REPORT OF THE INDEPENDENT INQUIRY

REFERENCE 2000/315

MARCH 2003

COMMISSIONED BY
THE FORMER BRADFORD HEALTH AUTHORITY

CONTENTS

APPENDICES

1 MEMBERSHIP

Jagtar S Bhatoa	Solicitor (Chair)
Dr Clare Brabbins	Consultant Psychiatrist
Howard Davis	Registered Nurse
Roger Hargreaves	Social Worker

2 ACKNOWLEDGMENTS

2.1 We recognise that an inquiry of this nature is stressful for all concerned, and in particular for the families of Mr B and of Mr A and for the staff in the hospital, community and social care services who were involved in their care. We wish to put on record the frankness and co-operation of all who gave evidence, both written and oral.

2.2 A list of those who contributed including those who gave verbal evidence can be found in appendix 2.

2.3 We would also like to thank all those who gave us assistance at the former Bradford Health Authority; Bradford Hospitals NHS Trust; Bradford Social Services Department; the former Bradford Community Health NHS Trust; the Probation Service; West Yorkshire Police; Rampton Hospital; and other bodies in the statutory and voluntary sectors in Bradford.

2.4 We would also wish to record our appreciation to the secretary to the inquiry, Colin McIlwain, who handled the bulk of the administrative burden and made a valued contribution throughout, and to Sarah Worstead who latterly took over the secretarial role from Colin on his promotion within the NHS. We are also very grateful for the transcription service provided to us by Associated Verbatim Reporters who recorded our interviews.

Condolences

2.5 Mr B was 39 years old at the time of his death. We have heard about him from his family as well as from those involved in his care. He was someone who was liked by those with whom he came into contact. Despite the challenges he faced, he wanted to be independent and to participate in the experiences that life had to offer. We take this opportunity to offer our condolences to his family on his untimely death.

Anonymity

2.6 In accordance with West Yorkshire Strategic Health Authority policy, the subject of the inquiry will be referred to as Mr A and the deceased as Mr B. Members of staff are referred to by title rather than by name, as we wished our conclusions to focus on the services themselves rather than the individuals delivering them, and to encourage staff to be as open and candid as possible in interviews. Although we are critical of the actions of some staff, we did not come across any individual instance which could be said to amount to a lack of reasonable competence or care.

3 PREFACE

3.1 References to "the Trust" in the body of the report refer to the former Bradford Community Health NHS Trust, but the recommendations in Section 15 are of course addressed to its successor, Bradford District Care Trust. Although both men had been patients of the Trust's mental health service, their paths do not appear to have crossed within that service - Mr A was a patient of its special care service, Mr B of its acute service. In addition, Mr B was receiving support from the joint Trust/Social Services community learning disability and mental health services.

3.2 Mr B had been in contact with the learning disability services for most of his life, and of the mental health services since 1982. However, we agreed that the scope of our inquiry into his care and treatment should be limited to the period from January 2000 onwards, as events prior to that would have very limited relevance to the circumstances of his death. His history is, however, summarised at the beginning of Section 8 by way of background information.

3.3 From the beginning we have set out to be constructive, as we appreciate it is all too easy to be wise after the event. We have tried to identify and to praise good practice where this has been found, in addition to pointing out gaps and shortcomings.

3.4 Although Mr B fell outside the normal eligibility criteria for the learning disability services, he continued to receive care and assistance from them. He was admitted as an inpatient by the mental health service on 22 August 2000 not because of acute mental illness, but because he needed a refuge whilst alternative supported accommodation could be found. That both services extended help to him in these circumstances is greatly to their credit; there are many parts of the country where someone in his situation would have been left to fend for himself.

3.5 Mr A was a patient of the forensic arm of the mental health service, which until 2000 was usually referred to as the "special care unit" or the "special care service". Given its function, we would have expected this service to be setting the standard for the rest of the mental health service in the areas of risk assessment and implementation of the Care Programme Approach. We did not find this to be the case.

3.6 Having reviewed all the evidence, we have come to the conclusion that the encounter between Mr B and Mr A at the Bradford Interchange bus station on 19 September 2000, and the tragedy which followed, could not have been foreseen. However, the special care service should have recognised more clearly than it did that Mr A was potentially dangerous and that there was a significant risk of a serious assault against someone in his family or someone linked to events in his past life. This should have resulted in a more structured care package which was more explicitly directed to reducing the risk of harm to others; but given the complex and intractable nature of his disorders, it is not realistic to think that such a risk could have been removed entirely.

4 THE EVENTS OF 19 SEPTEMBER 2000

4.1 On the evening of Tuesday 19 September 2000, Mr A was at the bus station in the Bradford Interchange, waiting to catch a bus to visit his sister who also lived in Bradford. Whilst there he met Mr B, who was on his way back from his brothers' house to Lynfield Mount Hospital where he was an informal in-patient. Mr A recognised Mr B as a former neighbour, and someone who had been a friend of a man who had abused him sexually about 13 years earlier.

4.2 Instead of visiting his sister, Mr A boarded the same bus as Mr B and they got off together at a stop in Haworth Road, not far from Lynfield Mount Hospital. Instead of returning to the hospital, Mr B walked with or followed Mr A past the hospital to the grounds of the former Edmund Campion School on Rhodesway. Once in the grounds, Mr A without warning grabbed Mr B from behind in a stranglehold, but he managed to break free.

4.3 They did not part company, but instead walked together the short distance across the road into the grounds of Rhodesway Upper School. There, in a doorway, Mr A attacked Mr B again, taking a stranglehold and applying severe pressure to his neck. Then he placed Mr B's neck behind his knee to apply more pressure, then pressed down on his neck with his heels, levering himself against a wall to gain maximum force. The attack, which was captured on CCTV, lasted some ten minutes.

4.4 Mr A then made his way to Bradford Central Police Station and told the desk staff what he had done. Police and paramedics went to the scene and found Mr B's body.

4.5 Mr A appeared at Bradford Crown Court on 1 May 2001 charged with the murder of Mr B. He was found to have done the act charged, but to be "under disability or not guilty by reason of insanity" and he was sent to Rampton Hospital on a restriction order without limit of time, which means that he cannot be discharged without the agreement of either the Mental Health Review Tribunal or the Home Secretary.

5 BACKGROUND – BRADFORD'S MENTAL HEALTH AND LEARNING DISABILITY SERVICE

5.1 The City of Bradford has a population of 509,000, the main centres being Bradford itself, Shipley, Bingley, Keighley and Ilkley. From 1 April 2002, all mental health and learning disability services have been provided by the Bradford District Care Trust, which is a partnership between NHS services in Bradford and the Social Services Department of Bradford Council. This new Trust also provides mental health and learning disability services to the Craven District of North Yorkshire.

5.2 During the period covered by this inquiry, NHS mental health services were provided by two separate organisations - Bradford Community Health NHS Trust (BCHT) and Airedale NHS Trust. Both Mr A and Mr B were patients of Bradford Community Health Trust. Inpatient services for Bradford were provided from Lynfield Mount Hospital and for Airedale from Airedale General Hospital near Keighley, and each Trust had its own community arm.

5.3 With the inception of the Care Trust in April 2002, there is now a single organisation which incorporates the mental health and learning disability services of the two former Trusts together with the services for those groups provided by Bradford City Council Social Services Department.

5.4 There are four Primary Care Trusts (PCTs) in the district, established in October 2000. From April 2002 each PCT has been responsible for commissioning mental health and learning disability services on behalf of its residents. However, the Airedale PCT is taking the lead role in planning these services on behalf of all four PCTs.

5.5 Before the establishment of PCTs in the Bradford district, the responsibility for commissioning mental health services rested with Bradford Health Authority. The health authority had been established in April 1996 following the merger of the formerly separate Bradford Health and Bradford Family Health Services Authorities. In turn the Bradford Health Authority had been created in 1992 following the merger of Airedale District Health Authority with Bradford District Health Authority.

5.6 With the introduction of the NHS internal market in 1991 the responsibility for commissioning services was separated from the provision of services. From that year Bradford Community Health NHS Trust was established and this body provided the mental health services at Lynfield Mount Hospital and its associated community services. From 1991 to 2000 the commissioning of mental health services was the responsibility of Bradford Health Authority, and it retained this responsibility through the organisational changes identified above until October 2000. This period of time covers the contacts that Mr A had with mental health services and in particular the period from 1994 to 2000 when he was a patient of the forensic service and its forerunner. Between October 2000 and the abolition of Bradford Health Authority in March 2002 most mental health commissioning was devolved to the four PCTs in Bradford. The exceptions to this were the commissioning of places in medium secure units, due to the high costs of the individual cases, and some contracts with the voluntary sector that were not devolved by the health authority until April 2002.

5.7 Ultimate responsibility for commissioning mental health services, until the creation of PCTs in October 2000, rested with the Chief Executive of the Health Authority and its predecessor bodies. This responsibility was then delegated to the Director of Planning of the authority and the authority's Director of Finance was also involved given the funding of out of district placements at NHS and independent hospitals. A manager working for the director of planning had day to day responsibility for commissioning mental health. This manager worked closely with colleagues from the public health and finance disciplines, especially on medium secure issues. In addition a Regional Specialist Commissioning Group covering the former Yorkshire health region had responsibility for the commissioning arrangements for patients in high secure units. The regional group also led work on the development of strategy for medium secure units and assisted NHS Trusts health authorities, and subsequently PCTs, in the planning and development of local forensic services.

6 MR A – HISTORY UP TO JUNE 1998

Summary of Main Events

6.1 Mr A was born in Bradford in 1975; he has three elder sisters. His parents separated two years later, but he continued to have very regular contact with his father. He experienced very conflicting styles of parenting, his father being described in Social Services records as being punitive and over-controlling, his mother as passive and detached. There were problems with school refusal from the start of his school career, and throughout his childhood he was repeatedly bullied.

6.2 Social Services had been involved with the family since prior to his birth, although the main focus was on the three girls, and it was noted more than once that Mr A needed more professional attention than he was getting. In 1984, when he was nine, an increase in problems at school led to his being taken into voluntary care; many years later, he alleged that he had been repeatedly sexually abused by a thirteen-year-old boy at the assessment centre, and that he had told his social worker but had not been believed. He was discharged from care in 1986 but continued to live in a residential education support unit during the week.

6.3 In late 1987, when he was aged 12, he was abused repeatedly by a middle-aged male friend of his family who had several previous convictions for sexual abuse of young boys. When this man was arrested in 1988, Mr A was taken into care under statutory powers and placed with foster-parents. His behaviour at school, which had been satisfactory for some time prior to this point, regressed drastically, and at the same time his mother withdrew her previous co-operation with Social Services.

6.4 There then followed a period during which Mr A was moved from one care placement to another due to disruptive behaviour and repeated absconding. He began to offend, and by the time he was discharged "home on trial" in 1989 he had accumulated nine convictions. A year later, active casework was terminated as "*mother and Mr A are unwilling or unable to change behaviour or to discuss real problems," and* the case was finally closed in 1991. From then on, Social Services simply responded to Mr A's increasingly-frequent court appearances, mainly for taking cars and burglary, by finding accommodation during the periods when he was remanded in care; in 1992, when he reached 17, the case was handed over to the Probation Service.

6.5 In November 1991 Mr A suffered a serious head injury when he crashed a stolen car; he was unconscious for several days and also suffered a broken jaw and other injuries, and his spleen was removed. In June 1992 he was referred, by his GP, to a forensic psychiatrist in Bradford, as his mother was reporting “violent mood swings” since the accident. He was seen once as an outpatient before being discharged back to his GP in October 1993.

6.6 In early 1993 he had suffered a further sexual assault when he was in London, shortly after his return he was arrested for assaults on his mother and sister and was remanded in custody. Whilst in custody he was classed as a "vulnerable prisoner" due to bullying by other inmates, and an assessment was requested from the consultant psychiatrist in the special care service based at Lynfield Mount; this was his first contact with that service, which was about to open its secure ward, the Kestrel Unit. The psychiatrist recommended that he should be admitted to the Kestrel Unit for further assessment under Section 35 of the Mental Health Act, and she also commissioned a report from a forensic psychologist from the Regional Forensic Service.

6.7 Mr A was at Lynfield Mount for ten weeks. When he returned to court in August 1994, he was made subject to a probation order with a condition of residence, since there was concern about risk to his mother if he returned to live with her. "*Regular counselling and support by a community psychiatric nurse*" was offered, although it appears that he did not take this offer up.

6.8 However, he found it difficult to settle in hostels arranged by his probation officer, and eventually it was agreed that he should return home to his mother. There then followed what his probation officer described as a "*very settled period*" of several months, until he was again in trouble. He made a sexual advance to a girl who had apparently befriended him in childhood and on whom he appeared to have a fixation, and when he was taken to task he over-reacted and was charged with criminal damage. He was later targeted as a "pervert" by residents of the estate, and fled to Manchester, where he was remanded in custody following his arrest for further motoring offences; a psychiatric report was provided for the court by a psychiatrist from the North-West Region, and in August 1995 a further probation order was made.

6.9 In December 1995 Mr A's probation officer reported continuing concern about his fixation with the girl, who he had just discovered was pregnant by a young man who, he later alleged, had been one of his tormentors from childhood. In September 1996 he broke into the girl's house at night, stole items belonging to her, killed her cat, breaking its legs and laying it out on the doorstep, and then entered the bedroom and carried out what appeared to be a deliberate and sustained assault on her partner, using a weapon (the frame of a TV stand), attempting to strangle him and causing numerous injuries. Mr A was himself hit on the temple with an implement during the struggle and he took himself to Bradford Royal Infirmary afterwards, spending the night there before being arrested two days later.

6.10 He was sentenced to three years imprisonment, and in October 1997, nine months prior to his release, his new probation officer wrote to the consultant psychiatrist in the Lynfield Mount special care service, describing the offence and subsequent concerns about his mental state in prison, including probable delusions, and requesting assistance regarding his "*severe behavioural problems which put him at risk both of harm to himself and others".* The consultant psychiatrist agreed to discuss him with her newly appointed consultant psychologist colleague (who in his former role at the Regional Forensic Service had assessed Mr A during his hospital admission in 1994) and to inform the probation officer of the outcome.

6.11 It would appear that the consultant psychologist agreed to take responsibility for the case, but this was not communicated to the probation officer, who, having heard nothing more, wrote again in March 1998, reporting that Mr A was due for release in June 1998 and that a risk assessment meeting had been held in December, where it was agreed that "*a psychological report should be prepared prior to release particularly to look at the victim fixation*". However, the psychologist was unable to see him until mid-May, three weeks before his release date, and it was agreed that the assessment would continue on an outpatient basis following his release.

6.12 Mr A was released on 7 June 1998 and returned to live with his mother. He was on licence to the Probation Service until the end of March 1999, and he was also provided with a package of care from the special care service, based around out-patient appointments with the psychologist and, latterly, home visits from a community psychiatric nurse; this continued until he was arrested in September 2000 for the murder of Mr B. This period is described in more detail later in Section 7.

Accounts of his Personality, Mental State and Behaviour up to June 1998.

6.13 Mr A had no contact with mental health services until 1992 and only the briefest of contacts with an educational psychologist; however, it is possible to get a reasonably clear impression of him in childhood from his Social Services records. Unfortunately, however, all records of regular contacts with the Probation Service prior to March 1999, which would have been a very valuable source of information about him from the age of 17 onwards, appear to have been destroyed, contrary to the Service's normal destruction policy, although the summaries are still available and the probation officers who gave verbal evidence still had a good memory of him.

Childhood and Adolescence

6.14 According to the Social Services records he was, from an early age, nervous, timid and enuretic, guarded and isolated, and with a low self-image; and it was noted, even prior to the known abuse, that he was very reluctant to be touched by males. He was a loner at school and was frequently picked on, often retaliating violently and without apparent fear or restraint and doing considerable harm to people or to property. He was alternately quiet and introverted, and hyperactive and disruptive. He was prone to outbursts of rage when frustrated, and would then run away and hide; he always saw himself as the victim and would never accept responsibility for his own actions, even when he was "caught in the act".

6.15 On the positive side, he was seen as being of normal intelligence and he had areas of particular ability in athletics and computing. His general school performance was, however, well below his abilities due to truancy, low motivation and a reluctance (as opposed to an inability) to do any written work. When, however, some structure and consistency was introduced into his life at the education support unit, he demonstrated that he could conform, and show respect for other people and property; and, prior to the arrest of his abuser in 1988, he had been reintroduced to a mainstream school and had attended for some time with no major problems. The fact that he was able to behave within social norms for a prolonged period in an ordinary setting indicates that there was, at this point, no evidence of a serious underlying conduct or character disorder.

6.16 He later, however, accumulated five violence or firearms convictions between 1989 and his road accident in 1991; and he also had eight convictions for motoring offences but later admitted to a great many more. He was portrayed as a persistent joyrider "for kicks" - he liked the feeling of power and control, which he had never had in other areas of his life, it gave him status in his peer-group, and he was euphoric and heedless of possible consequences.

After the Head Injury

6.17 Immediately after the head injury in 1991, the most noticeable change was that he had a severe speech impediment, which improved only slowly, together with impaired memory; this provided yet another reason for the local youths to tease him, and his probation officer noted that he had become depressed, and fearful that he would never be able to make normal relationships, especially with women. The local police also observed that the former tearaway had suddenly become a model citizen - " *he was very polite to the police where prior to the accident he had been aggressive and volatile*." The joyriding stopped, and he no longer associated with the local group of joyriders, who in any case rejected him "*because he was so strange in manner*".

6.18 In June 1992 he was referred by his GP to a forensic psychiatrist for advice, as his mother was reporting "*violent mood swings*" since the accident; the psychiatrist in turn referred him to a psychologist for an assessment, but this showed no evidence of intellectual impairment following the head injury. The psychiatrist noted that there were "*symptoms suggestive of possible brain damage*" but concluded that these *"have been receding quite steadily*" and that *"most of his problems stem from his childhood experiences*". This view was repeated by another psychiatrist who prepared a report for a court appearance in April 1993. Mr A was discharged back to his GP by the forensic psychiatrist in October 1993.

6.19 The family view was that there *had* been a major change in him since the accident, but it was felt by the professionals that they tended to underplay the effects of his upbringing, and it was clearly difficult for those dealing with him during this period to decide to what extent he had *really* changed, given his long history of abnormal and at times very antisocial behaviour prior to the accident, and the fact that he was still a teenager. In the absence of any objective evidence, in the form of abnormalities in physical or psychological tests, it was hard for the professionals to tell whether any change was as a result of the accident, and if so, to what extent it would improve.

6.20 To the professionals dealing with him, the effects of the head injury seemed less significant at that time than those of his history of sexual abuse, and of the further sexual assault which had occurred in London in January 1993. His probation officer wrote that "*we are concerned that he may be suffering from severe post-traumatic stress disorder*," and shortly after his return from London, she expressed alarm at a deterioration in his behaviour - "*hitting out at everybody and acting out inappropriately"* which she ascribed to the sexual assault, and he was put on an "alert notice" due to his behaviour at the probation office. In February he was arrested and remanded in custody for assaults on his mother and sister, as a result of which his mother suffered a permanent injury; the assaults were triggered, according to Mr A, by insensitive remarks about sexual abuse and his speech impediment. His probation officer observed that *"there has been a change in the focus of his*

offending from motor-related crime and dishonesty towards violent, anger-related offending."

6.21 Putting all the available evidence together, it would appear that some of the most obvious effects of the head injury, and in particular his speech impediment, poor memory and depressed mood, *did* abate over the first couple of years, as would normally be expected, but that there remained a number of abnormalities of behaviour which had not been reported prior to the accident and which could not be explained solely in terms of his childhood history. For instance, when under stress his speech could become extremely pressured, and a probation officer observed that it was "*very difficult just to hold a conversation with him*". His behaviour in public could also be inappropriate, disinhibited and provocative, and another probation officer noted in 1996 that "*he is quite capable of appearing unsteady on his feet, eyes glazed, slurred, loud and aggressive without necessarily being intoxicated*". This type of behaviour made him especially vulnerable during his periods in custody, when he was targeted by other prisoners. When he *was* intoxicated or under the influence of drugs, his behaviour was a great deal worse, although apart from the assaults on his mother and sister he had only two convictions for violence in the period from 1991 to 1996.

6.22 During the ten-week in-patient assessment in 1994 the staff at Lynfield Mount found, as his family had reported, that if things did not go his way or if he was denied immediate attention he would quickly lash out verbally or by damaging property; that his behaviour towards other patients was provocative and his attitude to female staff inappropriate; and that he would not accept responsibility for his behaviour. However, they did not specifically attribute any of his behaviour to his brain injury, or even consider this as a differential diagnosis. In the light of the later prominence of the behavioural evidence of brain injury, this is a somewhat surprising conclusion; but he was still only 19, and this sort of behaviour is not in itself very unusual in immature 19-year-olds in the criminal justice system.

6.23 The staff noted, as had the staff at the education unit eight years earlier, that when subjected to a consistent, structured regime he could learn to moderate this behaviour. However, in a structured setting where behavioural limits are laid down for them, people with lack of inhibition, either due to brain injury or to immaturity or both, may well be able to behave better than in the community where they have to set their own limits, and the true extent of their disabilities may not therefore become obvious.

6.24 The forensic psychologist at the Regional Forensic Service to whom Mr A was referred confirmed the previous finding that there was no intellectual impairment, and a CT scan was normal. The consultant psychiatrist concluded that there was no evidence of mental illness, and reported to the court that he had "*a number of personality difficulties including low self-esteem, an immature response to events around him and poor impulse control"* and that his personality difficulties "*have arisen as a result of his disturbed childhood and the sexual abuse he has received on a number of occasions throughout his life".* Although his mother said in interview that he had had a succession of paranoid beliefs ever since his head injury and that shortly after his accident "*he thought he was being controlled from Mars*," no phenomena of this nature were observed during his hospital stay.

6.25 The probation officers also found that he responded to firm boundaries, and that when his life was stable he could make considerable progress, even attending college courses; the week before his arrest for the aggravated burglary in 1996, he obtained a job for the first time in his life, which the probation officers saw as a major step forward. They remained concerned, however, about his persistent tendency to see himself as the victim and to accept no responsibility for his actions, together with his provocative behaviour, and his extreme responses to the reactions he provoked from others; and they were especially concerned about his obsessive fixation with the girl who had befriended him in childhood. Mr A saw her as "his" despite the fact that there was no evidence at all of a continuing relationship, and could not be persuaded out of this belief. In verbal evidence the probation officers said that, whilst such obsessions were not uncommon in young men, the intensity and immovability of Mr A's belief was very abnormal.

<u>After the Aggravated Burglary</u>

6.26 After his arrest in September 1996 for the aggravated burglary, the probation officers were even more concerned about Mr A's lack of empathy for his victims and his persisting *"obsessive hatred*" of the girl's partner; and they were also concerned about his ritualistic killing of the cat, which he claimed was revenge for the death of his own cat. He would not accept that his behaviour was in any way unjustified, and there were fears for the safety of his victims after his release, hence the referral to the special care service for assistance with risk assessment and management.

6.27 His probation officer was also concerned about his behaviour in prison from the time of his arrest, which was significantly different to what she and her colleagues had observed before, even during his previous periods in custody (which since 1991 had amounted to about six months in total in three separate periods); her court report, written in April 1997, said that *"since he has been on remand ...I have personally witnessed a deterioration in Anthony's mental condition."*

6.28 The Inmate Medical Record (IMR) from Armley prison shows that a skull fracture had been diagnosed at Bradford Royal Infirmary when Mr A presented there after the aggravated burglary, but no further treatment was considered necessary. In the prison , however, he complained for several days of dizziness, blurred or double vision, headaches and vomiting, and for several weeks after admission he was preoccupied with his head wound, saying that the exudate seeping from it "*smelt of turps or battery acid*" which must have come from the implement with which he had been hit. At one point he "*wanted to wipe his wound all over the dayroom chairs*" and he was prevented from eating with the other inmates.

6.29 In addition, there were reports of him "*shouting and banging all night*," destroying furniture, and assaulting staff, and the impression is that, whilst the essential nature of his behaviour was unchanged, he was less inhibited, more extreme and less amenable to firm handling than had been the case when he was in Lynfield Mount three years previously, or indeed during his previous spells in custody. The probation officer also reported that Mr A was claiming to be the cousin of the film actor Jean Claude van Damme, and that the staff had injected his testicles with heroin; and the IMR notes in March 1997 that he "*asked for an HIV test because he had a syringe stuck up his nose by a hospital officer*" and in March 1998 that "*his spine is split in two*."

6.30 However, in interview his mother ascribed his episodes of disturbed behaviour to cannabis, to which he had an extreme reaction and which, she said, was readily available in the prison. The visiting psychiatrist who reviewed him in October 1996, six weeks after his arrest, thought that his bizarre beliefs and behaviour immediately following admission were probably a symptom of a post-traumatic organic brain syndrome following the recent head injury, and by the end of October, when he was seen again, he was reported as being no longer preoccupied with the head wound.

6.31 In March 1997, on the recommendation of his probation officer, a neuropsychological assessment was carried out prior to his trial. This found "*conclusive evidence of impairment of executive functions of the type commonly found in individuals who have sustained frontal lobe brain damage".* However, the psychologist's report makes reference only to the head injury in 1991, and not to the more recent one, and it is not clear whether he was aware that Mr A had suffered another blow to the head only seven months prior to the tests. Mr A was then seen by an independent forensic psychiatrist who concluded that he had an organic personality disorder, ie that his abnormalities of behaviour were not just related to his childhood experiences but that they were *"to a significant degree related to the permanent damage he sustained to that part of the brain where moral values are embedded and the restraints and controls on social behaviour ordinarily reside".* This diagnosis did not depend entirely on the neuropsychological tests, but also took into account the evidence relating to his personality and patterns of behaviour.

6.32 The consultant psychologist from Lynfield Mount who saw him at the request of probation shortly before his release in June 1998 (and who, whilst employed by the Regional Forensic Service, had previously assessed him in 1994) noted in the IMR that there was *"evidence of paranoid cognition and overvalued beliefs."* However, he concluded that these were isolated ideas which did not appear to be symptoms of a generalised psychosis. He noted the earlier finding of frontal lobe disorder. The probation officer, in her referral, had asked "*if you had thoughts as to whether or not it would be appropriate to refer Mr A for head injury assessment as it would appear that the head injuries he received a few years ago are the root of his problems*," and he initially concluded that there would be "*no harm in getting a neuropsychological view*" but he later decided that this would not be productive in view of the length of time which had elapsed since the brain injury.

6.33 In summary, therefore, at the point of his release from prison in June 1998 Mr A presented a very complex picture of abnormal and at times bizarre behaviours, many of which were of very long standing but some which had become apparent only very recently. A range of causal factors had been identified - his upbringing and personality, the history of sexual abuse, the first head injury and possibly the second, and his sensitivity, as a result of the head injury, to cannabis and alcohol. He was regarded by the Probation Service as potentially dangerous as a consequence, in particular, of the circumstances of his latest offence, and his mother was reluctant to have him home in view of his unpredictability and his violence towards her and her property. He was not and never had since 1991 been uncooperative with the statutory agencies, but the consensus of the professionals dealing with him was that his problems were not amenable to any kind of straightforward medical treatment.

7 MR A – CARE AND TREATMENT BY THE BRADFORD SPECIAL CARE SERVICE AFTER JUNE 1998

The Circumstances of the Referral

7.1 Until his arrest for the aggravated burglary, Mr A's support in the community had since 1992 been provided by the Probation Service, and the mental health services had provided only a succession of assessments; an offer in 1994 of anger management by a CPN had not been taken up by him. Although the individual probation orders were of no more than two years duration, the courts during this period made five new orders, so there was never a significant period of time during which he was *not* subject to an order.

7.2 The probation officers saw Mr A on a weekly basis at office interviews and had occasional contact with his mother, and their specialists helped him to get into further education and, eventually, employment. Their initial aims as set out in 1992 were to challenge and explore the reasons for his offending; to help him to work through the trauma of his abuse; to assist him to develop more positive and constructive use of his time; and to monitor progress and assess risk.

7.3 However, their efforts to involve Mr A with a specialist sex-abuse counsellor were unsuccessful, and although they considered undertaking this work themselves, since they had built up a relationship of trust with him, they recognised that it would be long-term and that it could not be completed within the timespan of a probation order. They continued, however, to be very concerned at the way in which the abuse still dominated his thinking, and about his unresolved intense hatred for his abuser and his feelings that he had not been protected by those responsible for his welfare. In 1993 a probation officer, concerned at the implications for his mental state, wrote that "*there is a real danger that, should he not receive appropriate help, his personality may fracture."*

7.4 The aggravated burglary in September 1996, which followed months of concern about his fixation with the female victim, marked what one probation officer called a *"turning point*" in their view of him, a view which was shared by the police. Up to that point, the nature of his offences had not been especially abnormal in the context of persistent offenders generally, and they did not see the risk of serious violence as being very high, but the particular circumstances of this offence, and his subsequent lack of understanding or remorse, together with evidence of deteriorating mental state whilst he was in prison, caused them to conclude that he was potentially dangerous, and they therefore triggered their pre-release risk assessment process and made the referral to the special care service at Lynfield Mount. They clearly felt that he needed more therapeutic input than they could provide, but in addition to that, they could only supervise him after release for two-thirds of his licence, which would mean a total of just over six months. They were, therefore, looking to the local forensic service to provide the long-term therapy and management of risk which they had neither the expertise nor the legal remit to carry out.

Expectations of a District Forensic Service.

7.5 Before we examine in detail the care which was provided to Mr A by the Bradford special care service, it is necessary to consider what is a reasonable expectation of a district outpatient service of this nature, as compared with the mainstream mental health service. The development of national standards for mental health services is still in its infancy, and the Department of Health Specialised Services National Definitions Set focuses primarily on the inpatient element of local services. The definition it gives for "Low Secure Forensic Care" is "*care delivered by a forensic team....distinct from similar services provided by general mental health services. The person admitted to these services usually presents with behaviour at a level of risk greater than general mental health services could safely address."*

7.6 In this definition, risk appears to be the defining factor. It would, therefore, be reasonable to assume, first of all, that a forensic service would place a greater emphasis than would a general service on the protection of the public, and secondly that it would have both greater expertise, and better-developed systems and processes, in the area of risk assessment and management; and that this would apply both to its in-patient and its out-patient services.

7.7 It follows from this that, since the Care Programme Approach is intended to be targeted on those patients who present the highest risk, it should be best-developed within the forensic element of a district service; and in particular, that there would be a stronger emphasis on a multi-disciplinary approach to risk assessment and management, which is accepted as being especially important in complex high-risk cases. Given its higher staff-patient ratio and lower turnover, a forensic service should be able to engage in much more detailed care planning and implementation and should be better able to ensure that contact is maintained with patients in the community. It should also have good liaison with the criminal justice agencies, and in particular with the Probation Service when the two services have patients/clients in common.

7.8 In addition, it is reasonable to expect that a forensic service would have expertise, or access to expertise, in a wider range of mental disorders than would a general service which focuses primarily on serious mental illness. In particular, it should be equipped to address issues relating to personality disorder, acquired brain injury and drug or alcohol misuse, areas which a general service might regard as peripheral to its central concerns but which are strongly associated with a high risk of harm to others.

The Initial Assessment Process

7.9 The referral from Probation was passed from the consultant psychiatrist at Lynfield Mount to the consultant psychologist, on the basis that the primary problem appeared to be personality disorder rather than mental illness, and it was then assessed by him personally without the involvement of any other member of the multi-disciplinary team. At that time, there was no system in operation of team scrutiny of incoming referrals, or team review of assessments. Due to pressure of work, the psychologist was unable to see Mr A to begin the assessment until three weeks prior to his release from Armley prison; he then continued to see him as an outpatient, having at least 12 sessions with him over the next 10 months.

7.10 The main purpose of these sessions appears to have been to acquire history and to establish trust and rapport as the basis for long-term counselling in relation to the sexual abuse. This was, however, a slow process since Mr A could not "stay on task" for prolonged periods, although he *was* able to co-operate with psychometric testing aimed at defining the nature of his personality difficulties. The psychologist noted the findings of the tests carried out in prison which had identified a high likelihood of frontal lobe disorder, and the subsequent finding by a forensic psychiatrist of an organic personality disorder.

7.11 He does not, however, appear to have liaised with Probation (who had at least limited contact with Mr A for the first six months after release) or to have sought access to their records as support for the history which he was slowly obtaining from Mr A himself. Since he had not been present at the pre-release risk assessment meeting in December 1997, and no further meeting was convened, he does not appear to have been in a position to fully understand the concerns of Probation and the Police which had led to the referral. Whilst Probation had certainly been looking for several years for someone to provide long-term counselling in relation to the sexual abuse, they were also looking for the specialist forensic service to assess and manage the risk, to others outside Mr A's family, that they had identified following the aggravated burglary.

7.12 However, although details of this offence, including witness statements, could have been obtained through Probation, together with the supervising probation officers' observations over the months preceding it, the psychologist made no attempt to obtain this information or to analyse it, and he admitted in interview that he was "*never able to get a full picture of what happened there from Mr A and so...there was the potential for more serious harm but we were not able to work with the specific circumstances that were antecedent or precursors to it because we did not know what they were."*

7.13 In fact, there is no evidence in the notes that the psychologist began to explore Mr A's offending history *at all* until September 1998, three months after his release, and the initial focus then was on his much earlier history of motoring offences. There are, however, three references in the first six months to new behaviour which had at least some overtones of that which had caused Probation and the Police such concern. In May 1998, whilst still in Armley prison, he told the psychologist of another girl who he believed had had his child, who he regarded as "his" and who he was going to live with on release; in October the psychologist noted "*concern about rejection from women who Mr A is attempting to talk to*;" and in December he was reported as having "*been hit by a friend for attempting to take friend's girlfriend*."

7.14 In addition, although Mr A was living with his mother, and the psychologist acknowledged in interview that she was the most likely victim of any further violence, there was no recorded exploration of Mr A's feelings or behaviour towards her or indeed any contact with her until she initiated this herself in October 1998. When the psychologist finally met with her in February 1999, the notes contain no observations about circumstances at home, apart from a brief reference to continued expression of paranoid ideas, and the main purpose of the meeting would appear to have been to obtain additional history about the abuse.

7.15 However, as a result of what Mr A had been telling him about "*friction and arguments*" at home, together with phone calls from both parents, the psychologist in April 1999 made a request for a home assessment by a community psychiatric nurse.

Risk assessment, initial care planning, and compliance with the Care Programme Approach (CPA.)

7.16 The CPA policy in force at that time, dating from 1996 and revised in June 1997, required all cases open to the mental health service to be registered, although in the case of the lowest level, "minimal CPA" there was no requirement for documentation other than the registration form, provided that an assessment and plan of action was in the running record. However, any patient "*who is considered to be at significant risk of harm to others*" was required to be on full CPA *and* the supervision register, in which case "*records will be kept of warning indicators and past history indicating risk*."

7.17 Since risk is the main reason for the existence for a forensic service, and since Mr A had been referred to that service specifically because of risk to others, he should at least have been *considered* for inclusion on the supervision register. This would have required a multi-disciplinary meeting including the consultant psychiatrist, and although it is not explicit in the policy, it is clearly implicit that any decision *not* to place a patient on the register when there was evidence of risk should have been clearly recorded, with reasons.

7.18 However, the service did not at the time have any agreed definition of what constituted a "significant risk". From the interviews with the three staff who had most contact with Mr A, they appeared to hold widely varying views as to the level or nature of the risk which he posed, and it was not clear that they were speaking a common language when they used terms such as "high" or "low" risk, or indeed that they were speaking the same language as Probation or their colleagues in the acute mental health service.

7.19 In interview, the consultant psychologist identified the primary risk as being to Mr A's mother; he saw the previous assault on his sister, and the aggravated burglary, as being "*quite isolated*" and "*did not believe that there was a significant risk of him assaulting someone outside the family framework*." He acknowledged that Mr A frequently made threats against former abusers or people whom he felt had wronged him, but "*put great store by the fact that his threats were not followed by any concerted action to enact them*". However, in relation to the aggravated burglary, where Mr A had sought out and attacked a man against whom he had long held a grudge, the psychologist accepted that "*he had certainly exhibited some form of planning*."

7.20 The CPN also thought that there was a danger of impulsive violence towards Mr A's mother, but thought that Mr A was himself at risk from the responses which his disinhibited behaviour could attract, and did not think that he was a significant risk to anyone outside the immediate household. However, in interview Mr A's mother said that he continued to visit his sisters and "*two of them didn't know how to back off...violence could erupt easily...my grandchildren weren't safe in case they were there and he started chucking stuff."*

7.21 The consultant psychiatrist, whilst agreeing that the primary risk was to his mother, saw him as at *"high long-term risk of violence to others*," and the probation officers, in their closing summary in 1999, reiterated their previous view that "*the chances of Mr A reoffending remain high, his behaviour is unpredictable, he can be violent and he seems to have no real victim awareness*."

7.22 Although the CPA policy required a risk assessment to be carried out, the formal multi-disciplinary risk assessment tool used for forensic inpatients had not yet been extended to community patients due to the amount of time required to complete it. Risk assessment was, therefore, in the words of the CPN "*based on how you felt as a team*". The CPN felt that, since there was very limited scope for changing Mr A's behaviour, a more formal risk assessment would not actually have altered what they did; however, (assuming that the level of risk was the reason for his being retained within the special care service) it would have been difficult, without a proper baseline, ever to reach the conclusion that the risk had abated to the point where he could be discharged or transferred to the mainstream service.

7.23 At the point at which Mr A was referred to the CPN, 10 months after his release, he had still not been registered for CPA, nor had the consultant psychologist drawn up a risk assessment, or even addressed risk in his running notes, or indeed drawn up any kind of care plan, formulation or summary, or sent any letter to the GP. <u>This was a clear breach of the policy requirements</u>.

7.24 The CPN was then designated as CPA key worker, but the consultant psychologist continued to act as "lead clinician" and he was also the CPN's clinical supervisor, there being no community team leader in the special care service. This was contrary to the CPA policy, which required first-level nurses acting as keyworkers to be under the supervision of a "G" grade nurse, and it was an unsatisfactory arrangement. The policy made it clear that the CPA key worker had "*accountability for and authority to undertake*" a series of tasks which included "*co-ordinating an assessment of the client's needs*" and "*ensuring that an individual care programme is agreed"* together with "*authority to take decisions regarding the aftercare of the client without first seeking approval*". However, since fulfilment of these tasks in this case would have required the key worker to insist on action by his supervisor, the CPN was clearly not possessed of sufficient autonomy or authority to discharge the key worker role; and in addition, there was a lack of objective clinical supervision by a professional not directly involved in the case.

7.25 The consultant psychologist was the sole member of his profession in the Bradford special care service, and was managerially responsible to the Clinical Director of the mental health service. In addition, he had an agreement for mutual supervision from a colleague who was in a similar post in another Trust. However, his colleague, in her written evidence to the inquiry, stated that the focus of their meetings was "*mainly upon forensic service development issues*" and specific clients were discussed only occasionally. She could not recall any discussion with the psychologist about Mr A prior to his arrest for the killing.

7.26 A CPA registration form was completed on 21 June 1999, recording Mr A as being at "low risk" of harm to others (which in this context would have included his mother, his sisters and their families.) The registration form simply recorded the planned inputs of time with a very brief statement of their purpose. It provided no space for a detailed care plan or risk assessment, but the expectation of the policy was that this would be incorporated into the running record; however, this was never done. In addition, there is no record that any consideration was given to his being placed on the supervision register, even though the consultant psychiatrist, who would have had to make that decision, had become involved by this time.

7.27 In the absence of any written statement of roles and objectives, it is difficult to establish from the record what precisely was intended to be the role of the CPN. It appears that he was asked initially to do a one-off assessment of home circumstances, but it would not in any case have been possible to do this at a single visit due to the difficulty of keeping Mr A "on task," and so he agreed to visit at fortnightly intervals. On the CPA registration form his role is described as to "*provide mental health monitoring and family support in the community*;" this is repeated unchanged on subsequent review forms, and the psychologist stated in interview that the CPN's role "*was primarily to offer family support*."

7.28 In practice, the CPN interpreted this as being an arbitrating and mediating role between Mr A and his mother, reducing tension and possible flashpoints by identifying specific situations and behaviours which led to discord, and helping Mr A to learn more appropriate ways of dealing with them, and this was identified in interview by both himself and the psychologist as their major input aimed at reducing risk. After June 2000, when the CPN was threatened by Mr A on a visit, they focused more attention on this area by visiting jointly.

7.29 However, the probation officers who had supervised Mr A in previous years had observed that he was least volatile when kept fully occupied, and of course it would also reduce his contact with his mother and his exposure to cannabis and alcohol. The Probation Service therefore targeted this area in its supervision plan. The CPN himself came to the same conclusion over time, but the psychologist admitted that its significance "*had not occurred to him*," and the failure to tap into this prior experience at the outset meant that filling his day with constructive activity was never given a sufficiently high priority as a means of reducing risk.

7.30 The CPN noted that when Mr A's computer broke down "*it was a big blow*," and his behaviour deteriorated, but this was not in any case an ideal way for Mr A to spend his time, as his main use of the computer was to access pornography sites and he ran up large phone bills which his mother had to pay. He attended a college course, and the CPN did put considerable effort into helping him to find a job, but, given Mr A's limitations, his chances of getting through an interview were slim, and his chances of holding a job for any length of time thereafter even less, and each rejection tended to add to his frustration and further depress his self-esteem. There was, however, no evidence of any concerted attempt to look for ways other than employment of occupying his time, for instance by involving other agencies, and the community team did not have any support workers who might have been able to spend more time with him than the CPN could afford.

Ongoing Work and Review

7.31 The plan, as from June 1999, was that the consultant psychologist and CPN would see Mr A on alternate weeks. However, whilst the pattern of the CPN's visits was maintained reasonably well, Mr A was an irregular attender for his out-patient appointments with the psychologist, often turning up late or on the wrong day, and when he did attend he was often not in a mood to do any therapeutic work and so the session was cut short. For this and other reasons, such as the cancellation by the psychologist of some sessions due to illness or to his leave arrangements, there were substantial gaps in the out-patient attendances, and during these periods he was seen only fortnightly by the CPN.

7.32 Both members of staff felt that progress, insofar as there was any, was very slow due to Mr A's highly-unstable mood and variable ability to focus on the major issues, together with his very limited ability to retain new behaviour or new insights. It was, as the psychologist said, always a question of "*working with the here and now*" and of hoping that advice which was constantly repeated would eventually bring some long-term benefit. The fortnightly visits by the CPN would appear to have had very little effect on the situation at home; although Mr A's mother was grateful for his visits, since "*we could both actually talk to him about our concerns without violence erupting,"* it was only possible to deal with the "issue of the moment" and a great many other issues could arise in the following fortnight. The CPN said that this frequency of visiting was not dictated primarily by workload, but was the normal practice for most patients in the community.

7.33 Four CPA review meetings were held on the due dates, but these involved just the consultant psychologist and the CPN except for one meeting in September 1999 which was attended by the consultant psychiatrist. The inquiry was told that both Mr A and his mother were notified verbally and invited to attend, but as the meetings were held at 9.00 on Monday morning "*as this was convenient for us*" it would seem that little priority was attached to getting them there. In interview, Mr A's GP said that he had not been invited to contribute to the reviews, and although he saw Mr A several times over a two-year period, the only communication he appears to have had, apart from the very brief CPA review forms, was letters from the consultant psychiatrist during the three-month period when Mr A was receiving medication.

7.34 The reviews did not result in any significant modification to the plan set out on the original registration form; in particular, the risk to others continued to be recorded as low. Both CPN and psychologist said in interview that, since positive change was such a slow and uncertain process, their assumption was that this input would have to go on perhaps for many years.

Accounts of Mr A's Personality, Mental State and Behaviour after June 1998

7.35 Since this was the first period during which Mr A had been under the *continuous* care of a mental health service, it is not easy to get a clear picture as to how his mental state and level of functioning compared to previous years for which, bearing in mind that the Probation running notes have been destroyed, the main record is only the occasional assessments by psychiatrists and psychologists, mainly in connection with court proceedings. His mother, however, said in interview that he had actually changed little since the road accident in 1991, and that in some ways his behaviour was

better during the period after 1998 than the period immediately following the accident, in that he was relatively less violent and destructive in the home.

7.36 This appears to be reflected also in his level of recorded offending, which, prior to the killing, was much lower in the period after 1998 than in the earlier period, consisting of nothing more than three convictions for "drunk and disorderly" whereas between 1991-96, in addition to the assaults on his mother and sister and the aggravated burglary, there had been a string of convictions for burglary, theft, criminal damage and motoring offences. The Police said that, certainly after 1998, they were aware of his mental impairments and he might be warned rather than prosecuted for minor infractions of public order, but a check of their records showed that such instances were not in fact many in number.

7.37 Mr A's mother also felt that it was difficult for professionals who saw him briefly once a fortnight to get a clear understanding of him due to his great volatility, and the fact that the consultant psychologist would never see him in a "black mood" as he would not, when in that frame of mind, keep his out-patient appointments. He could, she said, be pleasant and reasonable one minute, but then switch with minimal provocation to being verbally and physically violent. These changes were completely unpredictable and could be triggered by a few incautious words, and it was "*like walking on a minefield*." He would wake her during the night to ask questions or make statements to which she was expected to respond, and as he was very demanding and she was fearful of his likely reactions, she was anxious to give the answers he wanted. She felt that it was only when, in June 2000, he became violent during the CPN's visit, threatening him and damaging furniture, that both the staff took her reports seriously, and she said that there was then a marked change in their attitude.

7.38 The staff described Mr A's attitude to his mother as like that of a young child, or as a "*love-hate relationship*". He could show genuine warmth and concern, but he was very dependent on her, expecting her to wait on him hand and foot and to resolve problems such as the debts he got her into, as he would "*spend all his money the day he got it*" and then run up huge phone bills on the Internet, in addition to fines for minor public order offences. He was constantly arguing with her, being "always in the right," and was *"keen to let her be aware of his level of anger and frustration about the sexual abuse".* In previous years he had blamed her for not protecting him from abuse, and this appears to have been a persistent undercurrent in their relationship.

7.39 His mother also confirmed that paranoid ideas would surface from time to time, but again, this was not a new phenomenon; she recalled that, even before his prison sentence for the aggravated burglary, he had expressed the belief that she was poisoning him. However, such thoughts came and went, and were quickly replaced by others, often of a hypochondriacal nature. He also reported twice to his GP with what appeared to be hypochondriacal delusions or at least over-valued ideas, but, as there was no effective liaison between the GP and the forensic service, this information was never passed on.

7.40 There was, however, a fairly persistent delusion, that he was related to the Belgian film star and body-builder Jean Claude Van Damme, which had first been noted in prison by a probation officer; this continued to surface from time to time, even when he was otherwise relatively well. It had a slender basis in reality, in that he had a relative with a similar surname who had lived in Belgium and later Germany, and it appeared also to link with his obsession with body-building, which in turn seems to have been a means of boosting his self-esteem. The delusion appears to have been held with increasing intensity, although the Senior Medical Officer at Armley prison said to the panel that "*it was always said with humour....as if he was deliberately creating a fiction*."

7.41 In May 1999 the CPN, who had started visiting the previous month, noted that he was expressing a number of paranoid ideas, including the belief that his mother was poisoning his food, that the house and phone were bugged, and that the psychologist was in some way "*involved in the scheme of things*". There were also reports of his being very disinhibited in public, for instance doing press-ups in public places, so the CPN arranged for him to see the consultant psychiatrist.

7.42 The psychiatrist found that he had some paranoid ideas but also some insight, and that the illness process, if any, was at "*an early stage*". She thought (as did the CPN) that the paranoia might be a consequence of cannabis use, or - more likely - that it was decompensation as a result of the stress of the therapeutic work he was doing with the consultant psychologist. She started him on a low dose of an anti-psychotic, which was later increased.

7.43 The psychologist had been aware of the previous reports of paranoid ideas and indeed had observed these on his first interview with Mr A. He felt, however, that due to their transitory nature they were more consistent with decompensation at times of stress than with a true psychosis, and he also thought that he was "*much more likely to be disinhibited when he drank alcohol, and paranoid when he smoked cannabis*." The psychometric testing which he carried out at the start of the assessment, and which largely confirmed the previous subjective descriptions of Mr A's personality, recorded a high score for features of an anxiety disorder, and there is evidence at several points in his history since 1991 that his thinking could become disorganised, along with marked pressure of speech, when he was in situations which were likely to generate stress or anxiety.

7.44 Mr A's mother also observed a very strong relationship between cannabis use and paranoia, but felt that alcohol had much the same effect, and in some ways was worse since the effects lasted longer. Both substances appeared to have a heightened and prolonged effect on him; he claimed not to drink more than four pints at a time, but was frequently in trouble for being "drunk and disorderly," and his mother said that the effects of either substance would be apparent for at least three days afterwards.

7.45 The staff's approach to this was to counsel him on a regular basis about the drawbacks of both cannabis and alcohol, but his mother said that this had little effect because, although he "*always wanted to stop*," he would not be able to resist the temptation when he had one of his frequent downswings of mood.

7.46 The initial response to the antipsychotic was encouraging. At his outpatient appointment a month later he was reported as being happy with it; he no longer thought his family were against him, and his thoughts were noted to be more ordered and his listening skills improved. His mother also felt that it had had a positive effect; however, after three months he stopped it and could not be persuaded to restart. His explanation to the psychiatrist was that it made him "*paranoid*;" it caused him to fall deeply asleep, and when he woke up he felt that someone might have "*messed with him*." He repeated this explanation when interviewed for this inquiry. His mother said that he was often awake during the night; there are several reports of his going without sleep for long periods, and it appears that he had a long-standing fear of being abused during his sleep which may well have stemmed from his experiences in childhood.

7.47 Three months later there was a further report that he believed his mother was poisoning him, and that there was a great deal of tension between them. However, this did not result in a re-referral to the psychiatrist. At around the same time the consultant psychologist noted that he had been "*more chaotic*" over the previous three months, possibly due to cannabis use, and had not as a result been able to engage in any meaningful therapy. In June 2000 he was reported to have spent five days in London, "*looking for Kylie Minogue in order that she could pass on a message to Jean Claude Van Damme*" whom he believed to be his cousin and a witness to the abuse he had suffered.

7.48 The internal review of Mr A's care and treatment, which was carried out by the Trust following the murder, thought that this particular incident was very significant and might indicate the onset of a true psychosis. However, as has been indicated, the delusion about Jean Claude Van Damme had been present, at some level of intensity, for at least four years previously. In addition, whilst there is no note of any other trip to London apart from the one in 1993 when he was sexually assaulted, his mother said in interview that such journeys were common. He was obsessed with celebrities, and having (she believed) on one trip met Melinda Messenger, "*he wanted to keep going back*". He also made regular trips to other towns in the region, apparently in order to escape boredom and the tense atmosphere at home, and to get away from the area where he was known.

Summary - Accounts of Mr A's Personality, Mental State and Behaviour after June 1998

7.49 Although the CPN and the psychologist were expressing increasing concerns about Mr A's volatility in the period immediately prior to the killing, it is by no means clear that this represented a genuine deterioration, as opposed to their increasing awareness - following the threats to the CPN - of a situation which had in fact existed for some considerable time. His mother certainly felt that the latter was the case, and that in fact his mental state was rather better in the weeks preceding the killing than for some time previously. Overall, the record does not indicate that there was any major, sustained change in his mental state between his release from prison in June 1998 and his arrest for the killing in September 2000; rather, there was a pattern of great fluctuation in the way he behaved and presented.

7.50 Equally, there is no evidence of a *substantial* difference between his mental state post June 1998 and that which had been observed in the period between his head injury in 1991 and his arrest for the aggravated burglary in 1996. After his arrest, when he was on remand and then serving his sentence, there was concern about a heightened level of disturbed behaviour and paranoid thinking, but this might well be explained by the nature of the prison setting, by closer observation, by the availability of cannabis or by the temporary exacerbation of his existing brain damage by the second head injury, and his behaviour after release appeared to revert to a similar pattern to that reported prior to his arrest.

7.51 This pattern was generally consistent with the 1997 diagnosis of organic personality disorder and with the impulsiveness, loss of inhibition and poor social judgement commonly associated with frontal lobe damage, and, as is again common in such cases, it was accompanied by an exaggerated response to alcohol and cannabis use and to circumstances which would generate frustration or anxiety. Although he had been impulsive and lacking in judgement as an adolescent prior to his road accident, in the absence of any brain damage there would normally have been signs of maturation by his late 20s.

7.52 Although delusional ideas, often of a paranoid nature, surfaced from time to time, these were never persistent or pervasive, and there is no evidence of a developing illness process. It is also questionable whether he met the criteria for a dissocial or antisocial personality disorder, which would have raised questions about his "treatability". There was no clear evidence of a persistent conduct disorder in childhood, and although his behaviour was frequently anti-social, he could at times demonstrate genuine warmth and remorse, and in the words of the consultant psychologist he "*did not appear to have the belief systems you see in people with an anti-social personality disorder...the sense of entitlement and inability to have any understanding of other peoples' perspective*". The internal review gave his diagnosis as "*borderline personality disorder arising from sexual abuse"* but there is no reference to such a diagnosis in any of the documentation, nor did it arise during the interviews.

7.53 However, even if he did not have a dissocial personality disorder, his impulsivity and concern only for the moment meant that he was rarely able to stop and think about the effect his behaviour was having on others, and by the same token he could not hold onto insights, which *"would disappear just as quickly as they arrived*". For this reason he was not suitable for insight-oriented psychotherapy, and the psychologist described his role as one of "*psychological containment*."

7.54 It was clear that the sexual abuse still intruded constantly into his thinking, but that due to his impulsivity he lacked the mental resources to cope with the powerful feelings which this could generate. He was frequently anxious about his sexuality and about the possibility that anyone who knew about the abuse, or knew that he had been segregated as a "vulnerable prisoner" might think that he was homosexual or that he was himself an abuser. His attitude to homosexuals was ambivalent, and although he often spoke in derogatory terms about them, he sometimes visited gay bars and laid himself open to sexual approaches.

Observations - Mr A's Care and Treatment post June 1998

7.55 There is no doubt that Mr A fitted the criteria for referral to a district forensic outpatient service. He had, first of all, a serious mental disorder (or more precisely, a number of disorders which had the cumulative effect of producing a serious impairment of normal mental functioning.) Secondly, at least some of his offending, and especially the "index offence" of the aggravated burglary in 1996, could be directly related to one or more of those disorders. Thirdly, he presented a continuing risk of serious harm to others, based not just on the subjective judgement of professionals but also on his objective record. However, he did not meet the criteria for detention under the Mental Health Act, not just because of the doubts about his "treatability," but also because the level of previous offending or of identified risk, whilst significant, would not have been sufficient to justify the long-term use of a scarce and expensive secure placement.

7.56 It was clear, also, from the previous history and the succession of professional opinions, that there was very little scope for bringing about any fundamental change in his mental processes, not least because of the irreversible effects of his brain injury. In such cases, the best that can realistically be achieved is small, incremental changes in actual behaviour, and then only by targeting input to the areas most likely to achieve results. Where the person himself has very little ability to change, direct psychotherapy or counselling of any kind should not be the sole or even the primary intervention, and priority should be given to manipulating or reordering his environment, as far as this is possible, in order to remove potential sources of stress or conflict and to provide structure, consistency, and occupation. In Mr A's case, there was already a succession of observations to the effect that he functioned best when in such an environment; however, it is far more difficult to achieve this when the person is in the community than when they are in a closed institution.

7.57 In addition, given that the purpose of his being referred to a forensic service was to address concern about risk to others, and that that risk would be present again from the day of his release, it was essential that attention should be paid to ways of reducing *immediate* risk as well as to effecting long-term change. However, the service failed to recognise or to address the concerns of the referring agency or to make an assessment of short-term risk. The consultant psychologist, as his sole intervention, embarked on at least the exploratory stage of long-term psychotherapy; this was not in itself inappropriate, and indeed had been recognised for years as an unmet need, but although it did hold out the possibility of an *eventual* reduction in risk, it was not likely to reduce it in the short-to-medium term and might even increase it due to "decompensation". In so doing the psychologist did not properly investigate the circumstances of the then "index offence," the aggravated burglary; he was very slow even to recognise the well-established risks to Mr A's mother; and he did not appreciate that there might be even greater risks to his sisters and their families, given that they had less skill in handling him and that there were young children present.

7.58 This failing might have been corrected if there had been a proper process of multi-disciplinary assessment and review within the service, but it was said to the panel that the weekly team meetings were not long enough for a systematic review of cases, and the psychologist was effectively left to make all the decisions on his own. Even when, after 10 months, he brought in a colleague, the CPN was subordinate to him and not in a position to exert the necessary authority as key worker to ensure that CPA processes were followed. There was, in particular, no input, other than for a brief three-month period, from the psychiatrist, or any input at all from a social worker, both of whom might have been expected to bring different and broader perspectives to the assessment of the case.

7.59 The CPA policy was not fully implemented at any stage. Although staff in mental health services often feel that CPA procedures are oppressive and bureaucratic, and of marginal value in terms of actual case management, full compliance with the CPA requirements from the outset would in this particular case have prevented the major failures in assessment and care planning. However, not even the CPA procedures could have compensated for the vagueness which was apparent in the service's approach to the assessment and grading of risk.

7.60 As a consequence of the failure to make a broad assessment or to draw up a proper intervention strategy, the psychologist and the CPN spent a great deal of time on a narrow range of interventions which proved, by their own evaluation, to be of very limited effectiveness, whilst failing to consider or to explore other approaches which might have been more productive. For instance, whilst the CPN did put considerable effort into helping Mr A look for a job, he recognised at the same time that if he found one he was unlikely to hold it for more than a few days, and his time might have been better spent in looking for ways to occupy Mr A other than in paid employment, perhaps with the assistance of other agencies.

7.61 By the same token, whilst all the professionals at Lynfield Mount accepted the previous finding of frontal lobe impairment and an organic personality disorder consequent on the head injury, there was insufficient consideration of the implications of this. The interventions employed involved brief contacts at, at best, two to three-weekly intervals, which was "standard practice" for community patients of the service. However, these interventions were recognised as being largely ineffective due to Mr A's impulsiveness and inability to retain new learning from one session to the next; but these are common features of acquired brain injury, and services specialising in this type of problem adopt different patterns of intervention which are designed to maximise learning. Expertise of this nature was available in Bradford in the Head Injury Rehabilitation Team provided by Social Services, but it was never accessed.

7.62 It was also recognised that alcohol and cannabis use were major factors in destabilising his mental state and increasing risk, but the approach adopted never went beyond exhortations to desist, which, given his difficulty in thinking other than for the moment, were unlikely to have any effect. His mother indicated that his use of these substances was directly related to fluctuations in his mood and that he was at least to some extent "self-medicating," but although this is a very common phenomenon there is no evidence of any attempt to explore its significance. Substance misuse is an area of particular difficulty in relation to people with acquired brain injury, and there is no

certainty that anyone else would have had an answer to it, but it was certainly a problem which should have been shared with the multi-disciplinary team and with the local agencies specialising in brain injury and substance misuse.

7.63 Finally, although there was clear evidence that the antipsychotic medication had had at least some beneficial effect, the issue was not pursued further after Mr A refused it, and the psychiatrist immediately discharged him from her clinic. Even if there was no underlying psychotic illness, the medication may well have been having a positive effect by reducing his level of anxiety and arousal. There is no certainty that he could have been persuaded to restart it, but the issue should at least have been kept "live" and his mental state monitored over a period by means of repeat out-patient appointments, or at the very least by a re-referral when the paranoid delusions began to surface again. Although one of the CPN's roles, as defined in the CPA documentation, was to monitor mental state, his primary focus was on mediation between Mr A and his mother, and there is no evidence that he was re-assessing Mr A's mental state in any systematic way, either by monitoring against agreed "relapse indicators" or by exploring for signs of disordered thinking.

7.64 One factor which may go some way to explain these failings is that both the consultant psychologist and the CPN were relatively new to their particular roles. The CPN had gained his experience mostly in secure forensic units, had not had any formal training for community work nor worked in a large community team under an experienced CPN, and had moved out from the secure ward into the community only about 12 months before taking on Mr A's case. By the same token, there was also a dearth of community experience amongst the nurse managers in the service.

7.65 The consultant psychologist, who was the CPN's clinical supervisor, and who had previously worked at the Regional Forensic Service, had been working at a secure unit in the independent sector for three years until his appointment to the Lynfield Mount post in October 1997, which was around the time that Mr A was first referred by Probation. The assumption of his consultant psychiatrist colleague appears to have been that, as he was a consultant forensic clinical psychologist, he would fall into the over-arching role which has traditionally been adopted by the consultant psychiatrist in this type of service, and which was embodied in the CPA policy, and that she could simply act as, in her words, "*an adjunct*," coming in to act in a narrow medical role as and when requested. In practice, however, the psychologist continued to act largely as a specialist therapist rather than taking on board the overall responsibility for planning and managing a full package of care for Mr A.

7.66 This did, however, appear to be a failure on the part of one individual to understand what was expected of him in this particular situation and it does not undermine the principle that overall clinical responsibility should ideally be assigned by the multi-disciplinary team to the consultant professional who has the most appropriate skills in the particular case. In Mr A's case, that was clearly the consultant psychologist.

7.67 In addition, some responsibility must attach to the service management which had a duty to ensure that, as he was a new member of staff in a new role, the expectations of that role were clearly defined and that he (and his colleagues) understood them. The role of consultant psychiatrist is well understood both by postholders themselves and by their colleagues, but it cannot be assumed that consultants in other professions will automatically fall into a similar role.

8 MR B – HISTORY

Background

8.1 Mr B was aged 39 at the time of his death, and had lived in Bradford most of his life. He had a learning disability, which his family believed to be the result of a head injury when he was aged 5, although this could not be confirmed from the records which were available to the inquiry. He had attended a special school, as had all but one of his seven brothers and sisters, and although he seems to have been the least able member of the family, two of his brothers also needed some support from the rest of the family in adult life. According to the Social Services records, family members "*tended to become fractious with one another*". Mr B senior died in 1984; Mr B continued to live with his mother until March 1999 when she moved to Wakefield, and she gave evidence to the inquiry.

8.2 The family was well-known to Social Services throughout Mr B's life, and assessments show that he was thought to have no more than a mild learning disability, but that this was compounded by the family environment and the reluctance of his mother and sisters to allow him to take more responsibility for himself and to develop self-care skills. As a result, he appeared to function well below his potential. He did, however, have basic self-caring abilities and could get around by himself on public transport, and indeed, he appears to have spent much of his time travelling by bus around Bradford and West Yorkshire. It was said by witnesses that his interpersonal skills were adequate, but that he was often looking for friendship and could be over-friendly, and that strangers might perceive him to be vulnerable.

8.3 In 1982 he developed a psychotic illness which responded well to treatment with a depot injection, supplemented at times by oral antipsychotics and benzodiazepines. For the next 12 years he attended outpatients and there was little overall change in his mental state, with his depot being increased or decreased as minor symptoms or side-effects came and went. His mother from time to time reported him to be argumentative, disturbed or violent at home, and in interview it was clear that she saw this type of behaviour as being a symptom of his illness which needed to be controlled by medication.

8.4 However, any acute symptoms would disappear quickly after admission to Lynfield Mount, and without any increase in his medication, and it appeared to the staff that they were the result, not of any major change in his mental state, but of upheaval within the family, and of his limited ability to cope with this and with his own anxieties and frustrations. He was on occasion given respite at such times in a learning disability hostel, but it appears from the records that his family preferred him to be in hospital as he did not have to pay for it.

8.5 Until 1989 Mr B remained an on-going case to the learning disability arm of Social Services, but the case was then closed as the staff felt that they could not achieve anything useful for him in view of his family's lack of co-operation. From then on the service merely responded to referrals. In 1993 responsibility for the case briefly alternated between the learning disability and mental health teams, and this occurred again in 1999 although agreement was eventually reached to share it; this issue is discussed in more detail in Section 12.

8.6 From 1994 onwards there was a progressive change in the way he presented at times of family crisis, in that he tended to be reported more frequently as being depressed, but again, the periods of depression were of short duration. In March 1999, after yet another very brief admission to Lynfield Mount, he was discharged to stay with one of his brothers, his mother having refused to have him back because of his behaviour.

Care from January 2000 Onwards.

8.7 In October 1999 Mr B moved to live in a flat on his own, supported mainly by his sister as his mother had moved to Wakefield. He had never lived on his own before, however, and when after Christmas 1999 his sister's input was reduced, as she had got a full-time job, it became apparent that he was unable to cope. His self-care deteriorated rapidly and he allowed visitors into his flat who stole his property. He was given respite care by Social Services in February, but after two days was adamant that he wanted to return home, so support was arranged from a home care agency. This was, however, only three one-hour visits per week, so a good deal was still left to the family.

8.8 A CPA meeting was held on 5 July 2000 attended by Mr B's mother and his sister, although Mr B himself declined to attend. The minutes record a number of causes for concern which had built up over the previous six months:

- poor self-care in his flat, related not to lack of essential skills but to emotional isolation and loneliness. He was reported as walking around naked in his flat and wearing his clothes inside-out, and he appeared tearful and under stress,
- his need for company made him vulnerable to exploitation,
- he was verbally hostile to his mother and sister,
- he was taking tablets excessively and haphazardly,
- his family were worn out with the strain of caring for him,
- he refused to go to day care.

8.9 A decision was taken to increase the support from the agency, to take steps to control his use of oral medication and to look for supported accommodation. However, in early August the agency withdrew, due to allegations against its staff by Mr B and what it regarded as unjustified criticism by his mother.

8.10 On 8 August Mr B was brought to Lynfield Mount by the Police following a heated argument at his sister's house in which he made threats of suicide, but he settled quickly on the ward and denied any suicidal intent. He then appears to have come under the influence of another relative, who his mother regarded as being primarily interested in gaining access to his money. He ignored his mother's warnings and, as this relative was offering to look after him, he requested discharge back to his flat. There being no evidence of any acute mental illness, he was discharged on 16 August 2000.

8.11 He was readmitted on the 22nd, having been brought to hospital by his mother. There was no suggestion on this occasion of violence or disturbed behaviour, but his mother was concerned about his inability to cope in his flat, and especially that he was being mistreated by his relative. As it appeared that the care arrangements had broken down, he was admitted for "social reasons" to ensure his well-being until alternative arrangements could be put in place. It was said to the inquiry that such admissions were not unusual in the case of patients who were very well-known to the service, if there was no reasonable alternative.

8.12 The ward staff found him to be much the same as on the previous admission, and their main concerns during his stay were about his physical rather than his mental health. After his admission his family surrendered his tenancy, thus leaving him homeless and ruling out any further attempt to return him to his flat with support. Whilst Mr B wanted to return to the flat, the professional view was in any case that he would be better in fully-staffed accommodation if it could be found, and the mental health and learning disability teams, working jointly, looked for suitable provision to which he could be discharged. Whilst some possibilities had been identified, nothing had been finalised at the time of his death, and it was possible that he would have needed to remain on the ward for several more weeks.

8.13 However, it was clear that, after many years during which he had been very reluctant to leave home, Mr B had now got used to having more freedom, and as the weeks passed he became increasingly frustrated by the length of his stay and the apparent lack of progress in finding accommodation. To this was added frustration over money; his mother would cash his benefits book and bring the money to the hospital, but she then asked the staff to issue it to him at no more than £5 per day, as he had no concept of budgeting and would spend everything he had unless controls were exercised. In practice this proved to be very difficult to achieve, as the staff had no legal authority to withhold the money from him if he insisted on having it, and could only use persuasion.

8.14 At the beginning of September his mother went on holiday for a fortnight; she made arrangements for him to receive his money, but the arrangements broke down and the Benefits Agency sent the giros to her address in Wakefield, where they could not be accessed. Mr B therefore ran short of funds, and this added to his frustration. He began to demand the keys to his flat or to threaten to discharge himself, and on 15 September he said he would "*rather be homeless than stay in this place*". The duty doctor and his social worker both came to the ward and he was persuaded to stay, although the social worker was concerned about his agitated and confused state of mind and thought that he would have been detainable under the Mental Health Act if he had not agreed to remain.

8.15 It is possible that, in addition to frustration about lack of accommodation and money, he may also have been suffering from a benzodiazepine withdrawal syndrome. Prior to the CPA meeting in June he had been on a regular prescription of 1mg of lorazepam, in two 0.5 mg doses per day, together with chlorpromazine, but concern was expressed that he was not taking it reliably and that there were "*stocks of tablets around the house*," and so the consultant wrote to the GP on 24 July asking that both prescriptions should be

gradually reduced, in the case of the lorazepam in 0.5 mg steps, with a view to stopping them altogether.

8.16 The GP records show that the first reduction in the lorazepam was made on 2 August. When Mr B was admitted to Lynfield Mount six days later, the admitting doctor noted his account that he was taking "*blue tablets plus an injection,"* and also noted that "*the medication needs to be checked"* (with the GP). This should have been done by the admitting doctor himself, but was not done, so the staff were not aware that he was still on a regular dose of lorazepam which had only just been reduced. Apart from two "as required" doses of 1 mg lorazepam a few days after admission, plus occasional sleeping tablets, he was given no more benzodiazepines, and when he was out of hospital for six days in August the GP refused a further prescription as he had been informed by the hospital that all oral medication had been stopped.

8.17 Mr B's mother said in interview that when she saw him on 18 September following her return from holiday he was "*high as the sky,"* and she felt that he was not on sufficient medication. However, apart from the isolated report of a period of apparent confusion on 15 September, the ward staff did not observe anything which they regarded as an abnormal mental state, as opposed to irritability, and whilst the withdrawal from lorazepam might have contributed, this irritability was largely understandable in view of Mr B's increasing frustration at the situation he was in. He had also been taking the oral medication for many years, and it would have had the effect of blunting his arousal and making him more docile, so it is understandable that his mother would have noticed a considerable difference in him after it was stopped.

Observations - Mr B

8.18 Mr B was not someone whose needs fitted into the traditional pattern of services. He had only a mild learning disability, which meant that he did not mix well with the users of learning disability hostels and day centres, who would mostly have moderate-to-severe disabilities; but at the same time he did not have enough social or self-care skills to cope on his own or to protect himself against exploitation. In addition, he had a mental illness; however, his symptoms were always at a low level and there is no evidence that the illness ever had more than a marginal effect on his level of functioning. His primary disability was his learning disability, coupled with the effects of his family background and his failure to develop an adequate level of living skills due to his long-standing dependence on his family.

8.19 In social policy terms he could be classified as a "vulnerable adult," the Law Commission's definition of which is *"a person who is or may be in need of community care services by reason of mental or other disability, age or illness, and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation".* However, his level of disability was not such that he lacked the capacity in law to make important decisions about his life, and nor was he so vulnerable on a day-to-day basis as to justify any legal restrictions on his freedom.

8.20 His last admission to Lynfield Mount was purely for "social reasons," and it would have been more appropriate for him to be housed in Social Services residential accommodation if it had been available. Whilst the staff had a "duty of care" to ensure that his personal care needs were met, and to monitor his physical and mental health, and they did these things, they did not have any grounds for restricting his normal freedom of movement, even if they had been legally able to do so. He was undoubtedly vulnerable, and the staff were well aware of this, but he was no more vulnerable than he had been throughout his adult life, and the records show that throughout his stay he maintained his usual lifestyle and spent much of his time off the ward, travelling around.

8.21 There was a failure by the admitting doctor to check his pre-admission medication, which in other circumstances might have been serious. However, this appeared to have been an isolated oversight by an individual rather than any weakness in procedures. In this particular case, it did not have any major detrimental effect on Mr B's care or well-being, nor was the reduction in his overall level of medication inappropriate. Tranquillising medication can depress the mental abilities of people with a learning disability and thereby make it more difficult for them to learn new skills or to function independently, and the consultant was rightly concerned that he should not be given powerful drugs unless they were strictly necessary to control an underlying mental illness.

9 THE KILLING

Previous Contacts Between Mr B and Mr A

9.1 Mr A stated after his arrest that he had first met Mr B in 1987, when he was aged 12 and Mr B was 26. The two families lived close to one another on the Allerton estate in Bradford, and the man who abused Mr A also lived nearby. Mr A claimed that Mr B was the abuser's "*best friend*," but the abuser himself, who was interviewed by the police after the killing, denied this and described Mr B as no more than a *"loose associate*". Whatever the truth of this, there is no doubt - and this was confirmed in interview by the mothers of both of them - that Mr B and Mr A were friends of the abuser during the same period, and that each knew of the existence of the other. Mr A's mother recalled that at one point, Mr B had actually visited their house.

9.2 Mr A later alleged that Mr B had "*known about the abuse*" although he said that he had never witnessed it directly. There is no evidence to substantiate this, but what is known, from the Social Services record of the time, is that the abuser was an obsessive, persistent homosexual paedophile who took photographs of his victims, including Mr A, and who kept large numbers of photographs in his flat and exchanged them with other contacts. The panel's view is that, whether or not Mr B *did* know about the abuse, it is understandable, given that the abuser behaved in this way, that Mr A assumed that Mr B would have known about it.

9.3 After the abuser was arrested in 1988 and Mr A was taken into care, there is no evidence of any further contact between Mr B and Mr A for 12 years. However, Mr A's mother said that Mr B was very distinctive in appearance and behaviour and was often to be seen around the town, and much the same could be said about Mr A, so it is quite possible that they had at least caught sight of one another over the years. Mr A said that, in June 2000, when he was returning from his trip to London to make contact with his supposed cousin Jean Claude van Damme, he came briefly face-to-face with Mr B as he was passing through the Interchange (Bradford's central bus station); Mr B, he said, appeared to recognise him when he nodded to him, but then looked away. This appears to have triggered memories from the past - Mr A said in interview that at this point he "*started to think about Mr B."*

9.4 Mr A's mother also said in interview that "*a few weeks before*" the killing, Mr B had approached her in a cafe at the Interchange and had asked for her address as he wanted to visit Mr A. She would not tell him, however, and she did not relate this conversation to Mr A. It does appear, therefore, that during the summer of 2000, Mr A and Mr B had each been thinking about the other, perhaps because a chance meeting had revived old memories for both of them.

9.5 There is no evidence to suggest that they ever had any contact with one another through the mental health services or that either of them was aware that the other was known to those services. They each dealt with a different arm of the service, and their visits to the Lynfield Mount site were far less frequent than their visits to the Interchange; Mr A went to Lynfield Mount only for his out-patient appointments, and Mr B only at those times when he was an inpatient, his depot injection being given at a community clinic or at home. Both, however, were regular visitors to the Interchange; Mr A said that he used to go there weekly to cadge cigarettes, whilst Mr B appears to have spent much of his time travelling by bus around the area.

Movements on the Day of the Killing

Mr B

9.6 On the morning of 19 September Mr B, who had been short of funds for the previous two weeks due to his giros being sent to his mother's address, once again had access to money after her return from holiday, and according to the nursing record, asked for £40 from the hospital cashier, but eventually settled (under protest) for £20. As indicated earlier, such disputes were not an unusual occurrence. He then went into town to buy some socks and a watch. Later that day he again requested money, and another argument ensued with the staff, as a result of which he said that he was going to the police and left the ward. His mother rang up at 7.15 pm and the nurse recorded that "*he had turned up there..... shouting and swearing at his family".* The family was advised to request the police to bring him back to the ward.

9.7 At the staff changeover at 9.00 pm he was noted to be absent, but was expected within the next half-hour. At 10.15 pm, as he had still not returned, the staff rang Mr B's mother's number in Wakefield but there was no answer, and at 11.18 pm they initiated the "missing person" procedure by faxing his details to the Police. The Police policy, however, was not to take any immediate action to look for a missing informal patient unless the hospital was able to give some indication as to their likely whereabouts, and to say that they were at a high risk either of suicide or of violence to others. The faxed details could be used, however, to identify the patient if they came to the notice of the Police in any other way. At this stage the staff knew nothing other than that they had been expecting him back from Wakefield and he had not arrived, and they were not therefore asking or expecting the Police to conduct any kind of search.

9.8 It is apparent that there had been a misunderstanding at 7.15 pm, in that when Mr B's mother rang, the staff assumed that she (and Mr B) were at her house in Wakefield, when in fact she was at the house of one of his sisters in Bradford, and he was at the house of his two brothers, also in Bradford. The staff therefore expected that it would take some time for Mr B to return by whatever means, and were not unduly concerned by his lateness. What had in fact happened, as related in interview by his mother, is that he had gone to his brothers' address and they in turn contacted his mother at his sister's house, before putting him on a bus bound for the Interchange, where he would get another bus to the hospital. The CCTV cameras picked him up at the Interchange just before 9.00 pm, waiting for a bus to the hospital; at this point he was approached by Mr A. They got on the bus together at 9.18 pm.

9.9 At 12.45 am his mother rang saying that she was very concerned about him and felt he might be suicidal - "*apparently he had had a row with his brother."* He had last been seen at 8.30 pm by his brothers boarding a bus with the intention of returning to the hospital. The staff nurse in charge of the ward subsequently tried to ring the Police on the official contact number, but could get no reply until 2.15 am. The Police had actually found Mr B's body at 11.38 pm, but that information was not passed on to the hospital until later in the morning, after the family had been informed.

Mr A

9.10 Mr A had been seen earlier in the day by the CPN, who found him "*in a neighbour's garden helping him with car repairs and drinking a can of Special Brew*." He described him as "*pleasant in mood and manner*". His mother said that he had in fact "*been up all night*" working on the car. According to Mr A when questioned by the Police, he in fact drank three 500 ml cans of Special Brew (strong lager) and then in the evening set off via the Interchange to visit one of his sisters; on the way he bought and smoked some cannabis. On the basis of his previous history, this combination of a substantial amount of alcohol, cannabis, and lack of sleep was likely to have a very marked effect on his mental state, and his behaviour at the Interchange just before he met Mr B, as recorded by the CCTV, was described by the Police as *"jumping up and down in front of people and acting really strange."*

The Killing

9.11 The sequence of events which followed the meeting between Mr B and Mr A has been described in Section 4. The Police were satisfied, from the CCTV evidence, that Mr A initiated the contact, but as to what passed between them thereafter there is only Mr A's account. He has in fact given several accounts, first of all to the Police shortly after his arrest, then to a succession of psychiatrists whilst on remand, then to the staff at Rampton, and most recently to the inquiry panel. However, these accounts are inconsistent, and it is very likely that his actual recollection both of the events and of his thoughts and feelings at the time will have been affected by his intoxication, and that he has then attempted to give rational explanations for his behaviour. He also gave the panel a detailed account of his road accident in 1991, an event of which, in view of the severity of the head injury he suffered, he is most unlikely to have any first-hand recollection, and it appears therefore that he may be prone to confabulation, ie unconsciously creating a "memory" to fill a gap in actual recall.

9.12 It would not, therefore, be safe to draw any conclusions from his accounts as to whether he had formed any prior intention to harm or to kill Mr B before meeting him that night, or what motivated him to act as he did, or whether he was in any way influenced by delusional beliefs. All that can be said for certain is that Mr B fell into a class of people against whom he had frequently expressed hostility - that is, adults who had known or suspected, (or could reasonably have been presumed to have known or suspected), that he was being sexually abused but had failed to take any action to stop it.

9.13 By the same token, it is not possible to say whether Mr B realised that he was in danger and if so, why he took no action to protect himself. However, it is clear from all the accounts of him that he was very vulnerable, in that, in the words of his mother, "*he thought everyone was friendly*". He was lonely and constantly seeking company, and given his intellectual limitations, he would have no reason to see Mr A as anything other than a former friend. He was also very passive, and in his mother's words "*frightened to death"* of violence, and he was unlikely to be anywhere near as strong as Mr A, who was younger and who was obsessed with physical fitness.

Observations - The Killing

9.14 In respect of Mr A, there is no evidence that his mental state in the days leading up to the killing was significantly different to what it had been for some time previously; in fact, after some concerns had been recorded in early summer, he appeared to have entered a relatively settled period, and his last contacts with the CPN on the day of the killing, and with the psychologist seven days earlier, had not elicited any grounds for fresh concern. Although it was quite possible, given the frequency of their visits to the Interchange, that Mr B and Mr A would one day meet face-to-face again, their meeting on 19 September was clearly by chance, and there is no evidence that Mr A was planning any harm to Mr B or that he had made any attempt to contact him.

9.15 It is also clear that Mr A's mental state on the night was significantly affected by alcohol and cannabis use and lack of sleep. However, this was by no means unusual; his sleep pattern was abnormal, and the amount of alcohol and cannabis he claimed to have consumed was not out of the ordinary for him. There are several previous accounts of disinhibited behaviour in public of the kind observed on the CCTV at the Interchange, and since he was well-known to the Police, such incidents would normally result in a warning or in a conviction and fine for a public order offence - his mother said that at one stage he had several such fines outstanding at once.

9.16 Although Mr B fell into a category of people - which included his parents, teachers, and social workers - who in Mr A's view, should have protected him from abuse, this was a fact known only to Mr A himself. A thorough risk assessment would not, therefore, have identified Mr B specifically as a potential victim. The abuser himself *would* have been identified, but in fact he was not in danger as he had long since left the area.

9.17 In respect of Mr B, although there had been some concerns about his state of mind a few days earlier, these had abated by the day in question, and the staff had no reason to believe that he was any more at risk in the community than he had always been. He may well have been in a bad mood that day, for a number of reasons - his mother had just returned from holiday, and he was still annoyed with her for (as he saw it) leaving him without funds; he had had an argument with the hospital staff, also about money; and he had then had a further argument with his brothers. However, it is clear from his history that such arguments, and bad moods, were extremely common and did not of themselves place Mr B at increased risk. It does not, in any event, appear from what is known about the killing that Mr B's state of mind at the time was of any particular significance - there is no evidence that he was behaving abnormally either at the Interchange or later.

9.18 Although there *was* a misunderstanding on the part of the staff as to where Mr B had actually turned up after he left the ward in the late afternoon, this had no significant effect on what they actually did. They advised the family, as they had on several occasions in the past, to get Mr B back to the ward, and they assumed, correctly, that this was what was happening. Had they known the exact position - that Mr B was actually in Bradford not Wakefield, and that he had been put on a bus which should get him back to the ward by about 9.45 pm -10.00 pm - they might have initiated the "missing person" procedure somewhat earlier than 11.00 pm, but this would not have saved Mr B's life - the Police would have recorded his details, but would not at that stage have gone searching for him, and it is clear from the CCTV at the Interchange and at the school that he had left the Interchange with Mr A at 9.18 pm and that the assault had taken place, and that he was in all probability dead, by about 11.00 pm.

10 SUBSEQUENT ASSESSMENTS OF MR A

10.1 Mr A was subsequently seen prior to his trial by three forensic psychiatrists, and the panel also visited Rampton Hospital, interviewed Mr A himself and the consultant psychiatrist and other staff responsible for his care, and obtained a considerable amount of documentation relating to Rampton's assessment of him, which was still ongoing at the time of the visit in May 2002. Although the inquiry's terms of reference relate to his care and treatment prior to the killing, it is appropriate to examine these later assessments insofar as they may be able to throw light on the adequacy of the earlier assessments made by the Bradford special care service.

10.2 The Bradford consultant psychologist acted as "appropriate adult" during the Police interview of Mr A immediately after his arrest, and neither he nor other colleagues who saw him in the immediate post-arrest period observed anything substantially different to his normal presentation. However, the three consultant forensic psychiatrists who later saw him prior to his trial all found a substantially greater degree of disjointed and delusional thinking than had been reported in any earlier assessment, including a previous assessment in 1997 by one of the same psychiatrists. Mr A was not able to give any of them as coherent an account of the offence as he had given to the Police (even though his mother, who was present at the Police interviews, thought that he was still under the influence of drink and drugs) and in particular, he tended to confuse the identities of individuals in relation both to the offence and to his past life.

10.3 The psychiatrists all agreed that he was unfit "by reason of insanity" to stand trial. As reported to the court and then by the local press, their findings conveyed the impression that he might have developed a serious psychotic illness in the period prior to the killing which had gone unrecognised by the special care service; and, as has been noted above, the Trust's internal review had raised the same question. However, when the first of the psychiatric examinations took place he had already been on remand at Armley prison for four months, and the history of his previous time there in 1996-8 suggests that this passage of time might have had an adverse effect on his mental state.

10.4 In addition, the psychiatrists were working from the records which were to hand, and they did not always have a complete picture of his previous history, one of them, for instance, concluding that "*no symptoms of abnormal beliefs were present until May 1999*". In fact, whilst this was the first formal psychiatric record of such beliefs by the Bradford service, there were references to delusional beliefs in Probation and prison records as far back as 1996, and from his mother's account it would seem that such beliefs had surfaced from time to time ever since the head injury in 1991.

10.5 It is possible that the delusions had gradually become more prevalent and more fixed over time, but, along with the fragmentation of his thinking, they may simply have become more apparent through "decompensation" when he was subjected to a succession of formal psychiatric examinations about extremely stressful subjects. The Lynfield Mount staff had never put him under such pressure; in fact, in working with him in relation to the sexual abuse, the psychologist had deliberately worked at a very slow pace over many sessions, allowing him a large measure of control over the content of the sessions and not employing probing techniques or pressing him to address difficult issues until he was ready. The Senior Medical Officer at Armley prison, who had been surprised when Mr A was found unfit to plead, also observed in his evidence to the inquiry that Mr A's speech became pressured when under stress, but that "*once you get through his excitable phase he is really quite focused on the content of your conversation*."

10.6 It does not necessarily follow, therefore, that his underlying mental state, as revealed by the psychiatrists prior to his trial, was substantially different to what it had been for some years previously, and this is borne out by the subsequent observations of the staff at Rampton. Although they also noted his tendency to confuse identities, their detailed descriptions of Mr A's behaviour are otherwise not dissimilar to those in the Bradford records, and even after almost twelve months of assessment they had not been able to come to a firm view about the underlying causes of that behaviour, other than that he presented a complex picture of personality, post-traumatic and organic disorders. The earlier finding by a neuropsychologist of frontal lobe disorder could not be confirmed by recent tests; however, his overall presentation, including his fixed delusional beliefs and a tendency to silly, prankish behaviour, was very much consistent with the effects of a serious brain injury.

10.7 It does not appear, therefore, that the Bradford special care service failed to recognise a florid or developing psychotic illness in the months leading up to the killing. Taken overall, the evidence tends to support his mother's view that such change, if any, that had taken place since 1991 had been limited and gradual, and that the several periods of overtly disturbed behaviour or abnormal thinking were due mainly to the temporary effects of anxiety, stress, alcohol or cannabis, any one or a combination of which could cause his precarious hold on reality to be lost. It does appear, however, that the strength and intensity of some of his delusional beliefs, and in particular the delusion relating to Jean Claude van Damme, did increase over the years, and that because they were trying to intervene in the least stressful way and to maintain his level of functioning, rather than to probe for underlying pathology, the staff in the Bradford service may not have realised the full severity of his disordered and delusional thinking.

11 THE BRADFORD SPECIAL CARE SERVICE

11.1 It is clear that, in a number of respects, the care provided to Mr A in the period after June 1998 fell below the standard which it is reasonable to expect from a district forensic service. In particular:

- there was insufficient focus on the immediate risks to others, as opposed to long-term therapeutic needs,
- risk definition and assessment was not sufficiently well developed,
- there was an absence of multi-disciplinary or multi-agency processes for assessment and review,
- CPA requirements were not observed, and there was a lack of mechanisms for enforcing them,
- there was a failure to liaise with the Probation Service, or to bring in other agencies or services which might have been able to contribute,
- a very limited range of interventions was adopted, and the level or frequency of input was not sufficient to have any significant effect,
- the consultant psychiatrist was not sufficiently involved in care planning or in monitoring changes in mental state or the need for medication,
- the consultant psychologist did not assume the overview role and responsibility for meeting service obligations which would traditionally be carried out by the consultant psychiatrist in a case such as this.

11.2 Some of these failings were undoubtedly due to lack of familiarity of the consultant psychologist and CPN with their particular roles, and some may have been unique to this particular case. However, it appeared to the panel that the majority of them indicated serious shortcomings in the special care service as a whole, and in particular in its community service.

The History of the Service

11.3 Some of these shortcomings appeared, in turn, to stem from the way in which the service had evolved. There had for many years been a forensic service based at Waddiloves Hospital in Bradford, but without secure beds, and the service at Lynfield Mount was created in 1994 mainly as a response to pressure to provide alternative secure care for a group of patients who were at that time placed externally at great expense, both in the NHS and in the independent sector. It was initially termed the "special care unit" and it had 12 secure beds plus 10 open beds transferred from Waddiloves. When the consultant forensic psychiatrist left, he was replaced by the present consultant who was not at that time qualified as a forensic psychiatrist. The service gradually developed a community arm, initially in order to provide after-care for discharged inpatients; however, it later began to acquire patients such as Mr A who had not come through the inpatient route.

11.4 It was clear to the panel that the service had evolved without any clear plan or direction, with commissioners (and the management of the Bradford mental health service as a whole) seeing it as a convenient solution to the problems posed by several groups of "difficult patients" without considering whether, taken together, the needs of these groups were compatible with one another or could be accommodated within a single service of this size. As the 2002 Business Case for the development of the service states, it has *"a number of components which have developed independently of each other over a number of years".* It did not until recently have a clear identity as a forensic service, and did not formally call itself such until 2000 when the consultant was accredited as a forensic psychiatrist. During the period being addressed by this inquiry, it was providing in-patient services to up to four distinguishable groups in a single secure ward, together with a range of outpatient and community functions.

11.5 The inpatient groups were, respectively; patients with histories of serious offending requiring long-term care in a low-secure setting (the service's original intended function); patients with histories of serious offending requiring medium-term rehabilitation in a low and non-secure setting; acute patients needing assessment and treatment in a low-secure setting; and patients transferred for a short period from the acute wards during a period of disturbed behaviour. It was thus straddling the functions of a traditional forensic service and that of an intensive care facility for the acute service. Although the latter role has now ceased, it continues to have a very broad spread of functions; this is not just a consequence of unplanned evolution, but is inherent in the Yorkshire strategic plan for forensic services (June 2000), drawn up by the Yorkshire Specialist Commissioning Group, which sets out seven distinct functions for a district forensic service.

Definition of the Service

11.6 The panel received only one document which contained a written description of the service's role and objectives, and this post-dates the events dealt with in this inquiry. It is titled "Osprey House and Forensic Community Liaison Team - Operational Policy and Procedures" and, with the exception of the patient referral process, it covers only the non-secure elements of the service. The two most noteworthy features of this document are, firstly, that its eligibility criteria are very broad indeed, and secondly that it makes almost no mention of risk to others.

11.7 The panel found that the staff interviewed, from both the special care and the mainstream services, displayed a similar lack of certainty about the special care service's boundaries and purpose, and had differing interpretations of its eligibility criteria. In particular, there was a tendency to see the service as being potentially responsible for any patient who happened to have a history of offending, whether or not that offending was directly related to their mental disorder, and whether or not they posed a serious risk to others. This tendency was reinforced by the fact that the special care service was responsible for liaison between the mental health service as a whole and the courts and prisons, thus identifying all offenders with mental disorders as "forensic" and creating a tendency for them to flow towards that service even if their needs could be adequately met by the mainstream service.

11.8 This failure to define the special care and the mainstream services in relation to one another had tended over a period of years to result in a "one-way traffic" in which the special care service had found it difficult to set limits to numbers of referrals, and then had found it difficult to transfer patients back to the mainstream service, either because that service would not accept them, or because the transfer process was excessively protracted, or because it was feared that they would receive inadequate support or be discharged prematurely. As a result, the special care service had accumulated an out-patient caseload which was too large to be compatible with the intensive supervision of high-risk patients, with the sole consultant psychiatrist in particular having an excessive number of community patients given that she was also required to have an overview of, or to be episodically involved in providing treatment to, the whole of the community caseload which in February 2002 amounted to 96 patients. The excessive size of the community caseload was noted in 1997 in a report by the Bradford Mentally-Disordered Offenders Steering Group, and again in October 1999 by a Regional needs-mapping exercise.

The Community Service

11.9 The community arm of the special care service had evolved, in many respects, like a "first generation" hospital-based community service from the late 1970s, in that it began through nursing staff following their discharged patients out into the community, whilst retaining a part-time role on the wards. Very little management or commissioner attention seems to have been devoted to it relative to the inpatient service, to which it remained closely tied. The absence of any long-term drive to develop a fully-fledged community service was demonstrated when, at one stage, the sole free-standing CPN post was temporarily deleted as a "cost improvement" and the cases reallocated to ward-based staff.

11.10 The community service also lacked clear lines of management or of clinical supervision, with no dedicated manager of its own, and indeed a dearth of management with community experience. At the time of the killing there was just one full-time CPN post in the team, plus a social worker and the Criminal Justice Liaison Nurse, who was the senior nurse in the team, but who had a specialist role and did not carry a caseload or any formal management responsibilities. By February 2002 the number of CPNs had increased to 2.6, but the catchment area had been extended to include Airedale. However, even a team of this size is not large enough to perform the full range of functions and to meet the standards expected of a modern multi-disciplinary community mental health team, which will usually have a core membership (ie CPNs and social workers) of at least 8-10 staff including a specialist team leader who, if a nurse, is likely to have had formal community training and extensive community experience.

11.11 The team, such as it was, was also geared primarily towards the needs of discharged inpatients, who had for the most part been in the mental health system for many years. The expectation was that the nurses who supervised patients in the community would have got to know them (and their history) as inpatients, and that their mental state would normally be stable on discharge, and so only a limited reassessment would be needed, and the team therefore had little experience of the very different processes involved in taking on patients like Mr A who were not well-known to them, who did not come with

extensive documentation, and whose mental state and behaviour might be unstable and unpredictable.

11.12 In addition, the service was focused on the needs of people with severe and enduring mental illness, and had neither experience nor expertise in the wider range of conditions with which a fully-fledged forensic community team might reasonably be expected to deal. The consultant forensic psychologist had been recruited in 1998 at least in part to address this deficiency, by introducing expertise in the area of personality disorder, but he was effectively the sole practitioner in this area, the other team members recognising that their expertise was very limited, and so there was an absence of the "checks and balances" which are normally found in multi-disciplinary teams whose members have overlapping knowledge-bases.

11.13 Another feature of fully-developed community mental health teams is that they will have support workers or access to them, and access to a network of contacts and resources which will supplement what they are able to offer directly. Building up these networks does, however, require time, and is often the primary responsibility of the team leader. It is not realistic to expect that a team with a "core" of just two or three people, all carrying full caseloads, can replicate this kind of activity, and it is not therefore surprising that the Business Case concluded that there was *"a lack of therapeutic resources to support patients in the community*."

11.14 Given this, it is arguable whether at least some patients might not have been better served by the mainstream community mental health teams. It also raises the question as to whether a service ought to assume responsibility for patients such as Mr A if it is not equipped to provide them with a comprehensive package of care. Whilst, as has already been pointed out, he fell clearly within the criteria for a district forensic service, at the time he was taken on in 1998 the Bradford service was not yet calling itself such, and it had not yet developed the range and depth of out-patient provision which that title implies. However, it is most unlikely that the mainstream mental health service would have accepted him other than for the limited purpose of assessing and treating the apparent symptoms of psychosis.

12 ISSUES RELATING TO SERVICES FOR "VULNERABLE ADULTS"

12.1 In different ways, both Mr A and Mr B could properly be described as "vulnerable adults," a term which is now widely used to describe people who do not fall clearly into any one of the major categories of illness or disability, but who have a number of minor disabilities or impairments, which in combination have the effect of making it difficult for them to care for themselves or to cope with the demands of ordinary life. These combinations often include mild learning disability, environmental or social deprivation, acquired brain injury, personality disorder, alcohol and drug misuse, or the psychological effects of sexual abuse or other trauma.

12.2 People in this group often "fall through the holes" between the various care services, which tend to be tailored to the needs of the major categories of disability such as severe and enduring mental illness, or severe learning disability. Mr B fell between the mental illness and learning disability services, and at various points the two services argued as to who should take responsibility for him, and Mr A had a combination of impairments related to his personality, the brain injury, sexual abuse, and alcohol and drug misuse with which the local mental health service was not well-equipped to deal.

12.3 Social care services provided by local authorities should by law be "needs-led" and should focus on the practical consequences of the disability rather than the causes of it, an approach which is enshrined in the Department of Health policy guidance "Fair Access to Care Services" published in 2002. NHS services, by contrast, are much more focused on specific clinical categories. However, in practice there is often little distinction between the approach of the health and the social care services, since the latter have increasingly been reorganised into specialist services which mirror the clinical divisions within the NHS, and are now progressively being amalgamated with them in joint services. For many years, Mr B relied upon informal advice and support from his generic Social Services area office, but the area structure was then disbanded, its mental health and learning disability services were joined with their health counterparts, and they have in turn now been absorbed into the new Care Trust.

Services for People with Mild Learning Disabilities

12.4 The dispute between the mental health and learning disabilities services, as to who should take responsibility for Mr B, reflects a problem which is by no means unique to Bradford. The panel's conclusion is that Mr B did not suffer as a result of it, since the two services eventually agreed to share care and he got the services he needed, but the dispute (and the duplication of roles) absorbed a great deal of staff time to no useful purpose. Just before he died, it was agreed to commission a psychological report as a means of establishing whether his disabilities were due primarily to mental illness or to learning disability, but the panel's view was that the evidence *already* available indicated very strongly that they were due to a combination of mild learning disability and environmental deprivation, and that his mental illness, which had always been at a very low level, contributed very little.

12.5 The real issue was not about the *cause* of his disabilities, but about which service was best equipped to help him. In theory, he should have been able to look to the learning disability service, but in practice the Bradford service, like most of its kind, has to give priority to people with severe learning disabilities, and so adopts a threshold criterion which effectively excludes anyone with an I.Q of 70 or over. Even if it waives this requirement, as it did with Mr B, its ability to provide an appropriate service is very limited, since its residential and day care facilities will be overwhelmingly geared to those with severe disabilities, and the two groups are not compatible. In some respects, facilities for people with mental illness may be *less* inappropriate, and there is, therefore, a temptation to redefine the disability as being due to mental illness in order to ensure that the person is not excluded from services. However, this may have negative consequences, in that the person then becomes "labelled" with a condition which has marginal relevance to his or her actual needs.

Services for People with Acquired Brain Injury

12.6 By the same token, people with an acquired brain injury do not fit into any one of the current major service categories, and it may be necessary for them to adopt another "label" in order to qualify for long-term care from one or other of those services. However, the science of brain injury rehabilitation has developed rapidly in recent years, and it is increasingly recognised that people with this type of disability need a regime of care which is different to those normally found in, say, mental illness or learning disability services.

12.7 In the case of Mr A, the panel's concern was that the special care service, having recognised the evidence of an acquired brain injury, failed to adapt their normal regime sufficiently to take account of this, and that they were not fully aware of, and did not make use of, the expertise that was available in Bradford. Many areas do not yet have any dedicated community head injury service, but Bradford has since 1995 had a joint-funded Community Head Injury Rehabilitation Team, based within the Social Services Physical Disability Team, and with access to a neuropsychologist, and set up to cater for people *"who had suffered severe traumatic brain injury, sometimes needing specialist rehabilitation, but who did not fit particularly well either with the mental health service or with learning disability services".* There is an exclusion for people who are dependent on alcohol or drugs, but Mr A was not physically dependent although he arguably had a degree of psychological dependency.

12.8 Rehabilitation is most effective in the first year or two after the injury, and in Mr A's case, if he had been referred after 1998, the team would have concentrated on coping strategies, which might have included setting up a programme of structured daytime activity. In such a case, where there were issues other than the head injury, the team would provide advice and support to the mental health service rather than take over case management themselves.

Services for Survivors of Sexual Abuse

12.9 The psychological trauma resulting from sexual abuse is now increasingly recognised as a factor in a great deal of long-term psychiatric disability; however, getting appropriate help for survivors is rarely easy. One of the consistent themes in Mr A's history, from the point at which his abuser was arrested in 1988, was concern by professionals that he needed therapy, coupled with great difficulty in obtaining it. The issue was first raised by his teachers, but his then social worker concluded that the first priority was to stabilise his life and enable him to rebuild trust in adults, before attempting any formal therapy. This view was criticised at the time, but it accords with what we now understand about the limited scope for such therapy in the early years after abuse, especially when the victim is still a child.

12.10 However, stability was never re-established until he became an adult, and the question of therapy was next raised by the psychologist who saw him in 1992, and who thought that he needed long-term psychotherapy. In 1993 his probation officer wrote to Social Services saying that *"we have concluded that intense counselling is warranted and is not possible within the time allowable within our caseloads*" and asking Social Services to contribute half the cost of eight sessions from an independent counselling body at £100 per session. Social Services appeared to think this was too much to pay, but the project was later abandoned for other reasons which are no longer on the record, although Mr A is recorded in early 1993 as telling his GP that he "*does not want psychotherapy*."

12.11 With hindsight, however, bearing in mind the very limited progress later made by the consultant psychologist at Lynfield Mount over a two-year period, eight sessions alone would not have made any positive impression on Mr A's problems, and if the therapy had been terminated prematurely for purely cost reasons it could have done more harm than good. There was, however, a long period from 1993-97 when he was relatively stable and co-operating with Probation, when it might have been possible to engage him in a less intensive form of counselling, much as was attempted by the psychologist after 1998, if it had been available at the time.

The Role of the Probation Service

12.12 A great many "vulnerable adults" are also offenders, and as in Mr A's case, their needs often lie on the boundary between Probation and the mental health services, which raises the question of the relative role of the two services. The strength of Probation, which was well-demonstrated in Mr A's case in the period 1992-97, is that it is risk and offence-focused, provides a degree of structure and authority for people who have difficulty in setting their own boundaries, and has an emphasis on practical solutions, for instance to the question of daytime activity, as well as a large network of useful resources.

12.13 However, it is limited by the length of most orders, which prevent it from engaging in any long-term work; although Mr A was in fact a continuous client of the service from 1992-97, this could not have been predicted at the outset with any certainty, and if his offending had ceased for any prolonged period, then so would the work, regardless of the recognised long-term risks. In addition, the changes within the Probation Service have made it more difficult for probation officers to engage in the kind of "supportive casework" role demonstrated during that period, other than in the case of very high-tariff offenders who are on life licences or the sex offenders' register, and it is questionable whether Mr A would get the same kind of support had he been referred to them in present-day circumstances. This is bound to result, much as happened in his case in 1998, in an expectation that developing local forensic services will take on the primary responsibility for support and supervision which might previously have been undertaken by Probation.

12.14 Ideally, a local forensic service ought to embody the best qualities of Probation, and in particular the risk-and-offending focus, with an ability to provide therapeutic inputs and to manage degrees of pathology which are beyond the scope of probation officers, and to maintain care packages for as long as necessary. Where the two services can *both* remain involved, it may be possible for each to work to its strengths; Probation, in particular, has the advantage of the authority derived from the order and the potential for the probationer to be "breached" for non-cooperation. However, in Mr A's case, when the special care service took over the whole responsibility, it behaved too much like a mainstream mental health service, focusing too closely on his long-term therapeutic needs and paying too little attention to the issues of immediate risks to others which would have been the prime focus of Probation.

Issues Relating to Personality Disorder

12.15 There was not necessarily any conflict between meeting Mr A's therapeutic needs and the reduction of risks in the *long* term, since both objectives depended to some extent on his being able to come to terms with his sexual abuse so that he would not be so preoccupied with it, or be so likely to react violently to reminders of it. However, it was difficult to provide therapy for the "post-traumatic stress disorder" consequent on the sexual abuse, since his other disabilities prevented him from engaging effectively.

12.16 Some of these disabilities were a consequence of the head injury, but he undoubtedly had serious personality difficulties prior to his road accident, and many of his most prominent personality traits - such as, for instance, his persistent tendency to blame others for his own misbehaviour - had been apparent since childhood. This combination of overlapping disorders or impairments is very common in people who attract the label "personality disorder," and it means that any single therapeutic approach is unlikely to be effective in isolation.

12.17 However, in several respects Mr A was not, during the period from 1998 onwards, typical of most young men with serious personality disorders who come to the attention of mental health services. He did recognise, at least to a limited extent, that he needed help; he was prepared to co-operate with professionals and to keep appointments to the best of his ability; his drinking and drug misuse was not out of control; he had a stable permanent address and support from his mother; and he was not constantly in and out of custody, as he had been during his teenage years.

12.18 In addition, his anti-social behaviours were not thought to signify the presence of a serious anti-social personality disorder. He was, therefore, "treatable" in that he was accessible to the services and had at least some potential for change, and it was possible to plan some kind of intervention with the reasonable prospect that it could be delivered and that it might, in the long term, have some beneficial effect.

12.19 The Department of Health, through the National Institute for Mental Health, has recently published policy implementation guidance for personality disorder which expects that local mental health services will no longer "exclude" this group but will ensure that appropriate services are available for them, if necessary by creating specialist teams. In one respect, the Bradford service was already in 1998 well ahead of most current local services, in that it had within it one senior clinician - the consultant psychologist - who had expertise and an interest in this particular group. However, he was not supported by a team with similar expertise and interest, or one which was designed and resourced to provide structure to the lives of people like Mr A over a very long period.

12.20 Such a service would be extremely expensive, and the guidance is not accompanied by extra funding, and to implement it in present circumstances would in any case draw numbers of the most experienced and highly-qualified staff away from the services for people with severe and enduring mental illness, where they are already in short supply. However, without such a free-standing personality disorder team, local mental health services are in danger of accepting responsibility for problems which they are not equipped to manage, and of giving the impression that the risks to the public have been contained when in fact this is beyond their ability.

13 OBSERVATIONS ON THE TRUST'S INTERNAL REVIEW, ITS RECOMMENDATIONS AND ACTION TAKEN

13.1 The panel's terms of reference did not specifically extend to the Trust's post-incident internal review, but we felt that it would be helpful to describe briefly the process of that review, to summarise its main findings and to note any significant differences between our conclusion and the conclusions of that review.

13.2 In accordance with central government policy as laid down in Circular HSG 94(27), an internal review was established by Bradford Community Health NHS Trust following the killing. The review panel examined the circumstances around the death of Mr B with a view to identifying issues in the care of both Mr B and Mr A, or any of the supporting processes. The panel included senior clinicians from outside the Bradford service, and it was convened within two months of the killing.

13.3 The review's main conclusions in respect of Mr B were:

- That Mr B and Mr A had not met in the context of the provision of mental health services.
- That Mr B should have been in residential accommodation, but was in the most appropriate alternative care setting given the circumstances.
- That as details of Mr B's absconsion became clear the staff responded flexibly and pragmatically to the situation, but that there were certain aspects of the absence-without-leave policy which may have introduced delay.

13.4 The review's recommendations arising out of the care of Mr B were:

<u>Documentation</u>

- When patients leave the ward, staff should ascertain wherever possible their intended location and ensure that a note is made of this.
- On admission a range of contact addresses should be obtained and these should be updated on a regular basis.
- All staff should have on a regular (yearly) basis, refresher competence-based training on good documentation. Documentation standards should also be included at local induction.

<u>Absconsion Policy</u>

- All staff should receive formal training in the application of the Absconsion Policy. Ideally this should be done as part of local induction. The Trust may wish to extend this recommendation to include other key policies.

<u>Communication with the Police</u>

- The Trust should pursue with the Police a mechanism to fast track absconsion details to ensure a rapid and reliable communication channel is in existence.

13.5 Mr A's case was seen as more complex. The internal review concluded that the circumstances of the assault could not have been foreseen, but the panel identified a number of issues relating to the forensic service, which it believed would go a long way to minimise the risk posed by this group of patients. It made the following recommendations for the forensic service:

Workload

- There should be a review of the service. This should be undertaken using benchmarking techniques to determine outpatient and inpatient workloads for similar services as well as for service entry and exclusion criteria.

Self-Managed Teams

- The Trust should produce a clear policy on the management of teams and related approaches, which defines in general terms the scope, and limitations of self-management. In addition the forensic service should develop a clearly defined operational policy.

Patient Review

- The forensic team should examine review mechanisms to ensure that cases are reviewed regularly and formally. The design of the new procedures should be informed by external best practice.

Documentation

- The service should establish clear standards of documentation based on best practice.

Clinical Supervision.

- The service should review its process of clinical supervision to ensure that the process fully reflects the clinical profile of the service. A reconfigured management structure would assist in this.

Risk Assessment and Risk Management

- The service should review its process of documentation so that there is correspondence between the clinical records and the CPA process, particularly in respect of risk decision-making. The implementation of the FACE risk assessment process should reflect this recommendation.

Action on the Recommendations

13.6 The Trust took steps to act on the recommendations of the internal review, and on 21 January 2002 the Mental Health Directorate presented to the Trust Board an update on progress. It was reported that the following steps had been taken in regard to both the forensic and the mainstream in-patient services:

- There was now an early refresher training session on standards for documentation for nursing staff which was to be repeated on a regular basis. The same training was to be built in to induction training of all new staff.
- The front sheet of the admission document had been reviewed to ensure that "next of kin" and "significant others" are identified. Further, that this was to be updated on each admission, and the need to ensure that any changes during admission to this information were documented was to be emphasised in training.
- Specific guidelines had been developed for assessing all patients prior to their leaving the ward to ascertain why the patient is leaving, where they are going, with whom and when they are expected to return.
- Nursing staff were to assess where a patient was intending to leave the ward, that it was in accordance with the patient needs, and if not then the correct procedure to be followed. If the patient was a detained patient then to ensure that there was appropriate authority under the Mental Health Act for that patient to leave the ward.
- If the patient was to stay overnight off the ward then an address was to be obtained and documented.
- A training session had been developed on the application of the missing-from-hospital or absent-without-leave policy and this was included in the annual training programme to be delivered to all newly qualified staff by a senior manager as part of the induction process.
- A system had been agreed with local police for emergency or urgent notification of a patient being absent without leave where police assistance was required.

13.7 The following action was reported as having been taken in respect of the forensic service:

- An audit of the workload had been undertaken and a regular review of caseloads and caseload management had been introduced.
- An additional psychology post had been funded through the provision of two more forensic beds but at that time the post had not been filled.
- The forensic team had ceased to operate in a "self managed" form prior to the internal review, and a revised management structure had been formally agreed in January 2001.
- Operational policies had been overhauled for the entire service.
- The patient referral and assessment procedure had been updated and was stated to be fully operational and being audited.
- The standards for documentation were to be approved and implemented by 29 January 2001.
- An audit of nursing clinical supervision had been completed. This showed that adequate arrangements existed for nursing staff. Access to external supervision for senior nursing staff was to be facilitated.
- Consultants were to continue using existing arrangements for clinical supervision and external supervision was to be facilitated as required.
- The Trust CPA guidelines were stated to have been fully adopted and integrated into the patient review process. This was stated to be in addition to the risk assessment tool being used by the Forensic Service. This was to be audited on a regular basis.
- All outpatients were stated to be now assessed in line with the Trust CPA policy, including FACE risk assessment, with the intention that

enhanced FACE risk assessment would be developed specifically for forensic patients.

Observations - the Internal Review

13.8 The Trust went well beyond the requirements of HSG 94(27) in that it convened a review panel which had a majority of members from outside the Bradford service and which included senior forensic clinicians. It was also convened very quickly, and it had been preceded by an initial review by senior managers to identify any issues on which immediate action was needed. This was very good practice, which is far from universal in these circumstances, and the Trust is to be commended.

13.9 The findings and recommendations listed above are generally consistent with those of this external inquiry. However, our conclusion in respect of Mr B is that he was not an "absconder," since he was an informal patient and his leaving the ward on the afternoon of 19 September was not inconsistent with his normal pattern of activity. It would be more correct to say that, when he did not return at the expected time, he then became a "missing patient."

13.10 We also found that the nursing staff acted appropriately when they realised that he was missing, and, given that action has been taken to address the difficulty in communicating with the Police, we have no recommendations to make in respect of "missing patients" procedures. However, the terms of reference of an external inquiry require it to focus and report on the circumstances of the particular case, whereas an internal review conducted by the service's own management is entitled to take a much wider view and may well identify deficiencies in practice or procedure which did not actually affect the outcome of that case.

13.11 In the case of Mr A, the internal review took place before his trial, and we have had the benefit of a substantial amount of additional information which could not have been made available until after the trial, together with details of his early history which were, again, not available to the internal review. It is understandable, therefore, that the review's conclusions in respect of Mr A were somewhat limited.

13.12 The action taken by the Trust to implement the review's recommendations appears to have been satisfactory, and indeed many of the actions taken anticipate our recommendations in Section 15.

14 CONCLUSIONS

In Respect of Mr B:

14.1 In general, the care provided to Mr B was of a satisfactory standard, and the requirements of the Care Programme Approach were observed.

14.2 His disabilities were primarily a consequence of learning disability combined with social and environmental deprivation, and his mental illness played very little part.

14.3 Although the dispute between the mental health and learning disabilities services, as to which service should have primary responsibility, might have interfered with his care had it not been resolved, the two services did in fact work well together during the period under review (ie from January 2000 until his death).

14.4 His last admission was for social not medical reasons. It was fortunate that a bed was available, as there was no other accommodation available which was suitable for him. The staff responsible appeared to have been making all reasonable efforts to find accommodation which would meet his needs.

14.5 There was no justification for limiting his usual freedom, and whilst in hospital he was at no greater risk than normal.

14.6 His mental state may have deteriorated somewhat in the days before his death, as a consequence of his increasing frustration at having to stay in hospital, and possibly also of benzodiazepine withdrawal. However, there was no evidence that this led to increased risk.

14.7 The nursing staff took appropriate action to implement the missing person policy, and there was no evidence of any failure to observe a reasonable duty of care. The confusion about his whereabouts did not contribute to his death.

In Respect of Mr A:

Mental State

14.8 He presented a complex diagnostic picture. There was evidence of changes in personality and behaviour consequent on a serious head injury; a pre-existing personality disorder; the psychological consequences of childhood sexual abuse; a heightened sensitivity to alcohol and cannabis; a high level of anxiety, and decompensation when under stress; and delusional thinking which had been present, at least at a low level, for several years prior to the killing.

14.9 However, although his behaviour could be antisocial, he did not appear to fit the criteria for antisocial or dissocial personality disorder; he was willing to accept help; and there was reason to believe that he might over a long period of time be able to make some response to therapy, provided that this could be tailored to his particular needs. It was not, however, realistic to expect any fundamental change in his ways of thinking and behaving, as the effects of his brain injury were permanent.

14.10 Once his mental state had stabilised following his brain injury, there was no evidence of any major, enduring change in the years which followed; rather, there was a fluctuating presentation which appeared to be due to the effects of stress, alcohol and cannabis.

14.11 There is evidence that some of his delusional ideas may have become more prominent and more fixed over time, but no evidence to suggest that the special care service failed to recognise the onset of a major psychotic illness. However, since the staff of the service were trying to maintain and improve his level of functioning rather than to probe his mental state, it may well be that they failed to appreciate the full severity of his disordered and delusional thinking.

14.12 He responded positively to a brief course of antipsychotic medication, but refused to continue it, and there were no grounds at that stage for him to be given compulsory treatment under the Mental Health Act. However, his mental state should have remained subject to regular monitoring by the consultant psychiatrist.

The Referral to the Special Care Service in 1998

14.13 He met the criteria for referral to a district forensic service, in that he had a serious mental disorder plus a long history of offending; at least some of his offending was related to his mental disorder; and he presented a significant long-term risk to others. He did not, however, meet the criteria for admission to a secure facility.

14.14 The referral from the Probation Service was not subjected to multi-disciplinary appraisal, and the consultant psychologist who took sole responsibility for the assessment did not contribute to the pre-release planning or liaise with Probation, and so was never fully aware of the nature and extent of the concerns of the criminal justice agencies about the risks to others.

Risk Assessment and Management

14.15 There was a failure to recognise and to assess immediate as opposed to long-term risks. Information about his last conviction, for aggravated burglary, was not obtained or analysed. The service was slow to recognise the risks to his mother, and did not recognise the possibly greater risks to other members of his family with whom he was in regular contact.

14.16 It was recognised that there was a risk to people who were associated in Mr A's mind with the sexual abuse, although the failure to analyse the aggravated burglary led the consultant psychologist to conclude, erroneously, that he was not capable of planning an assault. However, even a thorough risk assessment would not have identified a specific risk to Mr B, since only Mr A was aware of his link with the abuser.

14.17 The initial intervention, of providing counselling in relation to his sexual abuse, was not inappropriate but would have an impact on risk, if at all, only in the very long term. Work to reduce the risk to his mother only began twelve months after his release from prison. The service then pursued a narrow range of interventions which were unlikely to have a lasting effect given his difficulty in retaining insights or internalising advice.

14.18 The service failed to build on the previous experience of Probation that the risks were reduced when he was constructively occupied, and it failed to analyse his use of alcohol and cannabis and to recognise that he might be "self-medicating" to control his mood swings, or to make use of locally-available expertise in the management of people with acquired brain injuries.

In Respect of the Killing:

14.19 There is no evidence that Mr A's mental state was deteriorating in the weeks prior to the killing. His mental state on the night in question was, however, likely to have been seriously affected by a combination of lack of sleep, alcohol and cannabis use.

14.20 There is no evidence that Mr A was planning any kind of assault on Mr B, and their meeting on 19 September 2000 was entirely coincidental. It is not possible to reach any conclusion as to Mr A's motivation for the assault; however, he had frequently over the years expressed anger towards adults who he felt should have protected him from sexual abuse as a child. Given that Mr B was an adult who, Mr A believed, had known about the abuse, it is understandable that he would have placed him in that category.

In Respect of the Bradford Special Care/Forensic Service:

14.21 Overall, the service did not perform to the level which could reasonably be expected of a fully established district forensic service. There was, first of all, insufficient focus, in both policy and practice, on risk to others as the main reason for the existence of the service, as opposed to meeting long-term therapeutic needs, and it incorporated too many distinct and potentially conflicting functions for a service of such a size.

14.22 Risk definition, assessment and management was not sufficiently well developed, and formal risk assessment processes had not yet been extended to the community service.

14.23 There was an absence of multi-disciplinary or multi-agency processes for assessment, care planning and review. There was a failure, in particular, to liaise closely with the Probation Service, or to bring in other agencies or services which might have been able to contribute to the provision of a comprehensive service.

14.24 Essential Care Programme Approach requirements were not being observed, and there was a lack of administrative mechanisms or line-management oversight to ensure that they were enforced.

14.25 The consultant psychiatrist's post was overloaded, which in part reflected a failure to establish clear boundaries between the special care and mainstream services, and she was not sufficiently involved in the planning of Mr A's care or in monitoring changes in mental state or the need for medication.

14.26 It was appropriate for the lead medical responsibility in Mr A's case to be assigned to the consultant psychologist, as he had the most appropriate expertise. However, the post had not been properly defined and the postholder did not assume the overview role and responsibility for meeting service obligations which would traditionally fall to the consultant psychiatrist in a case such as this.

14.27 The community team was underdeveloped and lacked dedicated management. It was not staffed or resourced to provide the level, frequency or range of inputs necessary in the case of high-risk individuals with complex needs, and only one team member, the consultant psychologist, had expertise in the area of personality disorder.

In Respect of Services for Vulnerable Adults:

14.28 The shortcomings in the Bradford services largely reflect deficiencies in this area nationally, although in respect of its dedicated community service for people with acquired brain injury, Bradford is ahead of the norm.

Changes in the Service Since 2000

14.29 These conclusions relate to the services as they were in September 2000, and the panel recognises that significant changes have taken place in the two-and-a-half years since. In particular, the findings of the internal review have been implemented; the CPA policies have been revised in accordance with the requirements of "Effective Care Co-ordination;" and a Business Case for the service has been accepted by the PCTs . The panel has also seen proposals for increased staffing and strengthened management for the forensic community team, which would appear to address some of the concerns listed above.

14.30 However, the panel does not believe, from the interviews with staff conducted in the spring of 2002, that the services have yet moved forward to extent that the conclusions above, and the recommendations which follow, are no longer relevant. In addition, the Business Case, which is concerned primarily with the development and expansion of the inpatient service, does not address many of the concerns set out above; in particular, it does not address the potential for such an expansion to exacerbate the problem of too many conflicting functions, nor does it fully address the weaknesses of the community service.

15 RECOMMENDATIONS

Processes in the Forensic Service for Referral, Review, and Compliance with the Care Programme Approach

15.1 The Bradford District Care Trust should, in the light of the findings of this inquiry, carry out a review to satisfy itself that adequate processes are now in place within the forensic service for the receipt, allocation and assessment of referrals, for the review of on-going cases and for meeting CPA requirements, and should share the conclusions of this review with the commissioning bodies. In particular, it should ensure that:

- Other than in the case of great urgency, all referrals are the subject of scrutiny by the multi-disciplinary team before acceptance and allocation, and that the team should agree which member is to assume primary clinical responsibility.
- Referring agencies are kept informed of the status of referrals.
- All on-going cases, including community cases, are subject to regular review involving members of all the professions represented in the staff team, and that there is no backlog of unreviewed community cases.
- There are administrative systems in place which will alert the responsible managers if CPA requirements are not being complied with.
- All CPA care co-ordinators have received appropriate training.
- The Department of Health guidance on "Effective Care Co-ordination" is being fully implemented, especially with regard to the full involvement of patients and their carers, and including the sharing with them of care plans and risk assessments.

Risk Assessment and Management

15.2 The Trust should ensure that policies and processes for the definition, assessment, monitoring and management of risk are in place to the standard which it is reasonable to expect of a district forensic service. In particular, it should ensure that:

- All new referrals, and all existing community cases, are the subject of a full risk assessment and management plan.
- All relevant information which is held by the Probation Service or other criminal justice agencies is obtained and evaluated as part of that assessment, and that those agencies are involved in or consulted about the assessment and care plan where appropriate.
- Where the Probation Service has a continuing involvement in the case, close working relationships are maintained and relative roles are defined as part of the care plan.
- Risk assessments take full account of the views of those living with or in frequent contact with the patient and of the possible risks to them.

Structure and Functions of the Forensic Service

15.3 The service commissioners, in conjunction with the Trust, should review the role of, and expectations placed upon the forensic service, and should consider whether it has, or can be given, the capacity to discharge to a satisfactory standard all of its present functions. In particular, they should ensure that:

- The criteria and thresholds for acceptance and retention of cases by the service are clearly set out.
- Its operational policies are consistent with the role of a district forensic service, especially in regard to the priority to be given to issues of risk to others.
- Its function is clearly defined in relation to the mainstream mental health service.
- The forensic service's Business Plan should be reviewed in the light of the findings of this inquiry.

The Forensic Community Team

15.4 If a dedicated community team is to continue to form part of the forensic service, the Trust and the service commissioners should satisfy themselves that it is capable of providing a comprehensive service and of meeting the standards expected of such a team. In particular, they should ensure that:

- It is managed by someone with the requisite qualifications and experience to manage a community mental health team.
- Nurses in the team have undergone a period of preparation and training prior to assuming full responsibility for cases in the community, and they are familiar with the principles of multi-agency working.
- Supervision arrangements are such that all team members receive clinical supervision from a suitably experienced member of their own profession.
- Team members acting as CPA care co-ordinators have the necessary authority to discharge their obligations and to ensure that CPA requirements are met.
- The team has the resources, or knowledge of and access to resources, sufficient to provide a comprehensive package of care including, where necessary, intensive support and daytime occupation.

15.5 The Trust and the service commissioners should consider whether the criminal justice liaison function is most appropriately placed in this team as opposed to the mainstream acute service.

Clinical Leadership of the Forensic Service

15.6 The Trust should ensure that there is clear clinical direction for the service as a whole. In particular it should:

- Review the job descriptions and job plans of the consultant forensic psychiatrist and consultant forensic psychologist to ensure that the roles are mutually compatible and that the expectations of the posts are reasonable.

- Ensure that adequate mechanisms are in place for clinical audit and review.
- Ensure that the CPA policy is amended where necessary to provide for consultant psychologists from other professionals to be the alternates of the consultant psychiatrists as the professionals with primary clinical responsibility, and to define clearly the obligations of that role.

Other Issues

15.7 The Trust should ensure that mental health staff are aware of the services available from the joint-funded Head Injury Team managed by Bradford Social Services, and how to access it.

15.8 The Trust should ensure that, where there is a question as to whether someone's needs would be better met from within its learning disabilities or its mental health services, that there are clear criteria for deciding the issue, and mechanisms to ensure that this can, if necessary, be done so quickly. If the case needs to be shared, one service should always be given lead responsibility.

APPENDIX 1 – TERMS OF REFERENCE

INDEPENDENT INQUIRY INTO THE DEATH OF MR B AS A CONSEQUENCE OF AN ASSAULT BY MR A ON 19 SEPTEMBER 2000

MAIN TERMS OF REFERENCE: MR A

General remit	to examine all circumstances surrounding the treatment and care of Mr A by mental health services.
Assessments	the quality and scope of his health and social care assessments and the related risk assessments.
Treatment and care	the appropriateness of his treatment, care and supervision in respect of: o his assessed health and social needs' o his assessed risk of potential harm to himself and others' o his previous psychiatric history and treatment' o his previous forensic history.
Compliance	the extent to which Mr A's care corresponded to statutory obligations and relevant guidance from the Department of Health (in particular Care Programme Approach HC(90)23/LASSL(90)11).
Care Plans	the extent to which care plans were effectively drawn up with Mr A and how those care plans were delivered and complied with.

ADDITIONAL TERMS OF REFERENCE: MR B

General remit	to examine all circumstances surrounding the treatment and care of Mr B by mental health and learning disabilities services from January 2000.
Assessments	the quality and scope of his health and social care assessments and the related risk assessments.
Treatment and care	the appropriateness of his treatment, care and supervision in respect of: o his assessed health and social needs, o his assessed risk of potential harm to himself and others, o his previous psychiatric history and treatment.
Compliance	the extent to which bcal policies were adhered to, especially those for patients who leave the ward whilst subject to inpatient care.
Care Plans	the extent to which care plans were effectively drawn up with Mr B and how those plans were delivered and complied with.

REMIT OF THE PANEL

To prepare a report on the incident and make recommendations on the lessons learned to the successor bodies of Bradford Health Authority and to the Bradford District Care Trust.

APPENDIX 2 – PROCEDURE ADOPTED

1 Everyone invited to give evidence to the panel will receive a letter in advance informing them:

- of the terms of reference and the procedure adopted by the inquiry,
- of the areas and matters to be covered with them,
- giving them the opportunity to provide written statements to form the basis of their evidence to the Inquiry,
- that when they give oral evidence they may raise any matter they wish, and which they feel might be relevant to the Inquiry,
- that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another inquiry witness,
- that it is the witness who will be asked questions and who will be expected to answer,
- that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2 Any points of potential criticism will be put to them, either orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

3 Any other interested parties who feel that they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

4 All sittings of the Inquiry will be held in private.

5 A summary of the findings and recommendations will be made public.

6 The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as is disclosed within the body of the Inquiry's final report.

7 Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on those findings.

8 Witnesses and other contributors, will not be named within the body of the report, but will be listed in an appendix.

9 At the conclusion of the Inquiry, the Inquiry records including witness statements and copies of transcripts of oral evidence will be held securely by the relevant health authority.

APPENDIX 3 – LIST OF PEOPLE INTERVIEWED

- Mr A ..... Subject of the Inquiry
- Mr A's mother
- Mr B's mother

- Service Development Manager ..... Airedale PCT
- Mr A's GP ..... Bradford
- Mr B's GP ..... Bradford
- Project Worker ..... Bradford Alliance on Community Care
- Chairman ..... Bradford and Airedale Mental Health Advocacy Group
- User/Carer Link Worker ..... Bradford and Airedale Mental Health Advocacy Group
- Public Health Consultant ..... Bradford City PCT
- Chair ..... Bradford Community Health Council
- Chief Officer ..... Bradford Community Health Council
- Vice Chair ..... Bradford Community Health Council
- Medical Director/Director of Mental Health Services ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Acting Professional Head of Nursing ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Chief Executive ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Registered Nurse ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Consultant Psychiatrist ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Court Liaison Nurse ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- CPN ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Joint CPA Key-Worker ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)

- CPN ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Consultant Psychiatrist ..... Bradford District Care Trust (ex Bradford Community Health NHS Trust)
- Consultant Forensic Clinical Psychologist ..... ex Bradford Community Health NHS Trust
- GP ..... Bradford Local Medical Committee
- Principal Care Manager, Learning Disabilities ..... Bradford Social Services
- Senior Care Manager ..... Bradford Social Services
- Manager, Disability Services ..... Bradford Social Services
- CTLD ..... Bradford Social Services
- Social Worker ..... Bradford Social Services
- Manager of Learning Disabilities ..... Bradford Social Services
- Senior Medical Officer ..... HM Prison Leeds
- Staff Nurse ..... Lynfield Mount Hospital
- Clinical Nurse Specialist ..... Lynfield Mount Hospital
- Senior Care Manager, Mental Health ..... Lynfield Mount Hospital
- Service Manager, Forensic Service ..... Lynfield Mount Hospital
- Ward Manager ..... Lynfield Mount Hospital
- Advocacy Care Worker ..... Lynfield Mount Hospital
- Named Nurse ..... Lynfield Mount Hospital
- Chair ..... Lynfield Mount User Monitoring Group
- Member ..... Lynfield Mount User Monitoring Group
- Senior Family Support Worker ..... Making Space, Bradford
- Consultant Forensic Psychiatrist ..... Rampton Hospital
- Social Worker ..... Rampton Hospital
- Forensic Psychologist ..... Rampton Hospital
- Registered Mental Health Nurse ..... Rampton Hospital

- Regional Commissioner, Forensics.....Selby and York PCT

- Detective Inspector .....West Yorkshire Police
- Sergeant .....West Yorkshire Police
- Probation Officer .....West Yorkshire Probation Service
- Probation Officer .....West Yorkshire Probation Service
- Probation Officer .....West Yorkshire Probation Service

APPENDIX 4 – LIST OF DOCUMENTS

BRADFORD COMMUNITY HEALTH NHS TRUST POLICIES AND DOCUMENTS

- Care Programme Approach – Joint Policy – Bradford Community Health NHS Trust and Bradford Social Services –September 1996 – Revised June 1997
- Clinical Supervision in Nursing – The Strategy – June 2000
- Mental Health Directorate – Trust Board – 21 January 2002 – Independent Inquiry Update
- Guidelines for Patients Leaving the Ward
- Lynfield Mount Hospital – Acute Adult Admission Unit – Guidelines detained patients removed to a police station – June 2001
- Lynfield Mount Hospital – Acute Adult Admission Unit – Action Plan re: Patient Homicide Report
- Mental Health Directorate – Adult Acute Admission Unit – Policy and Procedure for the Management of in-patients who "Abscond" or are "Missing from Hospital" – December 1998
- Internal Inquiry Report
- Forensic Service Outline Business Case Proposal – 5th Edition – January 2002
- Draft – Lynfield Mount Hospital – Osprey House and Forensic Community Liaison Team – Operational Policy and Procedures
- Managing violence and aggression policy, procedure and guidelines – "minimising the risk of violence and aggression"
- Lynfield Mount Hospital – Alcohol and non-prescribed drugs policy
- Lynfield Mount Hospital – Guidelines: patients valuables
- Lynfield Mount Hospital – Policy and Procedure for the Administration of Section 17 of the Mental Health Act 1983 – Leave of Absence from Hospital – August 1998
- Incident Reporting System
- Policy on Administration of medicines by nurses
- Policy and Procedure on individual access to health records – March 1999
- February 2002 – Forensic Service – Statistics and caseload analysis
- Suicides/open verdicts – Bradford population and Bradford Community Health NHS Trust 1996 – 2001 – Graph

- Learning Disabilities Management Structure
- Forensic Service – Patient Referral, Admission and Review Process
- Clinical Supervision: The 1998 Survey Results
- Mental Health Directorate – A strategy for clinical supervision of mental health professional
- Mental Health Directorate – Adult Acute Admission Unit – Policy and Procedure for the observation of in-patients – August 1998
- Guidelines for patients leaving the ward
- Clinical Supervision in Nursing – The Strategy – June 2000
- Responsibilities of the named nurse
- Lynfield Mount Hospital - Police Liaison Forum – Adult Acute Admission Unit – Minutes
- Rampton Hospital Authority – Physical Security Review of the Kestrel Unit, Lynfield Mount Hospital
- Risk Assessment and Risk Management in Mental Health – an introduction to FACE Risk Profile
- CPA Policy and Practice Guidelines for Health and Social Care Staff working in Airedale and Bradford – October 2001
- Central Induction – Training Details – Lynfield Mount Hospital

CASE NOTES

- Mr B Case Notes, Lynfield Mount Hospital
- Mr A Case Notes, Lynfield Mount Hospital
- Bradford Metropolitan District Council – Directorate of Social Services – Adult and Disabilities and Community Health Division Case Files – Mr B
- Mr B's Social Services Mental Health Team notes
- Mr A – GP Records
- Mr B – GP Records
- Social Services – Children's Records
- Rampton Hospital Authority – Extracts from records
- Inmate Medical Record, HM Prison, Leeds

MENTAL HEALTH ACT COMMISSION

- Visit to Bradford Community Health NHS Trust on 11 June 1998
- Visit to Bradford Community Health NHS Trust on 9 December 1998
- Visit to Bradford Community Health NHS Trust on 27 May 1999
- Visit to Bradford Community Health NHS Trust on 18 January 2000
- Full visit to Bradford Community Health NHS Trust on 26 September 2000
- Unannounced visit to Bradford Community Health NHS Trust on 22 May 2001
- Patient focused visit to Bradford Hospitals NHS Trust on 16 January 2002
- Note of visit of December 1998

DEPARTMENT OF HEALTH

- Mental Health Policy Implementation Guide – National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments
- National Institute for Mental Health in England. Personality Disorder: No longer a diagnosis for exclusion. Policy implementation guidance for the development of services for people with personality disorder + Appendix

WEST YORKSHIRE POLICE

- Custody Records – Mr A
- Witness Statements – 2000 arrest

PROBATION SERVICES

- Records and reports relating to Mr A

BAMHAG

- BAMHAG, results of a CPA Audit

BRADFORD COMMUNITY HEALTH COUNCIL

- An edited transcript of some of the material referred to when meeting the inquiry panel

OTHER

- Crown Prosecution Service, Bradford – Papers relating to 2001 trial
- UKCC – Position Statement on Clinical Supervision for Nursing and Health Visiting
- Mental Health Review Tribunal Rules 1983 – Statement of responsible authority
- Bridging the Gaps – Independent Inquiry into the Care and Treatment of Naseer Aslam – A report commissioned by Bradford Health Authority 1999
- The Dixon Team Inquiry Report – Report of the Independent Inquiry Team to Kensington & Chelsea and Westminster Health Authority, Westminster City Council, Newham Council, and East London and The City Health Authority – April 1999
- Complex Needs – Report of an Independent Inquiry into the care and treatment of Daniel Williams for Wakefield Health Authority – June 2001
- Bradford Health Authority – Director of Public Health Report – 2001