A SUMMARY OF THE REPORT OF THE LUKE WARM LUKE MENTAL HEALTH INQUIRY

Presented to the Chairman of
Lambeth, Southwark & Lewisham Health Authority
13 November 1998

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EXECUTIVE SUMMARY

1. Background

Michael Folkes was born in south London in July 1962. In April 1986 he was convicted on four charges of wounding and assault and, following a hospital order, admitted to the Denis Hill Unit at the Bethlem Royal Hospital, Beckenham.

He was treated for his psychiatric illness both in and out of hospital over the period up until 4 October 1994.

There were two periods of discharge in the community. The first, from 9 March 1992 to 3 January 1993, ended after he seriously assaulted a security guard at a LEB depot. The second, which began on 20 June 1993, ended on 4 October 1994 when he stabbed to death a friend, Susan Milner, at his home in Herne Hill. At this time he was known as Luke Warm Luke, having changed his name by deed poll.

Mr Luke was convicted of manslaughter at the Central Criminal Court in April 1995 and ordered to be detained for treatment at Broadmoor Hospital without limit of time. He remains a patient there today.

An internal inquiry into the incident was made by the Bethlem and Maudsley NHS Trust in 1994. Lambeth, Southwark & Lewisham Health Authority commissioned, on behalf of The Secretary of State, an independent inquiry in October 1995 chaired by Patricia Scotland QC (now Baroness Scotland of Asthal QC). The other members of the panel were Dr Helen Kelly MB BCh MRCPsych and Manny Devaux JP.

The inquiry was set up under Health Service Guidelines HSG (94) 27 which say "in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved."

The terms of reference of the inquiry are set out in full in the report. Broadly they covered the circumstances surrounding the treatment and care of Mr Luke Warm Luke as both an inpatient and an outpatient at the Bethlem & Maudsley Trust.

This document is a summary of the full report, produced by Lambeth, Southwark and Lewisham Health Authority.

2. The chronology

24 April 1986 – Michael Folkes admitted to Denis Hill Unit.

29 April 1986 – During a visit from his mother, to her surprise a nurse called him Luke. He said it was his name according to the Bible.

21 June 1986 – Two days after his medication was discontinued for a trial period, he assaulted a patient causing severe bruising and broken nose.

30 June 1986 Assaulted another patient.

24 July 1986 – Absconded while on escorted ground leave. Returned by police two days later.

24 August 1986 – Absconded again from unescorted leave.

12 September 1986 – Mrs Folkes reported to the DHU that Michael had visited her at work, unkempt and wild, with kitchen knife down his trousers, demanding money.

1 October 1986 – Mrs Folkes reported that Michael had assaulted his father. By his father's wish he was not charged.

3 October 1986 – Order under s37 of the Mental Health Act expired, Michael discharged in his absence.

20 October 1986 – Arrested for the robbery at knife point of a taxi driver of £15, five gold rings and a bracelet. Charged and remanded in custody.

28 January 1986 – Assessed by a forensic psychiatrist Dr Pamela Taylor who described him as 'an extremely dangerous man', advising he should be treated in a Special Hospital.

8 May 1987 – After conviction for the robbery, committed to Park Lane Hospital in Liverpool under s37/41 of the Mental Health Act with unlimited powers of restriction. He remained there until April 1990.

24 April 1990 – Transferred from Park Lane Hospital to Denis Hill Unit on trial leave under care of Dr James MacKeith as Responsible Medical Officer. Home Secretary consented to full transfer to DHU on 2 November 1990.

6 August 1990 – Depot medication discontinued. No medication until March 1991.

5 February 1991 – Psychotic material in speech during interview.

19 February 1991 – Assaulted a patient after misunderstanding that a game was being played.

4 April 1991- Mental Health Review Tribunal refused to discharge him.

20 January 1992 – Mental Health Review Tribunal discharged Michael Folkes subject to conditions, but deferred actual discharge.

9 March 1992 – First conditional discharge began. Left DHU to live at Effra Road hostel.

6 April 1992 – Mrs Folkes told DHU that Michael had threatened to kill her, was verbally abusive and smoking drugs. Conclusions of Dr Riley on 16 April and Dr MacKeith on 30 April: no relapse and no cause for concern.

Early June 1992 – Michael discontinued medication. No medication taken thereafter until readmitted in January 1993.

30 July 1992 – Moved into Lambeth Housing flat in Herne Hill. Flat structurally sound but squalid with no furniture except a mattress.

28 August 1992 – Mrs Folkes alleged that Michael was behaving in a threatening manner and smoking cannabis. Dr MacKeith and John Siderfin, Probation Officer, went to her house. During an argument with her husband, Mrs Folkes brandished a machete. Dr MacKeith and Mr Siderfin disbelieved her allegations. It was decided that Michael should have no further contact with his parents.

August – December 1992 – Each of six urine samples taken from Michael Folkes tested positive for cannabis.

15 September 1992 – Threatening behaviour by Michael to a fellow trainee at Brass Tacks.

22 September 1992 – Home Office added two further conditions to the discharge: 1. Not to go to his parents' address or approach his mother. 2. To accept testing for substance abuse when required by the RMO.

1 October 1992 – By deed poll Michael Folkes changed his name to Luke Warm Luke.

December 1992 – Luke's conduct at Brass Tacks deteriorated. In an interview with Dr MacKeith his speech showed "much manifestly psychotic material". Attempts to persuade him to resume medication were unsuccessful.

1 January 1993 – At LEB depot, Luke assaulted a security guard inflicting serious injury after the guard had said he could not recharge Luke's electricity key. Luke arrested. Guard did not press charges. Luke released and visited Maudsley Emergency Clinic on following day.

3 January 1993 – Dr MacKeith and police officers went to Luke's flat but could not gain admittance. Luke again went to the LEB depot where he was held by police and admitted to DHU under s2 MHA 1983. Later detained under s3 MHA 1983. During January "much more ill this time than before".

5 March 1993 – seen by Dr Horne from Broadmoor. Luke said that he was very scared of being readmitted to a Special Hospital. The threat and medication was thought to have improved his condition.

13 May 1993 – Mental Health Review Tribunal granted conditional discharge but deferred for Herne Hill flat to be decorated. Conditions included that he take his medication 'as directed by Dr MacKeith, RMO'.

10 June 1993 – This Ward Round was said to constitute the s117 meeting. Mr Siderfin (social supervisor) was not present because he had been asked at too short notice. There is no note of this s117 meeting other than in the ward round notes. Limited discharge plans included to administer depot at home fortnightly then monthly.

12 June 1993 Mr Luke left the DHU on leave. Returned to live at the Herne Hill flat, now redecorated and furnished. There followed six months of relative stability during which depot medication was taken regularly as prescribed.

31 August 1993 – Dr MacKeith's notes say Luke "wants oral medication – for review in future".

21 December 1993 – Luke told Dr MacKeith that he wanted "to come off depot onto oral medication."

18 January 1994 – depot medication discontinued. Luke was now prescribed self-administered oral medication – Stelazine. No prior notification to the Aftercare Team or the Home Office.

23 February 1994 – Luke showed Mr Siderfin a deed poll saying he had reverted to name of Michael Folkes.

30 April 1994 – Michael Folkes, his girlfriend and her parents flew to Miami, USA, to stay with the girlfriend's uncle and his wife for three weeks, but returned alone on 9/10 May.

5 July 1994 – Allegations made to Mr Siderfin by Mrs Folkes and Tony Folkes (Michael's brother) of threatening and/or violent behaviour by Michael. Mr Siderfin advised Michael to stay away from them.

6 – 22 July 1994 – Members of the Aftercare Team noticed unsettled or bizarre behaviour by Michael on a number of occasions.

22 July 1994 – In his Handover Notes, Dr MacKeith wrote that Michael/Luke's condition caused him some concern, and that there was a "possibility that he is relapsing."

30 August 1994 – Luke attended an appointment with Dr MacKeith at Maudsley outpatients. He said that sometimes he had been taking only one Stelazine tablet daily instead of two. He was exhorted to take the prescribed dose, but responded by saying that he wanted his medication reduced. Dr MacKeith said not so soon after recent problems. Dr MacKeith's impression was "no relapse". Also present was Dr Lawson who thought that Luke seemed to be on a fairly "even keel".

3 October 1994 – In the early afternoon, Luke went into the Maudsley outpatients department. He asked to see Dr MacKeith, but it was not the day of Dr MacKeith's clinic. He was agitated and sweating. The appointments staff had never seen him like that before. He made two telephone calls to the DSS, speaking in a loud voice and banging the phone down. The staff contacted Dr MacKeith's secretary, who contacted Dr MacKeith at Belmarsh Prison. Dr MacKeith was concerned that a significant relapse in his mental state had occurred, and asked that Luke be kept at the Maudsley. The Emergency Team, seeing Luke had quietened, did not stop him from leaving. When Dr MacKeith arrived home at about 6pm, he arranged that Sheryl Read (community psychiatric nurse) would visit Luke next day, accompanied by a male colleague for safety reasons.

At about 8.30 pm that evening, Mr Luke visited a friend, Miss O. In a statement to the police, Miss O said that in her flat, Luke became aggressive, took out a long pair of scissors and raised them above his head. He took property which was later found at his flat.

4 October 1994 – Miss Susan Milner, another friend of Mr Luke, visited him the same night at about 3 am with some food. She knocked and called to Mr Luke and he replied. Neighbours heard words spoken and the sound of a struggle.

At 3.15 am ambulance men went to the address. Miss Milner was lying on the grass outside the house with multiple stab wounds. Mr Luke was arrested and later charged.

At 5.01 am Ms Milner died in King's College Hospital. Mr Luke was arrested and charged. A urine sample taken at 8.30 am on 4 October was negative for cannabis, all other drugs and medication.

11 April 1995 – Mr Luke was convicted of manslaughter at the Central Criminal Court and ordered to be detained for treatment at Broadmoor Hospital under s37/41 MHA 1983 without limit of time.

3. The inquiry

The inquiry panel looked in detail at Luke Warm Luke's early life and admissions to hospital; at his three admissions to the Denis Hill unit and his two discharges; at the events preceding the killing of Susan Milner; at Mr Luke's experience with housing and daytime occupation; at the work of the aftercare team; the Home Office involvement; the medical records; the role of the forensic community psychiatric nurse; the probation service; social services and the police.

The panel also considered wider issues including the Mental Health Act 1983 and the role of tribunals of inquiry in homicide cases.

They comment in an Overview section on community care and supervision on issues to do with the aftercare team, the discharge plan and s117 meetings, housing, medication, the role of the hospital, compulsory treatment in the community and public perception.

In their **Foreword** to the report, the panel concentrate on the main issues and conclusions:

"There has been considerable criticism, much of it sensationalised and ill informed," the foreword begins, "of the policy of care in the community. Little is written about those forensic patients discharged into the community, during whose aftercare there is no occurrence of major violence or serious injury. There are about 2,700 restricted patients detained in hospital and the number of conditionally discharged patients under active supervision in the community is estimated at 1,200. Those who have treated, supervised and cared for those patients receive no public accolade and little, if any, recognition. On the other hand, those who have supervised or cared for a forensic patient during whose discharge there has occurred a homicide, are subject to the most rigorous scrutiny and, even where no fault is found, have a most uncomfortable time."

..."There is always a temptation for Inquiries such as this one to operate with the benefit of hindsight, which may permit that which was only a possibility at the time, to appear an inevitability. We have sought to address this potential problem by using the information which was available to practitioners at the time as the basis of our judgments. We take into account that Michael Folkes' case was one amongst many difficult cases and that the pressures inherent in the management of this case were not isolated but should be seen against the backcloth of the clinician's stressful caseload."

..."During this Inquiry some major themes have surfaced. Amongst the most important have been the continuing need for appropriate housing for vulnerable mentally disordered offenders, the importance and use of depot medication, the need for effective multi-agency working and the efficient flow of information and communication within the Aftercare team."

..."Each decision made in the care and treatment of a mentally disordered person involves risk. There is a risk inherent in the prescription of neuroleptic medication that it may cause damage to the basal ganglia and thus impair the patient's ability to function

in the long term. There is a risk that if given insufficient or no medication, the patient will suffer distressing psychotic episodes and may become a danger to himself or others. There is a risk that if the patient is detained in secure accommodation, there will be an unnecessary restriction on his freedom and, conversely, that if released without adequate resources and the necessary care and supervision to remain either symptom free or otherwise stable in the community, he will become a danger to the community around him. And so the list goes on.

"Every decision involves a balancing exercise. Sometimes clinicians will get that balance wrong, either by being too restrictive and conservative in the formation of the patient's treatment by the prescription of high doses of medication, or by being too permissive, leading to a deterioration in the patient's health. There are no simple answers. The complexity and the difficulty of the balancing exercise which clinicians have to make daily as the guardians of the patient's health and the public safety, should not be underestimated. Even the most eminent can be tested to the utmost of their skill, and occasionally fail."

..."This Inquiry, amongst other things, has highlighted the need for the provision of an out of hours duty team which would be available to support the Aftercare team's observations and management of patients during particular periods of difficulty in the community. Similarly, it has brought into sharp focus the importance of clinicians not being so overburdened that they do not have time for mature reflection or to foster appropriately strong links with their teams. The responsibility for ensuring that this takes place must rest with the Trust and the Health Authority. The Health Authority is entitled to expect that the services provided by Trusts will be delivered by clinicians who are properly resourced and supported so that they can provide the best quality of service to patients."

4. Criticisms of agencies

A number of critical comments are made by the panel. They draw attention to the 'striking similarity' between the attack carried out by Luke Warm Luke on the LEB security guard in January 1993, during his first discharge from the DHU, and the attack on Susan Milner that led to her death in October 1994.

In the periods leading up to both these events, the panel say that Mr Luke should have been readmitted to the DHU because he was showing signs of dangerousness.

They criticise the Aftercare Team of Dr MacKeith, Connor Kinsella (community psychiatric nurse) and John Siderfin (probation officer) for the level of aftercare planning, the lack of any written aftercare plan, poor risk assessment, failure to adopt the Care Programme Approach, the lack of a key worker, inadequate reports to the Home Office and inadequate inter-team liaison, communication and coordination, including the sentence: "Throughout the 25 months covered by both discharges, the three members of the Aftercare team did not meet once, all three together."

Mr Siderfin and Mr Kinsella met face to face for the first time only after the death of Susan Milner.

They also criticise the decision not to continue with depot medication for Mr Luke, pointing out that this medication was a major contributor to his stable condition for the first six months of his second discharge. The decision by Dr MacKeith to stop depot medication in January 1994 is described as follows: "This was an important decision in the care, treatment and supervision of the patient in the community. Indeed, it would be difficult to identify a more important decision. It meant that there would be a change to

the one feature of Luke's treatment which was responsible for Luke's steadiest six months in the community. The other members of the Aftercare Team, who also had responsibility for the supervision or care of the patient, should have been consulted, before any final decision was taken."

..."However, once notified of Dr MacKeith's reluctant agreement to the change to oral medication, each member of the team had the right to ask for...a meeting or initiate a discussion, thus the responsibility for this failure is joint."

The panel accept that Mr Luke wished to be taken off depot medication and that Dr MacKeith was responsible for directing his medication under the terms of the Mental Health Review Tribunal discharge arrangements. But they believe that the change from depot to oral medication was a fundamental change in Mr Luke's treatment. They say:

"If Dr MacKeith believed that it was unsafe for Luke to be trusted to administer his own medication, but that he had no option but to consent to it, he should have referred the matter to the Home Office, so that consideration could be given as to whether use should be made of the Secretary of State's power to recall him."

There is criticism of the fact that Luke was not found accommodation in a staffed hostel, rather than in a bedsit or flat, although it is acknowledged that considerable efforts were made to find him a hostel place, and eight such hostels rejected him.

However, the attack on the security guard at LEB was triggered by Mr Luke's belief that his electricity had failed because his key needed to be recharged, not because, as was the case, a previous tenant had not paid the bill. The panel say:

"On the 1st January 1993, at a time when he was known to the Aftercare Team to be mentally ill, Luke went to a LEB depot which was closed because of the Bank Holiday, and when told that this was not a place, even when it was open, where electricity keys were charged, he entered the depot without leave and assaulted one of the men employed to guard it. One conclusion is inescapable. Had Luke been living in a staffed hostel, this would not have happened."

Similarly, the panel report on the killing of Susan Milner during Mr Luke's second discharge, as follows:

"There appears to be little doubt that when Luke went to the Maudsley Out Patients Department, he was or was becoming mentally ill. In the early hours of the morning, he was in the flat at Herne Hill, when Ms Susan Milner visited him, and it was there, in the hall, porch, and in front of the house, that she received injuries from which later she died. There is no avoiding the thought that had Luke not been living independently in that flat, but had been living instead in a hostel with 24 hour supervision, Ms Milner would have been unlikely to have died as she did on the 4th October 1994."

5. Recommendations

The panel make a number of major recommendations, covering the following issues:

- involvement of social supervisor, CPN and family in discussions over treatment,
- attendance at and advice to Mental Health Review Tribunals,
- recording of hearings of MHRTs,

- attendance at s117 meetings and record keeping,
- aftercare planning, including the contents of an aftercare plan, handover procedures, crisis handling, housing and occupation,
- discharge and aftercare arrangements, including risk management, drug monitoring, recall options and the need for guidance from the Secretary of State,
- the need for appropriate supported housing, and the responsibility of the aftercare team in this respect,
- the need for appropriate occupational centres,
- the importance of listening to the family,
- the supervisory role of the Home Office and the duty of the clinical team to keep them informed,
- the need for training in mental health for probation staff,
- the importance of training and a recognised management structure for forensic community psychiatric nurses,
- the need to develop a specialist unit within the Police Service, and for FMEs assessing detained persons to have psychiatric experience,
- improvements to the way the Emergency Team at the Maudsley Hospital works,
- the importance of 24 hour emergency and community support,
- the need for the Care Programme Approach to be implemented and monitored by the Bethlem and Maudsley NHS Trust, with sufficient time given to RMOs to engage in peer group meetings. Lambeth, Southwark & Lewisham Health Authority's proposals for joint commissioning are commended,
- the importance of keeping medical notes properly,
- the need to keep the deceased victim's family informed of the progress of the investigation of the death and to assist them in their understanding of the criminal process, with the provision of someone to be available from the Trust to the family of the victim and the patient,
- the need for a new Commission on Inquiries and a handbook for those conducting such inquiries.

6. Submission of the report

The Report of the Luke Warm Luke Mental Health Inquiry was presented to the Chairman of Lambeth, Southwark & Lewisham Health Authority at their meeting on **Friday, 13 November 1998.**