded as a voluntary patient. He discharged himself on 9 December 1992.

He spent the next few days in Crawford Square Hostel but was asked to leave after constant disruptive behaviour and went across the border to Buncrana, Co Donegal. He was arrested there for alleged petty theft and advised to return to Northern Ireland or be detained in St Patrick's Institute in Dublin.

He was readmitted to Gransha Hospital as a voluntary patient on 14 December 1992. He was assessed when he requested his discharge the following day. It was concluded that there were no grounds on which to detain him and he left the hospital Contrary to Medical Advice on 15 December.

From mid December 1992 until March 1993, Brian Doherty stayed in a variety of places, mainly hostels. On one occasion he was asked to leave a hostel after the discovery of an imitation firearm and bomb. His continued fascination with paramilitarism led him into further trouble when on 20 February 1993, he lay on a road in Strabane with a balaclava over his head pretending to be dead. When a passing motorist stopped, he got up and ran away. The motorist gave chase and a fight ensued.

His behaviour continued to cause concern for his mother, his probation officer and his social worker and an appointment was made for him to see the consultant psychiatrist at Gransha Hospital on 12 March 1993. On the day before he had gone to the Tyrone and Fermanagh Hospital with his mother and was offered admission but refused. He was admitted to Gransha Hospital the next day as a voluntary patient but refused to stay and discharged himself later that same day Contrary to Medical Advice. He had thus been a very short term patient in Gransha Hospital on three occasions, discharging himself each time Contrary to Medical Advice. On this last occasion his discharge letter stated, "Admission to a psychiatric hospital is unlikely to be of any therapeutic benefit."

5.7 Aged 19 Years

Brian Doherty's activities continued to be unpredictably erratic yet there did not appear to be any appropriate institution or system which could meet his needs. In March 1993, the consultant psychiatrist at Gransha Hospital saw Brian Doherty in Strabane Health Centre. He referred Brian Doherty to the Probation Board psychologist and in a letter to his General Practitioner, stated that he had seen Brian Doherty "accompanied by his probation officer who is obviously worried that some of Mr Doherty's behaviour will lead to extremely serious circumstances ... I am not convinced that we are dealing with mental illness in this case." He further recommended a joint meeting "to

see if there is a strategy that could be developed which might help". The proposed meeting did not take place.

Brian Doherty did not keep his appointment with the Probation Board psychologist but did agree to continue voluntary contact with his probation officer when his Probation Order ended on 8 April 1993.

There was a further "flashing" allegation made against Brian Doherty in late April 1993 and he went to England for a short time returning in early May. Meanwhile attempts by the social worker for mental health to have a case conference proved fruitless. When Brian Doherty returned from England his continued fascination with paramilitarism resulted in his being arrested on 14 May 1993 for planting a hoax bomb at a neighbour's door. He was released without charge but was arrested again on 28 May 1993 for wearing a balaclava and possessing an imitation gun. On this occasion he was remanded in custody until he received bail in the High Court on 10 June 1993. The bail was conditional on his remaining in residence in the Crawford Square Hostel. However he went missing and did not turn up for his next scheduled court appearance on 25 June. He was arrested and remanded to the Young Offenders Centre on 28 June 1993.

In July 1993 he was seen by the visiting psychiatrist to the Young Offenders Centre who reported that, "I have assessed him today and can detect no mental illness or significant mental handicap. However he has a set of behaviours that are at times bizarre."

Brian Doherty remained in the Young Offenders Centre until 28 October 1993 when he once again appeared at Strabane Court where he was charged with behaviour likely to cause a breach of the peace. He was given a one year Probation Order with an additional condition that he see the Probation Board psychologist.

During November and December 1993 three appointments were made for him to see the Probation Board psychologist. He was also due in court on four separate occasions during these two months. He turned up on the first occasion but ran away before his case was heard. He failed to show up on any of the other occasions. The Probation Service made a further appointment for him to see the psychologist on 21 January 1994. The decision had been made that if he didn't attend this appointment then he would be taken to court for breach of the Probation Order. Before this could happen, however, events had taken a tragic turn.

We have attempted to write a chronology of Brian Doherty's life and his involvement with the various agencies and institutions - this is contained within Appendix 6.

6.0 Admission and Discharge at the Tyrone and Fermanagh Hospital

Brian Doherty's first voluntary admission was on 6 January 1994 following referral from the Accident and Emergency Department at the Tyrone County Hospital, Omagh. He had presented at the Accident and Emergency Department with a painful arm after he had smashed up a phone box and some bins. There was no evidence of a fracture but he complained of life not being worth living, which was the reason he was referred to the Tyrone and Fermanagh Hospital.

Following initial assessment the impression was that Brian Doherty was "a 19 year old depressed, suicidal, homeless youth with a history of deliberate self harm having had previous inpatient treatment for depression".

Then, suddenly, after admission he changed his mind, and said he wanted to go home and that he was joking all the time.

He was persuaded to remain for further assessment and his GP was contacted by the ward doctor to ascertain more information. This initially proved difficult as Brian Doherty had admitted himself under an alias, ie. Brian Donnelly. However, once his real name was found more information was forthcoming.

On 7 January 1994, again he was requesting to leave and he was advised to remain for full assessment and to be seen by the Consultant the following week. Further information on Brian Doherty was now available following discussion with the Probation Service.

Despite the ward doctor's assessment of him and advice to him to remain for further assessment and to be seen by the Consultant, Brian Doherty discharged himself Contrary to Medical Advice on 10 January 1994. Prior to Brian Doherty leaving the hospital, he was referred to the ward social worker for assistance with accommodation and this was duly organised at the Royal Arms Hotel in Omagh. Despite the fact that he was taken to the hotel by the ward social worker, Brian Doherty did not stay at the hotel. No medical outpatient appointment was arranged and no further follow up was deemed necessary. However, the Probation Service were alerted that he had taken his own discharge Contrary to Medical Advice.

Brian Doherty's second voluntary admission to the Tyrone and Fermanagh Hospital was on 13 January 1994 at 10.20 pm, following referral, again, from the Accident and Emergency Department at the Tyrone County Hospital. He had sustained a laceration to his right hand following a break in and told the casualty officer he was suicidal. He was then sent to the Tyrone and Fermanagh Hospital and once there he stated the whole thing "was a lie" and that he was not suicidal.

The Senior House Officer's impression of Brian Doherty was that "he was not a psychiatric problem, he had a low IQ, was a pathological liar, had nowhere

to go on the night of the admission and was therefore admitted for the protection of society."

On 18 January 1994, Brian Doherty expressed a wish to be discharged. He was examined by the Senior Registrar, accompanied by a member of the nursing staff, who advised him to remain for the further assessment and to be seen by the Consultant. He refused to remain in hospital. As Brian Doherty was deemed to be homeless, he was again referred to the ward social worker who attempted to secure emergency accommodation for him. These efforts proved negative as the Northern Ireland Housing Executive had assessed him as homeless but not in priority need. He had been provided with information regarding accommodation by the Housing Executive and an application for housing had been placed on their waiting list.

It must be noted here that the previous emergency accommodation had been obtained due to the contact with Brian Doherty taking place outside of normal working hours. Therefore the Western Health and Social Services Board and the Northern Ireland Housing Executive out-of-hours procedures for the homeless were used. The social worker assessed the situation and determined Brian Doherty to be in priority need on the grounds of vulnerability. On the second occasion, contact with Brian Doherty was during normal working hours, and therefore it was the Northern Ireland Housing Executive who assessed Brian Doherty and agreed he was homeless, but did not deem him to be in priority need.

Brian Doherty claimed to know of a "squat" in Londonderry where he could stay, although the social worker advised against this. The social worker discussed with him the various hostels available, although this appeared not to be a viable option due to his history. As he was still keen to discharge himself from hospital, his home address in Strabane was placed on his records as the discharge address.

Brian Doherty subsequently discharged himself from hospital, Contrary to Medical Advice, at 5.00 pm on 18 January 1995. No follow up was arranged. Both the Probation Service and his mother were informed that he had taken his own discharge.

Within a few hours of leaving hospital the fateful encounter with Kieran Hegarty had occurred.

Comment:

There were many issues which the Inquiry Team felt it necessary to discuss concerning Brian Doherty's admissions to the Tyrone and Fermanagh Hospital. The issues are fairly consistent across the two admissions and are dealt with in this manner unless otherwise stated.

Ward policy within the male admission unit is that the consultant ward round takes place every Thursday morning. On both occasions Brian Doherty was admitted on a Thursday evening and subsequently discharged himself early the following week before the consultant ward round had taken place. Therefore on neither occasion was Brian Doherty seen by the consultant psychiatrist, nor was the consultant contacted on the two occasions when Brian Doherty discharged himself Contrary to Medical Advice.

On his first admission Brian Doherty was in hospital for five days, from 6 to 10 January 1994. His second admission was for six days, from 13 to 18 January 1994. Normal practice dictates that patients who discharge themselves prior the weekly ward round would be discussed at that ward round to determine what follow up, if any, is required. These discussions are recorded within the ward conference book and records show that in Brian Doherty's case, no discussion took place at the ward round following his first discharge.

On his second admission there are only two entries in his medical notes; his admission note and his discussion with the senior registrar prior to discharging himself. We find it surprising that this amounts to a detailed assessment of a young man on his second admission. The absence of being seen by a consultant psychiatrist during the two admissions is explained by the organisation of the ward round, which occurs every Thursday morning.

It was felt by the Inquiry Team that a more flexible, holistic approach to individual patient needs or circumstances would have been more appropriate in this case. Indeed, we would suggest that the needs of each individual should be catered for within a structure that reflects their individuality. It was quite disappointing to hear that the practice of weekly ward rounds has not changed and therefore it is conceivable that someone could still be admitted and be in hospital for five days without seeing a consultant psychiatrist.

Of interest was the unusual job share arrangement between the two junior psychiatrists and it was felt by the Inquiry Team that this may have militated against good communication and continuity of care. However, although we acknowledge that this was a short term measure and there is no evidence to suggest it did not operate effectively, we also feel that if there had been continuity of care within the junior medical staff, this may have led to a more detailed assessment and knowledge of Brian Doherty's history and future management.

The Inquiry Team were concerned that the named nurse appeared to be more of a theory than actual practice within the ward. On both occasions Brian Doherty had the same named nurse and despite this, we can find no evidence of a comprehensive account of nursing actions and rationale by the named nurse. On both admissions there is no recording of any description by the named nurse and there is a consistent lack of a nursing assessment, planning and of evaluation. We were informed that the policy is to allocate the same named nurse who dealt with the individual on previous admissions,

to subsequent admissions. This is an acceptable policy but not when the implementation is rigidly applied, even when the named nurse is on leave. We were also surprised that the nursing staff did not request that Brian Doherty be seen by the consultant psychiatrist on the second admission, and feel that perhaps the nurses were not advocating on his behalf.

The Inquiry Team were also concerned that the role of the social worker appeared to be quite narrow and we had difficulty in identifying any form of team approach. We also felt that although significant efforts were made to ensure that Brian Doherty had accommodation when he first discharged himself, on the second occasion a more neutral stance was taken, perhaps because, despite the time involved in organising this, Brian Doherty had failed to avail of the accommodation arranged for him at the Royal Arms Hotel.

D. ISSUES ARISING FROM THE INQUIRY PROCEEDINGS

7.0 Mental Health (NI) Order 1986

7.1 Introduction

The Terms of Reference refer to "the applicability of the provisions of the Mental Health (Northern Ireland) Order 1986" (referred to in this Chapter as "the Mental Health Order"). In addition the last section of the Chapter considers other relevant pieces of legislation.

In relation to the Mental Health order a number of preliminary points can be made:

- the Mental Health Order is intended to facilitate treatment, including the use of compulsion where appropriate. It should not be regarded as putting unnecessary obstacles in the way of treatment, obstacles which then need to be negotiated;
- the use of compulsion has to be set against civil liberties and the fact that mental health legislation (with the exception of Scotland) can entail depriving people of their liberty without recourse to a Court;
- the Board may wish to obtain legal advice about the views expressed by the Inquiry Team in this report.

7.2 Powers under the Mental Health Order

In considering this aspect, two distinctions are important:

- between "mental disorder", which is the general term, and "mental illness; mental handicap; severe mental handicap and severe mental impairment"

and "any other disorder or disability of mind" which are sub-categories of "mental disorder".

- between **detention for assessment** and **detention for treatment**.

Because "detention for assessment" is what it says, ie. compulsory admission to hospital for assessment it is only necessary to state that the person is suffering from "mental disorder" and not go into details of what kind of mental disorder (ie. "mental illness, mental handicap, severe mental handicap or severe mental impairment").

On the other hand if it is decided to detain someone for treatment it is necessary to specify whether the person is suffering from "mental illness" or "severe mental impairment". (Note that is not possible to detain someone for treatment simply on the grounds of severe mental handicap).

In order to admit someone to hospital compulsorily for assessment three criteria have to be met:

1. the person has to be suffering from "mental disorder",

2. the mental disorder has to be of a nature or degree to warrant detention in hospital for assessment;

3. failure to detain would create a likelihood of serious physical harm to the person or to others. "Serious physical harm" is defined - see Appendix 7.

There are certain exclusions from "mental disorder" but the phrase "by reason only of" is important:

"No person shall be treated under this Order as suffering from mental disorder or from any form of mental disorder by reason only of personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."

Since the distinctions between "mental handicap", "severe mental handicap" and "severe mental impairment" may be important in this instance (although not directly to the question of compulsory admission for assessment) it is as well to be clear about them. The distinctions are legal rather than clinical.

- "mental handicap" is defined as "a state of arrested or incomplete development of mind which includes significant impairment or intelligence and social functioning".

- "severe mental handicap" is defined similarly except that the degree of impairment is "severe" rather than "significant".

- "severe mental impairment" means "a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

The Guide to the Mental Health Order suggests that "severe mental handicap" equates to the "in need of special care" category in the Mental Health Act (Northern Ireland) 1961. "In need of special care" in that Act was defined operationally as:

"being socially inefficient to such an extent that he requires supervision, training or control in his own interests or in the interests of other persons;"
"Socially inefficient" is defined as:
- incapable of guarding himself against common physical dangers;
- incapable of managing himself or his affairs;

- in need of care for the protection of other persons".

The Code of Practice to the Mental Health Order makes clear that:

"The definitions of "severe mental handicap" and "severe mental impairment" include the term "severe impairment of intelligence and social functioning". That is not meant to restrict these definitions to persons whose intelligence level as measured by psychological tests falls below a particular figure. Assessment should take into account the total impairment both of intelligence and of social functioning." (Section 1.13 of the Code of Practice)

In the opinion of the Inquiry Team, the last sentence of Section 1.13 is particularly important. It should also be remembered that Section 1.2 of the Code of Practice states:

"The Order does not impose a legal duty to comply with the Code but the fact that the Code has not been followed could be referred to in evidence in legal proceedings."

7.3 How was the Mental Health Order applied in Brian Doherty's case?

There has been considerable variation in the way in which the Mental Health Order has been interpreted:

- Brian Doherty was detained in Muckamore Abbey Hospital, initially for assessment, which was then extended to detention for treatment. Detention for assessment was on the grounds of mental disorder and for treatment on the grounds of "severe mental impairment". Procedures did seem to be followed correctly, although it is probably unusual for compulsory admission for assessment to be deferred in the way which

occurred. His detention for treatment was not reviewed but simply lapsed because of the period of time he remained "absent without leave".

- His second detention (for assessment) was to Gransha Hospital on the grounds that he was suffering from "mental disorder" and the other criteria were met. He was regraded almost immediately as a voluntary patient, although there is no record of the reasons for this re-assessment.

- The forensic psychiatric evidence to the Court was that he was suffering from "severe mental impairment" (an option which coincided with that of Muckamore Abbey Hospital).

- The Court accepted a plea of diminished responsibility on the grounds of "mental abnormality". "Mental abnormality" is defined in the Criminal Justice Act (NI) 1966 as "an abnormality of mind arising from a condition of arrested or retarded development of mind or any inherent causes or is induced by disease or injury."

- The Transfer Direction from Prison to Carstairs under Article 53 of the Mental Health Order would have to be made on the grounds of mental illness or severe mental impairment.

It was decided not to use compulsory powers to detain during a subsequent admission to Gransha Hospital and on his two admissions to the Tyrone and Fermanagh Hospital.

The reasons given for not detaining him on these last two occasions were that he was not suffering from a mental illness, or if he were, the diagnosis would be one of "personality disorder" which, it was believed, excluded the use of compulsory powers to detain for assessment.

It could be argued that, on these occasions, he was suffering from "mental disorder" on the basis of his "significant impairment of intelligence and social functioning.". It could also be argued that the other criteria were met.

Possible reasons why it was considered inappropriate to use powers under the Mental Health Order on these occasions might include:

- because admission was to a psychiatric, rather than a mental handicap hospital, there may have been too great a concentration on diagnosing a "mental illness" rather than the more general category of "mental disorder" or an alternative category such as "mental handicap" (or "any other disorder or disability of mind" if minimal brain dysfunction was being considered);

- if, as seemed to be the case, the focus was on "personality disorder" as a diagnosis, due attention may not have been paid to the phrase "by reason only of...";

- there may have been some confusion between a purely clinical assessment of "mental handicap" (perhaps largely based on IQ tests and the legal definition of mental handicap, which includes "impairment of social functioning".

7.4 Other Relevant Legislation

The Disabled Persons (Northern Ireland) Act 1989 imposes a duty on Education and Library Boards to notify Health and Social Services Boards of young people who have received a "statement" of special educational needs. Health and Social Services Boards notified in this way have a duty to carry out an assessment of the needs of the person for personal social services. It is not clear whether this procedure was followed in Brian Doherty's case. If it

was, it might have helped in determining which community service was most appropriate.

The Housing (Northern Ireland) Order 1988 defines "homelessness" as "having no accommodation which he can occupy in Northern Ireland". In addition, applicants must be in priority need and not be intentionally homeless.

"Priority need" is defined as being in one of a number of groups:

- a pregnant woman, or a person with whom a pregnant woman resides;
- a person with whom dependent children reside;
- a person who is vulnerable as a result of old age, mental illness or handicap or physical disability or other special reason;
- a person who is homeless .. as a result of an emergency such as a flood, fire or other disaster;
- a person without dependent children who satisfies the Executive that he has been subject to violence;
- a young person who satisfies the Executive that he is a risk of sexual or financial exploitation.

The Children and Young Persons Act (Northern Ireland) 1968 imposes a duty on Training Schools to provide aftercare to young people who have been in Training School, until they reach their 21st birthday (Section 89 of the Children and Young Persons Act 1968).

8.0 Mental Health Assessment: Does Brian Doherty have a Mental Disorder?

8.1 Relevant Medical History

In order to reach an informed opinion about this issue, it is necessary to review Brian Doherty's life history in order to highlight social, psychological and medical factors that have had an impact on his development as a person, social functioning and mental health over the years.

He was born on 13 March 1974, the youngest of four children. His mother reports that she did not see him for 24 hours after the delivery, because of breathing difficulties. It is reported that he had been born with the umbilical cord around his neck and suffered from temporary lack of oxygen at the time of his birth. Subsequently his mother noticed an asymmetry of his face with swelling of the left side and slight muscle paralysis of that side of the face. This cleared up by the time he was two years old. His subsequent development was normal. However, the family environment was an emotionally disturbed one. His father was a heavy drinker and there was much violence in the home usually directed at Brian Doherty's mother but sometimes at the children. Social Workers at the time commented on a lack of consistent parenting over his formative years. When he was aged 9, the family broke up because of his fathers drinking and aggressive behaviour, the latter having gone to live in England.

There do not appear to have been any particular problems with Brian Doherty until he started school, where it became apparent that he was a slow learner. The educational retardation led to his being placed in a special school and accompanying behaviour problems resulted in his spending most of his school and teenage years in institutions because he was unmanageable at

home. These included a residential school, a training school and a mental handicap hospital.

His behaviour at home over the years has been characterised by temper tantrums and unpredictable aggression, various assaults on his mother throwing objects around the house and damage to furniture and fittings, running away from and staying out most of the night, refusing meals that were cooked for him, spending hours or days alone in his room and demanding to have the house to himself. He was a loner, not mixing with his peers of either sex. Indeed his relationship with his peers is most inappropriate. He tended to irritate them with provocative and childish behaviour and was scapegoated because of this. On the other hand he tends to bully the more vulnerable people he has had contact with.

There are many comments that he seems to have difficulty in distinguishing between fantasy and reality. Particularly worrying was his preoccupation with the paramilitary dimension which involved drawings of paramilitary figures, scattering imitation cartridge shells in the street, dressing up in combat fatigues with a mask and imitation gun and presenting himself to the neighbours and others in this guise. There is no evidence that he was actually ever involved with a paramilitary group though he frequently claimed acquaintanceship with the INLA. He also caused a great deal of concern locally by making imitation coffee jar bombs and putting them on neighbours windowsills. There are references to sadistic behaviour to animals and more bizarre activities such as disinterring corpses. Evidence for these behaviours is not secure since it depends entirely on Brian Doherty's self reports. There is however harder evidence of sexually inappropriate behaviour with several episodes of exhibitionism, masturbating openly in the prison shower room, undue interest in the other prisoners while they showered in the nude and the preoccupation with sexually explicit drawings while in prison.

There are numerous examples of irresponsible behaviour over the years such as climbing on roofs, cycling down the motorway the wrong way, lying as if dead on a road dressed in paramilitary uniform, discharging airpistols in a reckless fashion, tying a towel around another child's neck, threatening people with imitation weapons, fire raising in prison and numerous petty offences while at large in the community.

8.2 Clinical Assessment

He had difficulty in reading and writing and had a special difficulty with numeracy and he scored 69 on the Wechsler Adult Intelligence Scale. This particular test was carried out at Muckamore Abbey Hospital on 15 October 1991 and is considered to be a reasonable accurate estimate of his level of intellectual functioning. This places him at the borderline between mental retardation and the lower end of the average intelligence distribution in the community at large. It should be noted that his siblings appear to be functioning within the average range of intelligence. The fact that he is significantly lower in intellectual functioning than his siblings and his mother's account of birth complications, raises the possibility that he may have some degree of minimal brain damage, due to possible lack of oxygen, that could contribute to his problems of impulse control.

His behaviour over the years both in the community and in various institutions, including the psychiatric unit at Maghaberry Prison after the offence and in the State Hospital at Carstairs, has proved resistant to a wide range of management strategies. It is characterised by an immaturity, inability to learn from previous experience, problems in social and personal relationships as well as the reckless and irresponsible behaviour that seems to be motivated by the need to draw attention to himself and boosting his fragile self-esteem by impressing or frightening other people. This has led to people involved in his care, including his mother, being seriously concerned about him putting himself at the risk of being shot by the security forces in

error for an actual paramilitary. Prior to the brutal killing he was not regarded as a serious danger to other people.

The brutal and apparently motiveless killing occurred after a random meeting with the victim. The reasons for the homicide are not clear, though one can speculate that his brutal behaviour towards the victim reflects the ultimate acting out of his aggressive fantasies in a setting of a need to dominate other people and prove to himself that he is a tough, rambo like individual. What is certain is that he lacks remorse and indeed enjoys the notoriety that the killing has brought him.

8.3 Evidence for Mental Illness

Careful questioning of all the senior psychiatrists involved in his care and the on-duty junior psychiatrist at the Tyrone and Fermanagh Hospital, who examined him on the day of killing, has made it clear that Brian Doherty has never suffered from an overt mental illness such as depression or schizophrenia. On two occasions he did complain of hearing voices but these were isolated events and not consistent evidence of a schizophrenic disorder. There is little doubt that he did feel sad and miserable at times as a result of his unsettled life circumstances and erratic life style, but there is nothing to suggest that these depressed moods ever developed into a frank depressive illness requiring psychiatric treatment.

An interesting observation made by the Consultant Forensic Psychiatrist who has had close contact with him for 14 months in prison after the killing, is that during that period Brian Doherty has had several (3 or 4) episodes lasting hours or a few days, when for no reason he would stop eating, become depressed and agitated with ideas of persecution about the other prisoners or staff. During these periods he was irritable and hostile towards other people around him and sometimes physically violent towards them. It is conceivable that he may have been in such a dysphoric (emotionally disturbed) state at

the time of the killing and this may have contributed to his lack of impulse control at that time. Incidentally careful perusal of the voluminous case records and discussion with the various psychiatrists involved with his case has not revealed any such dysphoric episodes prior to the offence. Indeed, the general consensus was that he was more a danger to himself and a social nuisance rather than a danger to other people.

8.4 Evidence for Personality Disorder

Although the diagnosis of a formal mental illness such as schizophrenia or depression can be excluded, there can be no doubt that he has a personality disorder. Personality is the way that we consistently perceive, think about and react to the environment, which develops until adolescence and is then consistent for the rest of ones life. Personality disorder is diagnosed when the individuals personality and reaction to the environment is causing the person to be either mentally ill or to impair significantly their social and occupational functioning. In one of the major psychiatric diagnostic systems, the Diagnostic and Statistical Manual for Mental Disorders, 4th Revision (DSM-IV) of the American Psychiatric Association, defines personality disorder as an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individuals culture. This pattern is manifest in abnormalities perceiving and interpreting self, other people and events, inappropriate emotional responsiveness, interpersonal functioning and impulse control. This pattern is inflexible and is manifest across a wide range of personal and social situations and leads to clinical significant distress or impairment in social, occupational or other important areas of the individuals functioning. The pattern is stable and of long duration, its onset being traced back to at least adolescence or early adult life.

8.5 DSM-IV Criteria for Antisocial Personality Disorder

Brian Doherty meets the criteria for the DSM-IV category of antisocial personality disorder. The criteria specify that there is a pervasive pattern of disregard for and in violation of the rights of others occurring since the age of 15 years and that the individual is at least 18 years old. He demonstrates all the specified criteria which include the following:

- failure to confirm to social norms with respect lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest,
- deceitfulness, as indicated by repeated lying, use of aliases or conning others for personal profit or pleasure,
- impulsivity or failure to plan ahead, irritability or aggressiveness as indicated by repeated physical fights or assaults,
- reckless disregard for safety of self or others, consistent irresponsibility as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations, and
- lack of remorse as indicated by being indifferent to or rationalising having hurt, mistreated or stolen from another.

8.6 ICD-10 Criteria for Dissocial Personality Disorder

The other method of classification for mental and behavioural disorders is formulated by the World Health Organisation, 10th Revision (ICD-10). The personality disorder that is equivalent to the DSMIV antisocial personality disorder is the dissocial personality disorder. Brian Doherty meets all the criteria required for the diagnosis of this personality disorder which includes the previous diagnostic categories of sociopathic and psychopathic personality disorder. The criteria relevant to this case are as follows:

- callous unconcern for the feelings of others and lack of capacity for empathy,
- gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations,
- inability to maintain enduring relationships,
- very low frustration of tolerance and a low threshold for discharge of aggression including violence,
- incapacity to experience guilt and to profit from experience particularly punishment,
- marked proneness to blame others or to offer plausible rationalisations for the behaviour bringing the subject into conflict with society, and
- persistent irritability.

8.7 Psychopathy Checklist (PCL) Criteria

Finally, a Canadian forensic psychologist, Hare, has developed a Psychopathy Checklist (PCL). From using this, Brian Doherty scores within the psychopathic personality disorder range.

8.8 Implications of the Diagnosis of Dissocial Personality Disorder

Hence there is overwhelming evidence of severe personality disorder in the absence of mental illness. Such people who disrupt their lives and those of their families and friends, are often social nuisances and not infrequently come into conflict with the law. On rare occasions, because of their callousness and lack of concern for other and poor impulse control, do commit serious and sometimes motiveless violence, although such extreme cases are the exception rather than the rule.

The causation of Brian Doherty's dissocial (antisocial) personality disorder is probably the result of a variety of factors including inheritance, early pre-natal brain damage, lack of an appropriate male parent on whom to model himself,

inconsistent parenting by his mother and the physical and emotional abuse sustained in the very unstable family environment in which he was brought up. People with dissocial personality disorder are notoriously difficult to engage in treatment because of the problems they have in developing therapeutic relationships with their carers, lack of ability to learn from previous experience and their generally unsettled lifestyle that makes it difficult for them to persevere with constructive activity of any sort for very long.

A common pattern is for such people who drift around the various caring agencies presenting at times of crisis in their lives. Brian Doherty's behaviour fitted this pattern with involvement with Child Care, Mental Handicap, Probation and Adult Mental Health Services. His behaviour made him "a square peg in a round hole" wherever he attended whether it be in the community or in the various institutional settings, including prison.

8.9 Additional Diagnosis of Mental Handicap

In addition to the diagnosis of dissocial personality disorder, Brian Doherty's IQ is 69 which places him at the upper end of the Mental Handicap range.

Comment:

In the absence of a concomitant mental illness, the Northern Ireland Mental Health Order legislation specifically excludes people with personality disorder, as the sole diagnosis, being detained under the Order. However, Brian Doherty's situation is complicated by the presence of Mental Handicap. "Severe Mental Impairment" is defined under the Order as "as state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned". Brian Doherty's intelligence was estimated at 69 which

indicates a mild degree of mental handicap or impairment of intelligence. At face value, this may be interpreted as meaning that he does not meet the joint criteria of severe impairment of intelligence and social functioning with abnormally aggressive or seriously irresponsible conduct.

Nevertheless, the Code of Practice states clearly it "is not meant to restrict these definitions to persons whose intelligence level as measured by psychological tests falls below a particular figure. Assessment should take into account the total impairment both of intelligence and social functioning." Taking this qualification into account, the Inquiry Team are of the opinion that Brian Doherty could have been detained under this article of the Mental Health Order. However the Senior Registrar, who examined him just prior to his discharging himself Contrary to Medical Advice from hospital, did not consider that failing to detain him would "create a substantial likelihood of serious physical harm to himself or other persons" (Article 2(4), Mental Health (NI) Order 1986). The Inquiry Team carefully questioned the other consultant psychiatrists, psychiatric nurses, social workers and probation officers who had contact with Brian Doherty prior to the killing. None regarded him as dangerous to other people.

The diagnosis of dissocial personality disorder induced an inevitable feeling of therapeutic futility since such people are notoriously difficult to engage in treatment because of the problems they have in maintaining relationships with their doctors and other healthcare workers, their lack of ability to learn from previous experience and their generally chaotic lifestyle that makes it difficult for them to persevere with constructive activity of any sort for very long, including psychological treatment.

A common pattern is for such people to drift around the various caring agencies such as health, social services, probation and housing, presenting for help only at times of crisis in their lives. They consume an enormous amount of resource from the caring agencies and the penal services without

much effect. Brian Doherty's behaviour fitted this pattern with child care, mental handicap, probation, adult mental health services and housing, all having been involved with his problems. His behaviour made him "a square peg in a round hole" wherever he attended, whether it was in the community or in the various institutional settings, including prison.

Clearly there was a lack of co-ordination between the various services involved in Brian Doherty's care and confusion as to which caring agency had responsibility for him.

9.0 Was Brian Doherty a Danger?

The prediction of dangerousness is fraught with difficulty. Brian Doherty's behaviour was unpredictable. It probably still is. Yet the most useful guideline currently known to us is that best predictor of future behaviour is past behaviour.

Using this simple guideline, the Inquiry Team questioned a wide variety of people who knew Brian Doherty well prior to the killing. These people included psychiatrists, social workers, his probation officer, his mother and representatives of the local police. There was unanimity that his persistently erratic and irresponsible behaviour created a social nuisance and there was considerable anxiety that this reckless behaviour could put him at risk of being shot by the security forces in mistake for a paramilitary operative.

Everyone was agreed that he was not a real danger to other people. There was evidence of casual violence, sadistic behaviour towards animals and inappropriate sexual activity. However, such behaviour is not uncommon in personality disordered or delinquent young men and is not a reliable predictor of subsequent serious violence. At no stage did any one individual or any group of professionals collate the detailed life history of Brian Doherty which took this Inquiry Team several weeks to piece together. These people

were presented with an ever-changing situation demanding immediate action and had not the space or time for long-considered deliberation and had to act according to the evidence immediately before them.

The forensic psychiatrists who examined him following the killing agree that he is now a danger to other people. However, their views are strongly influenced by the brutal, apparently motiveless and impulsive nature of the killing - evidence that was not available to the people who dealt with him prior to the offence.

10.0 Community Care Issues

10.1 Introduction

The previous Chapter has described the range of services, both hospital and community, with which Brian Doherty was in contact. This Section reviews the way community services responded to his and his family's needs. It also considers whether there were deficiencies, for example, in the way services were organised, or co-ordinated and whether there were gaps in services.

10.2 The Community Services with which Brian Doherty and his family were in contact

It is worth repeating the range of community services with which Brian Doherty and his family were in contact:

1. General Practitioner
2. Belmont House Special School, Londonderry between the ages of 6 and 13
3. Social Services, Strabane (Family and Child Care Team) from the age of 10
4. Harberton House Assessment Centre, Londonderry at the age of 11

5. Child Guidance, Londonderry at the age of 12
6. Greystone Hall Boarding School, Limavady between the ages of 13 and 15
7. Police from at least the age of 14
8. St Patrick's Training School, Belfast at the age of 14
9. Clinical Psychology at the age of 14 and later on in his teenage years
10. Adolescent Psychiatry at the age of 14
11. Lisnevin at the age of 15
12. Muckamore Abbey Hospital from the age of 17
13. Social Services, Strabane (Mental Health Team) age the age of 18
14. Probation Service at the age of 18
15. Stradreagh Hospital, Londonderry at the age of 18
16. Gransha Hospital, Londonderry at the age of 18
17. Several hostels for the homeless at the age of 19
18. Northern Ireland Housing Executive at the age of 19
19. Probation Psychologist at the age of 19
20. Tyrone and Fermanagh Hospital, Omagh at the age of 19

Broadly speaking, Brian Doherty and his family were in contact with 20 different agencies over a 10 year period.

10.3 The organisation of the community services

How good were the community services in offering assistance?

The **General Practitioner (GP)** is in a unique position in being arguably the only professional who is able to chart an individual's progress "from the womb to the tomb" and to be in possession of a reasonably full picture of what is happening at any particular stage. However, s/he is not always able to co-ordinate community services.

In the case of Brian Doherty, the GP was in regular contact with Mrs Doherty and he saw Brian Doherty from time to time. Referral was usually initiated by Mrs Doherty and the impression was that the GP's response was purely reactive rather than based on any overall treatment plan.

The organisation of community services was such that the GP was working in relative isolation: while he was able to call on community health services, such as the Community Mental Health team, in practice it was more usual for them to contact him rather than for him to take the lead.

In addition, he was unable to attend case conferences which were planned on at least two occasions. It is not unusual for GP's to have difficulty in participating in case conferences, often because these are convened at times which may not take account of GP surgery or domiciliary visiting hours. On the other hand, for the reasons given above, the GP's contribution to case conferences can be substantial.

A criticism of the General Practitioner service in this instance is that links with other community health services appeared to be tenuous and the GP was therefore unable to contribute to co-ordinating these services.

The Inquiry Team noted with concern the absence of any formal review undertaken by the primary care services following the tragic incident. We recommend that this should be carried out routinely after all such untoward incidents.

The **education** service identified Brian Doherty's learning difficulties early on, carried out specific testing and placed him appropriately in a special school. They also had access to a range of facilities, which included Greystone Hall boarding school and Child Guidance assessment in Londonderry.

The education service were also good in recognising their limitations as regards his family situation and involved social services appropriately. They were flexible in making joint arrangements with social services to enable him to be a boarder Monday to Friday but at home at weekends.

A minor criticism might be that the facilities were not absolutely local (Londonderry and Limavady).

Social Services (Family and Child Care Team) were consistent in their help to Brian Doherty and his family during the time he was at home and beyond that. They acknowledged the major problems which existed at home and took steps to have him assessed at **Harberton Assessment Centre**. They also did their best to maintain him at home but also recognised when this was beginning to be impossible and attempted to make intermediate arrangements.

They initiated appropriate case-conferences, particularly with the Education Service who co-operated fully.

Criticisms of social services, at this stage, might be:

- that they were, perhaps, too "child-focused" rather than considering the family as a whole, in particular the mother's needs,
- they did not necessarily have access to the full range of facilities. For example, there are references to "shared-care" (in the form of professional fostering - foster-parents perhaps working in partnership with Brian's mother) but this was not available,
- they did not have access to "clinical" child psychiatry locally to assess Brian Doherty's disturbed behaviour further. It must be noted, however, that since January 1993, the Western Board have had an area-wide child and adolescent psychiatric service operating within the Board area - this

now comprises of two fully staffed teams operating in Londonderry and Omagh.

- recommendations arising out of case conferences, although clearly articulated, were not actively followed-up. For example, the proposal to make arrangements for mother-child training.

Social Services (Disability/Mental Health/Mental Handicap Team). Quite apart from the fact that Brian Doherty was in Muckamore Abbey Hospital when he reached his 17th birthday (the age at which it would normally be regarded that he would no longer be the responsibility of the Family and Child Care Team), there appeared to be considerable difficulties in deciding which community team should continue to take an interest. This in itself calls into question the artificial organisational structure of teams along client-group lines. After he left Muckamore Abbey Hospital the local **Mental Handicap Service** did not feel that the services they were able to offer were appropriate.

Even when it was decided that the **Mental Health Team** (in spite of the fact that the last service which Brian Doherty had been in contact with at that point was Muckamore Abbey Hospital) should be responsible, their approach tended to be a more reactive one rather than involving longer-term planning. Perhaps understandably (since Brian Doherty's mother had not been diagnosed as suffering from a mental illness) the focus continued to be on him rather than the family.

This kind of "crisis management" (as distinct from "crisis intervention") was unfortunately also evident at the level of individual social workers: for example, at the point of Brian Doherty's discharge from the Tyrone and Fermanagh Hospital, where the issue was regarded as getting him accommodation regardless of its suitability or his ability to cope (for example, if he had been allocated a house by the Northern Ireland Housing Executive).

Unlike the Family and Child Team, Social Services did not appear to have access to staffed hostel accommodation or appropriate day care.

On a broader organisational front, once **Adult Mental Health Services** were involved, the whole geographical question of where Strabane (and, indeed, within Strabane town and the rest of Strabane) "belonged" - whether in the Northern Sector or Southern Sector - caused some problems as regards continuity of care, although it is acknowledged that GP's (and patients) should have freedom of choice and Brian Doherty was particularly mobile.

As regards **Adult Mental Handicap Services** in the community, although a decision was taken that he was not mentally handicapped, the community services available would not have been suitable, since they were (understandably) geared much more to the needs of people who were more overtly mentally handicapped (for example, in relation to toileting and self-care generally).

Community Health Services. Health Visiting and even Community Psychiatric Nursing (CPN's) were notable by their absence, although one might understand that, as regards CPN's, the fact that his mother did not have a formal mental illness may have been a factor.

It is difficult to comment on services provided under the **Youth Training Programme** (YTP) since arrangements to place him with a YTP in Strabane were overtaken by events. He was involved in a West Belfast project while he was in St Patrick's Training School. Not much information is available but it would seem to be important that Youth Training Programme training should be meaningful and should be geared to the interests and abilities of trainees as well as ensuring that additional help is available if there are specific problems, as there were in his case in the West Belfast scheme.

The **Probation Service** areas are not co-terminous with Health and Social Services Boards. This did not seem to particularly affect working relationships in this case and an attempt was made to provide consistent help over a two year period. The facilities available to the Probation Service in Strabane were limited: the only staffed hostel being the MUST hostel in Cookstown. In day care, it was a question of using existing volunteering and youth training schemes, the latter arguably not geared to Brian Doherty's special needs.

Criticisms of the Probation Service might be the lack of designated facilities, most particularly staffed hostel accommodation in the Strabane area.

The **Police** were involved with Brian Doherty and his family at an early stage. He was well known in the area but viewed virtually throughout more as a nuisance - and potentially putting himself more at risk - than as a significant threat to others. It could be argued that the police attitude was unduly lenient but a comment of this kind needs to be put in the context of the "Troubles" which were continuing at this time.

Nevertheless Brian Doherty's behaviour did seem to be taking a downward course from relatively harmless actions to more overtly anti-social activity and subsequently to petty crime. This is reflected to some extent in the charges which were brought against him. However, even here various courts took quite a lenient view. A further criticism is the long intervals which occurred between court hearings, during some of which further offences occurred.

Hostels for homeless people. Several hostels were involved at different stages (Crawford Square in Londonderry, Simon Community in Londonderry). Brian Doherty had also stayed for a brief period at Cuan Mhuire (Sister Conscillio's) in Newry. In addition, bed and breakfast type accommodation was retained by the Northern Ireland Housing Executive as temporary accommodation. Hostels are used to cater for a largely transient population,

are often aware of people who may present problems and may even have an informal "black-list".

While recognising the financial and other problems facing hostels for homeless people, their inability to provide services for someone like Brian Doherty should be acknowledged and discussion initiated with, for example, the Council for the Homeless, about positive steps which might be taken to improve the situation. In this respect, the Western Health and Social Services Board is to be commended for commissioning a research project into the issue of mental illness in hostels for homeless people in its area.

As regards bed and breakfast accommodation, it could be questioned whether fairly impersonal provision of this kind could meet the needs of young people like Brian Doherty.

The **Northern Ireland Housing Executive** seemed to take a fairly bureaucratic view of Brian Doherty's housing needs: he could be deemed to be homeless but was not in priority housing need. In reality, as has been pointed out already, it is very questionable whether being allocated a house would have helped.

Comment:

Brian Doherty and his mother were in contact with a large number of agencies over a ten year period. In the earlier stages, services provided appropriate help, although this tended to be concentrated on him rather than his mother.

Partly because of a lack of specialist services in the Strabane area, including semi-secure accommodation, efforts to introduce a degree of control over his behaviour also meant an increasing detachment from his local community.

Linked to this was an increasing tendency for him to be passed from one service to another and a degree of compartmentalisation leading to the view that once another service had taken over, total responsibility rested with them.

This was minimised in the early stages by the sharing of information and plans through the medium of case conferences but at a later point it did not prove possible to organise case conferences. This failure must be regarded as a serious defect in community services.

Even when case conferences were held, proposed action was not always followed up.

Linked to this was a relative weakness in the way members of staff worked together as a team, in different settings. This was particularly the case in Primary Care where there was little evidence of a team ethos.

In spite of frequent abscondings, both St Patrick's Training School and Muckamore Abbey Hospital achieved some positive results, which suggests that constructive efforts in a controlled setting could effect some change for the better, even though this might be short-lived.

As Brian Doherty moved towards adulthood, there was a greater likelihood of him coming into contact with community services such as hostels for homeless people and the Youth Training Programme which were less geared to meeting his specialist needs.

10.4 The Co-ordination of Community Services

How well were the community services co-ordinated?

Prior to Brian Doherty's commital to Training School at the age of 15, working relationships between the relevant community agencies were excellent. Both the **Education Service and Social Services (Family and Child Care Team)** carried out detailed assessments, reviewed them and shared information through the forum of case conferences. However, some representatives of community health and social services felt they were unable to attend such conferences.

Services were provided in a co-ordinated way and the Education Service was extremely flexible in facilitating the use of boarding-school. The decision to discharge Brian Doherty from Boarding School was fully justified and social services responded appropriately, although it might be queried, in retrospect, whether the circumstances of this very serious act of aggression by Brian Doherty at the age of 14 were fully investigated.

Brian Doherty's committal to **Training School** appeared to lead to a weakening of communication with **Social Services**. (Social Services actually "closed" the case in June 1989, the transfer to Training School having taken place in January of that year, although it was subsequently re-opened). The geographical distance of St Patrick's Training School from Strabane was a contributory factor, which also meant that Brian Doherty's resettlement in the local community was made more difficult. This was further compounded by his later transfer from St Patrick's Training School to Muckamore Abbey Hospital.

It should be emphasised that Social Services (Family and Child Care Team) did continue to maintain some contact with the Training School and made fully available the substantial background information they had.

Working relationships between **St Patrick's Training School** and **Muckamore Abbey Hospital** were excellent: the hospital responded promptly to requests for help and advice and there was a good exchange of information, perceptions on both sides of how the evolving situation could best be handled varied. Initially, the hospital would have preferred to offer advice about management but increasingly the Training School were feeling out of their depth in relation to some of his behaviour. The ambivalence is reflected in the issue of maintaining the Training School Order but also admitting Brian Doherty to hospital as a detained patient so that he was, in a sense, detained twice over.

When he moved to **Muckamore Abbey Hospital** the detachment from **community services in Strabane** was even more evident. Again, this was compounded by his age (approaching his 18th birthday) and uncertainty as to which team should accept responsibility for him ("Disability", "Mental Handicap", "Mental Health" - although he had never been diagnosed as having a mental illness).

Within the **Mental Handicap Service** while there was appropriate communication between Muckamore Abbey Hospital and Stradreagh, the relationships was one of equals, rather than Stradreagh being an extension of Muckamore. Perhaps unusually, at this point, he was deemed not to be mentally handicapped, even though, immediately prior to that, he had been assessed (and detained) as being "severely mentally impaired".

The relationship between the **Mental Handicap Service** and the **Mental Health Service** was also ambiguous, since it was decided that Brian Doherty was not suffering from a formal mental illness (as distinct from possibly having a personality disorder). The episode of him being detained on his first admission to Gransha Hospital was perfectly justifiable given the circumstances of the admission and he was regraded as a voluntary patient very quickly.

The relationship between **Social Services (the Community Mental Health Team)** and **Probation** followed a similar pattern, with Social Services taking the view that responsibility had now passed to the Probation Service, although they did continue to share information and contact with the consultant psychiatrist at Gransha Hospital was facilitated.

Working relationships between **Social Services** and the **Northern Ireland Housing Executive** (Omagh) were sound, but they were along fairly formal, procedural lines rather than being based on an assessment of individual need.

During this period following Brian Doherty's absconding from Muckamore Abbey Hospital there were at least two occasions on which a **case conference** involving all interested parties was proposed. This did not take place on either occasion and this failure must be regarded as a serious defect in the system of care.

Linked to this was the absence throughout of a formally designated key worker whose main role would have been to ensure consistency and co-ordination. It is fully acknowledged that this would have been particularly difficult in the case of someone as mobile as Brian Doherty and it is recognised that he is not unique in having intermittent contact with a large number of services.

Comment:

In the early stages, community services, were, on the whole, well co-ordinated. There are two exceptions to this: action proposed at case conferences was not always followed through. Secondly, the GP worked in relative isolation from other community services.

Communication among community services weakened as Brian Doherty grew older. This was partly because the appropriate services were at some distance from his home, but also because of uncertainty about who should share responsibility for him. This was compounded by the absence of a jointly agreed care plan and the absence of a designated key worker.

10.5 Were there gaps in Community Services?

A number of potential gaps have been identified in preceding sections:

The availability of professional fostering in the Strabane area (to facilitate "shared care") would have been valuable.

Alternatively, access to a small, well-staffed children's home would have been useful. Greystone Hall carried out very constructive work and the stay in Harberton House helped to clarify the problems at home but in neither case was it possible to initiate joint parent-child management training. (It must be said that, given Brian Doherty's learning deficits, the prospects of such an approach having lasting effect can be questioned, but it **might** have helped his mother to cope better).

The geographical distance of the Training School did not help and possibly contributed to Brian Doherty's frequent absconding (although at a later stage being "on the run" appeared to be part of his espousal of a Rambo-type lifestyle). The distance also weakened communication with local community services and, combined with the further transfer to Muckamore Abbey Hospital, made reintegration into his local community much more difficult, although increasingly attempts at positive help - for example, referral to the Youth Training Programme in Strabane - were overtaken by events.

As he moved from Family and Child Care to Adult Services the absence of locally-based staffed hostel accommodation - whether Mental Health, Mental

Handicap, Probation or for Homeless People - is evident. Those facilities which were available catered either for people with long-standing mental health problems like schizophrenia or for people with very severe mental handicaps, or - in the case of hostels for homeless people - were not in a position to deal with very deviant behaviour.

A similar comment applies to day care. The facilities which were available did not appear to be appropriate. In the case of the "mainstream" Youth Training Programme there is a need for preparation training for young people like Brian Doherty, perhaps along the lines of the Belfast based Give and Take Scheme.

Finally, in this section, the Inquiry Team discussed whether a set of risk indicators could be produced which might act as an early warning device for identifying younger people who might require particular attention. A list of possible indicators is reproduced in Appendix 8.

11.0 The Public's Perception of Mental Disorder and Psychiatry in Practice: Some General Observations

11.1 What is Illness?

Drawing the borderline between health and illness is remarkably difficult. Doctors look for underlying disturbances of bodily function to account for physical illness. This is not always obvious even in painful or disabling conditions, eg. frozen shoulder or low back pain.

11.2 What is Madness?

Defining mental disorder is even more difficult since much less is known about the functioning of the mind. The popular conception of madness or mental disorder relates to bizarre or unusual behaviour that is out of keeping

with what is considered normal for the society or culture within which the person lives. Such a broad definition has inherent problems. On the one hand it may provide a label for socially unacceptable behaviour behind which the perpetrator is permitted to take refuge and thereby evade the legal consequences of their antisocial activities. Alternatively the use of such a label may provide those authorities with a political expedient to devalue and degrade the dissenter, and by defining him as mentally ill to violate his freedom and destroy his dignity. The classic example of this process was the misuse of diagnosis of mental illness by the Soviet Government to incarcerate political dissidents.

11.3 Madness, Medicine and Psychiatry

Over the last hundred years, psychiatrists have adopted a more focused approach to madness based on the application of the methods of medical science. The aim has been to identify illnesses due to mental malfunction that can be recognised (diagnosed) and treated. Successively more rigorous diagnostic criteria have evolved over the years.

In medicine a syndrome is a cluster of signs and symptoms that occur together and are characteristic of a specific mental disorder. Though mental disorders have long been recognised as part of the human condition, it is only within the last 100 years that psychiatrists have identified a series of mental syndromes or illnesses in which the mental symptoms and behavioural signs follow a consistent pattern and respond to a varying degree to psychiatric treatment. These can be divided into severe illnesses where the mental disturbance causes the person affected to lose contact with reality and misinterpret what is going on around them. Such mental illness include schizophrenia, which is often associated with hallucinations (hearing voices, seeing visions), delusions (false beliefs about themselves and their environment), loss of emotional responsiveness, lack of drive and social withdrawal. Disorders of mood (depression/elevation) cause major mental

syndromes: depressive disorder, characterised by depression of mood, poor appetite, weight loss, difficulty sleeping, feelings of worthlessness and suicidal ideas and mania, characterised by elevation of mood, inflated self-esteem, talkativeness and overactivity. Physical disease or damage to the brain can cause mental malfunction and behaviour disorder. Less severe forms of mental illness are those in which contact with reality is retained. These are often related to stress or problems of living and include less severe forms of depressive illness, syndromes that are dominated by anxiety symptoms of various types, obsessions (recurrent intrusive thoughts or compulsions) or physical symptoms of mental origin (somatoform disorders). All these syndromes are recognised as medical conditions that require psychiatric treatment.

11.4 Personality Disorder and Mental Illness: Are there Differences?

Such mental illnesses interrupt the person's wellbeing with the development of new symptoms or signs of mental dysfunction, for example, anxiety or depression, delusions and hallucinations. The symptomatology will tend to resolve after weeks or months of treatment or when the stressful circumstances triggering the symptoms are no longer present. Sometimes, of course, the illness becomes chronic or deteriorates in spite of treatment. In contrast, personality disorder results from a disturbance of the longstanding, characteristic patterns of perceiving, relating to and thinking about the environment itself, that are a feature of an individual's personality make-up from adolescence onwards. There is a deeply ingrained pattern of personality traits or behaviour that interfere with the individual's social or coccupational functioning and cause the person or society to suffer. The abnormal personality traits lead to persistent difficulties over the years, though they may get less in middle age and later life.

11.5 Dissocial (Antisocial/Psychopathic) Personality Disorder

A severe form of personality disorder is dissocial personality disorder which leads to a pattern of irresponsible and antisocial behaviour, that frequently results in conflict with society and the law. Over the years opinion amongst psychiatrists about the contribution of psychiatric treatment to people with dissocial personality disorder has been divided. Such people lead erratic, chaotic lives and their irresponsible behaviour often brings trouble upon themselves. They are difficult to engage in treatment, which has to be a long term exercise over years with an uncertain outcome. This has led many psychiatrists to regard them as untreatable and to leave society to impose sanctions on such individuals. One distinguished psychiatrist with a lifetimes experience of treating psychopathy (Whiteley, 1982) has described the psychopath as "a social isolate on the fringes of organised society, uncertain of how he stands in relation to others, and of what is expected of him, and of what he should expect of them. It often seems that his behaviour is designed to cause the maximal emotional response in others which somehow might overflow onto him and give him some brief existence in a world of real interaction".

11.6 Is Dissocial Personality Disorder a Medical Problem?

In view of the formidable difficulties in carrying out treatment with such individuals, psychiatrists and other mental health professionals often have a sense of futility and there has been a tendency to regard people with dissocial personality as not really part of psychiatry's province. However, recent brain imaging research is identifying local brain dysfunction in some of these individuals. Further there is some evidence of a disturbance of brain chemistry (low concentrations of serotonin) in dissocial personality. The two main systems of classification of mental disorder (DSM-IV and ICD-10) classify a range of personality disorders including dissocial personality disorder as forms of mental disorder. Finally, recent research on treatment

suggests certain psychological therapies targeted at specific behaviours of the person with personality disorder may be helpful (Tyrer, 1988; Tyrer et al, 1993; Beck et al, 1990). Indeed, there are some exciting new developments from the United States that identification in early childhood and intervention with parent and child training and medication may significantly reduce future risks of antisocial behaviour (Moir and Jessel, 1995). Hence, there is a growing body of evidence to support the assertion that involvement with people with this dissocial personality disorder is a legitimate medical endeavour and that future treatments may be more effective.

Comment:

The community in which Brian Doherty lived regarded him as a troublemaker and "not all there". Though tolerated for the most part as a social nuisance, there was some scapegoating by the children of the neighbourhood, who saw him as a buffoon to be taunted and made fun of.

The local public's attitude towards him as someone who was "mental" contrasts with the approach of the mental health workers, who had contact with him shortly before the killing. The latter regarded him as having social problems but no mental illness. The discrepancy between these two points of view can be accounted for by the differing criteria used for diagnosing mental disorder. The public used the broad criterion of deviation from what is considered normal behaviour in the local community. In contrast, the mental health workers used a more focused medical model which requires the person's mental state and behaviour to conform to certain diagnostic criteria that define a psychiatric syndrome before a diagnosis of mental illness can be made.

Whiteley's vivid portrayal of the basic features of the psychopath accurately reflects the essence of Brian Doherty's personality and behaviour. It also provides a common theme that links the public's perception of Brian

Doherty's behaviour with the clinical classification of the mental health professionals. However, the diagnosis of dissocial (psychopathic, antisocial) personality disorder does induce in many psychiatrists a feeling of therapeutic futility since it is commonly believed that such disorders are untreatable. Such views are held by the Tyrone and Fermanagh psychiatrists who were involved with Brian Doherty's care during his two periods of inpatient observation there.

The Inquiry Team present evidence that dissocial personality disorder is a clinically recognised form of mental disorder. Although it provides a formidable therapeutic challenge to psychiatrists and other mental health workers, recent research indicates that certain treatments may be of some benefit and worthy of trial. Because of the chaotic behaviour of such people and the difficulty in engaging them in therapy, they cannot be readily treated within the confines of the conventional adult mental health services. A special framework of care will be required over and above that provided by the standard adult mental health services. This is likely to require additional resources in terms of staff and training. However, it may well be cost effective since such people already consume large amounts of resources across the health, social work and penal systems as part of their chaotic life style.

E. RECOMMENDATIONS

12.0 General Observations

It is important to make clear that the vast majority of mentally disordered people are living safely in the community. The event that we are dealing with is extremely rare. It is some 35 years since the previous killing by a Tyrone and Fermanagh patient occurred. Since then there have been approximately 40,000 people discharged from the Tyrone and Fermanagh Hospital.

All the healthcare, social work and probation professionals who worked with Brian Doherty before the killing, including those who had dealings with him in the hours beforehand, agree that there was no evidence that Brian Doherty was a danger to other people. Indeed the consensus was that he was more at risk to harming himself by his irresponsible and erratic behaviour. He was regarded as a social nuisance rather than a danger to others. The police in his locality, who knew him well, concur with these views. We accept that based on the available evidence, this was a reasonable conclusion at the time.

Nevertheless, there is no room for complacency. Everyone concerned must examine their practice in order to minimise the possibility of such a tragedy recurring. The Inquiry Team have identified a number of weaknesses and ambiguities in the provision of care and the interpretation of the mental health legislation that require to be addressed in order to improve the quality of care and its co-ordination as well as to clarify the ambiguities in the Northern Ireland Mental Health legislation, which have played a significant role in this particular case.

We propose a number of recommendations, some of which can be readily implemented without the need for extra resources. Others involve a critical review of the Mental Health (NI) Order 1986 and some redrafting.

Finally, we have taken a fresh look at possible treatment strategies for people with severe personality disorders associated with seriously irresponsible behaviour based on a review of recent research findings. We recommend a novel approach. Undoubtedly this will involve additional resources being provided. These are likely to be offset by the savings due to a reduction in the misuse of the resources of the many agencies that people like Brian Doherty use and misuse as a result of their chaotic lifestyles. A more effective and efficient use of resources in this way will lead to greater protection of the public, although it would be presumptuous of the Team to conclude that our recommendations, if implemented, can entirely eliminate the risk of such a rare and unpredictable event occurring at some time in the future.

13.0 Tyrone and Fermanagh Hospital

The reader is referred to the comments made on pages 36-38. These outline areas of concern in the provision of care. We make the following recommendations:

13.1 RECOMMENDATIONS

(i) All new inpatients should be seen by the consultant responsible for their care or a senior psychiatrist deputising for him/her within three days of admission, unless the patient has been examined by the consultant or senior deputy at an outpatient clinic or in the community in the one/two days prior to admission.

(ii) Management should arrange the consultants' contract to allow more frequent review of inpatients' progress according to the patients' needs.

(iii) All potential discharges Contrary to Medical Advice should be discussed with the consultant psychiatrist responsible for their care or a senior deputy.

(iv) All individuals who discharge themselves Contrary to Medical Advice should be offered an early outpatient clinic review.

(v) There should be a recorded review of all patients who discharge themselves at the next multidisciplinary team meeting in order to formulate an aftercare plan and liaise with the relevant community services.

(vi) A detailed mental state assessment and care plan should be entered in all newly admitted patient's casenotes. This should be updated at least once per week.

(vii) When patients who have been detained for assessment are regraded as voluntary patients, there should be a detailed written record of the reasons for regrading.

(viii) There should be an immediate review of the implementation of the named nurse procedures.

(ix) The nursing staff should be reminded of their responsibilities in relation to record keeping (UKCC Standards for Records and Record Keeping, 1993).

14.0 Co-ordination of Care between Services and across Disciplines

There can be no doubt that after Brian Doherty left Muckamore Abbey Hospital, there were problems concerning which adult service should take responsibility for his care. He was considered unsuitable for the mental

handicap service based at Stradreagh Hospital because of his relatively "high" IQ. Further there were no secure facilities at Stradreagh Hospital suitable to contain his erratic and aggressive behaviour. The Community Mental Health Team did not get involved on an ongoing basis. The situation was complicated by his admissions to different hospitals on different occasions. The possibility of arranging a case conference for all the professionals involved in his care was considered but not implemented. Hence no coherent long term care and supervision plan was ever formulated. As a consequence, the various agencies involved with Brian Doherty reacted in response to crisis rather than in a planned way.

Doubtless, his erratic and chaotic lifestyle, wandering around the country at random, created serious difficulties in engaging him in any form of therapy. The uncertainty about his placement either in the learning difficulties service or the adult mental health service contributed to this, possibly compounded by a feeling of therapeutic futility amongst those professionals involved with him. It needs to be pointed out that the erratic, restless and irresponsible behaviour pattern manifested by Brian Doherty is a typical feature of people with severe personality disorder and therefore has to be taken into account when formulating a management plan for them.

We understand that there was a fortnightly meeting of the managers of the mental handicap and mental health services (Unit Services Group). Presumably this dealt with management issues in common to the two services. Certainly there is no evidence that that Group discussed the relative merits of Brian Doherty's placement in one or other of their respective services.

It is essential that these communication difficulties and interservice uncertainties are dealt with by setting up a forum to resolve the difficulties and ambiguities about the aftercare of such difficult patients. We make the following recommendations.

14.1 RECOMMENDATIONS

(i) The importance of team working between hospital, community and primary care needs emphasis and constant review.

(ii) A multidisciplinary panel with representatives from all the relevant mental health, mental handicap, social work, probation and education services, should be established to consider the most appropriate care package for at risk patients where there is uncertainty as to which agency should be the one to take the lead caring role. An appropriate chairperson for such a panel would be a forensic psychiatrist. The main role of this panel would be to resolve interagency disputes and uncertainties about the "ownership" of people who did not fit into the standard services on offer.

(iii) The group of patients who do not fit into the conventional services should be carefully defined and referred to the co-ordination panel for allocation to the relevant caring agencies.

15.0 Defining a Group of At Risk Patients who need Special Supervision

The vast majority of people with mental health problems live safely in the community. However, there are a relatively small number of people like Brian Doherty, who because of severe personality disorder, limited intelligence or chronic psychosis, put themselves and others at risk because of violent or seriously irresponsible behaviour. As we have already pointed out such people lead chaotic lifestyles and are difficult to supervise or engage in treatment. Such patients need special supervision. Like the Christopher Clunis Inquiry Report, we suggest that such patients should form a special supervision group to be cared for a specialist multi-disciplinary team who have a limited and protected caseload. Such people are difficult to care for

and need to be followed up intensively with close supervision. We agree with the Christopher Clunis Inquiry Report that an appropriate definition is patients who suffer from mental disorder and who are assessed by their consultant psychiatrist as requiring close supervision and support and who meet two of the following criteria:

(a) patients who have been detained in hospital under the Mental Health Order on more than one occasion,
(b) patients who have a history of violence or of persistent offending,
(c) patients who have failed to respond to treatment from the general psychiatric services, and
(d) patients who are homeless.

The supervision group needs to be cared for by a specialist multidisciplinary team who have a small protected caseload. An appropriate leader would be a forensic psychiatrist and the team could consist of a mixture of mental health care disciplines including clinical psychology, social work, specially trained community psychiatric nurses and nurse cognitive behaviour therapists and other relevant disciplines.

Each patient in the supervision group would have his/her needs assessed and be assigned to a key worker, usually a specially trained community psychiatric nurse. The latter would work exclusively for the specialist team and could call in specialist therapeutic expertise from forensic psychiatry, clinical psychology, nurse cognitive behaviour therapy and other relevant disciplines. The key workers would have a small caseload of not more than 12 patients and would follow patients across Health and Social Services Board boundaries in order to keep in touch with them.

The forensic psychiatrist leading the team would require access to regional secure beds in the proposed new Northern Ireland Regional Secure Unit to

deal with people like Brian Doherty, who can not be readily managed in community settings.

It is probable that in the case of some patients, like Brian Doherty, compulsory care in the community will be necessary to ensure regular supervision and compliance. The Christopher Clunis Inquiry recommendation for a supervised discharge order is a useful model to follow and would have been particularly appropriate for Brian Doherty's management.

15.1 RECOMMENDATIONS

(i) The Mental Health Services and other relevant disciplines in the Western Board area should co-operate to identify patients using defined criteria for at risk patients for inclusion in the supervision group. A specialist team led by a forensic psychiatrist with access to back up medium secure unit beds should be established. The specialist team should be multidisciplinary in nature.

(ii) Each supervision group patient should have a key worker, usually a specially trained community psychiatric nurse with a very limited caseload and the facility to refer to other members of the team with special expertise.

(iii) The key workers should follow patients across Health and Social Services Board boundaries until responsibility is formally transferred to a local specialist team.

(iv) Compulsory supervision will be necessary from time to time using a supervised discharge order. This will require new legislation.

(v) A compatible information system between mental health and social services should be established to facilitate greater continuity of care.

16.0 Implications with regard to the Northern Ireland Mental Health Legislation

The specific exclusion of personality disorder unless accompanied by other forms of mental disorder means that it is difficult to detain for assessment and treatment people with severe personality disorder accompanied by potentially violent and irresponsible behaviour. This certainly contributed to the difficulties concerning Brian Doherty's compulsory detention in hospital. Yet, such a power is necessary if the supervision group suggestion is implemented since a significant number of patients in this category will have severe personality disorder without other manifestations of mental illness.

The Northern Ireland Mental Health Order definition of severe mental impairment, "a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned", is open to ambiguity of interpretation particularly as the Code of Practice states clearly that it is not meant to restrict the definition to persons whose intelligence level as measured by psychological tests falls below a particular figure. Assessment should take into account the **total impairment** of intelligence and of social functioning. These ambiguities require clarification and if necessary legislation to implement the changes.

16.1 RECOMMENDATIONS

(i) The Department of Health and Social Services (Northern Ireland) should review the 1986 Mental Health Order with the aim to introducing an additional category of mental disorder, namely severe personality disorder. This could follow the wording of the English Mental Health Act 1983 (Section 3) "... such treatment is likely to alleviate or prevent a deterioration of his condition".

(ii) All staff likely to use powers under the Mental Health (NI) Order 1986 should have received induction training in its use.

(iii) In addition, there should be regular refresher training in the use of the Mental Health (NI) Order 1986.

(iv) Training should include full knowledge of the additional guidance contained in the Guide to the Order and the Code of Practice.

(v) In all instances where a voluntary patient is discharging him or herself Contrary to Medical Advice, consideration should be given to the desirability of using powers to detain for assessment.

(vi) All staff likely to use powers under the Mental Health (NI) Order 1986 should have ready access to legal advice concerning any aspects where they are unsure of the interpretation of the Order.

17.0 Other Issues

A number of other issues emerged from the Inquiry Team's investigations and are discussed in the body of the report. From these issues we make the following recommendations.

17.1 RECOMMENDATIONS

(i) We recommend to the Western Health and Social Services Board that our report is made public.

(ii) The report presents an opportunity to engage the public in discussion of wider issues relating to mental health and the role of professionals working within this field.

We would recommend that the Western Health and Social Services Board take the lead in promoting greater community involvement in mental health services.

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APPENDIX 1

WESTERN HEALTH AND SOCIAL SERVICES BOARD

PRESS RELEASE

16 May 1995

BOARD SETS UP REVIEW IN DOHERTY CASE

The Western Health and Social Services Board is to review and examine the circumstances surrounding the admission and discharge of Brian Doherty to the Tyrone and Fermanagh Hospital.

This was announced today by the Board's Area General Manager, Tom Frawley.

"The manslaughter of Kieran Hegarty has caused immense trauma to everyone involved and indeed to the whole Northern Ireland community. At this time our thoughts and sympathy are with the bereaved and all those affected by Kieran's death", said Mr Frawley.

The whole case raises many complex issues which the Board now wishes to consider further.

"There was simply no way that Mr Doherty could have been detained against his will under the mental health legislation which pertains in Northern Ireland" said Mr Frawley.

The law - which is different in Northern Ireland from the rest of the United Kingdom - is very precise as to when people may be compulsorily detained. This can only happen when someone is diagnosed as being mentally ill and who, as a result is a danger either to themselves or others.

This was not the case with Brian Doherty.

"In every instance of a serious untoward event in our service we undertake a review of the case", Mr Frawley continued.

"Because of the gravity of this case we want to revisit all the issues involved. I have therefore initiated a full review which will be chaired by an independent person from outside the Western Board".

The Board's review will be undertaken as soon as the appropriate people can be brought together. Mr Frawley went on to say that Board staff would co-operate fully with the review team to ensure that the team's report could be completed as thoroughly and as quickly as possible.

APPENDIX 2

WESTERN BOARD INQUIRY TEAM

Professor George Fenton (Chairperson)

Professor George Fenton was born in Derry, educated at Ballymena Academy and Queen's University Belfast, graduating with a medical degree. He trained in Psychiatry, Neurology and General Medicine in Belfast, Glasgow and London. He held senior academic and clinical posts at the Maudsley Hospital, London, from 1967-1975, following which he spent eight years as Professor of Mental Health at Queen's University Belfast. He has held his current position as Head of the Department of Psychiatry at the University of Dundee since 1983.

He is the first non-Scot to have been Chairman of the Scottish Division of the Royal College of Psychiatrists; he is now a member of the Council of the College. Although a general psychiatrist, his research interests are in the field of relating brain function to behaviour. He has published over 120 scientific papers including a significant number on the forensic aspects of psychiatry. He is Honorary Consultant Neurophysiologist at Broadmoor Hospital, one of the Special Hospitals for the care of mentally ill offenders in England and Wales.

Mr Eamonn Deane

Eamonn Deane, husband of Sally and father of four, has been involved in youth and community work in Derry for more than 25 years. Formerly a school teacher, Mr Deane became a full time community worker in 1973. He contributed to a variety of publications on issues of social concern, is editor of the monthly, community magazine "Fingerpost", and has edited "Lost Horizons: New Horizons" for the WEA and "Beyond Hate: Living with our Differences". The founder and full-time Director of Holywell Trust, a community development initiative in the North West, he belongs to a range of organisations including Chairman of Northlands Centre; Chairman of Acorn Projects; Vice-Chairman of Derry Health Cities Project; Founder Trustee of Northern Ireland Voluntary Trust; Chairman of Foyle Basin Council and General Editor of Yes! Publications.

Mr Stanley Herron

Mr Herron qualified as a psychiatric social worker at Manchester University in 1963. He was subsequently responsible for the development of community

mental health services, and services for homeless families in Belfast until October 1973. Mr Herron worked as Senior Social Worker in Alexandra Gardens Day Hospital in North Belfast until March 1980, when he joined the Social Services Inspectorate in the Department of Health and Social Services, with responsibility in the mental health field. During this period mental health legislation was being reviewed and Mr Herron contributed a social work perspective to this process and to the production of the Code of Practice under the Mental Health Order which was issued in July 1992.

Mr Herron retired from the Civil Service in March 1993 and took up a position as Assistant Director for Training, Policy and Research with the Northern Ireland Association for Mental Health. Mr Herron currently works part-time with the Health and Health Care Research Unit at Queen's University Belfast.

Mr Brendan Mullen

Mr Mullen is currently Programme Manager for Mental Health/Manager of PAMS and Medical Services for the North Down and Ards Community Health and Social Services Trust. Mr Mullen is RMN and RGN trained, commencing his nursing career in 1980 as a qualified Staff Nurse at the Downshire Hospital. After completing a one year's course in alcohol and drug dependency in 1985, Mr Mullen was appointed to Charge Nurse in the Alcohol Treatment Unit at the Downshire Hospital, later moving to be Charge Nurse for the Community Addiction Team. Mr Mullen moved to the North Down and Ards Trust in 1989 and was appointed Assistant Director of Nursing Services for Mental Health in 1991, and Locality General Manager in 1992, before moving to his present post.

In 1993 Mr Mullen completed a BSc (Hons) in Professional Development and Nursing and is presently completing his second year of DMS/MBA at the University of Ulster.

APPENDIX 3

August 1995

Dear

I am writing on behalf of Professor George Fenton, who has been appointed Chairman of an Inquiry Panel to examine the admission and discharge of Mr Brian Doherty from the Tyrone and Fermanagh Hospital during January 1994.

As part of their examination, the Inquiry Panel have requested to meet with you at _____ on _____ in the _____.

I would be grateful if you could let me know as soon as possible if you are able to attend. I can be contacted at _____.

Thank you for your assistance.

Yours sincerely

_____
on behalf of Professor Fenton,
Chairman, Inquiry Team

APPENDIX 4

LIST OF THOSE INTERVIEWED BY THE INQUIRY TEAM

Dr I Bownes, Forensic Psychiatrist, Western Health and Social Services Board

Mrs V Crossle, former Senior Social Worker (Mental Health), Gransha Hospital, Londonderry

Dr I Curran, Consultant Psychiatrist, Stradreagh Hospital, Londonderry

Mr B Doherty, subject of Inquiry

Mrs C Doherty, mother of Brian Doherty

Dr K Gillespie, Unit General Manager, Area Mental Health Unit, Western Health and Social Services Board

Mrs K Hegarty, mother of Kieran Hegarty

Mr G Hegarty, father of Kieran Hegarty

Mr G Madden, Social Worker (Mental Health), Omagh Community Mental Health Team, Area Mental Health Unit, Western Health and Social Services Board

Dr P Mannion, Consultant Psychiatrist (Tyrone and Fermanagh Hospital), Area Mental Health Unit, Western Health and Social Services Board

Mr K McCain, Staff Nurse (Named Nurse), Lime Villa, Tyrone and Fermanagh Hospital, Omagh

Mr B McCann, Charge Nurse, Lime Villa, Tyrone and Fermanagh Hospital, Omagh

Mr M McCrystal, former Senior Social Worker, Strabane Social Services

Mr T McGonigle, Probation Officer (Londonderry Team), Northern Ireland Probation Service

Dr G McGovern, Locum Senior Registrar, Tyrone and Fermanagh Hospital, Omagh

Detective Superintendent B McVicker, Strand Road CID, Londonderry

Mrs T Mitchell, SEN, Lime Villa, Tyrone and Fermanagh Hospital, Omagh

Detective Constable G Mohan, Strabane RUC Station, Strabane

Dr A O'Hara, Consultant Psychiatrist (Gransha Hospital), Strabane Community Mental Health Team, Londonderry

Dr B Quigley, Strabane Health Centre, Strabane

Dr O Shanks, Consultant Psychiatrist, Muckamore Abbey Hospital, Antrim

APPENDIX 5

DOCUMENTS WHICH THE INQUIRY TEAM HAD ACCESS TO DURING THEIR INVESTIGATIONS

Health Records:

Health Visiting records

Western Education and Library Board records (special education department)

Strabane Social Services casenotes

Harberton House casenotes

Muckamore Abbey Hospital casenotes

St Patrick's Training School records

Accident and Emergency Department (Tyrone County Hospital, Omagh) records

Tyrone and Fermanagh Hospital casenotes

Gransha Hospital casenotes

Miscellaneous Documents:

Area Mental Health Unit Internal Inquiry Report by Dr O Hill

Psychiatric Report on Brian Doherty, provided by Dr T White, Consultant Forensic Psychiatrist

Northern Ireland Probation Service records - chronology of contact with Brian Doherty

The Mental Health (Northern Ireland) Order 1986

The Mental Health (Northern Ireland) Order 1986 - Code of Practice

The Mental Health (Northern Ireland) Order 1986 - A Guide

Diagnostic and Statistical Manual for Mental Disorders 4th Revision - DSM-IV

Admission Guidelines - Area Mental Health Unit, Western Health and Social Services Board

Discharge Guidelines - Area Mental Health Unit, Western Health and Social Services Board

Documents relating to the arrest and trial of Brian Doherty:

Transcript of the Honorable Mr Justice Higgins' summary of trial procedings, dated 15 May 1995

Psychiatric Report on Brian Doherty, provided by Dr Maden, Consultant Forensic Psychiatrist

Psychiatric Report on Brian Doherty, provided by Dr F Browne, Consultant Forensic Psychiatrist

Police records in connection with the arrest and charging of Brian Doherty for the murder of Kieran Hegarty

APPENDIX 6

CHRONOLOGY OF BRIAN DOHERTY'S LIFE

13.03.74	Brian Martin Doherty born at Strabane Hospital.
September 1980	Assessed by Educational Psychologist as "borderline Educationally Subnormal".
05.09.83	Admitted to Belmont House Special School, Londonderry.
1984	First contact with Strabane Social Services.
24.05.85	Alleged violent incident involving another child.
1985	Parents separated.
13.12.85	Admitted to Harberton House Assessment Centre, Londonderry for a six week assessment (Section 103 of Children and Young Persons Act).
13.01.86	Referred by Harberton House to Child Guidance, Londonderry.
07.02.86	Returned home from Harberton House.
February - September 1986	Regular home visits by social worker.
26.09.86	Social Work contact terminated by agreement but offer of further help made.
September 1986 - February 1987	Deterioration in Brian Doherty's behaviour.
26.03.87	Case conference with Social Services and Education Welfare held. Placement as a boarder at Greystone Hall, Limavady proposed.
03.04.87	Brian Doherty admitted to Greystone Hall, Limavady.
30.05.88	Class report states "He will throw objects at the slightest provocation and is a distinct danger to the safety of his classmates".

August - September 1988	Absconded from Greystone Hall. Spent brief period with father in England. Alleged incident involving an airpistol. Case conference held - "full medical and psychiatric assessment indicated".
Summer 1988	Brian Doherty sent to United States by a childrens charity for a holiday - returned home due to shoplifting and an assault on a child.
23.09.88	Mother ill. Brian Doherty admitted to Harberton House, Londonderry (Section 103).
24.09.88	Absconded from Harberton House - returned by the police.
26.09.88	Absconded again from Harberton House. Went home and told his mother he had a shotgun - spent entire night away from the house.
28.09.88	Place of Safety Order (Section 99) granted. Admitted to St Patrick's Training School in Belfast.
14.10.88	Application for Interim Training School Order made.
21.10.88	Interim Training School Order granted by Juvenile Court.
18.11.88	Further Interim Order granted by Juvenile Court.
21.11.88	Assessed by clinical psychologist. Wechsler Intelligence Scale for Children: full scale IQ 60.
22.11.88	Case conference held involving all agencies.
24.11.88	Case conference held - proposed return to Greyston Hall and home at weekends. Also agreed to refer Brian Doherty to Adolescent Psychiatry.
02.12.88	St Patrick's Training School notes indicate Brian was seen by aconsultant from the Adolescent Psychiatry but no report held on file.
12.12.88	Case conference held.
16.12.88	Interim Training School Order reviewed by Juvenile Court and withdrawn.
04.01.89	Brian Doherty returned to Greystone Hall, Limavady.

18.01.89	Principal at Greystone Hall describes Brian Doherty's behaviour as very disruptive.
25.01.89	Letter from Principal at Greystone Hall reports an incident involving Brian Doherty where "he twisted a towel around a younger pupil's neck and tried to lift the pupil off the floor." Intervention by a member staff prevented a fatal injury. Brian Doherty to be removed from Greystone Hall.
26.01.89	Place of Safety Order (Section 99) to St Patrick's Training School,Belfast. Absconded frequently - charged with breaking and entering on one occasion.
10.02.89	Appeared in Limavady Court with the above offence. Remanded to Lisnevin Remand Unit.
21.02.89	Court report refers to an occasion (Christmas 1988) when Brian Doherty injured his mother with an airpistol - the police were called and removed the air pistol. Same report recommends a psychiatric evaluation.
21.02.89	Remanded to Lisnevin Training School.
21.03.89	Strabane Juvenile Court : Training School Order granted (care, protection or control). Conditional discharge in relation to charge of breaking and entering.
15.06.89	Case closed by Social Services.
June - July 1989	Absconded frequently from St Patrick's Training School
07.08.89	Charged with breaking windows in a house. Remanded to Lisnevin Remand Unit.
13.09.89	Further report from clinical psychologist confirming findings of earlier report.
12.10.89	Absolute discharge for offence referred to on 7 August 1989.
02.03.90	Appeared in Dungannon Juvenile Court relating to charge for theft in July 1989 - given absolute discharge.
April 1990	Commenced Youth Training Programme from St Patrick's Training School.

25.10.90	Referred to Young People's Centre.
27.11.90	Report completed by consultant psychiatrist from Muckamore Abbey Hospital.
29.01.91	Absconded from St Patrick's Training School and entered a woman's house in Turf Lodge in West Belfast - alleged sexual element to this in relation to the woman's five year old daughter.
04.02.91	Case review held at St Patrick's Training School. Further referral made to consultant psychiatrist at Muckamore Abbey Hospital, with particular reference to the alleged sexual incident in January 1991.
20.02.91	Seen by consultant psychiatrist at Muckamore Abbey Hospital - no psychosexual problem identified. Recommended that a longer term plan be drawn up involving all appropriate agencies.
13.04.91	Planned Youth Training Programme in Londonderry failed.
April 1991	Further absconding from St Patrick's Training School - on one occasion was charged with burglary by the Gardai in Donegal and received a six month suspended sentence.
May 1991	Charged with assault and criminal damange for attacking a youth on a bicycle.
13.06.91	Seen for the third time by the consultant psychiatrist at Muckamore Abbey Hospital.
July 1991	Frequent abscondings from St Patrick's Training School.
30.08.91	Detained for assessment in Muckamore Abbey Hospital under the Mental Health (NI) Order 1986.
12.09.91	Detained for treatment in Muckamore Abbey Hospital.
16.09.91	Absconded from Muckamore Abbey Hospital and went to his father in England.
08.10.91	Returned to Muckamore Abbey Hospital by the police.
11.10.91	Disruptive behaviour led to Brian Doherty being held in seclusion. Consultant psychiatrist questioned whether Brian Doherty was severely mentally handicapped.

15.10.91	Brian Doherty tested using Wechsler Adult Intelligence Scale: full scale IQ 69. Clinical psychologist states "functioning at the very top end of mental handicap. In my opinion he is suffering from 'mental handicap' within the meaning of the Mental Health (NI) Order 1986. Case conference held involving staff from Muckamore Abbey Hospital and St Patrick's Training School. Decision made that St Patrick's Training School had nothing further to offer Brian Doherty.
07.11.91	Case review in Muckamore Abbey Hospital. Training School Order would remain until Brian Doherty's eighteenth birthday.
21.11.91	Court case adjourned until 16 January 1992.
23.12.91	Home leave arranged for Christmas
31.12.91	Absconded from Muckamore Abbey Hospital. Returned by police on 6 January 1992.
16.01.92	Court case adjourned until 12 March 1992.
14.02.92	Home on leave - did not return as planned and remained absent.
05.03.92	Letter to consultant psychiatrist at Muckamore Abbey Hospital from the Northern Ireland Office - Training School Order due to expire on 20 March 1992, but St Patrick's Training School would continue to have a responsibility for Brian Doherty until his 21st birthday.
12.03.92	Court case adjourned until 9 April 1992.
15.03.92	Detention under Mental Health Order lapsed due to 28-day interval.
18.03.92	Mrs Doherty requested help from Strabane Social Services - confusion as to which team should deal with Brian Doherty and it appears referral was not dealt with at this stage.
20.03.92	Training School Order expired.
09.04.92	Strabane Magistrates Court - Brian Doherty receives probationary one year sentence for offence committed in

	May 1991.
28.07.92	Referred by consultant psychiatrist at Stradreagh Hospital to GP who in turn referred on to Strabane Social Services.
18.09.92	Referred to psychiatric out-patient clinic but did not attend. Gransha Hospital requested notes from Muckamore Abbey Hospital.
29.10.92	Probation Service records an alleged "flashing" incident by Brian Doherty - Strabane Social Services informed but no further action considered necessary.
30.10.92	Consultant psychiatrist at Gransha Hospital requested a home visit by mental health social worker.
13.11.92	Went to Leicester. Arrested for criminal damage but given a conditional discharge.
18.11.92	Returned home via Larne, made contact with the Probation Service in Belfast.
20.11.92	Home visit by consultant psychiatrist from Stradreagh Hospital at the request of GP.
04.12.92	Admitted to Gransha Hospital as a detained patient for assessment - handcuffed due to aggressive behaviour, accompanied by three police officers.
08.12.92	Regraded to voluntary patient - discharged himself.
09.12.92	Went to Crawford Square Hostel but was asked to leave. Went to Buncrana - alleged theft and advised to return to Northern Ireland or be detained in St Patricks Institute in Dublin.
14.12.92	Readmitted to Gransha Hospital as a voluntary patient. Discharged himself contrary to medical advice on 15 December 1992.
10.02.93	Stayed for four days in Simon Community, Londonderry.
18.02.93	Stayed one night in MUST Hostel, Cookstown.
20.02.93	Court case set for 11 November 1993 in connection with incident involving Brian Doherty lying in the road and being assaulted by a motorist.

24.02.93	Admitted to Gransha Hospital as a voluntary patient. Intoxicated on admission, accompanied by Mrs Doherty and the Probation Officer. Also allegations of exposing himself to children. Later discharged himself contrary to medical advice. Discharge letter states "admission to a psychiatric hospital is unlikely to be of any therapeutic benefit."
11.03.93	Brian Doherty seen at the Tyrone and Fermanagh Hospital with a view to admission but refused to stay.
25.03.93	Brian Doherty interviewed by consultant psychiatrist from Gransha Hospital (and Probation Officer) in Strabane Health Centre. Decision to refer Brian Doherty to the Probation Board psychologist.
29.03.93	Consultant psychiatrist at Gransha Hospital wrote to GP following his meeting with Brian Doherty. "I'm not convinced that we are dealing with mental illness in this case ... recommend a joint meeting to see if there is a strategy that could be developed which might help."
31.03.93	Appointment with Probation Board psychologist - did not attend.
08.04.93	Probation Order expired. Voluntary contact continued.
24.04.93	Allegation of Brian Doherty "flashing" at neighbour's girlfriend. Went to England and returned on 6 May 1993.
27.04.93	Letter to consultant psychiatrist at Gransha Hospital from mental health social worker. Proposed case conference proved not to be feasible.
14.05.93	Arrested for planting a hoax at neighbour's door. Released without charge.
28.05.93	Arrested for wearing balaclava and in possession of an imitation gun. Remanded in custody.
10.06.93	High Court bail granted to Brian Doherty on condition he resided at Crawford Square Hostel.
22.06.93	Left Crawford Square Hostel - police notified.
25.06.93	Failed to appear in Court.

06.07.93	Brian Doherty committed to Young Offenders Centre for possession of a replica firearm - Muckamore Abbey Hospital casenotes requested by prison psychiatrist - neither mental illness or significant mental handicap detected by prison psychiatrist.
28.10.93	Strabane Magistrates Court - received one year probationary sentence with an additional condition that he sees a psychologist.
11.11.93	Missed further appointment with Probation Board psychologist. Also due to appear at Strabane Magistrates Court - attended but then ran away - case adjourned until 18 November 1993. It is unclear where Brian Doherty was residing at this time.
18.11.93	Did not appear at the Court. Case adjourned.
24.11.93	Further appointment with Probation Board psychologist arranged for 16 December 1993.
02.12.93	Strabane Magistrates Court on a charge of criminal damage to police station - case adjourned.
16.12.93	Did not attend Court or see the Probation Board psychologist - further appointment made for 21 January 1994.
31.12.93	Arrived at Cuan Mhuire, Newry (hostel for people with alcohol problems) but not admitted.
06.01.94	First admission to the Tyrone and Fermanagh Hospital.
10.01.94	Discharged himself Contrary to Medical Advice.
13.01.94	Second admission to the Tyrone and Fermanagh Hospital.
18.01.94	Discharged himself Contrary to Medical Advice.

APPENDIX 7

THE MENTAL HEALTH (NI) ORDER 1986

PART I - INTRODUCTORY

Interpretation

(4) In determining for the purposes of this Order whether the failure to detain a patient or the discharge of a patient would create a substantial likelihood of serious physical harm -

(a) to himself, regard shall be had only to evidence -

(i) that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself; or

(ii) that the patient's judgment is so affected that he is, or would soon be, unable to protect himself against serious physical harm and that reasonable provision for his protection is not available in the community;

(b) to other persons, regard shall be had only to evidence -

(i) that the patient has behaved violently towards other persons; or

(ii) that the patient has so behaved himself that other persons were placed in reasonable fear of serious physical harm to themselves.

APPENDIX 8

DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS
4th Revision - DSM-IV

Conduct Disorder

A. A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals

(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (eg. a bat, rick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (eg. mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of Property

(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favours or to avoid obligations (ie. "cons" others)
(12) has stolen items of nontrivial value without confronting a victim (eg. shoplifting, but without breaking and entering; forgery)

Serious violations of rules

(13) often stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

(15) often truant from school, beginning before age 13 years.

B. The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Type based on age at onset:

Childhood-Onset Type: onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years

Adolescent-Onset Type: absence of any criteria characteristic of Conduct Disorder prior to age 10 years

Severity:

Mild: few if any conduct problems in excess of those required to make the diagnosis **and** conduct problems cause only minor harm to others (eg. lying, truancy, staying out after dark without permission)

Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe" (eg. stealing without confronting a victim, vandalism)

Severe: many conduct problems in excess of those required to make the diagnosis **or** conduct problems cause considerable harm to others (eg. forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).

GLOSSARY

Adolescent Psychology Resource Unit - a Belfast-based unit providing specialist adolescent psychology services

Ardmore House School - a special school facility, based in Downpatrick and managed by the South Eastern Education and Library Board

Belmont House - a special school facility, based in Londonderry and managed by the Western Education and Library Board

Crawford Square Hostel - Londonderry based hostel for homeless men

ESN - Educationally Subnormal

Glencraig Camphill Community - a mental handicap community based in Bangor, Co Down

Greystone Hall - a special school (boarding school) facility, based in Limavady and managed by the Western Education and Library Board.

Harberton House - Childrens Home and Assessment Centre based in Londonderry and managed by the Western Health and Social Services Board

Lisnevin - Training School and Remand Unit for adolescents, based in Millisle in Co Down.

Lissue Hospital - Child Psychiatry Inpatient Unit in Lisburn - now closed

Muckamore Abbey Hospital - Mental Handicap Hospital, managed by the Eastern Health and Social Services Board Mental Handicap Hospital, and based in Muckamore, Antrim

Rupert Stanley College - now renamed Whiterock Centre, part of the Belfast Institute of Further and Higher Education

St Patrick's Training School - Training School for adolescents based in Belfast

Young Offenders Centre - Detention Centre for juvenilles based at Hydebank in Belfast

Young Peoples Centre - Adolescent Unit managed by the Eastern Health and Social Services Board, based in Belfast

Youthways - Youth Training Programme at the North West Institute of Higher and Further Education