Report to Northumberland, Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of Damian Neaven

May 2004

This report is available in large print and can be translated for people whose first language is not English on request.

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Executive summary

1 The inquiry was established under the terms of HSG (94)27, following the conviction and sentence of Damian Neaven on 5 September 2001 for the murder of David Huitson. This assault occurred on 4 March 2001 and Damian Neaven had been discharged from the Collingwood Court of the former Newcastle City Health NHS Trust on 12 December 2000.

2 The panel concluded that unless Damian Neaven had actually been deprived of his liberty (and there were no grounds to do so) it is hard to see how different treatment or care could have resulted in the offence of murder not taking place.

3 Throughout Damian Neaven's history of involvement with psychiatric services the panel found many examples of good practice and consistent willingness to help a difficult, complex and dangerous man.

4 However, the panel found that there were areas where lessons could be learned and these were:

- The interface between general adult services and the regional forensic service (recommendations 1 and 9)
- The liaison arrangements between the mental health service, the police and the probation service (recommendations 3 and 4)
- Care Programme Approach (CPA) implementation and in particular the incorporation of social circumstance reports, the role of the care co-ordinator, the inclusion of contingency plans and home visits (recommendations 5,6,7 and 8).

1 Introduction

1.1 General

We were appointed by the Northumberland, Tyne and Wear Strategic Health Authority (SHA) on 19 September 2002 to enquire into the health care and treatment of Damian Neaven and to deliver to the Authority in due course our report, including findings and recommendations.

At all relevant times Damian Neaven was involved with psychiatric services of the Newcastle City Health NHS Trust which became part of the new Newcastle, North Tyneside and Northumberland Mental Health NHS Trust (the trust) on 1 April 2001.

The inquiry panel consisted of:

- Mrs Margaret Crisell, solicitor advocate, Chair
- Dr Paul Collins, consultant forensic psychiatrist, South West Yorkshire Mental Health NHS Trust, Wakefield
- Mr Martin Manby, Director, Nationwide Children's Research Centre
- Mr David Brown, Director of Mental Health Services, Craven, Harrogate and Rural District Primary Care Trust.

1.2 Terms of reference

1.2.1 The Inquiry was established under the terms of the Health Service Guidance (HSG) (94) 27 following the conviction and sentence of Damian Neaven at Newcastle upon Tyne Crown Court on 5th September 2001 for the murder of David Huitson.

1.2.2 The terms of reference were as follows:

- To consider the report of the Internal Inquiry (with external assessors) conducted by the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust and;
- To examine the circumstances surrounding the health care and treatment of the above patient, in particular:
  - The quality and scope of his health care and treatment and the assessment and management of risk.
  - The interface between mental health services, in particular adult psychiatry and forensic psychiatry.
  - The appropriateness of the treatment, care and supervision in relation to:
    - the effectiveness of the implementation of the Care Programme Approach
    - assessed health and social care needs
    - risk assessment in terms of harm to self or others
    - previous psychiatric history including drug or alcohol abuse
  - The extent to which his care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
  - To consider the effectiveness of inter-agency working, with particular reference to the sharing of information for the purpose of risk assessment.
  - To prepare a report and make recommendations to Northumberland, Tyne and Wear Strategic Health Authority.

1.2.3 The panel had access to the internal inquiry report, which was read and fully noted. They met with the chief executive of the trust who had instigated the internal inquiry himself. The panel also met with the medical director of the trust. The panel found the inquiry report to be a thorough and useful piece of work. The panel noted that it (the panel) had had access to a far wider spectrum of information than the internal inquiry, and had had the benefit of more time and resources with which to interview a large number of witnesses and to analyse the written information in great detail.

1.3 Meetings and consideration of evidence

1.3.1 The panel met on:

19.11.2002	at the offices of the SHA
14.01.2003	" " " " " "
15.01.2003	at St Nicholas Hospital and the offices of the SHA
24.01.2003	at the offices of the SHA
06.02.2003	" " " " " "
07.02.2003	" " " " " "
02.04.2003	at a high security hospital
20.05.2003	at the offices of the SHA
21.05.2003	" " " " " "
28.07.2003	" " " " " "
29.07.2003	" " " " " "
29.09.2003	" " " " " "
21.11.2003	" " " " " "

1.3.2 The panel visited Damian Neaven (DN) at a high security hospital on April 2nd 2003.

1.3.3 The panel considered comprehensive documentation from various agencies including health, probation and the police.

1.3.4 The panel also received documentation/information from the clinical and social work team at the high security hospital.

1.3.5 The panel heard evidence from a number of witnesses. All those who gave formal oral evidence received transcripts of their evidence and were given the opportunity to amend and approve those transcripts.

1.3.6 The agencies involved have been afforded the opportunity to disclose fully all relevant information or documentation.

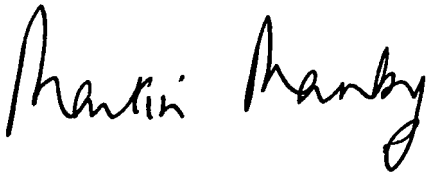
1.3.7 The close relatives of the victim and of DN, and DN himself, have been offered the opportunity to talk to the panel and have done so.

1.3.8 The panel had access to a letter which DN admitted writing after his conviction, addressed to a Newcastle family known to the victim's family, which contained implicit and explicit threats.

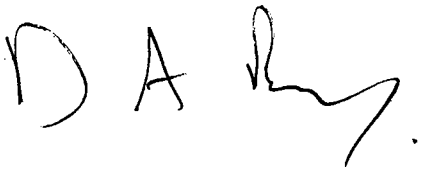
1.3.9 The inquiry panel assumes that all evidence received, whether written or oral, has been based on full and frank disclosure.

Margaret Crisell

Paul Collins



Martin Manby



David Brown

2 Narrative of key dates and events

This narrative is based on the written and oral information to which the panel had access. The panel has endeavoured as far as possible to ensure that the information is correct. It cannot be a comprehensive account of all events in DN's life, but is intended to summarise, as needed in the light of the terms of reference, the key events of DN's life up to the date of the murder, with some brief information in respect of subsequent events insofar as it may cast a light upon his care and treatment before the murder, or add to biographical information.

2.1 Background

2.1.1 Damian Neaven (DN) was born 7.10.78.

2.1.2 In or about 1978, his parents separated. For a period of about 10 years DN appears to have been brought up by his mother, with support from his grandparents.

2.1.3 In or about 1989, when DN was 10 or 11, his mother remarried a man who had two older boys then aged about 16 and 18.

2.1.4 In or about 1989 his mother and stepfather had another child, a girl, thus 10 years younger than DN. It is reported that DN was close to his stepbrothers and very fond of his half sister.

2.1.5 There was some contact between DN and his father during DN's childhood.

2.1.6 Up until about the age of 11 or 12, school and home reports of DN were very positive. He was reported to be a happy, friendly little boy who was intelligent and achieved well; bookish and well behaved.

(Many professionals have expressed the view to the panel that DN is an intelligent man.)

2.2 Aged 11/12 onwards – 1988/9 to 1994/5

2.2.1 It appears that DN's physical development from this age was precocious, in that he grew very quickly and his appearance was very mature, tall and with a deep voice.

2.2.2 By his own account, at 11 years old DN started taking drugs, first cannabis, then at age 12, LSD and alcohol; at 13, amphetamines and at 15 heroin.

2.2.3 By then DN was regularly drinking large amounts of lager and vodka.

2.2.4 According to his own account, DN became involved in a substantial number of undetected criminal acts from a relatively early age, as well as the offences for which he was convicted. A large number of these arose out of aggressive incidents between pupils at secondary school, were violent to varying degrees, and many related to 'gang' behaviour and retributive acts. He claims that he witnessed domestic violence at home, which only stopped when he committed an act of violence himself against the perpetrator.

(The accounts DN has given of the extent of his violent behaviour may not be wholly reliable; he himself has indicated that some accounts he has given, particularly since the murder, may have been exaggerated, and the panel has no means of corroborating the extent and detail of what he has alleged; the police told the panel that criminal activities on the scale described by DN would probably have come to their attention. However it is quite clear, and is agreed by all who had dealings with him, that DN moved in a culture of violence, intimidation and revenge, to a greater or lesser degree, from a relatively early age. It is also the case that DN suffered various injuries as a result of fighting or being involved in violent incidents.)

2.2.5 At 13 after problems at his first secondary school (comments were apparently made that he was lively and intelligent, but his behaviour was disruptive to a point where the school 'ran out of options'), the available records indicate that an agreement was reached that DN would move to another school.

2.2.6 Having attended the next school for a while, DN was expelled for aggressive and abusive behaviour at age 15.

(This was the point at which the first referral to psychiatric services was made by DN's GP – see later)

2.2.7 DN was then referred to a school for children with behavioural difficulties, which he did not attend, choosing to enrol at a tertiary college. Here, he states that he developed an active social life and neglected his lessons, leading to his early (involuntary) departure. This was repeated later when he re-enrolled at the same college.

(Some time in 1994, around the period when DN had left school and enrolled at college, he had his first formal involvement with the criminal justice system, involving trespassing on land with an imitation or replica firearm. He was convicted (his first recorded conviction) on 10.3.95).

2.2.8 DN had some brief attempts at work, involving as the panel understands it a local YTS scheme with which he did not persevere, and then in or around September 1995 a scaffolding apprenticeship out of the area, which was initially successful but was terminated after DN became involved in an incident of criminal damage involving the foreman. There do not appear to have been charges laid. Subsequently DN returned to Newcastle and remained based in the area.

2.2.9 From 1994 until 2001, DN had involvement both with psychiatric services and the criminal justice system. The history of contacts with psychiatric services is dealt with under section 3 below and the criminal justice involvement under section 4 below.

3 Contact with psychiatric services

3.1 The first recorded referral to the psychiatric services was in April 1994, when DN was 15. His GP referred him to the Young Person's Unit at the Newcastle General Hospital (YPU) after his expulsion from school but the unit declined the referral stating that they did not accept referrals where the only problem was aggressive behaviour. Shortly afterwards, a further referral was made to the Fleming Nuffield Unit at the Newcastle Royal Victoria Infirmary; the referral was accepted, and an appointment was sent out but DN did not keep it.

(In December 1994, when he was 16, DN committed his second recorded offence, of Assault Occasioning Actual Bodily Harm (AOBH) against a minor, for which he was convicted on 21.7.95.

In January 1995 DN committed his third recorded offence, again of AOBH, for which he was convicted on 29.9.95.

In June 1996, DN committed his fourth recorded offence of Grievous Bodily Harm (GBH), against the aunt of the victim of his second offence. He was convicted on 6.11.96.

In November 1996 DN committed his fifth recorded offence, of criminal damage to a car, for which he was convicted on 28.1.97.)

3.2 The next recorded referral to the YPU by the GP was in January 1997, when DN had complained to the GP of excessive outbursts of aggression, and 'paranoia' interpreted by the GP as anxiety. Three appointments were offered, which DN did not attend, although his mother attended one. It appears to be the case that the reasons for the non-attendances were commitments to court and further involvement in crime (see below) which led to DN being remanded in custody for a short time.

(On 31.3.97 (aged 18) DN committed his sixth recorded offence, the most serious to date, of Section 20 Wounding and Criminal Damage. In April 1997 he was briefly remanded in custody at Low Newton Remand Centre.)

3.3 The next recorded involvement with psychiatric services was while DN was on remand in April 1997 when he was referred to the Newcastle Adolescent Forensic Service (the Kolvin Unit). He was seen at Low Newton Remand Centre, referred by the prison authorities and found to be preoccupied with violence, expressing feelings of 'paranoia' and depression. In the community he had apparently been consuming massive daily doses of alcohol to overcome the feelings of 'paranoia'. He gave an account of extensive antisocial behaviour and of resolving difficulties by violence. It was intended that he should receive some help with anger management but he was granted bail about a week later.

(In relation to this assessment by the Kolvin Unit, there was no reference in the clinical notes to any symptoms of mental illness.)

3.4 The third recorded referral by the GP to psychiatric services was to the YPU on 24th April 1997, just after he had left Low Newton. DN was offered an appointment and seen by a consultant clinical child and adolescent psychologist ("the clinical psychologist") on 10th June 1997.

DN was assessed by the clinical psychologist as suffering from mixed conduct and affective disorders, which underlay an extreme problem of anger control, and was described as 'dangerous'. The clinical psychologist arranged for DN to be prescribed antidepressants and he underwent a series of further appointments for an anxiety management programme. The problems were identified as extensive, intensive and chronic, with a poor prognosis and the clinical psychologist felt he should have been seen and treated 'years ago'. DN himself apparently told the clinical psychologist that by the time he was thirty he was likely to be in prison or dead.

The clinical psychologist commented, among other things that he appeared to be in the high average range intellectually, that his background was marked with exposure to violence, and absence of consistent care and control. His abuse of alcohol and drugs was noted, as well as his anxiety and suspicion.

There was no diagnosis of mental illness, and the panel was informed by the clinical psychologist that there was no evidence of thought disorder or delusions, though there had been some serious reactive depressive episodes.

The clinical psychologist developed a supportive and trusting relationship with DN and offered him regular appointments which by and large DN attended consistently throughout the rest of 1997

and until he was imprisoned in 1998. During this time the clinical psychologist carried out a programme of intensive one to one work with DN on anger control and anxiety management. In a report for court for the Section 18 offence committed in March 1997 (see section 4), the clinical psychologist comments that pharmacological and psychiatric treatments were not relevant to DN's problems, which required complex and time consuming psychological approaches (which the clinical psychologist had employed for the 16 sessions he had had with him). If the therapeutic aims were to be sustained, DN would have to be enabled to continue this treatment. (This was not possible because DN was sentenced to custody.)

(The clinical psychologist commented to the panel that he had tried to get DN's trust and to alter some of his perceptions but time was against them. He said that he would have gone on with DN as long as possible, had he not been imprisoned, and then tried to get him transferred to an identified person in the adult services (DN was approaching 20). He emphasized the importance of continuity, of building a relationship, with someone like DN, and said that it was not a good idea to have several people dealing with him. He clearly made a strong and, to an extent, lasting impression on DN.)

(In August 1997, DN committed his seventh recorded offence of intimidation of two of the witnesses to the section 18 and criminal damage offences committed in March 1997.)

3.5 While briefly remanded in connection with the intimidation charge in August 1997, DN was seen both in the Bridewell (court cells) and at Low Newton again, by a representative from the Kolvin (forensic adolescent) Unit. He appeared, briefly, suicidal, and presented as unpredictable and vulnerable. It was agreed between the Kolvin Unit and the YPU that the clinical psychologist should continue with him; in the event he was bailed and the appointments continued anyway.

(On 29.1.98 DN received a custodial sentence of 8 months for the Section 20 wounding, criminal damage and intimidation charges. He served six months of this sentence partly at Low Newton and partly at Northallerton Young Offenders' Institution (YOI). He was released on youth licence in July 1998.)

3.6 During this sentence, some concerns were expressed to the prison via the probation officer about his mental health. In the autumn following his release from prison, DN's GP referred him again to the Kolvin Unit. He was said to have ceased his medication while in

prison, to be drinking to excess, to be suffering unrest and unhappiness, increased 'paranoia' and difficulty in controlling his feelings. He was sent an appointment by the Kolvin Unit but he did not attend. The Unit wrote to DN's GP suggesting a referral to the clinical psychologist. There appears to have been no further contact.

(Concerns had been expressed to his GP by his probation officer as her involvement was coming to an end, and she was worried that there would be no statutory involvement with DN after that point.)

(In January 1999 DN was convicted (eighth conviction) of theft from a vehicle and fined.

In March 1999 he committed the offence of possessing an offensive weapon and affray for which he was convicted (ninth conviction) in June 1999.)

3.7 There is no further reference to contact with the psychiatric services until June 1999, when the GP referred DN to adult psychiatry, after concerns expressed about his feelings of aggression. He was seen by a senior psychiatric registrar, (psychiatrist 1) in July 1999. Psychiatrist 1 took a detailed history from DN including noting some of the previous criminal convictions. She had seen a letter from the clinical psychologist of the YPU dated 11th June 1997. DN presented to psychiatrist 1 with a history of very heavy drinking (the equivalent of twenty pints per day), anxiety, paranoid feelings, drug abuse and aggression. On mental state examination psychiatrist 1 noted no evidence of psychotic symptoms. Specifically there was no evidence of delusions, thought disorder or perceptual abnormalities such as hearing voices. She concluded that DN had a background of paranoid and anti-social personality traits, a current dependency on alcohol and possibly an anxiety or panic disorder. She noted the family background of violence and heavy drinking, concluding that "despite this, possibilities exist for treatment". She then outlined a comprehensive management plan involving a combination of medication, referral to a local specialist drug and alcohol unit, referral to the community team for anxiety management and an intention to review him in six weeks. She noted the possibility that addressing his alcohol problem might help him control his anger. DN was offered an appointment six weeks later, which he cancelled himself by telephone and was then offered a further appointment. He did not attend the arranged appointment at the drug and alcohol unit and was discharged. Psychiatrist 1 outlined her views

to the GP in a detailed and comprehensive letter on 23rd July 1999.

(Psychiatrist 1 confirmed to the panel that she had found no evidence of psychosis, no evidence of mental illness and that she did not consider admission to hospital was appropriate. She was not surprised when he failed all opportunities for follow up as she felt he presented a typical picture of a young man, with certain traits, presenting in a crisis.

In the panel's opinion the diagnosis and management plan were appropriate. There was no evidence that he was mentally ill. The only potential gap in the information available to psychiatrist 1 would have been information provided by family members because DN seems to have attended alone.)

3.8 In September 1999 DN was referred back to adult psychiatry. He was seen urgently by psychiatrist 1 in the outpatient clinic following a telephone call that morning from DN's GP. The referral letter from the GP to psychiatrist 1 stated that DN had been brought to the surgery by his father and that he "appeared depressed". He was said to have taken an overdose of a friend's medication four days earlier but did not go to the casualty department because his father made him vomit up the tablets straight away. There is a reference to heavy drinking and concerns that he "seems to be suicidal" (from his stepfather and mother). The GP had started him on antidepressants and asked for an urgent assessment.

DN attended with his mother and step father but wanted to see psychiatrist 1 on his own. She once again took a detailed history. It emerged that his relationship with a fourteen years old girl had become known to her family and this was causing him concern. The relationship had commenced since the previous psychiatric clinic assessment. DN could offer no explanation why he had not complied with the previous treatment plan.

He was on bail for an alleged Section 47 assault and breach of probation. Examination of his mental state did not reveal any evidence of psychosis. He was said to be preoccupied with recent events and to have suicidal ideation but no definite plans.

His presentation confirmed to psychiatrist 1 a picture of anti-social personality traits but without any evidence of current mental illness. It was agreed with DN that he would spend some time away from home, would take the medication prescribed by the GP and be seen again by Psychiatrist 1 one week later. DN did not

attend the next appointment with her or a further appointment which was offered for the 9th November 1999.

Psychiatrist 1 once again sent a detailed letter to the GP outlining the assessment and the management plan.

Following his failure to attend on 9th November 1999 she wrote to him again with a copy to the GP, saying that DN would be discharged if he did not contact the clinic.

(On the basis of the presentation recorded both in the GP's letter and the clinical records the formulation of abnormal personality traits was reasonable.)

(DN was convicted of shoplifting in January 2000, with a £60 fine.)

3.9 In February 2000 DN was referred urgently by his GP. The GP's letter mentioned that DN had a two week history of mood swings and was aggressive with a depressive mood.

He was seen, on the same day as he was referred, by a senior house officer in psychiatry (psychiatrist 2) who took a detailed history. The doctor discussed his assessment with the consultant psychiatrist (psychiatrist 3). DN's problems were thought to be due to an anti-social personality disorder, a history of drug abuse and of previous head injuries. He was thought not to be at risk to himself but to be at a high risk of aggression because of his long-standing history and his personality type. No symptoms of psychosis were noted. He was thought possibly to be depressed. He was treated with anti-depressants (already started by the GP) and a mood stabilising drug. Psychiatrist 2 intended to review DN one week later and telephoned the GP to outline the management plan. When reviewed one week later DN's presentation was unchanged and his medication was therefore adjusted. An EEG (brain waves test) had been ordered because of the history of head injury. He was reviewed on the following week and continued to describe the previously noted symptoms although the doctor thought that these had lessened slightly. DN failed to attend further outpatient appointments on 7th March and 20th April 2000 and was discharged from the clinic.

(Once again the diagnosis and formulation of a fundamental personality disorder with other associated mood and behavioural problems were appropriate.)

3.10 On 12th September 2000, DN was again referred to psychiatric services by his GP and seen in outpatients department by a house officer in psychiatry (psychiatrist 4)

The brief referral letter says that DN wanted help for his anxiety. DN's mother also attended to give information.

The presenting problems were noted to be panic attacks, thoughts of harming other people, episodes when DN reported seeing himself, in his mind's eye, causing injuries to other people, and the report by him that he had recently followed two strangers in the street. DN reported that he could not sleep and was terrified that he might harm someone. His mother reported that she was afraid to leave DN's sister with him and also said that his girlfriend was frightened to be with him.

By now, DN was self medicating with tranquillisers (valium) which he bought from drug dealers. He was also using heroin (and had last taken some on the morning of the appointment with psychiatrist 4) and was occasionally using crack cocaine. In the history, which is very detailed, it is noted that DN had said he "never heard voices".

On examination there were no signs to indicate psychosis. It was thought that the visual images were not true hallucinations. Psychiatrist 4 gained the impression that DN's view was that the responsibility for his actions would pass to her and to the psychiatric services.

A risk assessment was documented in the medical notes and a management plan included referral for further investigations and referrals to the drug and alcohol team, and to psychology and the forensic services. DN was given a two week supply of Diazepam (valium) and told that he would have to have a urine test for drugs on his next attendance.

(Psychiatrist 4 told the panel that had she been more experienced she would have arranged for the urine test to be taken before prescribing him any medication and would have given him a prescription for a shorter time. The relevance of this point is that DN's subsequent admission to Collingwood Court followed his report that he had overdosed on these tablets.)

(The referral letter to the forensic services which was compiled some days later following DN's admission to Collingwood Court indicated the view that he was suffering from a personality disorder and was not mentally ill.

Once again, on the basis of the information in the files, a diagnosis of a severe personality disorder is quite reasonable. There are no recorded symptoms to indicate schizophrenia or some other

psychosis. Patients with severe personality disorders will often report odd thoughts or visual experiences which are not indicative of schizophrenia or some other psychosis.)

3.11 On the 10th November 2000 DN was admitted to the Freeman Hospital following an alleged overdose of diazepam as a result, he reported, of having had a 'vision' of himself killing his girlfriend and then finding himself holding a knife to her throat.

3.12 On the 11th November 2000, DN was discharged from the Freeman to St Nicholas' Hospital and admitted as an inpatient in Collingwood Court under the care of a locum consultant psychiatrist (psychiatrist 5). On admission he was noted to have good 'insight' into his condition, and was placed on appropriate observation levels.

3.13 The admission to Collingwood Court

(DN remained an inpatient in Collingwood Court until 14.12.00 when he was discharged home with a comprehensive package of after care.)

3.13.1 On the 13th November 2000 DN was assessed by psychiatrist 5. He was noted to be cooperative, was put on an appropriate observation, treatment and nursing programme, and was given a provisional diagnosis of personality disorder (sociopathic).

3.13.2 On 13th November 2000 a risk assessment completed by psychiatrist 4 found him to be at risk of violence to others

3.13.3 On 14th November 2000, psychiatrist 4 wrote a letter of referral to forensic psychiatry. The team was seriously concerned about its ability to manage DN on the general adult ward. She asked for an assessment, perhaps with a view to taking over his management, and additionally a forensic psychology assessment and help ' in the near future'.

3.13.4 On 15th November 2000, DN was reviewed by psychiatrist 4 who took another detailed note of his history and presentation and concluded there were no abnormal perceptions, no formal thought disorder and that he had insight into his condition.

3.13.5 On 16th November 2000 he was again reviewed on the ward. It was concluded that there was no evidence of psychosis, no evidence of an affective disorder and limited evidence of anxiety. There were however several indications of personality disorder. Appropriate treatment and nursing plans were put in place.

3.13.6 On 21st November 2000 an EEG was carried out which proved to be normal.

3.13.7 On 22nd November 2000 a specialist forensic psychiatric registrar (forensic psychiatrist 1), carried out a full diagnostic and risk assessment, the report of which, dated 30th November 2000, set out a detailed history and made certain observations and recommendations. It was reported that DN suffered from anxiety symptoms, violent thoughts differentiated between ' normal' violence ('sorting out someone who has annoyed him') and 'abnormal' violence, and violent images – sometimes referred to as flashes. The ' normal ' violence was not amenable to psychiatric intervention, and there was a risk of future violence. The 'abnormal' violent thoughts were related to the violent images. Psychiatric intervention with the anxiety disorder might diminish his risk of violence, as would work with substance abuse which could cause aggression and irritability on withdrawal, and disinhibition when 'using'. Forensic psychiatrist 1 agreed with a previous diagnosis of paranoid and antisocial personality traits, a generalised anxiety disorder, and substance misuse. She recommended certain medication to dampen down arousal levels, and treatment and therapeutic techniques including cognitive therapy, drug monitoring, and tailored exposure to stresses, and offered to review DN and attend meetings.

(Forensic psychiatrist 1 informed the panel that she looked carefully for signs of schizophrenia, but could not make DN fit that diagnosis. In her view – shared with all others who had treated him – there were no signs of psychosis. The 'normal' violence – revenge, rough justice, etc, did not arise out of any psychiatric morbidity, but might be escalated by substance misuse. She also informed the panel that the 'abnormal' thoughts would have been appropriately dealt with by the forensic psychologist. She did not offer to take the case on behalf of the forensic psychiatry service.)

3.13.8 The admission continued with careful monitoring of DN's mental state and gradually increasing periods of leave. From the 24th November onwards the main objective of the nursing plan was to reduce anxiety levels in DN.

3.13.9 On 4th December 2000 it was noted at a team meeting that DN would require a key worker, ideally from the forensic psychiatry service.

3.13.10 On 6th December 2000 psychiatrist 5 wrote to the consultant forensic psychiatrist (forensic psychiatrist 2), asking for further guidance as to what criteria would have to be fulfilled for DN's

management to be taken over by the forensic team. On 7th December 2000 forensic psychiatrist 2 promptly replied, making it clear that as DN appeared to be managing without difficulty in a non secure bed, it would not be appropriate to consider him seriously for transfer as an inpatient for the forensic service which only had beds in medium security conditions. In terms of after care, forensic psychiatrist 2 was of the view that a change of team at the point of discharge would be unwise, and in addition that the forensic psychiatry service did not operate on a district, but rather on a regional basis. He did however offer to remain involved for at least a limited period, highlighting the care programme approach meetings as a forum for forensic input and offering review by forensic psychiatrist 1, or further assessments, for example by forensic psychology.

(Psychiatrist 4, the senior house officer to psychiatrist 5, had already requested forensic psychology input. Psychiatrist 5 told the panel that forensic psychology could have provided the most helpful intervention; the nature of DN's symptoms demanded a psychological approach. Forensic psychiatrist 1 also told the panel that this would have been helpful. However at this point in the admission it was not forthcoming as the referral had not been received by the forensic psychologist.)

3.13.11 In his reply forensic psychiatrist 2 also mentioned the possibility of involving the assertive outreach team.

(However the panel later learned that the criteria for this were not met at that time.)

3.13.12 On the 7th December 2000 DN was referred by the current senior house officer (psychiatrist 6) to the drug and alcohol team. He explained the background briefly and noted that the forensic psychiatry team had been reluctant to take over DN's care. A community psychiatric nurse (CPN 1) from the drug and alcohol service assessed DN on the ward on 13th December 2000. DN told CPN 1 that he took valium and heroin to reduce anxiety, paranoia, depression and hallucinations. CPN 1 found DN's mood to be within normal parameters and that DN was thinking quite positively about a future without illicit drugs. He agreed to offer DN some treatment sessions.

3.13.13 By now plans were being made for DN's discharge from inpatient care. DN had been having some leave. There were anxieties about certain reported events during those leaves: specifically reports of further violent images, DN's admission that he had taken some heroin, and his report that he had followed a stranger. There was

also one report in the nursing notes, of which psychiatrist 5 was not aware, that DN thought that people were putting thoughts into his head. The clinical team was aware of these events and managed them. On 11th December 2000 forensic psychiatrist 1 was present at a meeting on the ward, and had a brief interview with DN, who she noted was much calmer and less anxious. His medication was being further adjusted. She also noted that he was aware of and happy with his discharge plan. She agreed to liaise with his CPN and clinical team.

(There is confusion about the nature of this meeting. The procedures for discharge would involve the care programme approach (CPA) (see elsewhere in this report). There is a document in the records apparently recording a CPA review, with attendance by Psychiatrist 5, the general adult CPN (CPN 2), CPN 1 and forensic psychiatrist 1. This document appears to be signed on behalf of DN's key worker on the 20th December, and 27th December by DN. The document sets out clearly the complexity of need (full multidisciplinary, the highest level), the highest level of risk (serious violence) and a detailed after care package to support the level of need and risk. It is unclear however when this meeting took place. It may have been the meeting which forensic psychiatrist 1attended, by chance (she was not invited) on 11th December 2000 on the ward. The panel was told however that the meeting on 11th December would have been a multidisciplinary ward meeting.

Whether or not it was a CPA meeting, three things are clear:

- *forensic psychiatrist 1 took it to be one at the time;*
- *she had not been formally invited;*
- *she took the opportunity to review DN briefly.)*

3.13.14 As indicated above, the discharge package was very detailed. It involved:

- Outpatients' appointments for consultant review.
- weekly hospital clinic appointments for medication (including long acting anti-psychotic injections)
- referral to the drug and alcohol team for treatment and support
- allocation of a CPN (community psychiatric nurse) – (CPN 2) – with regular contact. CPN 2 would be the care coordinator after discharge.

- participation in the partial hospitalisation service structured activity support on anxiety related symptoms

3.13.15 The discharge summary completed by psychiatrist 6, confirmed a diagnosis of generalized anxiety disorder, substance misuse and antisocial personality traits.

(This inpatient hospital admission under the general adult services, of some five weeks duration, occurred following the reported taking of an overdose of diazepam tablets by DN, three days after his last contact with psychiatrist 4. Psychiatrist 5 queried whether DN had in fact taken an overdose.

The previous psychiatric clinic notes and opinions of the other doctors who had seen him were all available to the care team although psychiatrist 5 had considerable difficulty obtaining information about his care from the Young People's Unit. DN was examined on a number of occasions during this admission and the doctors also had the benefit of the multidisciplinary team assessment and opinion.

DN continued to report his symptoms of anxiety, paranoia, violent urges etc. as previously noted. Throughout this stay, psychiatrist 5's diagnosis was of a personality disorder and he excluded schizophrenia or any other psychotic disorder or affective disorder. The issue about which service ought to be managing DN was more in question than the possibility that DN had schizophrenia.

An entry in the nursing notes, on 10th December 2000, records DN saying that "he felt as though people had been putting these thoughts into his head, for example thoughts about his step-father, thinks that step-father putting thoughts in his head". In evidence psychiatrist 5 told the panel that he was not aware of this entry. However taking the totality of DN's presentation, including all other previous psychiatric assessments of him, and the views of the experienced nursing staff on the ward (who, in psychiatrist 5's view, would have flagged up this entry if they thought DN was psychotic) and keeping in mind the possibility that DN may have been able to "press the right buttons" in order to obtain more medication, for example, he was not of the view that DN was in that statement describing a symptom of schizophrenia.

During the admission and upon discharge DN was provided with a management plan which had a number of components that included anti-psychotic medication (used in his case not because he was thought to be mentally ill but because low doses of these medications are sometimes helpful in patients with personality

disorders) but also opportunities to access counselling and psychological forms of treatment including the referral to the drug and alcohol team, referral to forensic psychology and support from psychiatrist 5 and CPN 2.)

(The panel noted that during the admission, careful monitoring and recording took place both in terms of clinical and nursing involvement. The nurses (and others) reported an excellent professional relationship with psychiatrist 5, whom they described as thorough and involving.

Psychiatrist 5, the consultant, reported to the panel that he had tried to develop a therapeutic relationship with DN, and adopted a holistic approach with DN's family as far as possible. (His family, however, felt that after discharge they were not sufficiently involved.) All those responsible for his care at Collingwood Court felt that the signs pointed to a considerable improvement by the time of discharge. DN was reported to have been compliant and cooperative throughout his stay. Forensic psychiatrist 1 commented that DN really seemed to want help and to be asking for it.

There was unanimity that there would have been no grounds to detain DN under the Mental Health Act (see elsewhere in this report). He did not fulfil the criteria for compulsory detention.

It was however clear that there was anxiety about DN's history of violence and the extent to which he could or should have been managed on a general adult ward, although as forensic psychiatrist 2 commented, they did manage to nurse him without apparent difficulty. There was unease about the situation. Although the staff never felt personally threatened, DN did have an intimidating presence.

The panel gained the impression that, having been told there was no chance of forensic psychiatry taking him over, the ward 'got on with it' as best they could.

Psychiatrist 5 followed up the request for forensic psychology input in January, having had no response. Psychiatrist 5 was concerned about the difficulty he experienced in obtaining access to DN's notes from the YPU and said that they took a long time to arrive. (Forensic psychiatrist 1 also confirmed that sometimes it took 6 to 8 weeks to access notes from the YPU.) Psychiatrist 5 told the panel that had he seen them and known there was adolescent forensic involvement and probation input he would have been more combative with forensic psychiatry when they declined to take over his case. He commented that the amount of information

received from Northumbria Police was limited to one A4 sheet of offences and that this did not alert him to enquire further. (The information from the police was completed on a standard notification sheet.)

In the absence of a hindsight diagnosis of schizophrenia made after the murder, there is nothing of significance in the clinical records to suggest that the diagnosis of severe personality disorder reached during DN's stay at Collingwood Court both by the consultant and the specialist registrar in forensic psychiatry and their colleagues was inappropriate. Apart from the single recorded comment which with hindsight may have suggested thought interference by outside forces (a symptom of schizophrenia), all of the symptoms and behaviours reported by DN were entirely in keeping with the long held diagnosis of severe personality disorder. Even considering that single isolated "symptom", it is not uncommon for patients with severe personality disorder to experience psychotic-like symptoms either as a consequence of their disorder or due to the abuse of drugs. Patients with personality disorders often have difficulty accessing services within the United Kingdom. However this was clearly not the case in respect of DN who was offered an extensive care package.)

3.14 Post discharge events

3.14.1 After discharge on 14th December 2000 DN returned to live with his girlfriend. He had in place a package of after care, as set out above. Initially he appears to have attended some of the given appointments, including outpatients for review and the clinic for medication, his care coordinator, CPN 2, and later (31st January 2001) with the drug and alcohol team CPN 1. He only attended the partial hospitalisation service once.

3.14.2 On 20th December 2000 DN had his first arranged outpatient appointment with psychiatrist 5. He did not attend as he had been admitted to hospital for a physical problem.

3.14.3 On 27th December 2000 DN met the CPN 1 (from the drug and alcohol service.)

3.14.4 On 27th December 2000, DN was reviewed in the outpatient's department by psychiatrist 5. DN reported that he was drinking eight cans of lager per night in order to help him sleep. No symptoms of psychosis were noted. DN continued to report having images of violence but had contained any impulse to act out. He was

recorded as continuing to experience 'flashes' and being nervous, edgy and anxious.

3.14.5 On 28th December 2000, psychiatrist 5 wrote to the GP. He reported in outline the result of the of the outpatient's review on 27th December, including confirmation that DN was compliant with his medication and that while there was anxiety there were no psychotic symptoms.

3.14.6 On 3rd January 2001 DN met with CPN 2.

3.14.7 On 4th January 2001 DN attended a workshop for the partial hospitalisation service. This was the only attendance at this programme.

3.14.8 On 8th January 2001 DN reported that he had taken an overdose of 50 tablets, and was admitted briefly to the Royal Victoria Infirmary, but having received treatment, discharged himself against medical advice. The same day DN called in to see CPN 2, about the overdose. Psychiatrist 5 was apparently informed.

(It is not clear when DN discussed this with psychiatrist 5. There is no record of an outpatient's appointment until the 31st January. Certainly DN discussed it with CPN 2. However DN told the panel that he saw psychiatrist 5 straight after the alleged overdose, felt he needed to be back in hospital and was disappointed when psychiatrist 5 did not readmit him. He felt that psychiatrist 5 did not believe him. There is no record of a meeting between DN and psychiatrist 5 immediately after the alleged overdose).

3.14.9 On 10th January 2001 CPN 2 saw DN. DN was expressing concern about the side effects of his medication (dampening his libido). He did not express thoughts of a violent nature. There was no evidence of deterioration in his mental state, although he stated he felt anxious at times.

3.14.10 On 11th January 2001 psychiatrist 5 followed up the request for a forensic psychology input, having heard nothing.

3.14.11 On 12th January 2001, the forensic psychologist sent out an appointment to DN for the 24th January, which he did not attend.

(It appears that the forensic psychologist had not been told of the initial request for a forensic psychologist, and picked the referral up very quickly once she received the request direct from psychiatrist 5 .She said that she had not been part of the initial request for forensic input. She indicated that it was clear that on paper DN was high risk, and that forensic psychiatrist 1 agreed.)

3.14.12 On 16th January 2001 DN's mother saw DN's GP and reported that he was in a poor state.

3.14.13 On 17th January 2001 DN did not attend the medication clinic or appointment with CPN 2, who attempted to contact him by telephone but received no answer.

3.14.14 On 19th January 2001, DN attended at Collingwood Court, but declined his medication. He was apparently concerned about an application he had made for benefits. CPN 2 noted that his mental state appeared stable.

3.14.15 On 22nd January 2001 DN saw his GP who noted that he had stopped his medication, and was feeling better. He did not want to go on with any medication. He said he felt psychiatrist 5 did not listen to him, and did not believe him.

3.14.16 On 24th January 2001, DN attended an appointment with CPN 2. He appeared to be in a hurry. He stated he was stopping all his medication and declined to discuss the matter. There was no evidence of deterioration in his mental state. CPN 2 informed psychiatrist 5. This was also the date of DN's first arranged appointment with the forensic psychologist, which he did not attend.

3.14.17 On 31st January 2001, DN attended for an appointment with CPN 2. He reported no adverse effects from the lack of medication. He denied any distressing thoughts or dreams. He denied the use of illicit drugs.

3.14.18 Also on 31st January 2001 DN was seen again by psychiatrist 5. Having stopped his medication he reported that he felt better. He had been discharged from partial hospitalisation because of failure to attend the programme there. He reported that he was not drinking alcohol or using drugs.

DN did not mention any violent thoughts or images. There appear to have been no incidents in which he had engaged in stalking behaviour. He was due to be seen by the psychology department in the near future.

This was DN's last psychiatric outpatient appointment prior to his arrest for murder.

(There are no recorded symptoms of schizophrenia or other psychosis. From the information recorded there was no reason to alter the previous diagnosis of personality disorder. All of the elements of the discharge plan were in place but DN had by then

been discharged from partial hospitalisation. However psychiatric outpatient appointments, CPN contact, the drug and alcohol service and the forensic psychology service were all still part of the plan and available.

By the time of the last outpatient appointment DN had stopped all of his medication and subjectively and objectively seemed better.)

3.14.19 Also on 31st January DN was reviewed by CPN 1 (from the drug and alcohol service). He informed CPN 1 that he had ceased his medication, that he was not on any illicit drugs and was not associating with people who used them. He said he was spending time at home with his girlfriend, family and friends, and remained anxious about going out. He had no thoughts or urges to harm anyone although he still had violent images. His mood was reported as normal. A further appointment was offered.

(His mother and step father told the panel that as soon as DN was discharged he went back onto drugs and alcohol and to his old associates, who were in the flat for most of the time with himself and his girlfriend. CPN 2 said that DN had specifically told him he did not want his family approached or involved after discharge. There was no social worker involved. CPN 2 said it would not have been possible to visit DN at home, because of the risks involved. The home circumstances were therefore never assessed, and his mother and stepfather did not report their concerns to anyone.)

3.14.20 On 2nd February 2001 DN failed to attend another appointment with the Forensic Psychologist.

3.14.21 On 8th February 2001 DN attended for what was to be his last appointment with CPN 2. He was again in a hurry, was anxious about his benefit claim, denied any intrusive or violent thoughts and appeared relaxed with no evidence of any deterioration in his mental state. A further appointment was made for the 20th February, which he did not keep.

3.14.22 On 9th February 2001 DN attended his first and only appointment with the forensic psychologist, who noted a very violent history and made a further appointment, which DN did not attend.

(Both psychiatrist 5, consultant in charge of DN, and forensic psychiatrist 1 considered that DN needed forensic psychological treatment to address his abnormal thoughts.

The forensic psychologist told the panel that there was no evidence of mental illness, but that he was clearly high risk and a strategy was needed because of concerns about substance abuse

and disengagement. She indicated that her view might have been that he should have been a forensic case. The panel took this to mean that he should have been followed up by forensic psychiatry, rather than admitted to a forensic bed. There was never any indication he could or should have been sectioned, and forensic inpatient care was all in secure conditions. The forensic psychologist said that there was an inadequate amount of information about DN's forensic history, and that because DN had been discharged from Collingwood Court she did not have access to full information about him. She did not see the care plan.)

3.14.23 On 13th February 2001, DN missed an appointment with the forensic psychologist.

3.14.24 On 14th February 2001, DN missed an appointment with CPN 1.

3.14.25 On 15th February 2001 DN missed an appointment with CPN 2 but the appointment was rearranged.

3.14.26 On 20th February 2001 DN missed another appointment with CPN 2, who tried to contact him by telephone, and notified psychiatrist 5.

(CPN 2 told the panel that there was no contingency plan in place, and that he had not made contact with DN's GP.)

3.14.27 On 23rd February 2001 DN missed another appointment with the forensic psychologist. She followed this up on 26th February 2001 with a letter to psychiatrist 5, in which she confirmed that both she and forensic psychiatrist 1 felt it would be beneficial to meet with the adult team to discuss DN's future management, that she would support forensic psychiatrist 1's offer of attending a CPA (Care Programme Approach) meeting and that she would speak to CPN 2 about DN's failure to attend. The forensic psychologist then spoke to CPN 2, and it was agreed the matter should be raised at a CPA meeting.

3.14.28 On the same date, 26th February 2001, forensic psychiatrist 1 telephoned CPN 2, and was told by him that there had been no problems, although DN had stopped his medication with no reported ill effects. He told forensic psychiatrist 1 that forensic's contact was no longer needed. Forensic psychiatrist 1 confirmed she would attend a CPA.

(There appears to have been something of a misapprehension by CPN 2 about the level of risk perceived by forensic and general adult services. It is clear that although the forensic service declined to take DN on as one of their cases, they nevertheless regarded him as at high risk of violence. CPN 2 in his evidence to the panel

however commented that forensic psychiatry regarded DN as 'not too dangerous', and he stated that he himself did not regard DN as more dangerous than many people he had dealt with in his professional role, who also had a history of violence. He was not prepared to visit DN at home, without extra male support, because of his history of violence. He told the panel that there was no-one available to accompany him. However he did in fact go to the flat and leave a note on 1st March 2001.)

3.14.29 On 1st March 2001, CPN 2 attempted to contact DN by telephone. On receiving no reply, he left a note at DN's address.

3.14.30 On 4th March 2001 DN was arrested for a serious assault on Mr David Huitson.

3.14.31 On 6th March, Mr Huitson died and DN was charged with murder.

3.15 Subsequent events

3.15.1 DN was remanded in custody, and later, in September 2001, tried and convicted, having pleaded not guilty to murder. He pleaded self-defence.

3.15.2 While in prison after conviction DN was subject to further psychiatric assessment and as a result was transferred to a high security hospital with a diagnosis of schizophrenia.

(Note: There has been a considerable amount of information forthcoming since conviction, some of which has been used by the panel to try to throw light on previous events, or on biographical details.)

3.15.3 The Newcastle, North Tyneside and Northumberland Mental Health NHS Trust instigated an internal enquiry to which the panel has had access.

3.15.4 A letter was written from prison by DN containing threats which were indirectly but clearly addressed to the family of Mr. David Huitson.

4 History of involvement with the criminal justice services (forensic history)

4.1 As has been previously noted, following conviction for the murder of Mr D Huitson, DN gave information about a very large number of violent offences which he had committed and which were undetected. The extent and detail are however impossible to verify and he himself has stated that his own account is not always reliable.

4.2 DN's first recorded offence took place when he was about 15. He was convicted in March 1995 (aged 16) of trespassing on land with an imitation/replica firearm and received a conditional discharge.

(It is suggested that in this case, DN knew the witness, that the witness was related to a person between whom and DN there was ill feeling, that DN frightened this witness badly, and that he (the witness) was related to one or more of the victims of some of his future offences.)

4.3 In December 1994 the next offence was committed - assault occasioning actual bodily harm (AOBH) (Section 47 Offences against the Person Act 1861) - for which he was convicted and given a conditional discharge on 21st July 1995.

(This case involved an assault against a 16 year old boy, whose brother was known to DN. There was some sort of vendetta against these boys (one of whom may have been the witness in the imitation firearm case referred to above) and DN stalked and attacked the 16 year old.)

4.4 In January 1995 aged 16, DN committed two further offences, jointly charged and recorded as his third offence, again of Section 47 assault occasioning actual bodily harm, and threatening unlawful violence under Section 3 Public Order Act. He was convicted in August and September 1995 and on September 29th 1995 received two concurrent supervision orders each of one year.

(In respect of this Section 47 assault, DN attacked a person who he claimed had regularly threatened him when they were younger. In respect of the Public Order offence, he informed probation that he became involved when he was told that two youths had attacked his brother. The records appear to indicate that these two matters took place at different times and did not involve the same persons, but this is not entirely clear.)

4.5 On June 7th 1996 DN committed his next offence, of assault occasioning grievous bodily harm, under Section 20 Offences against the Person Act 1861. He was sentenced on 6th November 1996 to a combination of probation and 100 hours community service.

(Subsequently the combination order was revoked as DN was unable to complete the community service, and a further probation order was made. This offence was the most serious to date, in which DN severely assaulted the aunt of one or possibly two of his earlier victims. He beat the victim with a wooden fence post causing serious injuries to her head and body, and the panel is given to understand that she suffered serious psychological problems as a result, in addition to her physical injuries. DN told probation that he was provoked by her, and that there was a history of antagonism between them because of the earlier incident involving her nephews.)

4.6 The next offence committed on 29th November 1996 was of criminal damage to a car, for which DN was given a conditional discharge and compensation order in January 1997.

4.7 On 31st March 1997 DN committed the further offences of assault occasioning grievous bodily harm and criminal damage. He was convicted of these together with the offence of intimidating a witness committed on 12.8.97 and on 31st January 1998 received total concurrent sentences of custody of 8 months in a Young Offenders' Institute.

(The injured parties in this collection of serious offences were RH, a friend of Mr David Huitson's daughter C, whom DN assaulted with a ball pin hammer; Mr Huitson, whose car was then damaged by DN and his mother; and RH and C whom he subsequently threatened.

The panel has been told that the original charge was Section 18 Offences against the Person Act, but that the charge was reduced to Section 20, assault occasioning grievous bodily harm, to which eventually DN pleaded guilty.

It is clear that from the date of the original incident in March 1997, DN bore a grudge against the Huitson family. The panel has been told that the family endured intermittent further intimidation from DN up until the date of the murder of Mr Huitson – and, indirectly, afterwards.)

4.8 Subsequent to this period of custody, there were four further recorded offences, two of which involved theft. The other, and last, two were possession of an offensive weapon, and threatening violence contrary to Section 3 of the Public Order Act for which he received a one year probation order on 23rd June 1999.

(In relation to the offensive weapon charge, there is some evidence in the files that there was bad blood between DN and the complainant. The complainant was an in-law of an ex girlfriend of DN, whose relationship had allegedly finished while DN was in prison. He was put on probation. It is not clear whether the public order offence was proceeded with.)

4.9 On 4th March 2001, DN was arrested for an assault upon David Huitson.

4.10 On 6th March 2001 David Huitson died and DN was charged with his murder. He was convicted of murder on 5th September 2001 and sentenced to life imprisonment.

(DN gave himself up to the police very shortly after the offence, admitted the assault but claimed it was self-defence and that Mr Huitson had attacked him (DN) with a knife. He continued to plead not guilty to murder. He was convicted of murder. Subsequently he admitted to his probation officer that the assault had not been committed in self-defence and that he had carried the knife himself and the motive for the offence had been revenge. David Huitson had been involved as the owner of the car which DN had damaged in the incident in March 1997 and had been prepared to give evidence against him. Mr Huitson's daughter C, who had been known to RH, the victim of the assault in March 1997 had also been prepared to give evidence against him and DN had threatened both C and RH in August 1997, which had led to an additional conviction for intimidation of a witness. The family believed that DN continued to use intimidating tactics against them, particularly in their view in March each year, other than the year of his imprisonment (1998). Subsequent to his conviction, DN admitted writing a letter, to which the panel had access through the police, addressed to another local family, which contained clear threats against the Huitson family and others.)

4.11 General comment on forensic history

It is clear that a large number of the violent offences for which DN was convicted arose from vendettas and grievances. This confirms the generally held view that DN moved in a culture of violence and revenge.

5 Viewpoint of the victim's family

5.1 The panel met the victim's family twice, once at the beginning and once at the end of the inquiry process, and talked to them in detail about their perception of events. Their full cooperation with the inquiry process was much appreciated.

5.2 The family was keenly aware of DN's hostility towards them, following the victim and his daughter giving evidence against him in 1997. They noted that DN targeted them particularly each March (1999 and 2000 – in March 1998 DN was detained in a Young Offenders' Institution), the anniversary of the family having been witnesses to the offences of GBH and criminal damage, referred to in section 4 of this report. They described his behaviour towards them as a vendetta. The family said that they had not seen DN for a long time before the murder although they remembered Mr Huitson receiving a threatening phone call and being worried that he had seen DN near his daughter's flat.

5.3 The family had not been aware that DN had been admitted to a high security hospital, although the victim's daughter had heard rumours about this. They would have welcomed contact with the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust after the murder, and would have been happy to provide relevant information. Following DN's conviction the family continues to be very concerned about the possibility of his eventual release from prison with the potential for renewed threatening or actual violence towards them. Their fears have been considerably heightened by the knowledge of the letter DN had sent from prison, the substance of which they were made aware of by the police.

6 Viewpoint of the patient and the patient's family

Note: The panel was aware that DN denied the offence of murder, and pleaded self-defence throughout the trial. Later, after conviction, he admitted his guilt. The panel was also advised by the high security hospital that DN had admitted to exaggerating his accounts of violence towards his girlfriend. His own account of events may not be reliable. The panel decided, nonetheless, that reference should be made to DN's views about his care and treatment, as well as to those of his mother and step-father.

6.1 DN, his mother and step-father co-operated in providing information to the inquiry. They provided detailed information about DN's history and the care and treatment he received.

6.2 DN's mother and step-father said that DN had enjoyed junior school and done well there. They traced the start of his problems to the period when they married and his step-father brought his older sons to live with them, which they thought may have made DN feel that he had been pushed out. Serious problems began when DN was about fifteen by which time he was consuming large quantities of alcohol. After DN left home he kept in close touch with his family, visiting frequently.

6.3 DN could recall the names of a number of his probation officers. He had found alcohol awareness groups run by probation helpful. He remembered being on probation again for a year from June 1999, but not the reason for this.

6.4 DN had particularly positive memories of the treatment which he received for anxiety from a very experienced consultant psychologist (the clinical psychologist) at the Young People's Unit in 1997 when he was eighteen, which continued until he received a custodial sentence in January 1998. DN continued to use the techniques he learnt from the clinical psychologist and appreciated his concern. DN said that he attempted to contact him when he came out of the Young Offenders' Institution but was told that he would have to be referred to the adult mental health service.

6.5 DN's mother and step-father encouraged him to see his doctor when he needed to and commended the quality of service provided by the GP practice. DN confirmed his appreciation of the service provided by his GPs, including the help received from a member of the practice in January 2000 following his discharge from hospital.

6.6 DN's mother and step-father had concerns about the more extreme symptoms which DN displayed before he was admitted to hospital in November 2000. They were aware of his fears of harming people close to him (which DN confirmed), including his girlfriend and his grandfather. DN said that his urges to harm other people were prompted by hearing voices, but that he had chosen to describe these as 'thoughts' to psychiatrists and nurses. This was because he wished to avoid being diagnosed with schizophrenia, with its connotations of dangerousness to those close to him. DN's admission to hospital in November 2000 was prompted by DN's report that he had overdosed on the diazepam. DN and his mother were critical about the psychiatrist who had prescribed diazepam for him (on 8.11.2000) as DN had said that he was self-medicating on the drug and feeling suicidal.

6.7 DN remembered the ward staff who looked after him following his admission in November 2000 positively, in particular the nurses who spent time with him talking through his problems. DN said that psychiatrist 5 at the hospital was the first doctor to whom he described his intrusive thoughts as voices, which he claimed to have been hearing since he was fifteen. DN's mother met psychiatrist 5 at the hospital. She recalled his discussing the threat she was under from DN, and his saying that he had doubted that DN was hearing voices. DN's mother also recalled that DN was under pressure from his girlfriend to return to their flat, while he was in hospital. DN's mother thought that DN became disillusioned about his treatment in hospital, and felt that he was not getting the help he needed because the psychiatrist did not believe DN's description of his symptoms. Much later DN's mother learnt about DN's accounts of stalking people at that time, and this made her think that he should have been compulsorily detained in hospital.

6.8 DN considered that the professionals involved in his after care package were attempting to meet his needs. He said that he was disappointed when he saw psychiatrist 5 following an alleged second suicide attempt, and when he considered himself a danger to himself and to others, that he was not readmitted to hospital or offered further treatment. He said that after this he stopped taking his depot injection (see glossary), which made him feel

better, but only for a short time. DN acknowledged that he was using drugs heavily in the period after his discharge from hospital, and that he did not want his family to be aware of the extent of this. Both DN and his step-father considered that a lot of his problems then were caused by DN's drug use, and had been for a long time.

6.9 DN told CPN 2, whom he recalled seeing infrequently, not to visit or contact his family. He did not want his drug use to be discussed. DN did not remember being followed up by CPN 2 although he did recall being phoned by Outpatients about an appointment for his injection.

6.10 Although DN's mother had psychiatrist 5's phone number and knew she could arrange to see him if need be, both she and DN's step-father felt somewhat unsupported after DN's discharge from hospital. They were concerned about his drug use and the company he was keeping.

7 Quality and scope of his health care and treatment and the assessment and management of risk

7.1 NHS Mental health care and treatment is provided for patients via services organised into primary, secondary and tertiary levels. Primary care includes general practitioners and related professionals, who deal with the vast majority of patients who have mental health and related problems. Secondary services include local hospital and community services, usually co-ordinated and led by general adult psychiatric specialists, who care for the bulk of patients requiring more specialist care than that which can be provided by GPs alone. These secondary services include inpatient facilities in local psychiatric units as well as a range of community based facilities in clinics, day hospitals etc. A tiny proportion of patients under the care of the secondary services are referred for highly specialised care and treatment to tertiary level services, which are often organised on a regional basis, providing a service to a large geographical catchment area.

7.2 In the case of DN, primary care services were provided to him by his GPs practice. This GP service referred him on several occasions for more specialist psychiatric care to the secondary services provided from St Nicholas Hospital in Newcastle by the general adult psychiatric services and related services such as the substance misuse service. The relevant tertiary level service, to which DN was referred some months before the murder, was the regional adult forensic psychiatric service based at St Nicholas Hospital in Newcastle. In addition to the above services, DN had also been referred to the Young People's Unit and the Kolvin Unit when he was a teenager.

7.3 The standard of quality for health care provided by doctors is laid down by the General Medical Council. Standards include:

- An adequate assessment of the patient's conditions, based on the history and clinical signs and, if necessary, an appropriate examination.
- Providing or arranging investigations or treatment where necessary.
- Taking suitable and prompt action when necessary.
- Referring the patient to another practitioner, when indicated.

Guidelines also state that in providing care a doctor must:

- recognise and work within the limits of one's professional competence
- be willing to consult colleagues
- be competent when making diagnoses and when giving or arranging treatment
- keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- keep colleagues well informed when sharing the care of patients
- pay due regard to efficacy and the use of resources
- prescribe only the treatment, drugs or appliances that serve the patients needs

7.4 In considering the quality and scope of the health care and treatment provided to DN, the panel specifically analysed the significant contacts with adult psychiatrists, looking in particular at:

- how promptly DN was seen following referral
- what sources of information were available to the assessing doctor e.g. referral letter, interview with DN, other third party information, previous records etc
- adequacy of history taking
- findings on mental state examination
- diagnosis or formulation of DN's case and the reasonableness of this in the light of the information available to the doctor
- treatment / management plan

- follow up arrangements
- contingency plans
- communication with referring agency

The details of the contacts and comments are included within the narrative in section 3.

The panel notes the following:

7.4.1 DN was never denied access to or excluded from care at any level. He was seen promptly on all occasions when he presented for help either to the primary care or emergency services or when referred to secondary or tertiary level services. It should also be noted that he often failed to keep appointments arranged for him.

7.4.2 All of the professional staff involved in his care were appropriately qualified and experienced for the role which they undertook.

7.4.3 In general, the professionals carried out assessments of DN to a satisfactory standard, some of them very good. They kept detailed and satisfactory notes and communicated appropriately with other colleagues and GPs. However some differences arose between professionals in forensic and general adult services (see below).

7.4.4 Throughout the assessment of DN prior to his arrest for murder, all of the psychiatrists and psychologists who saw him excluded schizophrenia or psychosis as a diagnosis. DN was seen as a complex man with a variety of behavioural problems and mental symptoms. These were felt to be due to underlying personality traits thought by some to amount to severe personality disorder. This diagnosis was reached during the earliest assessments of him by the clinical psychologist who saw him at the Young People's Unit, who also concluded that DN suffered severe reactive depressive episodes. DN's reported symptoms of anxiety, depression, paranoia and fantasies/urges about violence were all thought to be a product of his personality disorder, and complicated by his drug abuse. No diagnosis of schizophrenia was made until after he was imprisoned.

7.4.5 When questioned by the panel, all of the professionals (psychiatrists, psychologists and nursing staff), were prepared to accept the possibility that DN's complexity of symptoms and behaviours prior to the homicide might have been the early stages of schizophrenia which has only now manifested itself clearly after the homicide but they were dubious about this hypothesis.

7.4.6 DN himself told the panel, and has also told the professionals currently caring for him, that he deliberately concealed the symptoms of his schizophrenia from those who were trying to provide care for him in Newcastle because he was afraid of being "labelled" as a schizophrenic. Once again, this proposition was considered doubtful by all of the professionals from Newcastle seen by the panel. It is apparent that DN's own account is not wholly reliable. He has recently shown some acknowledgement of a propensity to inconsistency.

7.4.7 On each occasion that DN was seen by health care professionals, a package of treatment measures were offered to him which included a range of support in the community, medication, follow up appointments, and at one point, inpatient care at Collingwood Court. On discharge from the ward he was once again offered a package of aftercare measures to try to help him deal with his problems in the community. At no point did any of the professionals consider that DN was detainable under the Mental Health Act 1983 (sectionable). This was because DN accepted voluntary inpatient care and the treatment offered to him, and in those circumstances he would not have met the criteria for compulsory detention.

7.4.8 DN had a history of failing to comply with treatment offered and missing outpatient appointments. Some weeks prior to the murder he started disengaging once again from services, refusing his medication and declining further appointments. The health care professionals who had contact with him considered his mood to be improved and he reported that he felt much better.

7.4.9 The professionals who assessed DN noted that he had a long history of violence, often motivated by grudges against others, criminal convictions, drug abuse, general instability and a general lack of fellow-feeling, described in various notes as lack of empathy and/or callousness. These feelings were noted during the earliest psychological assessment of him years before the murder, and continued during his subsequent contact with helping agencies. The limited role which health services could fulfil was clearly noted by various professionals, in that much of DN's violence to others was part of an extreme sub-culture of violence unamenable to therapeutic intervention. The management plan at Collingwood Court included a range of therapeutic support but also included the possible need for police involvement if DN's behaviour became violent and warranted this. In other words, much of DN's violence to others was, for him, normal and professionals attempted to focus upon that which was treatable.

7.4.10 Risk assessments were comprehensively carried out at the various levels of healthcare provision. The final comprehensive assessment carried out by the forensic service did not identify any new issues which were unknown to the secondary level services. At that time DN was seen to represent a significant risk to other persons, and much less so to himself.

7.4.11 The panel concludes therefore, that overall the quality and scope of health care and treatment offered to DN was of a satisfactory standard, and that the risks which he posed to himself and in particular to others were correctly assessed. At the point of his discharge from hospital appropriate management plans were in place to focus upon those aspects of risk which were potentially treatable by the health services. On the basis of the information available to those at that time caring for him in Newcastle, the panel concludes that the diagnosis, treatment and management plan were appropriate. In particular the panel was impressed by the diligence shown by the responsible consultant psychiatrist 5 in dealing with DN's case. In the next section, comments are made about an alternative approach to the way that his specific treatment might have been coordinated and overseen.

7.4.12 The panel accepts that at no point was DN detainable under the Mental Health Act 1983.

8 The interface between mental health services, in particular adult psychiatry and forensic psychiatry

8.1 The role of the regional forensic psychiatry service is to provide specialised assessment, care and treatment to patients referred to this service usually from various parts of the criminal justice system such as the courts, prisons, probation etc. In general therefore, patients of the service have come before the courts for one reason or another. The service provides both secure inpatient care and community care, the latter usually being for ex inpatients of the service, most of whom would remain in the community subject to some form of statutory enforceable treatment and supervision such as an ongoing Mental Health Act order, parole or probation licence. The forensic psychiatry service also fulfils a liaison role to the secondary general adult psychiatric services throughout the northern region. This service involves assessment and advice about risk which patients pose to others, and treatment and clinical management plans. The ongoing treatment is usually continued by the general adult services with the option of further forensic opinion and advice as needed. The patient in these cases remains the responsibility of the general adult psychiatry services.

8.2 In a small number of cases however, the forensic psychiatry service will assume joint responsibility for the patient, for example by providing a key worker usually from the community forensic psychiatric team. Sometimes, the forensic psychiatry service will take over full responsibility for the patient in the community, usually in circumstances where, without that forensic input, the patient would be unlikely to receive any care for whatever reason.

8.3 The regional forensic psychiatry service was not resourced or intended to provide a different or more intensive level of service to patients from Newcastle compared to that which they provide

to patients from other areas within the northern region. In other words, although geographically located in Newcastle, the service is not intended to provide a specific district service for Newcastle. This is a common way of organising forensic psychiatry services in the UK. It often leads however to an expectation on the part of local district psychiatrists that they ought to receive greater forensic input to their patients simply because of the geographical proximity of the regional service.

8.4 In the case of DN, the general adult services became increasingly concerned about the risk he might pose to others and referred him to the forensic service in Newcastle. The expectation of the general adult services was that because of the level of risk which DN posed to others, the responsibility for his care ought to be taken over entirely or in part by the forensic service. The assessment of risk provided by the forensic service was very comprehensive, as was the detailed advice and management plan recommended. The forensic service however did not offer to joint work or take over DN's care. This was on the basis that the general adult services could provide what DN required; that there was no need for inpatient care in the forensic service; that DN might well need crisis admission at some point and that no crisis admission beds existed in the forensic service; that the forensic service could not provide a different level of care for Newcastle residents; and that a change of clinical team at the point of discharge from Collingwood Court might be detrimental to DN's care. In evidence however the forensic service consultant, forensic psychiatrist 2, did accept that DN represented the extreme of a spectrum of risk to others which are seen by that service. The forensic psychologist, in evidence, said that she thought DN's care should have been taken over by that service.

8.5 The panel, while understanding the points of view of both the secondary (general adult) services and tertiary (forensic) services, takes the view that DN's care could, and should appropriately, have been taken over in whole or in part by the forensic service in order to oversee his community care. There was clearly no requirement for DN to receive inpatient care in the forensic service, nor was he detainable under the Mental Health Act 1983. Although it is likely that the forensic service treatment strategy would simply have continued along the lines which the service recommended to their general adult colleagues, forensic community workers would have been more experienced in dealing with the risks posed by DN. They would probably have been more tenacious in their attempts to keep him engaged in community follow up, because of the

different type of cases they deal with and the amount of time available to follow people up in the community. However the panel concludes that it is unlikely that even the forensic community service could have prevented DN from disengaging from treatment in the weeks prior to the murder. He was subject to none of the usual supervisory powers available to the forensic community service. The forensic community team would have had little prior opportunity to develop a therapeutic relationship with him, and his observed reluctance to engage with any service other than on his own terms made his compliance with after care less likely. In addition he would not have been subject to any statutory supervisory powers in the community to oblige him to comply with appointments.

8.6 At the time of the DN case, there was little interaction between the secondary and tertiary services outside of specific cases. The trust employed many locum consultant psychiatrists in the secondary service and there was less opportunity for working relationships to develop and be enhanced. The panel is pleased to note that currently the trust employs significantly greater numbers of substantive consultant psychiatrists and that there is now greater interaction between the secondary and tertiary services which can only lead to an improvement in the understanding of each services position by the other.

8.7 The panel received advice about the development of the community forensic team in the two years following DN's arrest. The panel heard that the forensic community team had gained experience in working with clients disengaging from mental health services and may be able to persevere for longer to encourage these people to resume contact. The team had the advantage of obtaining much more information about the background of patients, including their forensic history, than the adult psychiatric services and this provided a reliable basis for continuing contact. Although the forensic community team had no formal powers different from those available to the community mental health team, their links with the criminal justice services were considerably enhanced. Most patients were seen by the forensic team on home visits, and this aspect of the service was widely known. Where patients were considered to present a higher level of risk, joint home visits could be made. The forensic and community teams had developed more opportunities for considering and reviewing referrals and for developing communication systems. Another advantage was that multi-agency public protection panels (MAPPs) had now been introduced.

These have further increased the level of information available to the practitioners involved and have enhanced opportunities for interagency surveillance and intervention.

9 The effectiveness of inter-agency working, with particular reference to the sharing of information for the purpose of risk assessment

The importance of inter-agency co-ordination has been emphasised in numerous inquiry reports, particularly in the field of child protection. Emphasis has been placed on ensuring that recipients of services should have access to a full range of expertise from health, social services and other professionals; and also on the importance of ensuring effective communication between agencies to ensure optimal decision making and support.

In this section inter-agency work is defined as work between the health services, education, social services and the law enforcement agencies including the police and probation services.

9.1 There are no records of involvement by DN's family with social services. Education was the only service in contact with DN while he was at school. From 1995 until 2000 DN had almost continuous contact with criminal justice agencies, including periods when DN was supervised by probation, and a six-month period in a Young Offenders' Institution. From 1997 until February 2001 DN was in frequent contact with psychiatric and psychological services, including an extended period under the supervision of the Young People's Unit in 1997 / 98 and a series of referrals to adult psychiatry between 1998 and 2000. For the period when DN had contact with both the criminal justice services and psychological and psychiatric services from 1997 onwards, relatively few significant contacts between them are recorded.

9.2 DN's school reports record that he made positive progress at junior school and there were no problems which would have required inter-agency involvement. By contrast, DN's secondary school career was turbulent, including a number of assaults on teachers, expulsions, and referral to a unit specialising in behavioural problems. These issues were dealt with by the Education Service without reference to social services or specialist health services. There are no records of multi-agency case conferences during this period.

9.3 Probation records include a number of references to psychological support and to the need for psychiatric intervention. DN had sustained support from the Young People's Unit for much of 1997, a year in which he was subject to probation supervision. One of the probation officers who knew him well wrote a pre-sentence report in January 1998 in which he referred to the support of the Young People's Unit and commented that a custodial sentence would jeopardise his continuing psychological treatment; probation would continue to liaise with the psychological services if DN remained in the community. DN received a custodial sentence and was released on licence to the Probation Service at the end of June 1998. His probation officer recorded on 10.09.98 that she was worried about DN's mental health and his prospects. She wrote to his GP on 14.09.98, referring to the fact that DN had stopped taking medication (for anxiety and depression) while in custody and expressing concern about his feelings of unrest and unhappiness. The letter referred to DN drinking alcohol to excess and suggesting that a further referral to the mental health services might be appropriate. Following receipt of the letter the GP practice wrote to the forensic adolescent psychiatry service at Newcastle General Hospital on 16.09.98 making clear reference to the probation officer's concerns. The letter requested that an appointment be made to see DN, and the forensic adolescent psychiatry service wrote to DN on 20.09.98 offering him an appointment, which DN did not keep, on 7.10.98. The period of supervision under licence ended in October 1998.

9.4 In June 1999 the same probation officer prepared a pre-sentence report which acknowledged that DN was in touch with his GP regarding panic attacks. The report anticipated that a Probation Order was likely to be made and that the focus of work would include liaison with the psychiatric services. The twelve-month Probation Order was subsequently dealt with by duty officers. There is no evidence that contacts with the adult psychiatric services were established, and little evidence of any structured plan of work

during the following months. There is no reference in the probation records to the series of DN's referrals to adult psychiatry in July and September 1999 and again in February 2000. The Probation Order ended in June 2000 and there were no subsequent links between probation and the psychiatric services in the period up to March 2001.

9.5 On admission to Collingwood Court psychiatrist 5, obtained a standard sheet of information (dated 15.11.2000) from Northumbria Police containing brief details about DN's charges and convictions going back to 1995. He considered the contents significant, and had not expected any more from the police. With hindsight, it appears that an opportunity for discussion about DN's forensic history at that point between the police and the hospital would have been helpful.

9.6 Psychiatrist 5 told the panel that he attempted to obtain the records from the Young People's Unit when DN was admitted to Collingwood Court in November 2001. His reasons for needing access to these records were questioned and he only obtained them after a delay of several weeks. The psychiatrist 5 told the panel that had he been aware of the content of these records he would have argued even more strenuously for DN's case to have been taken over by the forensic psychiatric service. It appears that the forensic psychologist who eventually saw DN in February 2001 had not seen the records from the Young Persons' Unit or from the Kolvin Unit, and was not aware of the treatment provided to DN in 1997 / 8 by the clinical psychologist at the Young Persons' Unit.

9.7 Following DN's discharge from Collingwood Court on 14.12.2000 CPN 2 who had responsibility for the community mental health team took on the role of DN's key worker. Although other specialist Health professionals were involved in the care package which was put in place when he was discharged, there was no social work contribution and no contact with either police or probation.

9.8 Although the community mental health team frequently supervised patients in contact with the criminal justice services, there are indications that the CMHT's links with police and probation were not well developed. The panel received evidence from probation officers that relations with the adult psychiatric services were not as well developed as those with forensic psychiatry. Evidence received by the panel was that if the forensic team had been responsible for managing DN's care at the time he started to disengage from the after care package (ceasing to take

medication and failing appointments) it would have been more likely that an inter-agency strategy meeting, including the police would have been called, as indicated in the care plan. The forensic psychiatry team was aware that there was a police liaison officer at police headquarters who could have been consulted, taking account of the known risk of violence from DN. The panel's view is that it is doubtful that the involvement of other agencies would have altered the eventual tragic outcome. The police could have concluded that they had insufficient evidence of recent criminal activity to have intervened; and the probation service, who no longer had any formal responsibility for DN, might not have had the resources to become reinvolved. Nonetheless, had the forensic psychiatric services been more involved, inter-agency contact at this stage would have been more likely and would have been appropriate.

9.9 CPN 2 who became DN's key worker in December 2000 was in charge of a team of nurses and mental health social workers. He was the only person able and willing to take on responsibility for DN at that time and he advised the panel that there was no mental health social worker available to take on this role. CPN 2 considered that the skills of the psychiatric nurse and social worker members of his team were virtually identical. However, given that social work is a discrete discipline, with its own specialized training, it could be that social work involvement from the time of the CPA meeting on 11.12.2000 would have added a valuable additional dimension. A social work perspective could have emphasised the importance of addressing DN's problem in the context of his family and social networks and attached added importance to establishing links with DN's mother and stepfather. What is clear is that these issues were not explored, as there was no social services involvement with DN at this stage.

9.10 Summary

The criminal justice agencies (probation and police) and the psychiatric services both had significant levels of engagement with and responsibility for DN and these responsibilities overlapped between 1997 and 2000. Although the court was advised (in a pre-sentence report) in June 1999 that probation would seek to strengthen its liaison with the psychiatric services, this did not happen and opportunities for information sharing were not developed. Social services were not involved with DN at all before his arrest in March 2001. DN was no longer under the supervision of the probation service after June 2000 and there are no records

of his being the subject of criminal investigations by the police. The psychiatric services had no obvious point of contact with the law enforcement agencies from the autumn of 2000 and no advice was sought from the police about his supervision. The CPA meeting in December 2000 was attended only by health professionals. There are no records indicating significant levels of communication between the criminal justice agencies and the psychiatric services and no evidence that a dialogue between the two was attempted. The panel learnt that DN's GP had had prior experience in London of close liaison with psychiatric services including regular meetings with a community psychiatric nurse and sometimes with a consultant. He had attempted to establish face-to-face contact between his practice and the health professionals at adult psychiatry, but had not managed to do this. Although it is not suggested that enhanced inter-agency communication would have prevented the eventual tragic outcome, opportunities were missed to share intelligence and perspectives between the two agencies which could have enhanced the quality of the public protection services in the period leading up to 7th March 2001.

10 The appropriateness of treatment, care or supervision

10.1 Care Programme Approach (CPA)

10.1.1 In 1990 the Department of Health issued guidance (HC(90)23) on an approach “To provide a network of Care in the Community”, for people with severe mental illness, which would minimise the risk that they lose contact with services. The Heath of the Nation key area handbook for mental illness refined the original guidance stating that CPA involves:

- a systematic assessment of health and social care needs of the service user, with particular regard as to whether the service user has severe and enduring mental illness
- drawing up of a package of care agreed with members of the multi-disciplinary team, GPs, service users and their carers
- nomination of a key worker to keep in close contact with the service user
- regular review and monitoring of the service user's needs and the progress of the delivery of the care programme

10.1.2 In November 1999 "Effective Care Co-ordination in Mental Health Services” was published. It complemented the National Service Framework – Mental Health, and was designed to ensure consistency across the country. It introduced some key changes and reinforced previous good practice. The key changes were:

- a secondary service which combined health and social care
- integration of CPA with care management
- two levels of CPA – standard and enhanced
- single access to the service
- a single care planning process including review and risk management

- a named care co-ordinator for each person on CPA
- use of the framework of care planning regardless of the setting
- single information and audit requirements
- supporting the user and the user's carers

10.2 Pre-admission

10.2.1 Prior to DN's admission and from the initial contact he had with adult psychiatric services, he had been seen and assessed by a single practitioner, a doctor. DN's care and treatment was discussed with him and communicated to the GP in writing. The speed of assessment following referral was commendable and the outcome of the appointments described fully in letters. The GP seen by the panel confirmed that the service provided by the mental health trust was of a high standard.

10.2.2 On each of these occasions the doctors involved did not consider the necessity of a multi-disciplinary approach which would have been required for an individual with a severe and enduring mental illness. DN was however correctly registered on the CPA database as being in contact with specialist mental health services.

10.2.3 At the time of DN's admission the trust had not revised the procedures to reflect the 1999 guidance and documents still used terminology from the original policy.

10.2.4 Whilst noting this the panel recognised that, given that the position of DN was that of an inpatient about to be discharged from hospital, the process adopted was not diminished by the failure to fully incorporate the new guidance. This provided greater clarity about the position of those people under the care of secondary mental health services (health and social care) in other care settings.

10.3 Assessment

10.3.1 A systematic assessment would be expected on admission and this would take the form of gathering information available from previous records and other agencies, carrying out tests and investigations judged necessary, undertaking an appraisal of the individual's problems from the different perspectives of a

multi-disciplinary team and referring for specialist advice if required.

Medical notes describe the request for EEG and a specialized brain scan as well as routine blood and urine tests, and there are clearly recorded medical and nursing assessments of DN's mental state. The forensic service was asked to see DN and forensic psychiatrist 1 provided a very thorough assessment, which was obviously used later by the adult team. Police checks were requested although the information provided was limited.

There was no specific occupational therapy input nor was a social work assessment carried out (the latter is dealt with elsewhere in the report). The family members were seen by members of the team but did not feel that they had the opportunity to provide a great deal of information nor that what they said was fully taken into account.

10.3.2 There would be an expectation that the CPA process included an opportunity for the information gathered to be presented to a multidisciplinary team who would use it to formulate a plan of care. The records would need to describe the outcome of the meetings, who was present and any significant information that was brought up at the time. The decisions made by the team should reflect the information gathered by them.

There are, for the most part, clear records of the meetings which took place on the ward during DN's admission. The panel heard from the ward manager that the chairing of the multi-disciplinary meetings by psychiatrist 5 was the most effective she had experienced. It was evident that individual contributions were actively sought and the nurses made clear that the information they had made from observations of DN on the ward were utilised at the meeting. It was, however, acknowledged that the lack of a psychologist was a deficit and the communication between the team and forensic psychiatrist 1 surrounding the multi-disciplinary meeting on 11 December 2002 was poor. Even accepting the difficulties between the forensic and adult services about responsibility, it was clear that forensic psychiatrist 1 had made a significant contribution in the form of her assessment and had asked to be kept informed of the progress of DN's care and to contribute to the ongoing evaluation of the treatment plan.

During the course of the admission, assessment and reassessment took place and plans were identified to establish security and safety. Observation levels were determined using agreed tools or checklists and contracts agreed with the client. These were recorded in the notes.

10.4 Care Plan

10.4.1 The care plan followed on the ward was to avoid situations that would arouse DN's aggression and to assess anxiety. The ward rounds and reviews, whilst DN was an inpatient, record the assessment of symptoms and the conclusion, consistent with previous assessments, of anxiety problems and possibly personality disorder. The content of the discharge care plan reflected these conclusions. Members of the team agreed the plan itself, and there is a record of forensic psychiatrist 1 seeing DN on 11 December, where he described to her his acceptance of this plan. Psychiatrist 5 recorded his discussion with DN and his mother concerning the care plan and discharge.

The care plan elements together with their rationale were each described in the notes and covered partial hospitalisation, community nursing contact, outpatient contact and drug and alcohol team involvement. Given the details obtained from current assessments carried out at the time, particularly by forensic psychiatrist 1, the conclusions reached during previous contacts as an outpatient and information from the Child and Adolescent Unit, a care plan addressing anxiety and personality problems is not surprising and quite reasonable. The specific needs that were identified related to DN's illicit drug use and anxiety together with thoughts of violence and sexual imagery. These were each covered within the plan.

The panel was aware of three particular considerations in constructing the plan. The first issue was the importance of forensic input which is dealt with elsewhere in this report. Secondly, there was the possibility of a referral to the assertive outreach team. The panel heard that at the time of DN's discharge the assertive outreach team was at an early stage in its development, without its own consultant, and would have been unlikely to have been able to take the referral. More importantly it was clear from the operational policy of the team that DN's identified problems would not have met the eligibility criteria. At the time he was not refusing contact or treatment and there was no history of either intense or unsuccessful attempts to maintain engagement. Also, he was not considered as suffering from a severe and enduring mental illness.

The third issue was the involvement of psychology. The care plan included the need for cognitive therapy, but this had not commenced at the time of discharge. The notes record that a

psychologist in the adult service would supervise CPN 2 who explained to the panel that he was able to provide cognitive interventions. (No cognitive therapy was in fact undertaken.) However, there had been a delay in picking up the referral (made at the same time as the referral to forensic psychiatry) by psychiatrist 5 for direct input from the forensic psychology Department. Psychiatrist 5 followed this up himself on 11th January 2001 with the forensic psychologist, who had not been passed the referral and who then arranged an early appointment for DN. DN failed to attend for the first two appointments. He only in fact attended one.

There appeared to be no resource issue to compromise the care plan and it was comprehensive in nature. In the course of the clinical psychologist's evidence to the panel the importance of providing continuity and consistency with DN was highlighted and it could therefore be suggested that the care plan was fragmented and unlikely to succeed. The panel took the view that whilst the work the clinical psychologist had carried out clearly had a profound impact on DN, and it therefore made sense to try and replicate the arrangements, the adult service could not be criticised for establishing a wide ranging care programme that encompassed the specialist services and inputs that were available to them locally. In fact it was felt that the team should be commended for an inclusive approach that is generally accepted as good practice.

10.4.2 The decision about who to appoint as care coordinator is important and the most appropriate person to undertake the role may be influenced by a number of factors e.g. gender, the skills of particular clinicians, the availability of staff etc. It was made clear to the panel that CPN 2 was very experienced and felt able to undertake the work necessary with DN and indeed described having had experience of working with people who had similar problems over a number of years. CPN 2 considered the supervision arrangements provided for him were satisfactory and although his role encompassed team management as well as direct clinical work he did not describe any difficulties with work load that might have compromised his ability to deliver the agreed plan.

It was evident that the professionals involved in DN's care were aware of the care plan contents and the identity of the care co-ordinator.

10.5 Risk Assessments

10.5.1 Assessments of risk were carried out at frequent intervals starting from 8 November when psychiatrist 4 described DN's previous history of violence as well as the issues of self-harm. Thereafter there are assessments of risk, the first using the Newcastle City Health NHS Trust CPA Assessment Form on 13 November 2000.

A risk management plan was put into place on 19 November including assessment by a forensic psychiatrist; an acceptance by DN of responsibility to inform staff of any intention to act on his fantasies; and an agreement to avoid videos or TV programmes that might act to stimulate these fantasies and to remain abstinent from drugs and alcohol. It was further identified that observations be made every fifteen minutes.

Forensic psychiatrist 1's risk assessment identified DN's history of violence from childhood into early adulthood and the high risk of future violence given his life style. It identified two types of violence, one that was part of his lifestyle, which was not considered amenable to psychiatric interventions. It was noted that the anxiety disorder could fuel his predisposition to violence and make him more dangerous and that this second type of violence was amenable to treatment.

The misuse of drugs and alcohol was also considered a further risk of triggering violence and it was noted that DN would need continuing work in this area was made.

Finally forensic psychiatrist 1 described the intrusive images experienced by DN, which DN was able to reject, avoiding harm to potential victims. The approach to minimise the risk was described. This specified maintaining the low dose Depot medication, monitoring DN for substance misuse by breath tests and urine samples and working along cognitive lines to address intrusive thoughts with a nurse therapist or a community psychiatric nurse.

All these areas of risk and actions to address them were covered within the care plan, together with recognition that the family was particularly vulnerable. They were spoken to by staff about the risks that they faced from DN and given advice on what to do should they arise. Psychiatrist 6 completed a further risk assessment form on 14 December, identifying that the risk of self-harm or suicidal behaviour was no longer considered current but that the risk of violence remained.

It was considered by the panel therefore that the assessment of risk was comprehensive and the actions necessary clearly identified.

10.5.2 The implementation of the plan required co-ordination by CPN 2. A care co-ordinator or key worker is an important element of the care programme approach. This individual is expected to:

- maintain contact with the patient
- monitor whether the agreed health and social care has been and continues to be provided
- advise professional colleagues of any changes in the patient's circumstances that may require review and modification of the care programme
- ensure that the patient and carer know how to contact the key worker and other professionals involved in their case
- keep the GP informed of the patient's circumstances

It was clear from the evidence heard by the inquiry panel that both forensic psychiatrist 1 and the forensic psychologist felt that communication with them was lacking and only arose when they actively sought information rather than through a process of being informed of what was taking place. Both forensic psychiatrist 1 and the forensic psychologist felt that if they had been aware of the pattern of disengagement and of the decision to stop taking all medication they would have felt this was more significant than did the adult team. Against this the panel had to balance the views of the adult team that their approach with DN was based on the belief that compliance with the plan was largely dependent on his own motivation. The panel also had to keep in mind that the forensic service had not considered it appropriate to take on the case. It was also clear that DN's pattern of use of service was to disengage when it suited him and in his evidence to the panel CPN 2 made it clear that his response to DN's failures to attend and rearranging appointments was in the light of this previous history.

The first CPA review was to be held three months after DN's discharge. This was considered by the panel to be too long given his history and the risks identified. It is also inconsistent with the CPA level assigned.

Whilst the care plan was clear, the actions to be taken when the plan failed or in the light of disengagement were not specified. The panel heard from CPN 2 that it was agreed that he would talk to psychiatrist 5 in the event of the plan not being adhered to but there was no clarity about what would follow. There is a need for

a contingency plan to be established, particularly at the highest CPA level and its absence was a weakness in the care provided.

11 The extent to which his care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies

As to Department of Health guidance and local operational policies, see elsewhere in this report.

The Mental Health Act 1983 and the Code of Practice

11.1 The Mental Health Act 1983 (the Act) imposes a statutory framework for the compulsory detention of persons suffering from a mental disorder. The Code of Practice published by the Department of Health and the Welsh Office in conjunction with the Act contains guidance as to its implementation.

11.2 Part three of the Act deals with patients concerned in criminal proceedings or under sentence. Prior to the murder, DN was not subject to any criminal proceedings or sentence and this part would not at that time have been relevant.

11.3 Sections 2 and 3 of the Act set out the circumstances in which a patient may be compulsorily detained in hospital where no criminal offence has been committed. A crucial element is the willingness of the patient to stay and to receive treatment.

11.4 The imposition of compulsory detention under Sections 2 and 3 of the Act is only used where no other treatment option is available.

11.5 The panel considered whether the criteria for detention had been satisfied and whether DN should have been compulsorily detained. The consensus of all the medical and nursing personnel who had dealt with DN from his first involvement with the services up to the date of the murder was that the statutory criteria for detention were not met in his case. The reasons given were that at no time was DN thought to be suffering from a mental disorder or illness that would have made it appropriate to detain him in hospital for assessment or treatment. There were two issues here; first the symptoms he presented with, which were not thought to be indicative of psychotic or severe mental illness, and secondly, at the time when he was considered to need hospital treatment, the fact that he was willing to accept what was offered. Subsequent to having ceased his medication, when he had started to withdraw from elements of the care package, he was reviewed and his mental state would not have warranted compulsory measures.

11.6 The panel considered in this context whether the medical and nursing personnel had complied with their statutory obligations under the Act and was satisfied that they had.

12 Recommendations

The panel considers that it would have been appropriate for DN's care to be taken over by the forensic community service, and that there were problems of lack of communication, and a lack of understanding, between the adult and the regional forensic services. The panel has noted that steps have already been taken to remedy these deficiencies.

Recommendation 1

That the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust continues to strengthen the interface between general adult mental health services and regional forensic psychiatry services. This is already happening through more frequent meetings between the relevant senior clinicians.
The forensic psychiatry services could also help the general adult services by helping the development of local protocols for liaison between general adult services and criminal justice agencies, specifically the probation service and the police. These protocols should assist appropriate information sharing between relevant agencies.

The panel was concerned that records and notes from the adolescent service were not made available as a matter of priority to the adult service.

Recommendation 2

That the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust should ensure that robust mechanisms are in place to facilitate ready access to a patient's previous clinical records by the clinical team currently treating the patient.

Despite the considerable involvement of the criminal justice agencies, which overlapped with psychiatric services between 1997 and 2000, there was little dialogue between them, and opportunities for vital information sharing were not promoted.

Additionally opportunities to involve other disciplines including social work in the care plan were not fully explored.

Recommendation 3

That the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust and the Northumbria Probation Service should review liaison arrangements between the two services, taking account of developments since the arrest of DN, and establish protocols for joint working to ensure effective communication and information sharing; and should review existing liaison between adult psychiatry and the police and probation services, and firm up these arrangements where need be, building on the stronger links with these services already developed by forensic psychiatry.

Recommendation 4

That the Newcastle North Tyneside and Northumberland Mental Health NHS Trust should review arrangements for the support and supervision of potentially dangerous patients to ensure that inter-agency expertise, including the expertise of mental health social workers and the criminal justice agencies, is available to provide the most effective support to patients, their families and the wider community.

DN's risk assessment clearly identified continued drinking and use of illegal drugs as increasing the risk of violence. The panel heard accounts that DN had commenced drinking and using drugs almost immediately he returned home. The care co-ordinator informed the panel that he had not undertaken a home assessment or a home visit, as he did not think it was necessary. Additionally, that DN had specifically asked not to be visited at home, and that the care co-ordinator should not contact his family. The issue of safety when visiting alone was also raised although the panel was aware that he did call and leave a card when DN had not attended appointments with him.

Recommendation 5

That the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust should review its procedures to ensure that for a patient on enhanced CPA a full assessment of her / his social circumstances is carried out by appropriate professionals, and that these are reassessed on discharge.

During the course of the panel's enquiries it heard from the community forensic team that home visits that were considered to present a risk would take place with two members of staff. Within the general adult team this was more difficult to arrange. There was some uncertainty as to whether or not CPN 2 considered a home visit necessary but nevertheless there was some concern about the ability to undertake such a home assessment given the nature of the staffing.

Recommendation 6

That the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust should make explicit arrangements for staff to undertake home visits in safety and security with the appropriate policies to support this activity clearly understood.

It is important to make explicit the actions to be carried out by the clinicians described as contributing to an agreed care plan. The communication between these professionals is critical and the role of the care co-ordinator in ensuring that this takes place is key.

Recommendation 7

That the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust should ensure that its guidance on the role of the care co-ordinator is being followed in relation to communication between professionals.

The panel noted that the care plan was not specific about the actions to be taken if the plan failed or if the patient disengaged. DN was placed at the highest level of CPA and there should have been a clear contingency plan.

Recommendation 8

The requirement of a contingency plan is in the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust's new CPA procedures and this should be audited to ensure that required actions by professionals following disengagement by patients are thoroughly implemented.

The delay in the referral reaching the forensic psychology department was regrettable and arose through an ambiguity in the organisation that places the forensic psychology service as a separate and discrete department within the forensic unit. The expectation of a referral to the forensic service for clinical psychology via the forensic psychiatrist was reasonable but not appropriate in this case.

Recommendation 9

The arrangements for securing the input of clinical psychology from the forensic service should be made clear and explicit to the referrer from general adult services.

13 Concluding remarks

13.1 Throughout DN's history of involvement with the psychiatric services, the panel found many examples of good practice. There was a consistent willingness to help a difficult, complex and dangerous man, many of whose problems were not amenable to therapeutic intervention.

13.2 In particular, the panel commends the care given by the general practitioners, the prompt response to referrals, the quality of assessment by the psychiatrists, and the nursing care provided on the ward.

13.3 Despite the fact that there are lessons to be learned in terms of future care of similar patients, the panel is of the view that, unless DN had actually been deprived of his liberty (and there were no grounds to do that under the Mental Health Act), it is hard to see how different treatment or care could have prevented the offence of murder from taking place.

14 Glossary

Affective disorder

Another term for a mood disorder such as depression.

Anger management

Anger management is a specific strategy of treatment which aims to help the patient to overcome feelings of anger by training themselves to recognise situations where anger is likely to arise and dealing with the anger in a constructive way.

Antisocial personality disorder

In this type of personality disorder, the most prominent feature is a marked disharmony between the person's attitudes, beliefs and behaviours and the prevailing social norms. Such persons generally have a callous disregard for the feelings of others, a readiness to be violent and break the law, a general lack of stability in their lives, and a self-centredness and a difficulty in learning from past experiences.

Anxiety / panic attacks

Anxiety is a mood state in which the predominant mood is one of fear. Again, anxiety can range from mild (experienced by most people at some point) to severe. If the anxiety is accompanied by an over-whelming desire to get away from a particular situation, then it is termed a panic attack.

Assertive outreach

An active form of treatment delivery: the service can be taken to the service users rather than expecting them to attend for treatment. Care and support may be offered in the service user's home or some other community setting, at times suited to the service user, rather than focused on service provider's convenience.

Care coordinator

A worker with responsibility for co-ordinating CPA reviews for mental health users with complex needs and for communicating with others involved in the service user's care.

Care planning

The task of developing a plan to detail the aims of interventions, special areas of need or risk, who will do what to achieve the agreed outcomes and who will monitor and review the arrangements.

Care programme approach (CPA)

The care programme approach provides a framework for care co-ordination of service users under specialist mental health services. The main elements are a care co-ordinator, a written care plan and, at higher levels, regular reviews by the multidisciplinary health team and integration with the social services care management system.

Clinical psychologist

A clinical psychologist is a non-medical therapist who is trained and qualified to provide a range of treatments which can broadly be termed "talking treatment".

CPN

Community psychiatric nurses (CPN) have traditionally been associated with the follow-up and after care of people with mental health problems, maintaining contact with people in the community and carrying out tasks such as the administration of Depot medication, and co-ordinating and implementing programmes for care.

Conduct disorder

A behavioural disorder of childhood or adolescence which may be the forerunner of a personality disorder manifesting in adulthood.

Delusions

Delusions are fixed, false and bizarre beliefs, which are not amenable to reason and which are out of keeping with the person's social, cultural and religious background.

Depot injection

A depot injection is anti-psychotic medication which is usually in an oil based form and is injected intramuscularly for long acting use. Depending on the drug, the intervals between the injections could be anything from one week to one month.

Depression

Depression is an abnormal mood state in which the predominant mood is one of sadness. Depression can range in severity from mild (experienced by many people in the community) to severe.

Drug-induced psychosis

Psychosis can also be brought about by the use of drugs.
When someone has a drug-induced psychosis, their mental state and behaviour may be indistinguishable from someone who has a mental illness not related to drugs, such as schizophrenia.

Dual diagnosis

This term refers to patients who suffer from two major psychiatric conditions such as, for example, mental illness and personality disorder (including psychopathic disorder), or mental illness and substance misuse.

General adult psychiatry/forensic psychiatry

The term general adult psychiatry is used as a generic term to describe a range of mental health services which addresses the needs of the vast majority of patients who require psychiatric care either in the community or in hospital. Patients who are thought to represent a significant risk to others or who are prisoners are often referred to the forensic psychiatry services.

Hallucinations – auditory and visual

An hallucination is a perception with a stimulus. For example, the sufferer sees (visual) or hears (auditory) things which are not there.

Paranoia

A general term describing a morbid sense of being unreasonably mistreated by others.

Paranoid personality disorder

In this type of personality disorder, the most notable abnormality is that the person has a pervasive sense of mistrust of others.

Personality disorder

Personality disorders, as distinct from mental illnesses, are diagnosed on the basis of patterns of behaviour which are entrenched, displayed from a fairly early age, found in a wide range of personal and social situations, recognisable by others as the habitual way in which the person behaves, inflexible and maladaptive and which cause harm either to the person themselves or others or both. Although everyone has a personality of some kind and may have aspects (traits) of their personality which causes them or others problems now and then, a personality disordered person has such an inflexible way of thinking, feeling and perceiving their world that it can be said the balance of their personality characteristics or traits is abnormal. Persons with a personality disorder may also develop mental illness at some point. Personality disorders come in various types depending upon the predominant abnormality of the personality.

Prescribed and non prescribed drugs

Prescribed drugs are those which are legally prescribed by a medical practitioner. Some patients abuse such drugs, particularly those which are prescribed for psychiatric problems, and also painkillers. They may be abused in a similar way to non prescribed drugs which are the controlled drugs of abuse such as cannabis, stimulant drugs such as amphetamines and ecstasy, and opiates such as heroin and methadone etc. etc.

Pseudohallucinations

A mental symptom in which the sufferer typically hears voices which seem to be within his own head, as distinct from hallucinations proper where the voices are located in external space.

Psychosis

The term psychosis is used to describe an abnormal state of mind in which the person has lost contact with their understanding of reality and cannot distinguish what is real from their own inner mental experiences. The term is a general one and can be brought about by a range of mental illnesses such as schizophrenia or severe depression.

Risk assessment

The likelihood, high or low, that somebody or something will be harmed by a hazard multiplied by the severity of the potential harm.

Schizophrenia

Schizophrenia is a severe form of mental illness. The diagnosis centres around the patient experiencing a variety of bizarre beliefs or experiences which they believe to be real. Patients with other mental conditions or who abuse drugs can also experience similar symptoms and the diagnosis is often not clear-cut, particularly in the early stages.

Secure hospital/special hospital

Psychiatric inpatient care is provided in a range of inpatient units with varying levels of security, ranging from a locked door on a ward, through to the high level of security provided in Special hospitals which provide care for patients who are a grave and immediate danger to the public at large.

Senior House Officer/Registrar/Specialist Registrar

These are training grade doctors, the senior house officer (SHO) being the most junior grade; the specialist registrar in the final years of training before becoming a consultant.

Northumberland, Tyne and Wear NHS

Strategic Health Authority

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